

# **Doctors' moral beliefs and public policy**

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# Abstract

In this thesis, I address three related questions:

- First, suppose we legalise some controversial medical practice tomorrow. Should we respect the moral objections of those doctors who object to the practice? I argue that we should indeed respect those objections, and I provide two complementary reasons for doing so.
- Second, when the objections of doctors conflict with the interests of patients, how do we balance these two demands, and is there scope for compromise? I propose some criteria for resolving this conflict. I also suggest that the conventional compromise — compulsory referral — is morally problematic, and propose that the solution to this problem is to regard referral as ‘just another’ controversial medical practice.
- Third, in circumstances where prioritising patients’ interests means that we will eventually decide to overrule doctors’ moral objections, how might we expect doctors to respond to this, and is there anything we can do to reduce the harm to them? In my final chapter, I sketch some possible answers to this question.

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I'm grateful to the Hull York Medical School for its indirect financial support in the first two years of my studies, by offering a generous discount to PhD students who were also staff members. HYMS also allowed me to teach ethics to its undergraduates for six years, which was not only a lot of fun but also a source of many new insights. The students with whom I had illuminating discussions are far too many to list here (which is just as well, since I've forgotten most of their names) but their impact on my thinking collectively has been significant. Also, while I'm here, the heroic efforts of Laura Sadofsky to fit the square peg of my personal circumstances into the round hole of HYMS regulations are deserving of a special thank-you.

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Finally, there are two people who I honestly think can take the lion’s share of the credit for the next couple of hundred pages — not only because of their constant enthusiasm and support and badgering throughout the PhD itself, but also because of the enormous amount of themselves that they’ve dedicated over the past thirty-six years to making me into the kind of person who is even *able* to finish a PhD. In that context, dedicating the resulting thesis back to them seems a pretty insignificant gesture, but here it is.

To my parents: it’s both unnerving and deeply reassuring to realise how much of my life is following in your footsteps.

Toby Wardman  
December 2017

## **A note on pronouns**

An irritating fact about many languages, including English, is that there are no traditional first-person singular pronouns which don't impart gender. This is a stylistic headache. The problem is particularly acute when discussing hypothetical (or indeed real) individuals whose gender is genuinely irrelevant, especially members of professions such as medicine and nursing whose historical biases towards one gender or the other are still fresh in readers' minds. Unfortunately, extended discussions of multiple hypothetical individuals are a philosopher's stock in trade.

This forces us to choose between several unsatisfactory options:

- Just assume that everyone is a man. I trust the drawbacks of this option are obvious.
- Consistently use just one of the pronouns, either 'he/him' or 'she/her', but rule that this should always be interpreted as gender-neutral. This is unsatisfactory for several reasons, not least the fact that it shifts the burden of fixing the problem onto the reader, for whom the psychological task of shaking off all gender connotations can be distractingly difficult.
- Try to avoid personal pronouns altogether. Better writers may be able to cope with this, but I find it impossible to sustain without descending into stylistic awkwardness.
- Use 'they/them' as a gender-neutral personal pronoun. While this solves the problem of having to specify gender, it brings with it a whole new ambiguity between singular and plural. This is less of an issue in everyday language, where context can usually disambiguate, but in technical writing it quickly becomes unsustainable to use the same pronoun for not only every individual but also every group of more than one individual.
- Swap randomly between male and female pronouns as each new individual is introduced. This can be awkward in extended writing because it makes it hard to keep track of who is who, and generates confusion about whether referents are supposed to be the same or different.

In what follows, I have reluctantly settled on the last option on the list, in common with some other contemporary writers. The hypothetical characters I introduce each have a randomly assigned male or female gender. Where there is an extended parade of characters with the same gender within a single chapter, this is usually an attempt to avoid confusion or a distracting gender switch in the middle of an extended example. It's far from ideal, but at least this option means that my thesis is populated by a fairly random distribution of male and female doctors and patients — just like the real world.

## **A note on quotations**

Throughout my thesis, I have left untouched variations in spelling and vocabulary when I quote writers who use non-British varieties of English (except for correcting the odd typo here and there). On the other hand, I have silently omitted other authors' footnote and endnote indicators, and adjusted capitalisation without comment when necessary to fit with the flow of my own writing.

## **Author's declaration**

I confirm that this work is original and that if any passages or diagrams have been copied from academic papers, books, the internet or any other sources these are clearly identified by the use of quotation marks and the references are fully cited. I certify that, other than where indicated, this is my own work and does not breach the regulations of HYMS, the University of Hull or the University of York regarding plagiarism or academic conduct in examinations. I have read the HYMS Code of Practice on Academic Misconduct, and state that this piece of work is my own and does not contain any unacknowledged work from any other sources.



# Chapter 1: Introduction

In this introductory chapter, I lay the groundwork for what follows, describing the scope of my research and my broad approach, and attempting to answer some preliminary questions about definitions.

## I. Scope and definitions

Suppose we legalise some controversial medical practice tomorrow. Should we respect the moral objections of those doctors who object to the practice?

### *‘Controversial medical practice’*

Let’s define a clinical practice as ‘medical’ if it generally requires the participation of a doctor. This rough definition will do for my purposes, since I take it that there is general agreement that the kinds of practices I’ll be discussing are indeed obviously medical (examples follow shortly).<sup>1</sup>

When I talk about a *controversial* medical practice, I mean any medical practice which is legally permitted, but to which at least some doctors have a moral objection.

Some things are unexpectedly excluded by this definition. One example is practices that engender a degree of moral debate in society at large, or some parts of it, but rarely or never give rise to moral objections specifically from *doctors*. Child vaccination or (perhaps) emergency blood transfusion might fit into this category. Such practices might fairly be called ‘controversial’ in everyday discourse, but not for me: my specific focus is on practices

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<sup>1</sup> Consideration of practices for which there is no such agreement, such as capital punishment (which by statute requires the participation of a doctor in some US states but not others), exposes a need to sharpen up the definition. Several possible ways to do so are discussed by Lerman (2007, especially pp.1950-1953). Capital punishment is outside the scope of my thesis, though I will have a little more to say about possible analogies between capital punishment and more unambiguously medical procedures later in this chapter.

where there is controversy within the medical profession itself. If a controversy lies entirely or almost entirely outside of the profession, the issue is beyond the scope of my study.

I call a practice controversial if ‘at least some’ doctors have a moral objection, but as a lower limit, this is both vague and undemanding. Fovargue & Neal (2015) point out that problems only arise when a medical practice lies in the liminal zone between ‘somewhat controversial’ and ‘somewhat acceptable’: if a practice is clearly acceptable, then individual refusals are just “abuses of power” (Frader & Bosk, 2009), while if it is clearly *unacceptable*, then individual refusals are unnecessary. So, is a procedure controversial if one in a hundred doctors find it objectionable? One in a million? Just one, full stop? I leave this open. My instinct is that the same moral difficulties arise when one doctor morally objects as when a million do; the only differences are in the practical urgency to solve the problem.<sup>2</sup> But I don’t need to defend this instinct here, because there’s no shortage of practices in contemporary medicine that everyone will agree are obviously controversial: examples include doctor-assisted dying, terminal sedation, abortion, withdrawing or withholding life-sustaining treatment, presumed consent for organ donation, or virtually any other hot topic in modern bioethics. At the time of writing, the British Medical Association’s website provides “ethical guidance” under 64 different headings, covering a wide range of controversial and ethically challenging medical procedures as well as practical issues faced by doctors.<sup>3</sup> These are, I think, quite enough to be going on with. I have no intention of enumerating an exhaustive list, or providing criteria for inclusion or exclusion.

It’s also interesting to note that, while many moral objections are to *permissive* laws which objectors judge to be morally reprehensible (e.g. abortion), some are to the law’s failure to permit something which objectors judge to be morally obligatory. Savulescu & Schuklenk (2017), for instance, report their strong moral objection to opt-in systems for organ donation, arguing that this is “tantamount to killing innocent people” (p.166).

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<sup>2</sup> The question of how much controversy is enough to make a practice count as ‘controversial’ is separate from the question of whether a certain threshold of controversy itself provides a reason for respecting objections to that practice. I consider the latter question at the start of chapter 2.

<sup>3</sup> The full list is at <http://bma.org.uk/practical-support-at-work/ethics/ethics-a-to-z>.

While some controversies seem perennial,<sup>4</sup> other items on the list of practices that count as controversial has varied over time. The list also varies across different national, cultural, religious and legal contexts. Some practices which have historically been considered controversial in the UK are nowadays less so: for instance, the ethical and legal status of voluntary contraceptive sterilisation was hotly debated during the 1960s (Lewis, 2011), but by the early twenty-first century the procedure was sufficiently well established for authors in the *British Medical Journal* to remark that “it might seem surprising that there should be any fundamental controversy” about it, provided the consenting patient is competent and well-informed (Benn & Lupton, 2005, p.1324).<sup>5</sup>

In the same way, tomorrow’s hot potatoes are likely to be different from today’s. In motivating philosophers’ interest in the subject, some writers suggest that ethical controversies are more common today than previously (Macklin, 1998; Genuis, 2006; Weinstock, 2014) — but, be that as it may, there has certainly never been an era in modern history when medical practice has been dilemma-free. New ethical controversies continually arise as scientific, technological and economic developments continue to offer new medical possibilities, change the availability of treatments, and confer a greater understanding of exactly what is involved in various procedures.

Changes in society can affect this, too. Future shifts in our attitudes towards general moral issues are likely to challenge some of today’s instances of ethical consensus in medicine, or to make some old controversies easier to resolve. For instance, conservative commentators in the mid-19th century objected to the use of pain relief during childbirth on the grounds that the pain of labour and delivery was intended as a punishment from God (Ashwell, 1848, p.291), but by the later Victorian era such objections had almost evaporated in the light of widespread acceptance of the medical use of anaesthesia, including by Queen

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<sup>4</sup> Ezekiel Emanuel (1994, p.793) draws intriguing historical parallels between the contemporary debate about doctor-assisted suicide and a similarly vigorous debate in both the UK and the US between 1870 and 1923, inspired by the development of anaesthesia. He also traces English literature’s first explicit reference to euthanasia to an arguably aspirational passage in More’s *Utopia* (1516).

<sup>5</sup> There is still plenty of debate about *involuntary* sterilisation (World Health Organisation, 2014).

Victoria and the daughter of the Archbishop of Canterbury (Goodman & Gilman, 1970, pp.44-45).<sup>6</sup>

Plenty has been said about past and current controversies, and no doubt plenty more remains to be said about current and future ones. But I don't intend to add to the literature on the ethics of any particular procedure. I want to remain neutral about the moral status of controversial practices themselves, beyond making the simple observation that they are, as a matter of fact, controversial. So I won't be presenting arguments on whether presumed consent for organ donation is morally acceptable, or whether abortion should be legal, or whether any particular objection to doctor-assisted suicide holds water. Rather, my interest is in *all* controversial medical practices, and specifically in how we should respond to doctors who hold moral objections to those practices when they become legal.

Broadly, this stance means that I will do no more than stand on the sidelines when the most significant round of moral debate — 'Does medical practice X have a morally justifiable place in our society?' — is played out in mainstream society. The first point at which I hope to make a contribution with this thesis is the point at which society has already taken a decision to legalise a given practice, and is then faced with the question of what allowances to make, if any, for those who find themselves on the wrong side of that decision because of their personal moral views. This obviously limits the usefulness of what I can say, but on the other hand, by talking about controversial practices in general, I hope that my work can remain relevant in the future, even when the details of *what* counts as controversial have changed.

Having said all that, it would be difficult to address my questions properly without at least some reference to specific controversial practices at various points in my thesis. This is for two reasons. Firstly, from a practical standpoint, it will be useful to be able to refer to examples simply to give some concrete weight to what would otherwise be an entirely abstract

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<sup>6</sup> There is also the related view, not necessarily based on religious beliefs, that pain relief during childbirth is morally undesirable because it deprives the mother of her meaningful experience of pain. Although this position is rarely adopted by (modern) doctors, it is still occasionally given by individual patients as a reason for declining pain relief. Morally-based refusal of treatment by patients is an interesting issue, but it's quite separate from my concern here.

discussion. Secondly, as I will argue later, the answer to my first question ('What allowances should we make for doctors who have moral objections to a controversial medical practice?') depends to some extent on the features of both the practice in question and the objections that are raised to it. For both these reasons, I will refer fairly frequently to practices that are currently controversial in the UK, and sometimes to practices which have historically been controversial, or which are controversial elsewhere in the world. But the purpose of looking closely at these controversies will be to try to draw out more general lessons about moral objections — not to try to make progress on the controversies themselves.

### *'Doctors'*

In my research questions, I specifically talk about the objections of *doctors*.<sup>7</sup>

Of course, it's not just doctors who may object to controversial medical procedures. Many other healthcare workers, and indeed many lay people (people who don't work in healthcare), also hold strong views about the moral status of controversial practices such as abortion, doctor-assisted suicide, organ donation and so on. By focusing on doctors, I don't mean to minimise the importance of non-medics' views. Nor do I mean to suggest that the fact of holding a medical qualification, or being involved in medical or health practice, makes a person's moral judgements more worth listening to than the judgements of others who may also have given the issues a lot of thought, such as nurses, care workers, religious people, philosophers or politicians.<sup>8</sup>

Instead, the reason I've chosen to focus on doctors' objections (apart from the obvious practical point that I have to focus on *something*) is that the question of how to handle those objections is particularly pressing. Any member of society may have qualms about a newly legalised medical procedure, but from the point of view of a society that wishes to make that

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<sup>7</sup> In accordance with British usage, I use 'doctors' to mean 'medical doctors'. The favoured word in the United States is 'physicians'. I treat the two terms as entirely equivalent, and quote sources using either term without comment.

<sup>8</sup> For an interesting entry point to the debate about who, if anyone, has expertise on questions of medical ethics, see Caplan (1989).

procedure available to patients, doctors' qualms present particular difficulties.<sup>9</sup> I've already said that it's definitionally true that doctors play an essential role in medical procedures, a role distinct from that of non-doctors, whether lay people or other healthcare workers. (For instance, one of the key components of doctor-assisted suicide is that a fatal combination of drugs is prescribed to the patient, and prescription of drugs is normally reserved to doctors.) Furthermore, doctors often have a higher level of responsibility in such procedures than their colleagues — not just participating in them, but also authorising them and taking buck-stops-here decisions about them. For all these reasons, when a doctor objects to a procedure, the impact on those around him or her can often be greater than when others object. The question of what to do about moral objections to controversial medical procedures is therefore more pressing with respect to doctors than with respect to most other members of society.

Having said that, it would be surprising if the considerations relevant to doctors' objections were entirely different from start to finish from those relevant to other people's objections in analogous situations. So it may well be the case that much of what I have to say about how we should respond to doctors has relevance to other healthcare professionals too. I don't intend my deliberate focus on doctors to exclude this possibility.

### *'Refuse to participate'*

My main concern throughout this thesis is with the objections which lead doctors to refuse to participate in a procedure. Although a straight-up refusal to participate is only one possible manifestation of a doctor's moral objection to a controversial medical procedure — others include over-treatment or treatment in contravention of expressed wishes (Shaw & Downie, 2014) — it's nonetheless the consequence which is most often addressed in legislation, regulation and scholarly work, perhaps because (as I discussed a moment ago) it has the most obvious potential for direct impact on society at large.

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<sup>9</sup> For instance, one reason why the American Medical Association (1993) prohibits its members from taking part in capital punishment is that it argues that, in jurisdictions where the law requires a doctor to participate in the practice, capital punishment itself would be rendered impossible if all doctors refused.

But what exactly does ‘participation’ encompass?<sup>10</sup> Doctors can be involved with medical procedures in many ways, quite apart from literally wielding the scalpel (phial, pen, whatever), which might also be worthy of consideration. For instance:

- A doctor may be expected to refer a patient to another provider for a procedure, or otherwise authorise that procedure.
- A doctor may be expected to play a supporting role in a procedure to allow or help it to go ahead, for instance by assuming a colleague’s responsibilities so that the colleague is freed up to perform the procedure, or by providing associated medical care and advice to the patient before and after the procedure itself.
- A doctor may be expected to discuss potential treatment with a patient, which may mean presenting such a discussion in neutral, supportive or encouraging terms.

Two interesting questions follow from this list:

1. **The definitional question:** When I say that my main concern is ‘refusal to participate’, how do I define ‘participate’? Which of the items on the list above count?
2. **The ethical question:** Setting aside the question of definition, suppose it turns out that we should indeed make allowances in some circumstances for doctors who refuse directly to carry out a procedure because of their moral objections. In this case, for which of the other items on the list (if any) would it follow that we should *also* make allowances for refusal?

Since my aim at this stage is only to specify the scope of my research questions, I’ll address the definitional question now and leave consideration of the much more interesting ethical

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<sup>10</sup> There is some interesting recent legal history around the definition of participation. In UK law, *Janaway v Salford Health Authority* (House of Lords, 1988) established that the right to refuse to participate in an abortion, enshrined in the Abortion Act 1967, extended only to “actually taking part in treatment designed to terminate a pregnancy” and not to associated activities, a legal principle echoed in the GMC’s guidance on the subject (General Medical Council, 2013b, legal annex). In April 2013, that principle was briefly brought into question when a Glasgow appeal court found in favour of two Catholic midwives who objected to being required to delegate, supervise or support staff involved in performing abortions (Howarth, 2013). The court’s ruling was overturned by the UK Supreme Court in December 2014, which ruled that ‘participation’ meant only “hands-on” participation, and added: “Parliament will not have had in mind [when making allowances for objections] the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital, the caterers who provide the patients with food and the cleaners who provide them with a safe and hygienic environment” (BBC News, 2014).

question for later chapters. And since I'm concerned purely with definitions, I can simply stipulate that by 'participation' in a procedure I mean any of the following:

- an act by which the procedure is carried out directly and intentionally (I use the term 'intentionally' to exclude loopholes where the actor has a causal role in a procedure without realising it);
- an act which intentionally assists, supervises, or contributes to the ability of someone to carry out the procedure;
- an act which intentionally causes the procedure to be carried out automatically. (I presume this criterion is intended simply to close a possible loophole created by the first two. For instance, without this criterion, a doctor might press a button to activate a machine which delivers a fatal injection to a patient, and then try to argue that this wouldn't strictly count as 'carrying out the procedure' himself because the machine administered the injection automatically.)

These are not my words. My definition is closely modelled on a broad definition laid out (independently) by the Council on Ethical and Judicial Affairs of the American Medical Association (1993), mirrored by the report of a British Medical Association working party (1992, pp.117-118 & 200),<sup>11</sup> drawing in turn on Rosner et al (1991). This definition was constructed in a different context: the context of capital punishment. Capital punishment is not my focus here, but since most professional medical associations assert that it is unethical for doctors to participate in executions (Sikora & Fleischman, 1999),<sup>12,13</sup> the same question naturally follows in that context too: what counts as participating? The list of specific acts

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<sup>11</sup> In what follows, I refer mostly to the AMA Council's report as it's slightly more recent, but the BMA's working party drew almost identical conclusions and the reports, which were developed cooperatively in parallel, cited one another extensively.

<sup>12</sup> See, for instance, World Medical Association (1981, amended 2008); British Medical Association (2001, p.170); American Medical Association (1993); International Conference on Islamic Medicine (1981, section 4). Despite this near-unanimity among professional medical associations, doctors do frequently play a role in executions, especially in the United States where the doctor's role is sanctioned or required by law in the majority of states that still execute prisoners (Groner, 2002). A survey of US physicians in 2001 found that only 3% knew that the American Medical Association had even issued a statement on the subject, never mind that it held a position that emphatically enjoined its members not to take part (Farber et al, 2001).

<sup>13</sup> I set aside the separate question of whether an execution is a medical procedure, a pseudo-medical procedure, or something else.

that arguably do and do not constitute a doctor's participation in an execution may not apply directly to other procedures, but it *is* still relevant to observe how the line has been drawn between acts that count as participating and those that don't.

The AMA Council's report defines 'participation' broadly:

1) an action which would directly cause the death of the condemned; 2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; 3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

(American Medical Association, 1993, p.368)

The clear intention of this broad definition is to rule *in* a range of acts which might otherwise be grey areas, so as to allow the AMA to take a fairly strong position against capital punishment broadly. According to this definition, actually administering a lethal injection of course counts as participating, but so does equipping or assisting someone else to do so; preparing the syringe; witnessing an execution in a professional capacity; being on hand to provide medical assistance; determining death as part of the process; even testifying in court as to the prisoner's physical fitness for a future execution, though the AMA's position here is more complex: in a series of clarificatory notes, the report *does* allow doctors to provide medical assistance to prisoners awaiting execution, including treating conditions which are linked to the impending execution, such as anxiety, on the basis that providing such treatment does not in itself cause harm. Doctors are also permitted to witness executions in a non-professional capacity, for instance at the request of the condemned person, as long as they don't assist with the execution process in any way.

This is a very broad definition of 'participation' — probably as broad as it can reasonably be. And I acknowledge that my adopting such a broad definition is, in a sense, controversial. As I'll discuss later in my thesis, acts like referral or supervision are often *not* included in legal or regulatory provisions which seek to exempt doctors from acting in violation of their moral beliefs with regard to certain medical procedures. That is to say, when a law or regulation permits doctors to refuse to perform a controversial procedure for moral reasons, they often do *not* permit them to refuse other kinds of involvement that my broad definition would count as participating (referring a patient for the procedure, providing associated care, or relieving a colleague, for instance). So my definition is out of step with the definition given in some legal and regulatory positions.

But there is a good reason for this, and it does not (I argue) amount to sneaking in a substantive claim through the back door. When I adopt a broad definition of ‘participation’, I don’t mean to say that any two acts which both count as participating in a controversial procedure (under my broad definition) are automatically morally equivalent. At this stage, I’m only answering the *definitional* question (‘which acts count as participating?’); I haven’t begun to address the *ethical* one (‘which acts ought doctors to be allowed to refuse on moral grounds?’). I’ve presented no argument to the effect that doctors ought to be allowed to refuse all acts that count as participation, or that we ought to make equal allowances for all such refusals, or anything along those lines. In fact, I don’t intend *any* ethical claim to follow simply from the broad definition of ‘participation’ that I’ve adopted.<sup>14</sup> I leave open (for now) the possibility that different kinds of participation in different procedures might have different moral significance.

Indeed, one important practical motivation for me in using such a broad definition is to allow for exactly this discussion further down the line. At this stage, I don’t want to rule out by stipulation something which it might turn out should be included. For instance, if I defined ‘participation’ more narrowly so that it referred only to directly carrying out a procedure, this would preclude consideration of the act of referring a patient to another doctor for the procedure. But (legal provisions notwithstanding) many writers and practitioners do in fact want to consider whether the act of referral might carry the same moral culpability; I quote many of them in chapter 6, where I discuss this issue in detail. It would seem odd to rule out the entire discussion ahead of time simply by stipulating that only directly performing a procedure is of interest to me because (in many cases) the law has decided that only that counts as ‘participating’. Instead, at this stage I want to give a broad definition that allows for such discussions, and deliberately leave open the question of whether everything that falls under that definition is of equal moral significance, or equally deserving of accommodation. In other words, I want to be free to deploy ethical arguments to challenge the legal status quo.

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<sup>14</sup> To add to the complexity here, I admit that the AMA’s report *does* make that claim in the context of capital punishment. In fact, it approaches the argument from the opposite direction, by starting with the premise that doctors’ participation in capital punishment is always wrong and then seeking to draw the boundaries of what counts as participation in such a way as to include everything that it thinks is wrong and exclude everything else (1993, p.365).

## *'Conscience' and 'conscientious objection'*

Many of the writers I quote throughout my thesis make broad use of the terms 'conscience' and 'conscientious objection' to describe objections which are based on an individual's moral beliefs.

As ever in analytic philosophy, neither of these terms is without its complications. For a start, the question of exactly what 'conscience' *is*, metaphysically speaking, has no widely accepted answer. Some influential attempts to derive definitions of 'conscience' in the context of healthcare include those by Sulmasy (2017, 2008) and Childress (1997), and more generally Fuss (1973). Following McLeod (2012), Chloë FitzGerald expresses what she calls the 'dominant view' in bioethics:

Our conscience is an inner voice that signals to us when we are in danger of disrupting our psychological unity by an action, or when we have already performed an action that has disrupted our psychological unity.

(FitzGerald, 2014, p.26)

But there is an ontological ambiguity here, namely about whether the conscience is a specific faculty, as religious accounts seem to suggest (Lawrence & Curlin, 2007), or simply a label for the set of our moral beliefs which motivates us to act in particular ways. This doubt is unfortunate, because the important practical question of whether a particular objection counts as a *conscientious* objection might therefore seem to be a question about whether a given act falls into a particular ontological category, when in fact what's really at issue from a practical perspective is not a question of ontological status but simply whether a person's objection is motivated by her moral beliefs or by a motivation such as self-interest, obedience to authority, or what-have-you:

To avoid misleading reification, it may be best to avoid references to 'the conscience' altogether. [...] To make headway in relation to this issue, the focus should be on *claims of conscience*, and it is not particularly helpful to characterise them as claims that emanate from or are validated by 'the conscience'.

(Wicclair, 2007a, pp.30-31)

Wicclair's advice is probably wise, but very few writers, including Wicclair himself, seem to be able to stick to it, instead using the phrases 'the conscience' and 'moral beliefs' interchangeably. In this thesis, I follow this tradition. When I say 'conscience', I simply mean 'moral beliefs'.

There is a more substantive objection to the widespread use of the term ‘conscientious objection’ to address doctors’ moral objections. Using this term in the context of medicine implicitly suggests an analogy with other domains where that term has historically been widely used, most obviously in the context of military conscription. After all, the medical and wartime contexts share several important features: they are both examples of legally permitted or mandated practices to which individuals may object on the basis of their personal moral beliefs, and where that objection can lead to a refusal to participate in the practice altogether.

Despite the similarities, this analogy is controversial:

Although [healthcare] legislation ostensibly mimics that of military conscientious objection, it diverges considerably. Viewing conscientious objection in health care as analogous to conscientious objection to war mistakes choice for conscription, misconstrues the role of personal values in professional contexts, substitutes cost-free choices for penalized decisions, and cedes professional ethics to political decisions.

(Stahl & Emanuel, 2017, p.1380)<sup>15</sup>

To help resist the temptation to make the analogy between war and medicine too easily, I prefer the term ‘moral objection’ to ‘conscientious objection’ in the context of medicine. Having said that, since the latter term is fairly widespread, I will often quote other writers who use the term, and without comment take it to be equivalent to ‘objection motivated by a personal moral belief’, or some similar term. (I’ll have much more to say shortly about the detail of what it means to say that someone’s objection is ‘motivated by a personal moral belief’.)

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<sup>15</sup> Kolers (2014) makes a clear, if stipulative, distinction between conscientious objection (to a procedure), opposition (to an authority), and civil disobedience. The latter, he says, is different because it is “a communicative act aimed at changing an institution, whereas conscientious refusal may be limited to quiet individual noncompliance” (p.1).

‘We’

There are several references to ‘we’ in my research questions: for instance, ‘What allowances, if any, should *we* make for doctors who have moral objections?’. I use this in both a practical and an philosophical sense.

- **The practical sense:** By ‘we’, I mean ‘whatever governmental authority has the power to legalise or authorise medical activity in the jurisdiction in question’. Although I’m most familiar with the UK,<sup>16</sup> and I’ll make frequent references to the situation here along with less frequent references to the United States and elsewhere, I don’t intend my findings to apply solely to these jurisdictions. Very little of what I write is intentionally country-specific, and much of it can be applied to other jurisdictions, so I prefer to talk about legislative and regulatory regimes in the abstract (‘we’).
- **The philosophical sense:** Policy questions like these are (I will argue) part of a more general question: what is the *ethically appropriate response* to doctors’ moral objections? How *ought* we — society at large, all of us — to regard these objections? Would it be right for us to tolerate them, and if so, to what extent? Here, apparently practical questions about what ‘we’ should do are really philosophical questions about what the morally important factors are in the situation, and how they should be weighed against each other.

The answers to the philosophical questions will no doubt have practical implications for people in many roles (lawmakers, regulators, those responsible for legal and regulatory enforcement, healthcare managers, medical educators, doctors themselves), and I will allude to some of these practical implications. But the questions themselves are philosophical ones, and the philosophical dimension will be my primary focus. My use of ‘we’ in these kinds of questions is, I suppose, just a stylistic thing: I prefer a simple active formulation (‘What should we do?’) to a passive or more stilted one (‘What should be done?’; ‘What ought one

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<sup>16</sup> In the United Kingdom, the relevant authorities are fundamentally Parliament and the courts, together with agencies and organisations specifically empowered by law to regulate and govern the practice of medicine, including government ministers, devolved administrations, civil servants and the General Medical Council.

to do?'; 'What are the morally important factors in the situation and how do they weigh up?').

## II. Delineating 'moral objections'

So far, I have defined a 'controversial medical procedure' as a medical procedure to which at least some doctors have moral objections, or to which at least some doctors would have moral objections if the procedure were to be legalised. But doctors can object to procedures for all kinds of reasons. So what exactly do I mean by *moral* objections?

In much of the literature on doctors' objections, it's customary at this point to draw a straightforward distinction between moral and non-moral objections. An objection counts as a *moral* objection if the reason the doctor holds it is a *moral* reason (or an *ethical* reason — I treat the terms as equivalent in this context): that is, a reason based on the doctor's beliefs about what things are right and wrong. This could be because the doctor believes the procedure is intrinsically wrong, or because he believes it has features that make it wrong, such as harming people or contravening his duty as a doctor. Notable among the apparently non-moral kinds of objections ruled out by this simple definition are:

- cases of **pure clinical judgement**, where a doctor refuses to participate in or offer a procedure just because of (his assessment of) the clinical factors involved, e.g. if he thinks the procedure is not clinically indicated or would be futile.
- cases of **pure self-interest**, where a doctor refuses to participate in or offer a procedure just out of a desire to avoid risk, inconvenience or displeasure to himself, e.g. if he refuses to perform open surgery on an HIV-positive patient because he doesn't want to endanger his own health.
- cases of **personal preference**, where a doctor refuses to participate in a procedure for reasons of subjective taste or inclination, with no moral component.

However, this apparently clear distinction between moral and non-moral reasons can easily become fuzzy.

One practical complication is that a doctor's objection may be based on multiple reasons, some of which may count as moral and others not. For instance, with regard to a particular

procedure for a particular patient, a doctor may feel that the procedure is morally wrong *and* not clinically indicated *and* an inappropriate use of limited resources (Genuis, 2006). I don't have much to say about these complex cases in particular, although my instinct (for which I won't argue here) is that complex cases can fruitfully be addressed by isolating and analysing the contributing factors, and my contribution only sets out to be relevant to the directly moral parts of that analysis.

A second practical complication is the possibility that the doctor, or those around him, may be confused or deceived about the true basis for his objection. Maybe a doctor's motivation really *is* pure self-interest, deep down, but through a process of unwitting rationalisation he has managed to convince himself (or others) that his motivation is a moral one. I don't deny that this is a possibility, nor do I make any judgement about how common an occurrence it may in fact be. Instead, my work sets out to be relevant only to objections which *are* genuinely based on moral reasons — not those that merely appear to be. The practical question of how to distinguish the two is not something I will address.

#### *Moral and non-moral reasons*

More of a concern to me is the possible ambiguity about whether or not a particular reason really is a *moral* reason in the relevant sense. This is not so much an ambiguity in the definition of the term 'moral' as an ambiguity about whether a particular instance fits under that definition. The ambiguity can arise in two ways. Firstly, we might worry that a non-moral reason is masquerading as a moral one; secondly, we might worry that a moral reason is masquerading as a non-moral one.

The most tricky examples of (arguably) non-moral reasons masquerading as moral ones are those which involve objections based on professional norms and duties. By way of illustration, let's briefly consider three examples: abortion, doctor-assisted suicide, and capital punishment.

First, consider the quotation below, which is taken from the website of an anti-abortion campaign group in the US and appears under the title 'All abortion methods violate the most basic medical tenet: Do No Harm':

Primum non nocere! This Latin phrase meaning 'First, do no harm' is one of the principal precepts guiding all medical intervention. Like the Hippocratic Oath, which also vows to

‘never do harm’, it is a reminder that the physician’s role is to heal, not to harm. [...] No matter how much ‘relief’ abortion provides for the mother who doesn’t want a baby, it is a procedure that violates the most basic medical ethic.

(Abort73.com, retrieved 1 August 2017)

What’s interesting about this particular line of argument is that, although it refers to “the most basic medical ethic”, it actually appears to be independent of the doctor’s moral beliefs about abortion, in this formulation at least. Indeed, the website seems to intend its arguments to have force even for doctors who have no direct moral objection to abortion *per se* — who may, indeed, judge it to be desirable in some circumstances. Such doctors are urged to refuse nonetheless, because of the constraints of their professional duty (as articulated by the website). So would this kind of refusal count as a moral reason or not?

An analogous question sometimes arises in the context of doctor-assisted suicide. Helping another person to commit suicide may be permissible or even morally desirable in certain circumstances, but (the argument goes) it would be an unacceptable violation of professional norms and duties for a *doctor* to assist (McLachlan, 2010). So is this a moral or a non-moral reason for refusing to assist?

A third example of this kind of question arises with respect to capital punishment. In jurisdictions where executions are legal, the job of actually administering the fatal drug or drugs is sometimes assigned to non-doctors (nurses or medical technicians), and this is partly in recognition of the supposed conflict between the fundamental duties of a doctor and the act of executing a human being. Despite this, doctors are commonly involved in the process, for instance in preparing the convict for execution or in determining when death has occurred (Gaie, 2004). We can easily imagine a doctor refusing to take part because she has a moral objection to capital punishment in general. But we can also imagine a doctor who refuses to take part, even though she has no objection to capital punishment in general and may even support it, because she feels that participating would be a violation of her professional duty to do no harm. Again, for this doctor, execution *per se* may be permissible or even morally desirable in certain circumstances, but she judges an unacceptable violation of professional duties for her, as a *doctor*, to participate. So is her refusal based on moral reasons or non-moral reasons?

In all of these examples, an appeal is made to the ancient tradition of the medical profession to avoid doing harm, which is supposed to be important enough to outweigh competing

considerations such as the possible interests of other people or society in having a doctor involved in the procedure — or, indeed, the personal moral beliefs of the doctor. This raises the interesting question of whether one’s professional duties derive from the expectations of the society in which one works, or an alternative and perhaps loftier source (‘the ancient tradition of the medical profession’) which can outweigh or overrule society’s expectations. But I don’t yet want to try to answer this question, though I will tackle it in chapter 4 when I discuss the value of tolerance as a way to preserve cultural value. For now, I simply want to try to resolve the question of whether an objection based solely on professional norms and duties counts as a *moral* objection in the relevant sense.

According to one way of looking at the situation, it does not. The reason for objecting in these cases is not a normative claim (that acting in such-and-such a way is wrong), but rather a plain factual one (that it’s incompatible with the framework of duties which governs the profession in which the doctor works). While that framework of duties may itself be morally grounded — a doctor’s duty to do no harm, for instance, presumably has its origin in general moral principles — these general moral principles need play no direct part in the doctor’s reasoning in the situations I’ve described, any more than the general moral principles on which traffic laws are presumably based need play no role in the reasoning of a man who decides not to exceed the speed limit on an apparently safe and clear road simply because it would be against the law.

If this perspective is right, then reasons based on (interpretations of) professional norms and duties should lie outside the scope of my enquiry, since I only mean to look at moral reasons. But this conclusion makes me uneasy, not least because it flies in the face of much of the literature. Academic discussions of conscientious objection in medicine and healthcare frequently *include* reasons based on professional norms and duties like that described on the Abort73 website, and they do so without special comment, even when they explicitly claim that they are going to *exclude* objections based purely on professional norms and duties (e.g. Wicclair, 2011, pp.6-7). Similarly, in non-academic circles, objections based on professional norms and duties are often bundled together with more straightforward objections based on moral judgements about the procedures themselves, usually without any explicit recognition of the difference. For instance, the Abort73 website I quoted a few moments ago makes extensive reference to moral arguments against abortion, mostly based on religious convictions, alongside its appeal to professional norms.

So is there an alternative perspective, a way to categorise reasons based on professional norms and duties as moral reasons after all? One argument to this effect might be expressed as follows: isn't a doctor who cites professional duties when refusing to perform a procedure indeed making a moral judgement after all, namely the judgement that *she ought to allow* the constraints of her profession to outweigh what might otherwise be an appropriate course of action? Granted, this is a different sort of moral judgement from one that objects straightforwardly to abortion (or doctor-assisted suicide, or capital punishment); it is, I suppose, a second-order judgement about how first-order considerations should be granted relative moral weights. But it's clearly a *moral* judgement nonetheless. Generalising, the judgement that one consideration ought to outweigh another when deciding on a course of action surely is a moral judgement — hence the word 'ought' — regardless of whether the individual considerations in question are normative ('this is wrong') or straightforwardly factual ('this is forbidden by the rules').

But hold that thought. In the previous section, I said that I wanted to exclude objections that are clearly based on pure clinical judgement or self-interest from my discussion because these are clearly *non-moral* reasons for objecting. Well, let's return to the example of the doctor who refuses to perform open surgery on an HIV-positive patient out of a desire to protect his own health. As I indicated, this might be a case of pure self-interest; but on the other hand, it might come about because, for instance, the doctor feels that it would be *morally wrong* of him to put his health at risk because of his duties to other patients, his family, or society.<sup>17</sup> Or let's return to the example of the doctor who refuses to provide a treatment because he judges that it's not clinically appropriate. What if the reason behind this judgement is that he feels it would subject the patient to unacceptable risks or harms, or would waste resources which could be more appropriately applied elsewhere, or both? These are not reasons based on personal preferences or facts about the world. They are clearly moral reasons, and this is true in the same way as reasons to do with professional norms and duties. Although they may not express moral objections to particular

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<sup>17</sup> I pass no judgement on the appropriateness of such moral attitudes, except to make the following observation. As societies, we tend to expect a certain degree of sacrifice from medical professionals in the interests of patients, and this expectation is commonly reflected in doctors' guidance and codes of conduct. For instance, the very first requirement of guidance issued by the UK's General Medical Council is that doctors should "make the care of their patients their first concern" (General Medical Council, 2013, paragraph 1). But few would expect *unlimited* sacrifices in that regard. Doctors are not required *literally* to sacrifice their lives and those of their loved ones for their patients.

procedures, they clearly do express moral judgements about how competing considerations should be weighted.

Once we start down this road, it quickly becomes clear that *all kinds* of reasons can and frequently do involve moral judgements. Suppose, to take an apparently trivial example, that a doctor refuses to perform a particular operation because she suddenly remembers that her car is parked on the other side of town in a space reserved for disabled drivers, and she feels sufficiently guilty about this that she leaves the hospital and hurries across town to move the car, leaving someone else to perform the operation (or leaving the patient to go without). In this case, the doctor's reason for refusing to perform the operation is genuinely based on a feeling of duty (let's stipulate): she is not simply trying to avoid getting a parking ticket out of self-interest. Rather, she weighs her parking transgression against the interests of the patient, and decides that she ought to move her car. So this kind of reason for objecting also counts as a moral reason. But, I submit, it appears intuitively obvious that it's not the kind of objection we should automatically respect.<sup>18</sup>

So, in an attempt to distinguish between non-moral and moral reasons for objecting, we've identified a moral component in a very wide range of possible reasons, from the obviously serious to the obviously trivial. Thus, to say that an objection is based on a moral reason is not to say that we actually ought to grant it significant moral weight. Indeed, as I've just shown, the class of moral reasons encompasses some reasons where it's *not* really very tempting to say that objections based on those reasons deserve respect, such as feelings of guilt about trivial parking transgressions.

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<sup>18</sup> I'm not trying to make an argument about whether this particular kind of reason, or ones like it, are morally very weighty — I'm just saying that they can count as moral reasons. In fact, now we come to mention it, I suppose not all parking transgressions *are* morally trivial. A reason's moral weight — that is, how heavily it should be weighed against conflicting moral reasons — can vary considerably depending on the details of the situation, and it's not entirely clear to me that a doctor's duty to provide a particular treatment to a patient would *always* outweigh her duty to obey parking regulations. Disabled drivers do sometimes struggle to find appropriate parking spaces so they can benefit from shared amenities that non-disabled drivers find it easier to access. We might justifiably attach significant moral weight to rules which try to rectify this. Or, to adjust the example, suppose the doctor's car was instead parked in a space reserved for an emergency ambulance, or blocking the doors of a nearby fire station, or across the middle of a level crossing. If the treatment required by the patient was comparatively minor, the doctor might well weigh up her options and decide with some justification to abandon the patient so she could move her car immediately.

Clearly, in order to come to a good account of which objections deserve moral weight, we need to do more than simply identifying moral elements in the reasons underpinning them. We need a way to judge which count and which don't. So can we come to such an account? I think we can. In fact, I think there are two such accounts which are entirely compatible: one which is based on harm, and another which is based on tolerance. Spelling out these accounts will be the focus of the next few chapters of my thesis.

### **III. Challenges and implications**

The question of how to respond to individual moral objections to otherwise accepted states of affairs is a very difficult one: it's perennial, it occurs in many different contexts, and it often gives rise to vigorous and heartfelt debate. Nailing down a clear answer to this question, likely to be accepted by different people with a wide range of moral views, would be a spectacular advance. But, the field of ethics being what it is, it would still be a useful contribution to the debate if we could get even a little bit clearer about what a good answer would look like, or what issues should be taken into account.

Even this seemingly modest aim is hardly trivial. In the field of medicine, the difficulties involved in holding out against societal demands in the light of one's own moral standpoint go back to antiquity. It even finds expression in the classical Hippocratic oath, in which the physician commits never to administer a deadly medicine "even if asked".

These worries have shown no signs of letting up across the centuries. More recent historical circumstances such as the well-documented abuse of patients for dangerous medical experiments by the Nazis (Spitz, 2005) have fuelled the debate at various points through history. And, as I mentioned earlier, we have no reason to expect an end to the succession of new, potentially morally challenging practices that have gradually become part of legally accepted medical practice. The question of what to do when doctors object to legal procedures may change its focus over time, but as long as healthcare is considered a public endeavour, it's hardly likely to go away.

In what follows, I identify various reasons why (it seems to me) the question of doctors' moral objections is so sticky and difficult to answer, and why it evokes such strong feelings.

### *Personal and emotional significance*

Some of abstract moral philosophy's favourite thought experiments are far enough removed from real-life situations that they can usually be discussed in the abstract without much risk of fraying tempers or causing offence. ('Am I morally entitled to pull a lever which will release a trapdoor to drop a fat man off a footbridge into the path of a runaway trolley in order to prevent the deaths of five pregnant women tied to the track half a mile away?'<sup>19</sup>)

But the question of doctors' consciences is not one of these rarefied, emotion-free questions. Indeed, one common sticking-point in attempts to answer directly practical moral questions is the strong emotional reactions they tend to evince. When the *British Medical Journal* published a now-famous article by Julian Savulescu (2006) in which he proposed limits to doctors' rights to refuse to provide medical services on moral grounds, the avalanche of responses from readers included one who had been made to feel "physically sick" (Smith, 2006), and another whose letter included the following dramatic prediction:

Savulescu paints a terrifying portrait of his utopian future for medicine. A future in which medical practitioners are mere tools in the service of the state. A state which will dictate their actions regardless of their consciences. Conscience itself will be relegated to the realm of superstitious religion, unfit for the enlightened and obedient. [...] To paraphrase Orwell, if you want to understand Savulescu's picture of the future, imagine a boot stamping on a human face — *for ever*.

(Cattermole, 2006, emphasis in original)

Set aside, for now, the question of what Savulescu was actually proposing and whether the criticism of him was fair. My point is simply that such strong and visceral reactions are hardly uncommon, and they ought not to surprise us. Questions of moral objection in medicine strike to the very heart of people's most cherished personal beliefs, and what's at stake is a matter of direct and personal importance to the doctors involved. There can be no more central a part of someone's moral outlook than his core moral beliefs, whether these are perceived as transcendent cosmic imperatives (for example, as part of a wider framework of religious belief) or as the building-blocks of his personal identity, or indeed both. As I will argue at length in this thesis, there is potential for serious harm to individual doctors if questions like these are handled clumsily or without sufficient attention to morally relevant considerations. When a moral person is forced to act against her most

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<sup>19</sup> For British English speakers, 'trolley' of course means 'tram', which I suppose makes the envisaged situation slightly less absurd.

deeply-held moral convictions, the effect on that person can be devastating: the phrase used by Carl Cohen (1968, p.269) is “excruciating moral anguish”, while in the words of Piers Benn (2007, p.345), “the deepest values by which [the person] defines her life are under assault”. Moreover, the physical act of participating in a procedure about which one has moral reservations can be extremely traumatic (Raus et al, 2014; Haverkate et al, 2001).

On the other hand, as many other writers have pointed out, patients may lose out on benefits that they rightly expect, or may have their physical or mental wellbeing damaged, because of doctors’ objections to the treatment they need or want. This can happen most obviously if a patient ends up being denied treatment altogether, but it can also happen if she feels that her own beliefs and wishes are not being sufficiently respected, or that she is being judged morally — an experience that can be particularly harmful in the long term for patients for whom the very act of approaching a healthcare professional represents a step out of their comfort zone (see, for instance, concerns expressed by respondents in Earle & Evans, 2004, pp.32-33).

All this is not to say that it can never be justifiable to allow harms like these. It might be justifiable for doctors to suffer personal anguish, or for patients’ physical or mental wellbeing to be put at risk, if these harms are outweighed by other moral considerations — for instance, if they are the lesser of two evils in a situation in which it’s inevitable that something undesirable is going to happen no matter what. And it’s precisely because there is the potential for harm, sometimes severe, to doctors, patients and wider society, that the question of how to respond to doctors’ moral objections is not only sensitive but also very important from an ethical perspective. Clarifying the rights and wrongs of these situations is what my research is all about.

### *Practical implications*

In the same vein, abstract discussions about moral weight and potential harms must not lose sight of the fact that any robust answer to these questions will necessarily have significant practical implications. Individual moral beliefs die hard, if they die at all, and it’s far from guaranteed that doctors whose consciences put them on the wrong side of the law or professional expectations will simply acquiesce and suffer in silence.

Practically speaking, in a society in which good doctors are plentiful and applications to enter the profession are competitive, an apparently easy solution to the problem of moral conflicts presents itself: we could simply say that applicants whose moral beliefs would make them unable to discharge all the normal responsibilities of medicine should not enter the medical profession in the first place — or, presumably, that they should resign if they are unable to accept their prescribed role in a newly-legalised controversial procedure. This argument is indeed sometimes made by opponents of making allowances for conscientious objection, and it has some weight.

But not so fast. What if good doctors, or good applicants, are not plentiful? Or what if a change in the law conflicts with the moral beliefs of a substantial number of *existing* doctors (Greenawalt, 2006) — something that happens frequently when the law is changed, as the focus of my thesis implies? How many experienced doctors, as well as promising applicants, all willing and able to discharge the vast majority of their duties in ways that would make measurable positive contributions to the wellbeing of the populations they serve, ought we to be willing to sacrifice on the altar of professional moral uniformity with respect to a relatively narrow range of controversial issues? As one correspondent argued in the *British Medical Journal*:

If all conscientious objectors to abortion on demand — whether Secular, Catholic, Evangelical, Muslim, Orthodox Jewish, etc. — were to resign from the medical profession tomorrow (or even just those in posts where the issue arises — Obstetrics, General Practice, Genetics, Radiology, Anaesthetics, etc), where would that leave the provision of the equitable and efficient health service he [Julian Savulescu] desires?

(Watson, 2006)

I don't mean to make this argument too strongly. I'm not saying that there is no conceivable circumstance in which it would be better for us to expect a doctor to resign, or not to sign up for medicine in the first place, than to allow them to demur from a particular procedure or family of procedures. Doctors' (and other healthcare professionals') wishes to practise while refusing to perform some parts of their professional duties, and society's interest in allowing this, must be weighed against other important considerations, such as promoting public health, striving for equality of access to the administration of healthcare services, and meeting patients' individual needs, not to mention the arguable interest of the state in maintaining the visible primacy of laws properly made by democratically-elected governments over the choices of individual public servants and private citizens. Someone whose religious beliefs (as a Christian Scientist, for instance) made her unable to accept the

efficacy of conventional medicine against any kind of physical illness, and therefore unwilling to prescribe any drugs, would simply not be a good candidate for a medical career, and it would be hard to argue that society ought to make allowances so as to allow her to enter the profession while still living in line with her moral beliefs. And perhaps we might feel less sympathetic towards the moral objections of a doctor who signed up for the profession in full knowledge that she would be expected to perform the procedure to which she now objects.

But there is a line to be drawn, if only for practical reasons, somewhere between this extreme case and the equally extreme case in which a newly-legalised procedure is so controversial that it threatens the survival of the entire healthcare system because every doctor in the country would rather resign than be forced to participate in it. And this other extreme applies to applicants too: the suggestion that entering the profession disqualifies you from later raising an objection is only helpful when good applicants are plentiful. Where we draw this line between what objections we will accept and what we won't will define which doctors are allowed to practise medicine in our society and which aren't, and thus it's of great practical importance to the success of our healthcare system in general. A big part of what I'm trying to do in this thesis is to draw attention to factors that are relevant when trying to locate this line.

### *No easy consensus*

Even among liberal Western democracies that, by and large, tend to come to broadly similar positions about larger moral questions, there is a wide range of hotly-contested views on issues linked to controversial medical procedures and doctors' objections to them. To take just one current example: doctor-assisted suicide and euthanasia are illegal in all but a handful of Western jurisdictions, but continue to be hotly debated in the UK,<sup>20</sup>

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<sup>20</sup> See: Scottish Parliament (2010); R (Nicklinson) v Ministry of Justice (2012) EWHC 2381; House of Commons Library (2012); Macdonald (2013); House of Lords (2013).

Switzerland,<sup>21</sup> the Benelux countries,<sup>22</sup> the United States,<sup>23</sup> and Australia.<sup>24</sup> It goes without saying that political and public opinion are not settled on these questions. Nor is legal opinion, in jurisdictions where courts have expressed clear views. Nor, indeed, is academic opinion, as a large proportion of the academic references in this thesis demonstrate.

Most importantly for my purposes, nor is the opinion of medical professionals. Doctors' professional associations in different European countries differ in their stances with respect to doctor-assisted suicide in their own countries (Bosshard et al, 2008), ranging from clear opposition (Germany), through neutrality (Switzerland), to endorsement (Netherlands). Even just among UK doctors, when the British Medical Association first adopted a firm stance against doctor-assisted dying in 2006, it acknowledged a "broad spectrum of opinion within its membership" on the issue (British Medical Association, 2006). And in their evidence to the UK government-mandated Commission on Assisted Dying, Medical Protection Society representatives made a plea that any future law on assisted dying should explicitly recognise and allow for this spectrum of opinion:

In so far as any future law is concerned, [...] we're not taking the position on whether there should be one or there shouldn't be one, but what we do ask the Commission to consider is the position of the conscientious objector. And we feel that there should be provisions for conscientious objections within the law.

(Commission on Assisted Dying, 2011;  
transcript of verbatim evidence given by Dr Lillian Field, MPS legal adviser)

In the UK, the General Medical Council regulates the medical profession, which includes providing guidance for doctors about how their personal beliefs should be accommodated in a clinical setting.<sup>25</sup> The first edition of guidance specifically on this subject (published in

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<sup>21</sup> See: Hurst & Mauron (2003); Campbell (2009); Taylor (2011); House of Commons Library (2012).

<sup>22</sup> See: Emanuel et al (2016).

<sup>23</sup> See: *Washington v Glucksberg*, 521 US 702 (1997); *Gonzales v Oregon*, 546 US 243 (2006). To date, doctor-assisted suicide is legal only in the US states of Oregon, Washington and Vermont. Attempts to legalise doctor-assisted suicide in California (four times between 1992 and 2006) and Massachusetts (in 2012) have been defeated. Montana has no primary legislation on the subject, but case law there allows a defence of 'assisting a suicide' to murder charges against physicians.

<sup>24</sup> See: Cook (2013).

<sup>25</sup> A thorough description of the GMC's current guidance on doctor's moral beliefs forms the first part of Fovargue & Neal's (2015) *Medical Law Review* article. This article also includes useful summaries of the parallel guidance which applies to members of the pharmaceutical and nursing professions.

2008, in force until 2013) was noticeably sketchy. Although the authors clearly intended to allow doctors to refuse to offer some procedures and arrange some treatments based on their personal moral views (a practice referred to in paragraphs 21-24), the guidance did not actually state this explicitly. Nor, moreover, did it offer any general criteria for assessing when refusal was permissible and when it was not — a particularly striking omission given that the authors clearly did not intend for the right to refuse to be universal: some specific areas were mentioned in the final few paragraphs in which doctors were enjoined *not* to let their personal beliefs affect the services they offered.

Most curiously, very little advice was given to doctors faced with a possible conflict between their apparent right to refuse to provide a particular treatment with what the GMC said should be their overriding duty, namely to make patient care their first concern (paragraph 17). Doctors were left individually to try to reconcile these two requirements, aided only by various injunctions that they must not “delay or restrict [patients’] access to care” (paragraph 18), or “obstruct patients from accessing services or leave them with nowhere to turn” (paragraph 23). Of course, no doubt there *are* plenty of circumstances in which a doctor may exercise his moral views without affecting patient care at all, and so all these requirements can be comfortably satisfied within the GMC’s 2008 framework — but, as a Medical Protection Society spokesperson pointed out in evidence to the Commission on Assisted Dying (2011), there are also plenty of circumstances where a tension does seem to exist, and it’s in precisely those situations that doctors might reasonably look to their professional regulator to help resolve that tension.<sup>26</sup>

Accordingly, when the GMC rewrote its guidance on personal beliefs in 2013 following an extensive consultation period, it went some considerable way to addressing these deficiencies. The revised guidance *does* now clearly introduce the general principle that doctors can practise medicine in accordance with their personal beliefs, including refusing to provide certain treatments, so long as they act within the law and so long as four further conditions are satisfied:

- patients are not denied access to appropriate treatment (paragraph 4);

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<sup>26</sup> The MPS’s evidence also included a plea for greater clarity in other areas of law and regulation related to doctors’ moral beliefs which it perceived as ambiguous — specifically guidelines issued by the Director of Public Prosecutions outlining when doctors might be prosecuted for assisting a suicide.

- patients are not treated unfairly (paragraph 4);
- patients are not caused distress (paragraph 4);
- in an emergency, patients' lives or health are not put at serious risk (paragraph 13).

Admittedly, potential sources of ambiguity remain in the meaning of important terms like 'unfair', 'denied access' and 'appropriate treatment'. For instance, the issue of whether a controversial procedure is 'appropriate' will often be a point of contention between advocates and opponents of the procedure in question. (I examine this issue more closely in chapter 5.) But guidance can't be expected to address every detail; its main purpose is to lay out general principles. And by clearly establishing the general principles that (a) doctors may act in accordance with their personal beliefs, but that (b) the extent to which they may do so is contingent on the needs of patients, the 2013 guidance takes a big step forward in helpfulness compared to its 2008 predecessor.

If professional guidance was the only influence on doctors' decision-making in this area, then (in the UK at least) doctors would be in a reasonable position to try to resolve perceived conflicts between their personal beliefs and patients' needs as they arose in day-to-day practice. But guidance does not operate in a vacuum, especially on moral matters. The spectrum of views among individual professionals is reflected in a similar spectrum of positions among other organisations that seek to influence doctors' decision-making.

One viewpoint diametrically opposed to the GMC's is that of the Catholic Medical Association, whose consultative response to the GMC's draft version of the 2013 guidance included the following emphatic rebuttal:

The assertion that as soon as a doctor's views become irksome to systems and colleagues or potentially distressing to patients, they must abandon central beliefs has confirmed the resolve of many doctors that should the draft guidance be approved with its current injustice, domestic and European courts will be kept occupied with legal challenges for many years to come and international law would mandate opposition to such threats to human rights. [...] The guidance represents a low point in attitudes towards religious belief and rights of conscience. Being couched in suspicious and adversarial language, it disrespects religious patients as well as clinicians. It is to be hoped that there will be reflection within the GMC on how the august body advising doctors and regulating their practice permitted such an unbalanced draft document to reach public consultation stage with religious bigotry misrepresented as tolerance and the protection of all in our multi-cultural society.

(Catholic Medical Association, 2012)

By way of contrast, the British Medical Association's official policy since 2008 has been more conservative than the GMC's in the opposite direction. The BMA rejects a *general* principle of refusal in favour of specific exemptions in limited areas that are characterised by "moral seriousness" (this phrase is not elaborated in the BMA's position) as well as statutory provision:

At its 2008 Annual Representatives Meeting the BMA passed a resolution stating that doctors should only have a right of conscientious objection to those procedures where such a right is recognised by statute (to participating in abortion and certain forms of fertility treatment) and to the withdrawal of life-sustaining treatment from a patient who lacks capacity, where another doctor is willing to take over the patient's care.

(British Medical Association, 2013)

Finally, it's interesting to note that the striking lack of consensus about whether and to what extent we should make allowances for individuals whose moral beliefs conflict with prevailing legal or societal expectations extends well beyond medicine and into other domains of contemporary political debate. In these other domains, just as in medicine, society simply has not settled on the answer, and this lack of a consensus is particularly prominent when rules or expectations change. To take the example of equality and anti-discrimination laws:

- The UK's Equality Act 2010 made it illegal for providers of goods and services to discriminate against individuals on the grounds of their sexual orientation. After the Act came into force, some Catholic adoption agencies sought an exemption so that they could continue to decline to place candidates for adoption with same-sex couples. But no allowance was made for exemption based on moral or religious beliefs, and when a Leeds-based adoption agency pursued a high-profile case in the courts, the judgement went against it (BBC News, 2012). Other agencies closed, or cut their ties with the Catholic Church.
- The owners of a guesthouse in Cornwall were similarly rebuffed in a string of court judgements when they refused to allow a gay couple to stay in a double room on the basis of "a religiously-informed judgement of conscience" (BBC News, 2013). UK Supreme Court judges disagreed over whether the discrimination in question was direct or indirect, but agreed that in either case it could not be justified on the basis of the owners' moral beliefs. The author of the leading judgement, Lady Hale, commented that the job of judges "was no longer to enforce morality".

- When the Church of England decided in 1992 to ordain women as priests for the first time, special administrative provision was made in canon law for those whose theological beliefs made them unable to accept the new measures (Archbishops' Council, 2011). Provisions included financial help for clergy who resigned their posts for theological reasons, and special pastoral and managerial arrangements for churches whose congregations did not accept female priests. But twenty years later, despite having committed itself to the principle of ordaining women as bishops (a more senior rank), the Church's governing body failed on two occasions to overcome deep divisions about the extent to which theological objections should be accommodated (Archbishops' Council, 2013), with a significant number of members holding that to make equivalent special provision for dissenters this time around would undermine the aims of the change. When the change was eventually made, the degree of special arrangements to be made was itself a matter of controversy (Bingham, 2015).

These are all complex issues, no doubt each worthy of PhD theses of their own, and I don't want to commit to drawing any firm analogy with moral objections in medicine. For instance, I don't mean to make the controversial claim that discriminating against people with a particular characteristic in providing a service is morally equivalent to universal refusal to provide a particular service; nor that moral objections to provisions that aim to improve equality and fight discrimination are equivalent to moral objections to controversial medical procedures such as abortion or assisted dying. I simply mention these examples from wider society to point out that, in general, the extent to which we should allow people to act in accordance with their personal moral beliefs is very much a live question, not a done deal.

### *Confusion*

Debates around controversial procedures, and doctors' moral objections to them, are not only characterised by vigorous debate and clear differences of opinion. They can also sometimes be characterised by a degree of confusion — not just about ethical issues ('what's the right thing to do?'), but also about legal and regulatory issues ('what do the rules say I have to do?') and about conceptual or terminological issues ('what exactly is involved in doing this?').

A recent study provides some empirical evidence that confusion infects some individual doctors' thinking about the issue. Lawrence & Curlin (2009) conducted a US-wide survey of doctors in an attempt to correlate "intrinsic religious motivation" (p.1278) with views about how best to respond to conflicts between one's own moral beliefs and professional or legal requirements. One intriguing outcome was that a substantial number of respondents (some 36%) indicated that they agreed with both of a pair of statements which the survey authors intended to be incompatible:

(1) A physician should never do what he or she believes is morally wrong, no matter what experts say.

(2) Sometimes physicians have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so.

(Lawrence & Curlin, 2009, pp.1277-1278)

We might speculate about the factors that generated such an apparently surprising result. For instance, it seems to me that there are plausible interpretations of both these statements which make them not only consistent with one another, but uncontroversially true. Statement (1) could be interpreted as a truism (by definition, you should never do what you believe is morally wrong, since that's just what 'morally wrong' means), and statement (2) could be interpreted as an uncontroversial statement of fact equivalent to 'sometimes my duties conflict with my personal beliefs', without any implied judgement about which should be followed. If a given respondent understood them in that way, then there would be no inherent contradiction for that respondent, for it's perfectly consistent to maintain both that one's professional obligations sometimes conflict with one's own moral beliefs, and that one should always act morally.

Be that as it may, I doubt that *every* respondent interpreted these two statements in exactly that careful way. The fact that so many respondents agreed with both statements suggests that at least some of them might have done so because they felt genuinely unsure about their position, could see both sides of the argument, or were unclear about what exactly was at issue between these two standpoints.

#### IV. Breaking the deadlock

At the heart of all this controversy is, I think, a problem so simple that it almost seems unnecessary to say it explicitly: *people disagree about the morality of controversial procedures.*

Indeed, that's exactly what 'controversial' means in this context. A controversial procedure is a procedure which some people judge to be morally wrong, while others don't share that judgement.

But if the heart of the problem is simply a deadlock between moral views, then perhaps the way to break the deadlock is simple too: perhaps we just need to decide which side is correct and which is incorrect! That is, if we want to know how to respond to a doctor's objections about (say) doctor-assisted suicide, perhaps we just need to examine closely the morality of assisted suicide, and come to a judgement about whether the procedure is morally acceptable or not. If we know the answer to that question, we can then judge whether or not the doctor is correct to raise his objection, and hence (the argument goes) whether or not we should allow for that objection.

Can this approach work in practice? On the one hand, I think there are grounds for a certain pessimism about the possibility of breaking a deadlock simply by coming down on one side or the other (McLeod, 2008). Earlier in this chapter, I pointed out that many persistent medical controversies have deeply entrenched views and emotionally committed people on both sides, with no immediate prospect of resolving the differences between them.

But on the other hand, I don't want to say that this would be totally impossible. When I discussed the historical context of controversial medical procedures, I mentioned some procedures that were formerly controversial but which have since become widely accepted, and I suggested that some current controversies might undergo a similar transformation in the future. Whether this happens as a result of multifaceted societal change over a long period, or from one PhD student's slam-dunk refutation of a rival view, it can surely happen. To the extent that prevailing views can change simply because everyone (or nearly everyone) has recognised and moved to one side of the fence, the straightforward approach of weighing up rights and wrongs might not necessarily be futile.

Even if I accepted that many medical controversies are not about to vanish from society, it would still be perfectly possible for me to pick a controversial procedure and then write a thesis weighing up the rights and wrongs of that procedure for myself. Many other writers have done the same for particular procedures. If I could come to a conclusion about whether and in what circumstances the procedure was morally justified, I might then try to use that conclusion to deliver my verdict on how to respond to doctors' objections to the procedure. The usefulness of that verdict would obviously depend on the persuasiveness of my arguments for or against the procedure in question, and it would only be of interest to someone who agreed overall with my conclusions about the morality of that procedure (I'm not confident about being in possession of a slam-dunk refutation myself). But it would be a coherent approach to take, nonetheless.

For better or worse, this approach is *not* the one I want to adopt here. As I've already said, I *don't* intend to present arguments about the morality or otherwise of any given procedure. My approach, instead, is to take the fact of controversy (whether permanent or simply current) as a given, and ask: what then? How should we respond to doctors' objections in cases where *there is no immediate prospect of agreement* about the morality of what they're objecting to?<sup>27</sup>

This bumps me right back up against the deadlock I mentioned at the start of this section. For any given controversial procedure, some people think it's wrong, others don't. Once we've ruled out simply judging which side is correct as a way to break the deadlock, we need to find a different approach — a way to decide whether to respect a doctor's objection *without* taking a moral stance on the procedure itself. And this is the challenge for the rest of my thesis. This is not an easy task, but it does have the advantage that any success I manage to achieve ought to be of use to both sides of the moral debate, given that they don't rely on the correctness of either position.

The last thing I want to say on this subject for now is this is only an approach, not an argument. I see no particular reason to think that this is the only good approach, or that following it will take me all the way; I'm not even claiming that it's definitely possible to

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<sup>27</sup> It might be argued that the bare fact of persistent disagreement is reason enough to grant weight to an objection. I will consider this suggestion, among others, in the next chapter (p.51 of this thesis).

break the deadlock in a way that's satisfactory to both sides of the debate. Indeed, in the final chapter of this thesis, I will revisit this question and discuss reasons to be pessimistic about this. But in the meantime, this is the way I will proceed, as much in hope as in expectation.

### *A fundamental rule*

Given what I've just said, I want to sound a note of caution now about one strategy that will definitely not prove useful when trying to break the deadlock. This is a point so important that I will need to refer to it again and again throughout the rest of my thesis:

- **Fundamental rule:** There is no point in trying to use the moral value of a procedure as a premise in an argument about respecting objections to that procedure.

To illustrate this, take a very simple example. If the question is, 'Why should we let doctors refuse to perform an abortion?', one tempting answer might be, 'Because abortion is wrong!'. Now, that answer might be perfectly acceptable to someone who is willing to grant the moral wrongness of of abortion, but it carries no weight at all for someone who rejects that claim. The fact that some people judge a procedure to be immoral is an explanation for the fact that those people object to it, but it can never be a justification for respecting those objections for anyone who does not share that moral judgement — and, as such, it can never play a role in an argument intended to break the deadlock between those two viewpoints (Cohen, 1968, p.270).

Here is another way to put exactly the same point. The moral permissibility of a procedure such as abortion is one question; the moral permissibility of *allowing a doctor to refuse to participate* in a procedure such as abortion is a different question. It's a mistake to think that considerations relevant to the first question must also be relevant to the second.

It may seem unnecessary even to mention this apparently obvious principle, never mind to make it a fundamental rule. But it is not unnecessary. Confusion between the permissibility of a procedure and the permissibility of allowing someone to object to that procedure infects many debates in the literature, even debates between medical ethicists who have spent a considerable part of their professional lives working on the issue. One very clear example of this confusion is from 2007, in a more or less bad-tempered exchange between

Robert Card and Farr Curlin in the American Journal of Bioethics, on the subject of pharmacists' objections to providing emergency contraception:

The issue at hand requires balancing the moral values of the medical professional and the patient. Medical professionals are persons who possess autonomy rights, and hence may refuse care in some circumstances, yet we cannot forget to take the patients' moral values into consideration as well.

(Card, 2007, p.10)

Card's essay purports to meet these clinicians in the ring of moral discourse and knock them out fair and square. Yet, further scrutiny suggests the vanquished are only straw-men substitutes for the real opponents, and instead of boxing by the rules, Card has taken off the gloves and thrown 'the kitchen sink' instead. [...] In contradiction to Card's inferences, neither [of the most common arguments against providing emergency contraception] has to do with the autonomy rights of professionals. Neither puts the practitioner's interests above those of the patient.

(Curlin, 2007, pp.30-31)

Curlin's claim here is that the defenders of doctors' objections are not saying what Card says they are saying. He's right. But this is not because Card is determined to attack straw men. It's rather because the two writers are talking at crossed purposes. They are thinking about, and providing answers to, two different questions. The question Curlin wants to answer is: 'Should pharmacists provide emergency contraception?'. He claims, no doubt correctly, that those who answer in the negative do so for reasons that relate to the moral status of emergency contraception, like the following:

a) humans ought always to act in accordance with their nature; b) the nature of human sexuality includes both a procreative and unitive aspect of sexual intercourse; c) any action which intentionally and directly separates either of those two aspects of sexual intercourse is an act against human nature and is therefore illicit; and d) apart from sexual assault, the use of [emergency contraception] is intended to directly separate procreation from sexual intercourse.

(Curlin, 2007, p.30)

So far, so good. But the question *Card* wants to answer is: 'Should we permit objecting pharmacists to refuse to provide emergency contraception?'. This is a question whose primary relevance is not to pharmacists at all, but rather to the policy-makers and managers whose job it is to respond to pharmacists' objections. So it's no surprise that Card's answer is nothing to do with the moral status of emergency contraception, but rather to do with the moral status of allowing conscientious objections:

Objecting professionals may conscientiously refuse because they consider emergency contraception to be equivalent to abortion or because they believe contraception itself is immoral. This article critically evaluates these reasons and concludes that they do not successfully support conscientious objection in this context. Contrary to the views of other

thinkers, it is not possible to easily strike a respectful balance between the interests of objecting providers and patients in this case. As medical professionals, providers have an ethical duty to inform women of this option and provide emergency contraception when this treatment is requested.

(Card, 2007, p.8)

Confusion between these two different questions leads Curlin to make the following slightly bewildering complaint:

The problems go deeper. Card does not merely claim that practitioners are obligated to provide [emergency contraception]; he argues that they are obligated to do so *even if they have a conscientious objection*. [...] This is like claiming that a jury has an ethical obligation to convict the defendant, even if they are persuaded the defendant is innocent. To be sure, a judgment of conscience may be wrong, but it cannot be put right by setting it aside.

(Curlin, 2007, p.31; emphasis in original)

As far as I can see, the root of the problem here is that Curlin's interest is in whether emergency contraception is morally permissible — that is, *what the jury should decide* — whereas Card's interest is in whether pharmacists should be allowed to refuse to dispense it on moral grounds — that is, *whether they have the right to ignore the jury's verdict*. And neither side has recognised the difference, so both sides slide between the two questions, and Curlin ends up accusing Card of trying to use the answer to the first as an answer to the second. Unpicking their disagreement is hard work.

It's precisely this kind of confusion that I want to avoid with my fundamental rule. I emphasise it while it still has the disarming ring of obviousness precisely because the temptation to break it will arise frequently. It's an easy trap to fall into, but one I am determined to avoid.

Before I move on, a possible objection to what I've just said provides an opportunity for clarification. Here's the objection: Isn't it in fact the case that the moral value of a procedure is a relevant (pro tanto) consideration *both* to the permissibility of the procedure, *and* to the permissibility of accommodating an objection to that procedure? After all, if we think a procedure brings about significant moral benefits, then doesn't that weigh just as heavily against allowing doctors to refuse to perform it as it does in favour of legalising it in the first place?<sup>28</sup> My reply is: yes, but that doesn't help make any progress here. I agree that the fact society judges the procedure to have moral value implies that society has a pro tanto reason

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<sup>28</sup> Jonathan Hughes raised this point in discussion (2018).

not to accommodate doctors' objections to it, at least insofar as those objections might hinder the procedure's availability to those who would benefit from it. But society's view here is contested by those who judge the procedure to have moral *disvalue*, and what I'm trying to do here is to find a way to adjudicate between those two conflicting judgements without using either one as a premise. The problem, I suppose, is that the role of 'society' here, as I have very vaguely and broadly characterised it, is really two separate roles: the first to assess the moral value of the procedure, and the second to adjudicate (as neutrally as possible) between that assessment and the rival assessment of those doctors who disagree.<sup>29</sup> That second role is what interests me in this thesis, and my contention is that the fundamental rule I've just introduced is the right approach for those who must play that role.

## V. What I try to show in the following chapters

In this introductory chapter, I've tried to lay the foundations for what follows, first by defining the scope of my research questions, then by outlining some of the difficulties involved in any serious attempt to answer those questions, and finally by sketching my strategic approach to doing so. I'll finish now with a brief account of how the rest of my thesis will be organised.

In the following few chapters of my thesis, I will deploy one half of my answer to the question of how we should respond to doctors' morally-based objections, by arguing that *at least some such objections have moral weight*. We can account for this moral weight, I will argue, in (at least) two different ways:

- **Harm:** An important fact about personal moral beliefs is that to force someone to act against them often risks significant harm to that person.
- **Tolerance:** Some of the reasons that are often given to tolerate unorthodox cultures, views and practices within a heterogeneous society suggest equivalent reasons for tolerating dissent from doctors.

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<sup>29</sup> The issue of what to do when those in authority have a moral view but also want to respect those who disagree with them is an issue of tolerance, which I discuss in much more detail in chapter 4.

I will also consider and reject a number of other possible accounts.

Now, if my arguments in the next few chapters are successful, I will have shown that some doctors' objections have significant moral weight. But, by saying that an objection has moral weight, I am simply saying that it has one or more features which *count in favour* of making allowances for that objection. In the language of philosophical ethics, I say that some objections have 'pro tanto' moral significance<sup>30</sup> — not that they will be decisive in the final analysis. The strongest version of my claim in the first part of my thesis is merely that *we should consider* making allowances, and we should make allowances in the absence of any other morally relevant factors.

This is not an entirely trivial claim — it is sometimes held that doctors' personal moral objections should *never* in fact be granted moral weight — but it is not as significant as all that. Even Julian Savulescu, one of the most outspoken opponents of doctors' rights to value-based objections (of whom I have already said a little, and will say more later), acknowledges the *possibility* of situations where allowances can be made without affecting patient care at all, and agrees that, in these situations at least, allowances should be made:

When a doctor's values can be accommodated without compromising the quality and efficiency of public medicine they should, of course, be accommodated. [...] But when conscientious objection compromises the quality, efficiency, or equitable delivery of a service, it should not be tolerated.

(Savulescu, 2006, p.296)

So, when I argue that there are reasons to grant moral weight to doctors' objections, I'm not claiming that this in itself means we should always or often *actually accommodate* them. In fact, I won't even have committed myself to the claim that we should *ever* necessarily accommodate an objection in practice, because it may turn out that there will *never* be an actual situation where the value of accommodating a doctor's values will not be outweighed by other factors. If we adopt Savulescu's account, this would be the case if it turned out that accommodating doctors' values *always* turned out to compromise "the quality, efficiency, or equitable delivery of a service" at least to some extent.

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<sup>30</sup> It's customary in philosophical ethics to attribute the concept of a 'pro tanto' obligation to Ross (1930), even though the term he used was 'prima facie'.

So, even if everything I say in the next few chapters is right, whether we should *actually* accommodate an objection will depend on how the objection fares against other relevant considerations that also have moral weight — and this is the question I will tackle in the last couple of chapters of my thesis. Here I will complicate the argument by discussing issues which arise specifically in the medical context. In particular, I will focus on other morally significant considerations, such as patients’ interests, which might militate against respecting doctors’ objections. One such complication, the issue of referral, will be sufficiently meaty that it will demand a chapter to itself.

Finally, at the end of my thesis, I will ‘zoom in’ from the abstract level of foregoing chapters to sympathise with the lot of an individual doctor who runs up against limits to society’s tolerance of her personal moral views. Since the consequences of this situation might be severe, I will suggest some possible ways in which these consequences might be avoided, mostly by trying to justify to the objecting doctor why the limits are in place in a way that will be helpful to the doctor herself.

# Chapter 2:

## Some accounts that don't work

In chapters 3 and 4, I will elaborate on what I think are two good accounts of why doctors' objections deserve moral weight (harm and tolerance, respectively). But first I want to outline a number of other, less good accounts, and show why they don't work.

Some of these accounts I will simply reject. Others, I will argue, are wrongheaded, but they contain elements that are useful because they point to better accounts. It will come as no surprise that those better accounts are harm and tolerance — the accounts that I myself will defend in successive chapters.

### I. Wrongdoing, controversy and error

#### *Avoiding wrongdoing*

Perhaps the most basic account of why we should allow doctors to refuse to participate in controversial procedures is that those procedures are morally wrong:

A legislator might think that protecting conscience is so important that persons should not be made to act against conscience, however odd the basis for their judgments. But a legislator who believes that a particular procedure is seriously wrongful, and should be performed as little as possible, might approve a right of refusal independent of any special sensitivity about the conscience of those who refuse.

(Greenawalt, 2006, p.821)

Avoiding wrongdoing might be a very good reason not to legalise a controversial procedure in the first place; and Greenawalt's suggestion, which I suppose might have some weight, is that we might want to allow refusals even when we do legalise it, in a pragmatic attempt to limit its prevalence. But when we're looking for a reason why doctors' objections should be given moral weight, I hope that the reason for rejecting this account is obvious: it takes for granted precisely what is at issue, namely the moral value of the procedure in question. As such, it violates the fundamental rule I set out in chapter 1, that there is no point in trying to use the moral value of a procedure as a premise in an argument about respecting objections to that procedure.

Of course, there's nothing wrong with an *individual doctor* giving this account of why her objection should be respected. Indeed, it seems she must give something like this account if her objection is to count as a moral one. But those who disagree with the doctor's dissenting view will need a different account of why they should nonetheless respect it.

### *Avoiding policy error*

Closely related to the question of avoiding wrongdoing is the question of avoiding policy error. The idea here is that we should take doctors' objections to particular procedures seriously because those objections give us information that we didn't previously have — information that might lead us to conclude that there is indeed something immoral in those procedures, which might in turn prompt us to rethink their permissibility or being more careful when we approach similar decisions in the future. According to this argument, moral objections are a sanity check on the laws we pass, and if we shut our ears to them, we deny ourselves crucial information that might help us avoid or fix policy errors.

I agree, of course, that a good reason not to legalise a procedure is that it may be immoral. And in the same vein, it's possible that new information about the moral value of a procedure may come along after that procedure is legalised. This could come in the form of new, convincing arguments against the procedure, or simply in the form of more widespread objections than we anticipated. I accept that we should keep our ears open to such objections, and if they change our minds — that is, if a currently legal procedure turns out to have consequences that we realise are morally bad on balance — we should consider changing the law to make the procedure illegal.

But the question of which procedures should be legal and which should be illegal is not what's at issue in my thesis. What's at issue is rather how we should respond to doctors' objections to procedures *whose moral acceptability we (currently) grant*. As a society, we investigated the moral value of the procedure when we weighed up whether or not to legalise it. At that stage, if people who objected to the procedure had convinced us that their reasons for doing so were likely to be correct, then we would have had a strong reason not to legalise the procedure after all. Since we did in fact legalise the procedure, having taken into account the arguments of those who disagree, this implies we concluded that it was *not* immoral.

So, at best, the argument from avoiding policy error is an argument against closing our ears to objections. It is not an argument for granting those objections moral weight.

### *Controversy*

Perhaps what gives some objections moral weight is the fact that they are based on moral beliefs about practices that are controversial. This suggestion is made, for instance, by McLeod (2008) and Magelsson (2011), and most directly by Julie Cantor:

Would we tolerate a surgeon who holds moral objections to transfusions and refuses to order them? An internist who refuses to discuss treatment for diabetes in overweight patients because of moral opposition to gluttony? If the overriding consideration were individual conscience, then these objections should be valid. They are not (although they might well be permitted under the new rule). We allow the current conscience-based exceptions because abortion remains controversial in the United States.

(Cantor, 2009, p.1485)

So the reason we should give moral weight to doctors' objections to things like abortion is because abortion is controversial, and the reason we should *not* give moral weight to doctors' objections to things like pain relief is that pain relief is *not* controversial.<sup>31</sup>

This proposal has a couple of points in its favour. First, although some finesse may be required, it generates a very straightforward and practical piece of advice: respect objections to procedures that are controversial, and don't respect others. Second, it seems to reflect an intuitive pre-theoretical view of ethical practice in general: there is something that seems intuitively right about saying that we should make allowances for people who disagree with the prevailing view if the prevailing view is itself controversial.

But things can't be as straightforward as that. After all, nobody would advocate *always* following that principle. A quick glance at the politics columns of any national newspaper, or a stroll past the more-or-less-permanently-encamped bands of political protesters outside government and legislature buildings, is enough to drive home the point that many laws and practices are controversial when they're first implemented, and some remain so for a very long time. It can be many years until a particular policy becomes generally accepted, assuming it's not modified or repealed in the meantime. Equally, public support can persist for practices that have been outlawed for moral reasons: capital punishment in Europe may

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<sup>31</sup> I define what I mean by 'controversial' in chapter 1, p.11, of this thesis.

be one such example (YouGov, 2014). The endlessly shifting sands of controversy are a familiar feature of life in a politically liberal country. Yet we don't typically think that the objections of those who disagree with their country's prevailing drugs or taxation policies, for instance, are themselves a reason to respect those people's refusal to comply with those policies. In most cases, we expect people to abide by the requirements of the society in which they live, grudgingly or otherwise, and in many cases we think society justified in applying a degree of coercion to enforce those requirements. You will go to prison for using illegal drugs even if the policeman who arrests you, the judge who convicts you and you yourself all privately believe that your country's drugs policy is wrongheaded. To hold otherwise would be to tantamount to rejecting the general authority of the law to compel anyone to do anything of which they disapprove, and that's clearly going too far.

Indeed, even where I personally hold moral views about certain controversial measures which might lead me to agree with those who object to those measures, this is a long way from saying that I would want to allow those who object to have their objections recognised in law — and even further from saying that we should accord moral weight to *any* objection to *any* measure just on that basis. We are not tempted to write into all our laws a general conscience clause just in case the new law is controversial. And we resist still more strongly moral objections to rules that forbid things which we tend to think are impermissible anyway: ending the slave trade was highly controversial (Drescher, 1994) but few would argue that this controversy should have prompted 19th-century legislators to include a 'conscience clause' so that dissenting slave traders could continue to operate.

Another strategy for responding to the claim that controversy means we should respect objections is to think about how we would respond to hypothetical objections to practices where in fact there is no substantial controversy, and where we feel confident in our own moral views. To take a random example: children's schooling (allowing for home schooling) is compulsory in many countries. Most people, I assume, have no objections to this rule.<sup>32</sup> But suppose, counterfactually, that an undercurrent of resistance to compulsory schooling developed among some parents. Would we then want to grant moral weight to the objections of those parents, so that they were entitled to deny education to their children?

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<sup>32</sup> But see Bereiter (1973) for an interesting argument against compulsory schooling.

That, I think, is an interesting question. On the one hand, it seems to me that the answer is obviously ‘no’. Once society has decided that children have a right to education (of some sort or other, at least), and that this is an important enough right to introduce compulsory schooling, the fact that some parents hold moral beliefs to the contrary doesn’t appear to be a reason to allow individual children to be excluded from that right, any more than we allow those who disapprove of wearing seatbelts or paying taxes to plead exemption based on their private moral objections.

But, on the other hand, I think the emergence of a degree of controversy about a practice should at least ring alarm bells. After all, a large part of what reassures us that compulsory schooling is broadly *acceptable* is that it is broadly *accepted*. If a groundswell of opposition to this formerly uncontroversial practice were to arise, we ought at least to examine the causes of this new controversy — and that examination may prompt us to ask ourselves whether the law needs revising. Or, to revisit Cantor’s example from a few moments ago, if a substantial number of doctors suddenly started raising moral objections to blood transfusions or administering painkillers, we should look more closely at what was going on. It would be foolish to shrug off these warning signs simply because ‘controversy is irrelevant’.

Of course, this is an atypical scenario. When we think of controversial practices in modern medicine, we tend to think of practices that were relatively recently legalised and whose legalisation was controversial because the practices themselves were already controversial. In these cases, we don’t really need the fact of ongoing controversy to ring alarm bells for us: after all, before Oregon, Belgium and the Netherlands legalised doctor-assisted dying, they had already listened to those alarm bells and decided to go ahead anyway, so the fact they continued to ring after the relevant legislation was adopted didn’t provide them with any further information about the moral status of the procedure. Nonetheless, new controversies *can* sometimes arise about existing procedures, if, for instance, an improvement in our scientific understanding paints an existing procedure in a new light; and in that case, the *new* alarm bells are well worth listening to. Something like this happened with the over-the-counter marketing of thalidomide in the late 1950s and early 1960s (Botting, 2002). And, to take an example from outside medicine, most of us have a different moral attitude to burning fossil fuels now from the attitude we had fifty years ago.

In summary, I've argued above that, whatever it is that makes moral objections (sometimes) worth respecting, it can't be the bare fact of controversy; and, by the same token, it's not an appropriate response to controversy to allow objections, if we remain convinced that a procedure is morally appropriate on balance. But this doesn't mean controversy is irrelevant. The fact that some people disapprove of a rule indicates that they judge that rule to be inappropriate — and the more widespread the disapproval, the more confident we (society at large) need to be about the rightness of our position if we want to overrule people's objections. The existence of controversy is not enough to justify respecting objections, but it *is* enough to remind us to keep an open mind.

### *Reasonable disagreement*

Before we leave the question of error and controversy, let me present another version of the same argument. This is the argument that what counts is not just any old disagreement, but *reasonable* disagreement. If there is *reasonable* disagreement about the permissibility of a particular practice, the argument goes, then we ought to make allowances for the moral views of those who object to that practice.

If we take this line, we're faced with the immediate task of adjudicating which disagreements are reasonable and should thus be taken seriously, and which are *unreasonable* and can presumably be disregarded. It seems to me that we might try to do this in one of two ways:

1. by assessing the content of the contrasting positions on both sides of the disagreement — only 'reasonable positions' count;
2. by assessing the character of the people who disagree — only disagreements held by 'reasonable people' count.

(A third possible method, counting a disagreement as reasonable if *enough* people hold it, is just another version of the question of degree of controversy, which I dealt with a moment ago.)

Let's consider first method **1** — assessing the positions themselves. I suppose there are two possible interpretations of what constitutes a 'reasonable position' here:<sup>33</sup>

- **We could interpret 'reasonable' in the loose sense of 'morally acceptable' or 'defensible'** (roughly the sense in which it's used in phrases like 'it's reasonable to expect people who move here to speak the language'). If we take this interpretation, any attempt to determine whether a position is reasonable or not will immediately thrust us back into the controversy about the acceptability of the procedure itself — because, under this interpretation, the question 'Is it reasonable to object to providing sexual health services to same-sex couples?' is basically the same as 'Is it morally acceptable to provide sexual health services to same-sex couples?'. In this sense, asking whether a position is reasonable gets us no further than simply asking whether the procedure in question is morally acceptable in the first place, and of course there is no agreed right way to answer this question in the case of controversial procedures, since that's what 'controversial' means. So this is a non-starter.
- **We could interpret 'reasonable' in the stricter sense of 'deduced using sound reasoning from consistent premises'**, making it synonymous with 'rational'. But then our test will grant moral weight to rational but plainly unacceptable objections, like 'I refuse to countenance pain relief in childbirth because pain is God's punishment for original sin'. This is a perfectly reasonable position in the sense of being rationally deduced from consistent premises, but it is also one which (I submit) we clearly want to reject. At the same time, our test will *deny* moral weight to 'it's just wrong' objections, such as 'I just really feel in my heart that killing a patient is terribly *wrong*'. This objection stems from profound emotional commitments, but it's not rationally deduced from consistent premises. Yet it is (I submit) exactly the kind of objection we want to take into account (for reasons I'll discuss at length later in this chapter). So this interpretation of 'reasonable' seems both too broad in one sense, and too narrow in another. It, too, is a non-starter.

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<sup>33</sup> There is much more discussion in the political philosophy literature about the notion of 'reasonableness' as it relates to tolerance of moral disagreement. I revisit the issue of tolerance (including Rawls, 1993) in more detail in chapter 4, but other than that, I don't even scratch the surface. For a wide range of accounts and commentaries, see Brooks & Nussbaum (2015).

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That leaves us with method 2 — assessing the character of the people who disagree. Unfortunately, distinguishing ‘reasonable people’ from ‘unreasonable people’ is just as difficult and subjective as distinguishing ‘reasonable positions’ from ‘unreasonable positions’. Absent particular extraordinary conditions, most people are reasonable in the minimal sense of being capable of rational thought, so this will be too broad a criterion: nearly every disagreement will count as reasonable. But how do we narrow the definition? Do we exclude people whose intelligence or level of education falls below a certain threshold? Or who labour under the influence of ‘complicating factors’ such as religious beliefs, for instance? Or whose value systems are sufficiently different from our own? I trust it’s clear why assertions like ‘We can disregard these people’s moral objections because they are too stupid/ill-educated/religiously misled/different from us to count as reasonable’ are deeply problematic. Judging controversies by the people who hold them, using predefined criteria of ‘reasonableness’, is a recipe for controversy in itself.

I have only sketched the immediate problems that arise from trying to invoke controversy or reasonable disagreement as justifications for taking objections seriously. But I hope this is enough to indicate that these are no magic bullets, essentially because they either rely heavily on subjective criteria (what counts as ‘reasonable’, what counts as ‘enough controversy’), or because they cast the net far too widely to encompass any objection.<sup>34</sup>

## II. Personal freedoms and preferences

One possible argument for respecting doctors’ moral objections is that doctors, like the rest of us, are free agents who ought to be accorded the right to choose how they act in accordance with their personal preferences.

Taken on its own, this argument is clearly flimsy. Doctors may indeed be free agents by virtue of being human beings, but when one accepts a job — any job — one also accepts

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<sup>34</sup> And there is, I would argue, a further persuasive reason why accounts based on these claims will fail. It’s that these accounts overlook the crucial issue of how much harm is caused when a moral objection is disregarded. Whatever criteria we use to separate ‘reasonable’ from ‘unreasonable’ people, for instance, will end up subjecting those people judged ‘unreasonable’ to the potentially harmful experience of being forced to participate in procedures they find morally abhorrent. But, however ‘unreasonable’ we may judge them to be, those people are moral agents and harm inflicted on them has moral value. This seems to me a fundamental failing of any account based on controversy. But, since the notion of ‘harm’ is central to my thesis, I will not develop a detailed argument for its importance until chapter 3.

certain restrictions on one's freedom. If I take a job as a barista, I can't very well refuse to speak to customers, make coffee, or turn up for work on time, at least if I want to hold onto that job and the financial compensation it brings me. Like baristas, doctors are minimally expected to fulfil the requirements of their job: turning up on time, cooperating with colleagues, treating patients, abiding by the rules of their profession and so on. Of course, whether that list ought also to include the requirement to participate in medical procedures that they judge immoral is the big question. But that question can't be settled simply by pointing out that doctors are humans with the right to make free choices in accordance with their personal preferences. As long as they want to remain doctors, this is irrelevant.

Incidentally, Meyers & Woods (1996) argue that doctors in fact have special obligations because of the special nature of the medical profession:

Physicians have this obligation, we contend, because the image of them as un beholden free agents is a myth. Physicians are, in fact, deeply indebted to society, an indebtedness that brings with it a strict obligation to provide vital and socially sanctioned medical services. With this obligation comes the need to justify why one should be exempted from providing such services. The obligation to provide service comes from two sources: 1) The ways in which physicians receive extraordinary social benefits, and 2) The social harms that would be suffered should the service not be provided.

(Meyers & Woods, 1996, p.117)

Now, there is much to be said about the supposed special nature of the medical profession and the obligations that go along with it. Appeals to this special nature have been made by writers on both sides of the argument, and in several different contexts, and this isn't something I want to get into just yet. I'll consider the special nature of the medical profession in much more detail later in my thesis, especially in chapter 5, where I consider the question of whether being a doctor is inescapably bound up with acting on one's personal moral convictions (see especially the section of this thesis starting at p.164). At this stage of proceedings, all I'm saying is that appealing to the freedom that doctors have to act according to their preferences, simply by virtue of being human beings, is nowhere near enough to justify making allowances for their personal moral convictions when it comes to carrying out their professional duties.

### **III. Core moral beliefs, integrity and identity**

Some writers have argued that doctors' beliefs are worthy of moral weight if those beliefs are 'core', or 'fundamental', or 'very deeply held'. According to this idea, some beliefs give rise

to objections that have significant moral weight by virtue of being ‘core’ in this way, while other (non-core) beliefs do not.

This proposal has been prominent in recent discussions of doctors’ conscientious objections, so I want to spend some considerable time looking at it. In what follows, I first present and elaborate on the core-moral-beliefs view, and then argue that, although proponents of this view are quite right to argue that objections based on core moral beliefs have moral weight, this is true only because of the harm that is by definition involved in being forced to violate such a belief. There is nothing intrinsically special about objections based on core moral beliefs, it seems to me, that necessarily gives them more moral weight than, say, objections based on non-core beliefs where forced violation would also incur harm. In short, I will argue that what matters is not coreness but harm.

### *Characteristics of core moral beliefs*

Before we can consider whether core moral beliefs deserve moral weight, we first need to say what a core moral belief is. A helpful set of characteristics is suggested by one of the theory’s leading proponents, Mark Wicclair:

Core moral beliefs are an agent’s fundamental moral beliefs. They comprise the subset of an agent’s moral beliefs that matter most to the agent. They are integral to an agent’s understanding of who she is (i.e. her self-conception or identity). Accordingly, acting contrary to core moral beliefs is perceived by the agent as an act of self-betrayal. As religious conversions indicate, core moral beliefs can develop suddenly and change over time. However, they tend to be persistent and subject to change only in response to significant life events, such as near death experiences, tragic events, and extreme changes in fortune (good or bad). Although core moral beliefs need not be blindly held, they tend to be resistant to influence by others.

(Wicclair, 2011, pp.4-5)

I’ll say more in a moment about the first part of Wicclair’s characterisation, but on the latter part, I wonder whether Wicclair is right to point to the long-term stable nature of beliefs and their resistance to influence as a marker of ‘coreness’. This doesn’t ring quite true to me, for two reasons.

The first reason is a doubt about the fact of the matter. I just wonder whether many people’s core moral beliefs really *are* as change-proof as all that. Perhaps it’s rare for moral beliefs to change abruptly, except in those rare Damascene moments that cause people to re-evaluate their entire worldview, as Wicclair concedes. But it strikes me as entirely normal that core

moral beliefs also evolve gradually over somewhat longer periods of time, as those who hold them are exposed to new experiences, learn new facts, encounter others with different perspectives, and change and mature within themselves. If this were not the case, then it would be futile to encourage, for instance, medical students to develop their own moral views by reflecting critically on morally relevant experiences and their own reactions to them. But I don't think this is futile; in fact, it's one important aspect of medical education. In the same vein, when I reflect on my own experiences, it seems to me that many of my attitudes, including my most fundamental moral ones, are rather different now from how they were, say, fifteen years ago. And this is not because of any sudden change in fortune or dramatic life events, but just through my gradually growing older, meeting more people, learning more about the world and myself — even, I admit grudgingly, through my study of philosophy. So, while I daresay the fundamental planks of my personal worldview (both moral and otherwise) are fairly “resistant to influence by others” in the sense that I doubt anyone could talk me out of them *right now*, it does seem that gradual and cumulative external influences can effect, and have indeed effected, quite significant changes in my beliefs over the course of months and years. In fact, gradual change seems to me to be the norm, with sudden change correspondingly less likely. Does this fact make those beliefs any less ‘core’ or ‘fundamental’? I see no reason to think that it does.

The second reason I have doubts about Wicclair's ‘resistance to change’ characterisation is this. Recall, again, that our aim is to identify which beliefs have moral weight when it comes to objections based on them. For this purpose, I'm not convinced that ‘resistance to change’ is a relevant factor at all. Why should the possibility of a given moral position's evolving gradually in the future make a difference to whether we should respect that position today? Or, to approach the question from the other end, why should the particular history of how a position was acquired — since birth, in a bolt from the blue, or through a gradual lifelong process of moral reflection, adjustment and settling into equilibrium — make a difference to whether it deserves respect right here, right now? After all, the degree of changeability of one's beliefs is at least as much a consequence of personality traits such as personal confidence or stubbornness as it is a property of the beliefs themselves, and it would surely be odd to argue that more confident or stubborn doctors' objections have more moral weight than less confident or stubborn ones. On the contrary, it seems to me that a doctor's sincere moral belief provides just as defensible a basis for refusing to perform an objectionable procedure if that belief has solidified gradually for that individual over the

past ten years and might dissolve again through an equally gradual process over the next, as it provides if it lasts a lifetime.

But, although I quibble with this aspect of Wicclair's account, I'm perhaps being unfair by focusing on it. After all, he only says that core moral beliefs "tend to be" long-term resistant to change, not that long-term resistance to change is a defining or necessary characteristic of core moral beliefs. And although I disagree, it does seem right to say that core moral beliefs tend at least to be resistant to *immediate* reversal. As I said a moment ago, I doubt that anyone could talk me out of a fundamental plank of my worldview, moral or otherwise, simply by presenting me with an easy knockdown argument. The kinds of things that bring about changes in core moral beliefs are not simple and sudden realisations that a particular consideration has force, but rather the prolonged and gradual accumulation of life experiences: influences from other people, new concepts, new ways of thinking about things, reflections on one's own internal values and how they interact with the world.

The first part of Wicclair's account I quoted a moment ago points to a plausible explanation for this. My core moral beliefs are not beliefs whose truth I just happen to recognise on the basis of a chain of reasoning that might conceivably prove to have a faulty link somewhere along the line, as one might expect with more humdrum beliefs. Instead, my core moral beliefs have intricate connections to many different aspects of my worldview — they are interwoven with it.

Indeed, my core moral beliefs, if they are properly interwoven in this way, may even be part of what my identity actually *is*. Jeffrey Blustein (1993), quoted with approval by Wicclair (2000), argues that the person who acts against conscience "betrays some principle that is *constitutive* of self-identity" (p.297, emphasis added), and further observes:

It is in terms of this moral interest in personal integrity that I will understand the significance of appeals to conscience. Persons who claim that they cannot in good conscience do what they are asked or ordered to do [...] may be anticipating what will happen to self [sic] if they should not refuse, viz. they will be in a state of internal disharmony, and refuse partly because they value their own inner harmony.

(Blustein, 1993, p.297)

This useful commentary by Blustein contains two illuminating suggestions.

The first suggestion is about what core moral beliefs *are*. Blustein suggests they are those moral beliefs which, by virtue of their deep embeddedness in a person's worldview, are

constitutive of that person's self-identity, something we naturally value extremely highly. (I will have more to say later about what "constitutive of self-identity" actually means.) Because of this deep embeddedness, changing a core belief involves making an internally recognisable change to a fundamental part of oneself. This can happen gradually over time, through experience-based and reflection-based processes that modify and reshape many elements of one's worldview; or it can happen abruptly, as in the aforementioned Damascene experience. Sometimes, when such a change is poorly integrated into other aspects of one's inner life, it can be a deeply challenging and painful experience. But it never happens lightly or casually, on the spur of the moment.

The second useful feature of Blustein's account is the beginning of an explanation of *why* objections based on core moral beliefs should have moral weight. If my core beliefs are challenged, says Blustein, this is far more than simply a challenge to something I happen to believe. It's a challenge to something that's deeply bound up with my identity, perhaps to the extent of being constitutive of it. In other words, it's an assault on *my very self*, and that's (understandably) something I value greatly. To betray my core moral beliefs is to betray myself, and to betray myself is harmful to me.<sup>35</sup> (Hold that thought: I will shortly argue that the notion of harm is more central to the core-moral-beliefs account than either Blustein or Wicclair suggest.)

Morten Magelssen makes a similar case, pointing not only to the pain and distress caused to us by acting against our consciences (2011, p.19), but also to the way our moral choices contribute to who we are:

We choose to act to bring about desirable goods or states of affairs, but our choices also have consequences for our moral character. As Finnis explains, when we choose moral or immoral actions, we also choose to become a certain kind of person. [...] Morally important choices make us the persons we are, for better or for worse. The effects of our actions on our personalities are not something from which we can escape. Acting against your conviction

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<sup>35</sup> Here, and in what follows, it is possible to over-egg this particular pudding. The amount of harm inflicted on a doctor who's forced to act against her personal beliefs may be high, but it is, in a way, capped, because nobody is *required* to be a doctor. Membership of the profession, including ongoing membership, is voluntary (unlike, say, membership of the armed forces for who have resisted forced conscription in wartime). I consider the implications of this in more detail, starting on p.209 of this thesis.

in choice situations of great importance will injure your moral identity, sometimes with psychological and emotional repercussions.

(Magelssen, 2011, pp.18-19)<sup>36</sup>

And the American Medical Association's Code of Medical Ethics observes:

Physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons.

(American Medical Association, 2016, paragraph 1.1.7)

### *Core moral beliefs and personal integrity*

Here is a summary of the core-moral-beliefs account as I've explained it so far. A certain subset of a person's beliefs, 'core' moral beliefs, are so bound up with a person's self-identity that they are part of who that person is. Beliefs like this are so central to the person that to act against them would cause him significant harm. For this reason, doctors' objections to particular procedures, when based on those particular kinds of moral beliefs, should be granted significant moral weight.<sup>37</sup>

This hand-wave towards self-identity may be as much as needs saying about what makes core moral beliefs worth respecting. It's certainly as much as some other prominent writers have said. When Magelssen (2011) argues that respect for personal integrity is the foundation for recognising doctors' objections, he simply writes, "We all have deeply held convictions that we consider important to us, and which constitute central aspects of our identities" (p.18), and moves on to discuss why this is morally relevant. But this is not an *argument* for the claim that a person's core moral beliefs constitute part of that person's identity. Nor does it even say in much detail what this claim actually means. Yet the claim is hardly philosophically straightforward. In what sense is the phrase 'constitutive of self-identity' to be understood? And what grounds do we have for accepting it?

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<sup>36</sup> Magelssen's reference to Finnis (whom I do not cite directly) is to Finnis, J. (1986). *Fundamentals of Ethics*. Washington, DC: Georgetown University Press.

<sup>37</sup> As I said at the start of this chapter, that's not to say that we should always, or indeed ever, accommodate those objections. When society decides how to treat doctors with moral objections, other considerations have moral weight too. But, as I also said at the start of this chapter, one step at a time.

Indeed, when it comes to trying to give a better account of core moral beliefs and the role they play in people's lives, it's all too easy for even otherwise analytical writers to wax metaphorical. I talked earlier about "deep embeddedness" and beliefs which are "interwoven into my sense of self". Sulmasy talks about "one's deepest self-identifying moral beliefs" and says that when one acts in accordance with them, one is committed to "wholeness" (2008, p.138). And this shift towards lyricism extends well beyond medical ethics. In the last two decades of the twentieth century, considerable philosophical debate took place on the nature of personal autonomy, following pioneering discussions of the subject by Harry Frankfurt (1988, 1992) and Gerald Dworkin (1988). According to these accounts, a prerequisite of acting autonomously is to act *authentically*<sup>38</sup> — that is, in a way which is true to one's own deepest moral convictions and not to the expectations of others.<sup>39</sup> Here, again, we find the deep embeddedness of these convictions poetically expressed: an individual acts authentically when her actions "spring from the depths of the individual's being" and when she "lives in harmony with her convictions and inclinations" (Meyers, 1989, p.8, quoted in Oshana, 2007, p.415).

Charles Taylor goes further, arguing that one's identity in fact only *comes into existence* through acting authentically,<sup>40</sup> in accordance with one's personal convictions:

Being true to myself means being true to my own originality, and that is something only I can articulate and discover. In articulating it, I am also defining myself. I am realizing a potentiality that is properly my own.

(Taylor, 1991, p.29)

This is all very well. Philosophical discussions of identity and authenticity have a whole literature of their own, and I don't want to get diverted too far into it when my main focus is the ethics of doctor's objections. But on the other hand, some degree of diversion is

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<sup>38</sup> Dworkin, though not Frankfurt, favoured this term.

<sup>39</sup> Siguður Kristinsson traces the connection between autonomy and authenticity back to the work of Mill: "Individual human beings realize their potential, according to Mill, through exercising their capacity for autonomous choice while 'he who lets the world, or his own portion of it, choose his plan of life for him, has no need of any other faculty than the ape-like one of imitation'" (Kristinsson, 2007, p.4; quoting Mill, 1859, chapter III).

<sup>40</sup> One possible interpretation of Taylor's passage about "realizing a potentiality that is properly my own" is that he means to express something similar to Magelssen (2011)'s claim that our moral choices shape our future moral selves. If I choose to steal on a particular occasion, this means that I am, from now on, the kind of person that chooses to steal, and this is morally detrimental to me.

necessary to avoid an important practical difficulty: without a clear, less metaphorical account of what it means for a core moral belief to be embedded/interwoven/depths-springing/harmony-generating/potentiality-realising, it might be hard to identify *which* beliefs are core in this way. Kristinsson (2007) makes this point particularly vigorously, examining various competing conceptions of personal identity and concluding that Frankfurt's notion of "fidelity to self" (Kristinsson, 2007, p.1) is either ambiguous or incoherent with respect to each. And this might be a problem since the practical reason for wanting to be able to distinguish core beliefs from others, according to the overarching proposal I'm considering, is so that we know which objections have moral weight. After all, a given objection might depend on either a core belief or a non-core belief, and this can vary from individual doctor to individual doctor.

Suppose, for instance, that two doctors each object to offering sexual health or fertility services to same-sex couples (Appel, 2006). Even if we grant that both doctors are motivated by their personal moral beliefs (and not by non-moral factors such as distaste), their disapproval might still have different origins. One doctor might have a religious conviction that homosexuality is wrong, while the other might believe (independently of any religious convictions) that relationships that could not naturally produce children ought not to be encouraged. If the account I've presented so far is right, then we should grant each of these objections moral weight (independently of our approval or disapproval of the moral claims on which they are based) only to the extent that they are each based on core beliefs. But in the absence of any clear account of what it means for a belief to be constitutive of someone's self-identity, how can we establish whether either or both of these doctors' beliefs are core for them? For instance, is the first doctor's belief more or less likely to be constitutive of self-identity because it's linked to a religious worldview? That very much depends on what 'constitutive of self-identity' is supposed to mean.

To find a non-metaphorical answer to this question, we need to look beyond recent work on medical ethics and into the philosophical literature where the concept of a 'core moral belief' has its origins. Jeffrey Blustein's 1993 paper, whose characterisation of core beliefs as "constitutive of self-identity" is the jumping-off point for much of what I've written so far, is

primarily about *personal integrity* (its subtitle is ‘Maintaining integrity in the doctor-patient relationship’). Blustein writes:

It is tempting to say to the person who, by acting against conscience, betrays some principle that is constitutive of self-identity, ‘You owe it to yourself to try to repair your inner division’. The language of ‘owing’ suggests the special gravity of the problem: it is not just an unpleasant situation that the individual finds him or herself in and it is not just to bring the self greater happiness that the individual should work to resolve inner conflict. It is more like an instance of a moral duty we have to ourselves to lead personally integrated lives, to bring our actions and motivations into harmony with our principles.

(Blustein, 1993, p.297)

For Blustein, what’s at risk when a doctor is forced to act against his core beliefs is his personal integrity, his capacity to say truthfully to himself ‘I live my life according to my beliefs’. Personal integrity is preserved when we act in accordance with our core moral beliefs, and violated when we act against those beliefs. And we are under a moral duty to maintain our integrity — that is, to maintain the connection between our actions and our beliefs.<sup>41</sup> In the same vein, Lynne McFall (1987, pp.7-8) characterises integrity as coherence between one’s values and one’s actions.<sup>42</sup> Let’s call this the ‘coherence account’ of personal integrity.

The coherence account can be understood more widely than this. In a pointed critique of general utilitarianism in ethics, Bernard Williams suggests that our personal integrity is

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<sup>41</sup> Tangentially, I’m not entirely sure how to construe Blustein’s notion of “a moral duty we have to ourselves”. When we say we have a duty *to* someone, we normally mean that person is the source of the authority which gives rise to the duty. I have a duty to my employer to turn up for work on time, for instance, because my employer is entitled to impose that duty on me by virtue of the contract of employment that we’ve both agreed. Can a *moral* duty have an object in this way? What is the source of authority which gives rise to a moral duty? I suppose, if I promise you that I’ll do something, it could be said that I then have a moral duty *to you* to keep my promise. But this seems a different kind of thing. And if we *can* have a moral duty *to* someone, can that someone be oneself? For more on whether we ‘owe it to ourselves’ to be moral people, see Mendus (1985).

<sup>42</sup> Bleich (2002) also deploys the notion of integrity in defence of doctors’ objections, but he uses it in a different sense — to refer to the integrity of the medical profession in general. According to Bleich, just as *personal* integrity is preserved by a connection between one’s personal values and one’s actions, so the integrity of the *profession* is preserved by a connection between the goals and values of medicine and the actions of those who practise it, and this provides a reason for us to respect doctors’ objections when they’re based on such goals and values. There is an obvious analogy between the two kinds of integrity, but the notion of professional integrity also introduces complications. For instance, if the reason we should respect a *person’s* integrity is to avoid harm to that person (as I’ll shortly suggest), then what’s the reason we should respect a *profession’s* integrity? Can a *profession* be harmed, over and above its members? Bleich himself thinks the answer is no (p.257). As for me, I will have more to say about valuing the traditional goals and values of the medical profession when I discuss tolerance in chapter 4 of this thesis (especially p.127 onwards).

threatened when our core moral beliefs, deepest desires, lifelong projects and general attitudes come under attack — a fact which makes a utilitarian programme counter-productive because it forces individuals to subordinate their personal priorities to those of the greater good:

How can a man, as a utilitarian agent, come to regard as one satisfaction among others, and a dispensable one, a project or attitude round which he has built his life [...]? It is to alienate him in a real sense from his actions and the source of his action in his own convictions. It is to make him into a channel between the input of everyone's projects, including his own, and an output of optimistic decision; but this is to neglect the extent to which *his* actions and *his* decisions have to be seen as the actions and decisions which flow from the projects and attitudes with which he is most closely identified. It is thus, in the most literal sense, an attack on his integrity.

(Williams, 1973, pp.116-117, emphasis in original)

Bigelow and Pargetter (2007) cast the integrity net even more widely, describing personal integrity simply as the strength of will to maintain coherence between *desires* and actions, without any reference to normative content (values) at all.

One supposed problem with this broadening of the coherence account of personal integrity is that it struggles to make sense of why we generally regard integrity as a virtue. Bigelow and Pargetter's concept of personal integrity would apply equally to someone who reliably acts on a desire to eat candy, or to read books, as to someone who stuck to their guns on moral issues (Miller, 2013). And it seems to me that, although Blustein's, McFall's and Williams's accounts do make reference to specifically moral attitudes, they're vulnerable to a parallel objection. By defining integrity essentially as *coherence between values and acts*, they include no requirement that the values in question are the right ones. I concede that this seems right in one sense: we do indeed tend to admire the integrity of people who exhibit it, even if we explicitly disapprove of the content of their beliefs. We say of politicians whose policies we despise, 'Well, at least they have the courage of their convictions!'. But few people would be comfortable with taking this attitude all the way. It seems counter-intuitive to say that even people with morally abhorrent values exhibit great personal integrity when they consistently act on those values. Or, to put it the opposite way around, the more willing we are to swallow this and praise the integrity even as we despise the act, the more the question looms: why on earth should integrity be a good thing, if it implies consistent adherence to abhorrent values?

But is this really a problem? Not for our purposes. In fact, this perceived weakness in coherence accounts of personal integrity translates into a positive *strength* when it comes to the question of making allowances for doctors' objections. This is because the question of what we should do when doctors have objections to *otherwise permissible* procedures — objections which we do not share — is the whole issue here. By definition, doctors who object to legal and generally accepted procedures are out on a limb: their personal moral beliefs about those procedures are out of step with ours. So the fact that people with whom we disagree nonetheless have the courage of their convictions is precisely the point. If we want to say, 'We should grant moral weight to those beliefs even though we don't share them, because to violate them would be a threat to the doctor's personal integrity', we absolutely *need* to have an account of personal integrity which is independent of our judgement of the beliefs themselves, in order to have an objective justification for granting them moral weight. As I said when I stipulated my fundamental rule in the previous chapter, it would be no help at all if our notion of personal integrity included a stipulation that the beliefs being acted upon must be the 'right ones', because then that objective justification would be impossible.

### *Diagnosing core moral beliefs*

So far, I have presented an account of when a doctor's moral objection ought to be accorded moral weight. To recap: according to this account, we should grant significant moral weight to a doctor's objection if that objection is based on the doctor's core moral beliefs, rather than on non-core beliefs or on other considerations. Core beliefs deserve this special status because they are constitutive of self-identity — by which we mean that they're inescapably tied up with the values, desires and projects which are central to that person's life — in short, tied up with his personal integrity. And forcing someone to act against these kinds of beliefs therefore risks doing him significant harm.

The line of argument I've just been developing is essentially just a filling-in of details in support of the original suggestion by Blustein, Wicclair and others that distinguishing core moral beliefs from non-core ones is what provides justification for respecting doctors' moral objections to controversial procedures. But I now want to question whether this filling-in of details is actually very helpful — and to unpick the argument which I have just presented.

To get started, let's step out of the philosopher's shoes for a minute and into the shoes of the clinician, the policy-maker, the ethics committee member, or the judge. How helpful is what I've said so far to people like these — people who face practical questions about how to handle doctors' objections?

The answer is: not very. It's all very well having a more or less well-developed general theory of what core moral beliefs are and why we ought to respect them, but nothing that's been said so far has provided any practical guidance about how to identify those beliefs in practice. Without being able to identify them, no theory — no matter how detailed — can help us decide how we should respond to a particular real-life objection. So we need a way to distinguish core beliefs from other, non-core ones.

Sadly, it's not yet possible to scan someone's brain and read off a reliable report of which of their beliefs are constitutive of self-identity and which aren't. But that's not to say there is no hope for diagnosing these beliefs from the outside. Since our definition of 'core moral beliefs' specifies at least part of the role that these beliefs play in people's lives, they are likely to have externally discernible effects connected with that role. For instance:

- **Sacrifice:** If someone goes to considerable lengths and makes considerable personal sacrifices so he can live his life in accordance with a particular set of principles, be they religious or secular, this can be indicative of a core moral belief.
- **Resistance to pressure:** If someone refuses to act against one of his moral beliefs in the face of considerable opposing pressure, as in the case of a conscientious objector to military conscription, this can be indicative of a core moral belief.
- **Suffering from violation:** If someone does act against one of his moral beliefs and is thereby thrust into protracted moral turmoil or suffers significant emotional trauma, this can be indicative of a core moral belief. More usefully, if someone expects that they will suffer such harms if they were to act against a belief, this can also be indicative of a core moral belief.

Of course, these are only suggestions for possible indicators. Even if they turn out to be fairly reliable, they are unlikely to be foolproof. Sometimes, core moral beliefs are not easily diagnosed in advance, even by the individual who holds them. They may have no observable implications for ordinary life until a situation crops up that challenges them — or, indeed,

until after the challenge has passed and its implications have become clear. Equally, non-core beliefs may masquerade as core ones. An individual might feign inner turmoil after being made to act in a certain way, or honestly but incorrectly predict inner turmoil if he were to be made to act that way in the future. Or a traumatic situation may trigger psychological ill effects that are superficially similar to those we might associate with moral anguish, though they are actually unconnected with the victim's self-identity.

Given these possibilities, the obvious next question is how we're supposed to distinguish between genuine and only apparent instances of core beliefs in practice. This opens up a whole new can of worms. As I've already suggested, simply taking people at their word doesn't seem like a good solution — not only because people can dissemble, but also because genuine moral objectors may not recognise the source of their objections until it's too late.

So do we try to come up with some kind of testing methodology? Do we establish a procedure which requires each objecting doctor to explain her claim, and then tries to judge in an objective way as possible whether enough of the indicators apply for us to grant the status of 'core moral beliefs' to the reasons underpinning it? Dresser (2005) calls this the "draft board" approach", invoking the analogous challenges faced by tribunals set up in the UK in 1916 to decide whether conscientious objectors should be exempted from military conscription:

The 'draft board' approach requires objectors to explain and defend their opposition to performing a particular medical procedure. The approach seeks to separate sincere beliefs from the other motivations that can underlie conscience claims. Among the problems with this model are that it can be damaging to morale, it cannot detect skilled liars, and the review process may be incompetent or corrupt.

(Dresser, 2005, p.10)

Despite these problems, Meyers & Woods (1996) recommend establishing such a board; Card (2007) thinks such an approach is inevitable for conscientious objection in general; and Kantymir & McLeod (2014) express sympathy with the aim, if not the methodology. But to Dresser's list of problems, I'd be tempted to add (a) the potential for damage to the reputation of medical professions among the wider public, (b) the expense and complexity of establishing such bureaucratic boards, (c) the impracticality of assessing cases within a short enough time frame to avoid jeopardising patient care, and (d) the lack of a clear

guarantee that the outcome of such an investigation will be accurate anyway, even with the best will in the world on all sides.

And the draft board approach has another significant downside. All three of the indicators I proposed a moment ago are negative ones: Does the individual make considerable personal sacrifice in the cause of his belief? Does he resist considerable pressure to act against it? Would he suffer greatly if he were forced to do so? If a draft board wanted to test these indicators, this seems to provide a motive to apply pressure to objectors and put them at deliberate disadvantage in order to test their beliefs for ‘coreness’ — which seems an undesirable state of affairs, all else being equal. (Remember, it’s easy to spot witches. They’re the ones who use their supernatural powers to save themselves from drowning.)

So, even if there are certain discernible features which are indicative of core beliefs, these are far from infallible, and attempts to improve identification rates through close examination would have significant disadvantages. Even if some form of formal testing procedure is the only option we have for assessing genuine conscientious objections, it’s still an impractical way to try to distinguish core from non-core beliefs.

Still, if we need to make such a distinction, then short of mind-reading technology becoming available (or, I suppose, painstakingly detailed psychoanalysis of the deep mental states of any would-be objector), perhaps these indicators are the best we have for now. The question then is: *do* we really need to make such a distinction?

#### *Differences in kind between core and non-core moral beliefs*

If the core moral belief account is right, it implies that core moral beliefs are significantly *different in kind* from non-core ones, in that core beliefs are constitutive of self-identity and others aren’t. And this difference in kind is what licenses us to treat two superficially similar situations quite differently.

As an example, consider the case of a procedure which conflicts with a doctor’s moral beliefs, but not her *core* moral beliefs. Suppose a doctor disapproves of offering a particular intensive treatment to an elderly patient when limited resources mean that fewer younger patients will be able to benefit from the treatment as a result — but this happens not to be a core moral belief in her case. If the doctor acquiesces and participates in the procedure, she

may regret her participation and feel that she has acted wrongly, all things considered, but (according to our supposition) her sense of self will not be under assault in the same way, and she will not experience inner disharmony or excruciating moral anguish.

Importantly, it follows that we might respect one doctor's refusal to perform a particular act because her refusal is based on her core moral beliefs, but decline to respect another doctor's refusal to perform *that very same act* because her refusal happens to be based on non-core moral beliefs. For an example of this, suppose that Dr A and Dr B both refuse to prescribe emergency contraception. Dr A says, 'Emergency contraception can prevent implantation of a fertilised embryo. My religion teaches that life begins at fertilisation, so emergency contraception is a form of killing and I refuse to prescribe it'. Dr B says, 'People ought to be encouraged to practise safe sex and the general availability of emergency contraception undermines that, so I refuse to prescribe it'. Now, we might judge that Dr A's objection is based on a core moral belief (we ought not to kill), while Dr B's is based on a non-core moral belief (we ought not to encourage laxness about safe sex practices). If we make this assessment of the two doctors' respective beliefs, and we hold the view that prescribing emergency contraception ought to be one of the duties of a doctor in general, then we might respect Dr A's refusal to fulfil that duty while declining to respect Dr B's — even though both doctors are making moral judgements.

All this depends on our being able to draw a sharp difference in kind between core and non-core moral beliefs. But I now want to express a doubt about both the possibility and the usefulness of drawing a sharp distinction in this way. The doubts I'm about to express will lead me to conclude that, although the core/non-core distinction might be a reasonable philosophical account of doctors' reasons for objecting, its value in practical terms is actually pretty limited. When it comes to actually assessing moral beliefs, what we actually need is a far simpler account, and one which doesn't rely on making a morally meaningful distinction of kind between different beliefs that is often difficult in practice to draw. The result will be a substantial simplification of my argument so far.

### *Doing without 'coreness'*

Consider again one of the indicators I suggested for diagnosing a core moral belief: what I called 'suffering from violation'. If we see that someone suffers emotional trauma because he

acted against a certain belief, or if someone honestly anticipates that acting against a certain belief would lead him to suffer emotional trauma, then this is a clue that the belief in question is core (because, we suppose, emotional trauma is a symptom of acting in a way that damages one's personal integrity). And if the belief is core, this implies that violating it would harm the person, so we should grant it significant moral weight.

But now we have what looks like a strange chain of reasoning. It goes something like this:

1. Forcing this person to act against this belief would harm him.
2. If forcing someone to act against a particular belief would harm him, this suggests that the belief is core.
3. If a belief is core, then to force someone to act against it would harm him.
4. All else being equal, we should not harm people.
5. So, all else being equal, we should not force this person to act against this belief.<sup>43</sup>

This argument is valid, but it is strange because steps 2 and 3 make a detour which is superfluous to the conclusion. We could short-circuit the argument by omitting those two steps, and it would remain perfectly serviceable:

1. Forcing this person to act against this belief would harm him.
4. All else being equal, we should not harm people.
5. So, all else being equal, we should not force this person to act against this belief.

And this short-circuited argument has the benefit of not needing to invoke complicated philosophical notions of self-identity and personal integrity to account for the concept of core moral beliefs; in fact, it has jettisoned the notion of a core moral belief altogether.

Another way to appreciate the same point is as follows. I've already said that indicators of a belief's coreness are not foolproof, because non-core moral beliefs can sometimes exhibit, or seem to exhibit, similar indicators. While it's true that all core beliefs would cause harm if violated, because you can't act against a belief that constitutes part of your self-identity

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<sup>43</sup> In line with my comments at the beginning of this chapter, the *ceteris paribus* clause here ('All else being equal...') is intended to make this conclusion equivalent to 'We should accord significant moral weight to the belief' (when weighing up whether to grant refusal).

without incurring harm to you, it might not be true that all beliefs whose violation would cause serious harm are core beliefs. (Just because all As are F, it doesn't follow that anything F is an A.) So, at best, if a doctor's belief is such that violating it would cause him significant harm, this is only a *clue* that the belief might be core. How useful a clue it is will depend on how likely it is that non-core beliefs exhibit the same feature: in other words, how likely it is that significant harms will also be occasioned if we force someone to violate a non-core belief.

So, how many non-core beliefs will also lead to significant harm if violated? If we want to know how reliable our indicators of coreness are, this looks like an important question to answer. But something has gone awry here, because if we take a step back, surely this isn't an important question at all! What if it turned out that forcing someone to violate a non-core belief (that is, a belief that's not constitutive of self-identity) *does* sometimes lead to significant harm? Would we really want to say that such a belief doesn't deserve significant moral weight because of its non-core status? This can't possibly be right. I argued at length above that the whole reason we want to grant moral weight to core beliefs is that they lead to significant harm when violated (because they are constitutive of self-identity). If some non-core beliefs carry the same risk of significant harm as core ones, then by the same reasoning *they also deserve to be granted moral weight*. And if this is the case, the core/non-core distinction is neither here nor there.

What I'm suggesting is a simplification, for practical purposes, of the argument I've presented so far. When it comes to judging which beliefs ought to be granted significant moral weight, we don't need to invoke philosophically complicated notions of coreness, self-identity and personal integrity. What matters is simply harm. The relevant question is not 'Is this belief core?', but simply 'Would violating this belief harm the person?'. And this is why, in chapter 3, I will discuss the concept of harm in much more detail.

This doesn't mean that talk of 'core moral beliefs' is just misguided. The term may still pick out a genuine subset of a person's beliefs which are different in kind from the rest in that they are constitutive of self-identity. And it may be that, by virtue of this special feature, forcing the person to violate those beliefs will cause him significant harm. But, even if this is true, the point to appreciate is that the feature which makes a belief worthy of significant moral weight is not its coreness, it's the potential of its violation to cause harm. All that

philosophical and poetic detail about identity and personal integrity and springing from the well of one's being is interesting enough as an answer to the question about *what explains* the harm occasioned when a core belief is violated, but in itself it has no bearing on the practical question of which beliefs we ought to grant moral weight. And since my aim is to help clinicians, policy-makers, judges and the like to assess which beliefs should be granted moral weight, there's no need to take the detour into the core/non-core question once the fact of significant harm has been established.

I suppose it may even be that, as a matter of fact, *all and only* beliefs that are constitutive of self-identity (i.e. beliefs picked out by the term 'core moral beliefs') will lead to significant harm if violated. If that were the case, then by identifying a particular belief as core we would automatically know to grant it moral weight (which is of obvious practical value); and by realising that to force a person to violate a particular belief would cause them significant harm, we would automatically know that it was a core belief, constitutive of self-identity. That absolute equivalence, if true, would at least be of philosophical interest; but again, it would not be practically relevant.

Finally, I don't want to be unfair to Wicclair. My interpretation of his argument is that he thinks that the coreness of a belief is what makes it worthy of moral weight. If this is the correct interpretation, then I disagree with him; as I've argued, it's the harmfulness, not the coreness, that matters. But maybe Wicclair would in fact agree with me on this point, and the reason he focuses on core beliefs is because he thinks only these cause significant harm when violated. Perhaps, for Wicclair, the descriptors 'core' and 'harmful when violated' both pick out the same subset of beliefs. If so, then the only disagreement between the two of us is that, for me but not for him, violating a non-core belief can also be harmful to a person.

#### **IV. Consonance with the values of medicine**

Here is another proposal by Wicclair:

Suppose, say, that Dr L is Mr S's internist. Dr L is ethically opposed to providing pain medication because he believes that pain is a sign of a moral flaw and is therefore deserved. When Mr S requests pain medication, Dr L responds that he cannot in good conscience prescribe any. This appeal to conscience appears to merit no significant moral weight. [...] The amelioration of pain is an important goal of medicine, and according to generally recognized norms of medical ethics, it is not ethically justified to withhold pain medication from liars, cheaters, or even convicted murderers. Accordingly, insofar as Dr L's ethical values are judged to be contrary to the goals and values of medicine, it seems unwarranted

to assign significant moral weight to his appeal to conscience. [...] An appeal to conscience has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine.

(Wicclair, 2000, pp.216-217)

Here, Wicclair is proposing a constraint on the kinds of beliefs that can confer moral weight on doctors' objections: he wants to require that the belief chimes with one or more "goals and values of medicine". And he wants to use this constraint to explain why we should grant moral weight to, for instance, a doctor's sincere moral objection to participating in an abortion, but not to a doctor's sincere moral objection to prescribing pain relief. Be it right or wrong in itself, the objection to abortion corresponds from a more general respect for life, which is recognisable as a goal or value of medicine, while the objection to prescribing pain relief runs contrary to another goal or value of medicine, namely the reduction of pain and suffering. So, Wicclair argues, the first objection has significant moral weight, and the second does not.

Note that the actual *source* of the doctor's belief need not be a goal or value of medicine, so long as the belief itself *happens to correspond* to such a goal or value. For instance, in the case of objecting to abortion, the source of a doctor's respect for life may be a desire to obey God, and obedience to God is not a generally accepted goal or value of medicine. But, for Wicclair, the fact that the belief itself is an instance of something that *is* generally accepted in that way, namely a respect for life, is enough to satisfy the constraint, regardless of its source.

Now, on the surface this is a neat proposal. Not only does it appear to explain why we want to accept some moral objections and reject others, it also seeks to ground their acceptance or rejection in generally accepted criteria, thus sidestepping the difficulty of having to make external moral judgements about the truth of doctors' moral beliefs. According to Wicclair, if we can all agree that (for instance) respect for life is a goal or value of medicine, and we can all agree that (for instance) a doctor's objection to participating in an abortion reflects a respect for life, then we should grant moral weight to that objection.

Unfortunately, I'm not at all convinced that this constraint is either helpful or even really necessary. To see why, first consider one possible response to the constraint: that it falls victim to counter-examples. According to this response, there are objections which seem not to correspond to any generally accepted goal or value of medicine, but to which many

people would want to grant moral weight. Religiously-motivated objections might seem good examples of this kind of objection: when a doctor objects to offering sexual health or fertility services to same-sex couples because of a core moral belief that a child's interests are best served by being brought up in a home environment consisting of a married male and female parent, what is the generally accepted goal or value of medicine here? There is no widely-accepted goal of medicine to promote traditional family values, for instance. Yet defenders of the right to moral objection would hardly be content to exclude this kind of belief from the scope of that right.

Incidentally, I choose this specific example because Wicclair himself discusses it in some detail elsewhere and seems to grant its moral weight. While he does not endorse the belief itself, he *does* seem to judge that it would be appropriate grounds for the exercise of conscientious objection:

A concern for the well-being of children may be a poor reason for denying fertility treatments to lesbian women. However, if the belief that it is in the best interests of children to have a male and female parent who are married to each other is based on the perceived needs of children and not on alleged deficiencies in the moral character, skills, abilities and the like of lesbian women, refusals to provide fertility treatments to lesbian patients may not be subject to the charge of invidious discrimination. Moreover, [...] it may not rise to the level of seriousness that would warrant inclusion within the scope of a constraint on the exercise of conscience.

(Wicclair, 2011, p.98)

Don't get me wrong: I'm on Wicclair's side here. I agree that modern medical ethics does not, and should not, universally recognise a goal to promote traditional family values. But it also seems to me that there are *other* generally accepted goals and values which seem to apply here: promoting patients' best interests, perhaps, or promoting children's best interests, or ensuring that the treatment offered to patients does not result in significant harm to others, such as their future children. So, even if we only want to ascribe moral weight to objections corresponding to a goal or value of medicine, we can point to one of these goals in order to argue that this particular objection has moral weight after all.

The difficulty now is that, if we interpret "goals and values of medicine" in this broad way, Wicclair's constraint is rendered unhelpful. In fact, I find it hard to imagine *any* morally-based objection which couldn't be interpreted as corresponding to a goal or value of medicine, at least by the doctor who holds the objection. Recall the example of Dr L, who refuses to offer pain relief to patients because he thinks pain is a deserved punishment for

past misdemeanours. Wicclair says, again correctly in my view, that this conflicts with the reduction of suffering which is a generally accepted goal of medicine, and thus is excluded by his proposed constraint. But it seems likely that Dr L can sincerely connect his belief with other goals, such as promoting patients' best interests ('it's always in a person's best interests to receive moral edification through deserved punishment'), or promoting justice ('justice is being done through punishing people in this way'). So Dr L can argue that the goals and values of medicine *are* being served by his actions.

Of course, Dr L can only argue from his own perspective. Society at large is unlikely to share Dr L's assessment of pain as deserved punishment or as morally edifying. But that was never a requirement of Wicclair's criterion, and rightly so — because, after all, society at large is unlikely to share *any* objecting doctor's view of the procedure they object to, such as viewing same-sex couples as providing an unsuitable home environment to raise children. As I pointed out in chapter 1 when I described my fundamental rule (p.43 of this thesis), the fact of disagreement with society's moral views is what makes morally-based objections necessary in the first place. As long as we accept that *Dr L himself* genuinely holds this moral belief about pain and that it reflects generally accepted goals and values of medicine, the objection passes Wicclair's test and so it deserves to be granted moral weight.

In fact, even plainly mad moral objections can easily pass Wicclair's test. Suppose, absurdly, that a doctor holds the sincere belief that all disease is caused by demonic possession and that a sound beating followed by a sprinkling of holy water is the most effective treatment for most patients. This belief is obviously highly inappropriate for a healthcare professional, not to mention dangerous, but it's sincere and it can easily be argued to reflect the generally accepted goals of curing disease and acting in the best interests of patients. One would hope that mad moral objections like these were unlikely to arise very often in clinical practice, and it wouldn't be particularly tricky to deal with them if they did. But a constraint on allowable objections which sets out to exclude unacceptable objections but fails to exclude even mad ones is not going to be of much practical help to anyone.

How, then, *can* we avoid giving moral weight to sincere but mad objections, if not through a constraint like Wicclair's? My answer is: we can't. I reject Wicclair's constraint, but I propose nothing in its place.

There is a bullet for me to bite here. At the end of the previous section (p.74 of this thesis), I concluded that the reason we grant moral weight to a doctor's objection even if we disagree with that objection is that *it risks harm to the doctor* if we compel him to act against the beliefs on which the objection is based. Having committed myself to this line of argument, I have to take the rough with the smooth. If someone is genuinely and deeply committed to the belief that all pain is a deserved punishment for past wickedness, then (like it or not) to force him to act in a way that conflicts with that belief is likely to be harmful. To say otherwise is to deny his deep commitment to the belief after all. Goals and values of medicine have nothing to do with it; harm is harm.

Doesn't this mean I'm committed to granting moral weight to plainly mad objections, as long as those objections are sincerely based on moral beliefs for those individuals? Well, yes, it does. But, as I said at the very start of this chapter, to grant moral weight to a consideration is simply to say that the consideration has something to recommend it, morally speaking. And actually I think this is right: in general, if minimising harm is a morally desirable thing to do, then all actions which minimise harm in some way have at least that to recommend them. Protecting a doctor from coming to harm through forced self-betrayal therefore must *always* have at least pro tanto moral weight, even if the self-betrayal in question relates to beliefs that no sane person would share. Harm is harm, and no additional constraint (Wicclair's or another) can detract from the simple fact that failing to accommodate a deeply-held personal moral belief will harm those who hold that belief. The bullet is bitten.

But this is OK. I'm not thereby committed to saying that all moral objections, no matter how mad, must be *accommodated*. Moral weight is not the end of the story: we still have to judge whether, in the final analysis, it's the right thing to do. And I will suggest later that the right stage to throw out objections based on mad beliefs is when we weigh them against other considerations, such as concern for justice, patients' rights and public health. This weighing, unlike the process I've described in this chapter, must be informed by our own moral attitudes, including those which are publicly available and generally enforced. No conspicuously mad belief in pain-as-punishment or treatment-by-holy-water-and-beating will survive this process, because we will rightly decline to accommodate such beliefs in medical practice — even though we have acknowledged, and will regret, the harm we thereby cause to those who hold them.

### *Magelssen's objection*

Morten Magelssen (2011) shares my view that Wicclair's criterion of consonance with the values of medicine is implausible, but he rejects it for a different and much simpler reason. He claims that, to be respected, a belief must have a "plausible moral or religious rationale" (p.3), and he simply suggests that Dr L's belief that pain is deserved lacks this and so is not worthy of respect.

But I think Magelssen's dismissal here is too quick, for two reasons. Firstly, surely Dr L would dispute the claim that his belief has no plausible rationale. Plausibility depends on one's worldview, and *ex hypothesi* Dr L has a worldview according to which pain is deserved punishment (perhaps a Christian fundamentalist view along the lines of that advocated by Hemfelt et al, 2003). Of course, I'm not saying that society at large ought to accept that worldview. But the problem of doctors' moral objections, of course, is precisely what to do when society at large does *not* share the worldview, and thus the moral beliefs, of an individual doctor. If we could solve the issue of doctors' moral objections simply by asserting the plausibility of society's worldview and denying Dr L's, we would be home and dry. But we can't, and we aren't.

Secondly, as I pointed out in the preceding pages, Magelssen's reason — like mine — for wanting to grant moral weight to objections is that to deny them risks harm to the doctor. And, as I have just said, the potential for harm does not seem to depend on whether the moral belief in question has a plausible moral or religious rationale. The risk and severity of the harm to Dr L from being forced to act against his sincere moral beliefs is not dependent on the plausibility of his underlying reasons for holding that belief. I've already emphasised that this doesn't necessarily mean Dr L's objection should be accommodated. But, if it's not to be accommodated, this will be because its moral weight is outweighed by other considerations (chapter 5), not because it's ruled inadmissible or irrelevant *a priori* because we judge his worldview to be implausible.

## **V. Summary**

In this chapter, I've dealt with a number of reasons for respecting beliefs that I think don't work. Some of them, like the principle of avoiding wrongdoing, simply don't add up. Others

are more promising, but under close examination they end up pointing towards the more fundamental concern of *harm*. In the following chapter, I turn to this in more detail.

# Chapter 3:

## Harm

As I've already said, I think that doctors' moral objections to particular procedures have moral weight when it comes to deciding whether they should be obliged to participate in those procedures. By this, I mean that there are at least some objections doctors might hold for which we should consider making allowances (of some kind, either formally or informally) so that those doctors need not be compelled to act in ways that conflict with their moral beliefs.

My aim in this chapter is to justify this claim by giving the first of two specific reasons *why* this is the case — what it is about some moral objections that means that we should take them seriously in this way. The reason I set out and defend in this chapter is the *risk of harm*.

When a doctor refuses to participate in a procedure because it conflicts with her moral beliefs, she is not simply saying that she judges the procedure (or her participation in it) to be morally wrong. For sure, if something conflicts with her moral beliefs, she *does* judge it to be morally wrong — that's what it means to say that it conflicts with her moral beliefs. But this is not all. To say that a procedure conflicts with her moral beliefs also implies an expectation that to participate in it will affect her negatively in a significant way: it will harm her. In this chapter, I argue that this expectation of harm is justified, and that it is enough to grant pro tanto moral weight to her objection to the procedure.

### I. Defining 'harm'

Although the everyday meaning of 'harm' seems obvious, it can be quite tricky to try to draw the exact boundaries of the concept.

But there are several reasons why we might nonetheless hope to be able to draw those boundaries at least fairly accurately. The argument I want to make in this chapter points to one reason to be clear about harm. I say we should grant moral weight to doctors' objections

when it would risk harming them to fail to do so. For this to be any use as a piece of advice, we need to know what kinds of things count as harmful.

But there are other, even more obvious reasons to want to be clear about harm. We tend to think that (all else being equal) we should try to avoid harming other people. So it would be handy to be able to say what exactly counts as harm, so we know what to try to avoid. This has often been seen as a particularly pressing question for doctors, given that the obligation to ‘do no harm’ is often held up as a key tenet of a doctor’s vocation (Smith, 2005).

There are also reasons from other areas of philosophy to want a sharp definition of harm. For instance, the notion gets plenty of airtime in political philosophy, where John Stuart Mill’s so-called ‘harm principle’ famously maintains that the authority of the state to coerce individuals is limited to the duty of the state to prevent harm to its citizens (Mill, 1859). Again, if this principle is to be a useful one, a clear definition of what counts as harm and what doesn’t seems necessary so we can make the right kinds of laws and exercise political authority in the right kinds of ways.

So, in what follows, I try to clarify what counts as harm.

### *Wrongness is not harm*

An act can be harmful, even harmful overall, but not wrong. This can happen, for instance, in situations where a benefit to one person unavoidably means a harm to someone else. One example that has its roots in Mill (1859) is the harm I suffer if a potential employer turns me down after a job interview. Being turned down might be harmful overall to me: it might dent my self-esteem, reduce my future income and cause me unhappiness. But we wouldn’t want to say that turning me down for a job interview is necessarily morally wrong. There might have been a better candidate, or perhaps I tried to cheat during the application process or perhaps I would simply have been useless at the job. Equally, when we punish someone for committing a crime, we unambiguously harm him, but that doesn’t imply it’s always wrong to punish criminals.<sup>44</sup> And harm can be caused by non-moral agents, such as

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<sup>44</sup> Bentham on punishment: “All punishment in itself evil. Upon the principle of utility, if it ought at all to be admitted, it ought only to be admitted in as far as it promises to exclude some greater evil” (1781, chapter 13, section 1). Also, Mill, in a different context (talking about free trade): “all restraint, qua restraint, is an evil” (Mill, 1859, chapter 5).

natural disasters, but that doesn't commit us to the view that victims of such events have been wronged (Feinberg, 1986, pp.145-146).

Is the converse also true — can an act be wrong but not harmful? This is a little trickier, and I will say more in a few moments about the possibility of acts which we might want to judge as wrong even though they apparently involve no harm to anyone. But, regardless of how this issue comes out, it seems clear at least that a wrong act need not be harmful to anyone *in particular*, and importantly for my purposes in this chapter, if *I* do a wrong act, it need not harm *me* overall. If I rob a bank and get away with it, it may benefit me substantially. Even if the robbery weighs on my conscience (and it may not), and even if there is such a thing as moral harm occasioned by doing something wrong (which I will consider shortly), I may nonetheless judge that the opportunity to live out the rest of my life in luxury on a Caribbean island tips the balance of pro tanto harms and benefits in my favour.

The distinction between moral wrongness and harm is very important when it comes to doctors' moral objections. I want to invoke the harm that a doctor risks suffering if he performs a procedure to which he objects as a reason to respect that objection. But if we thought that an act could only be harmful if it was wrong, then I would need to argue that performing the procedure was wrong in the first place. And this would violate my fundamental rule: as I said in my introductory chapter, I want to steer clear of any argument for respecting an objection to a procedure that rests on the morality of that procedure. The point of invoking harm to the doctor is to try to give a reason to respect a doctor's objection *without* being committed one way or the other on the morality of the procedure that the doctor objects to.

### *Different accounts of harm*

It's easy to produce a list of things that are uncontroversially harmful. If one of my limbs is lopped off, I am clearly harmed. If I'm thrown in jail, I am harmed. If I'm turned down for a job which I would have benefited from, I am harmed. If I'm subjected to a prolonged and intensely painful experience, I am harmed.

There are edge cases, one of which I will consider in detail in a moment. But, before we even reach those edge cases, an important question is whether we can make sense of the central

notion of ‘harm’ as it occurs in uncontroversially harmful events. In other words, what is it about a harmful event that makes it harmful?

One common way to understand harm is in a comparative sense. An event is harmful to me if it makes things go worse for me than they otherwise would have (Raz, 1987, pp.327-331). So we can judge if an event is harmful to me by *comparing* the situation in which the event takes place to a situation in which the event doesn’t take place (but which is as similar as possible in all other respects). If things go worse for me in the first situation than in the second, then the event is harmful. To put it in philosophical jargon, we need to compare the possible world in which the event occurs with the nearest possible world in which the event does not take place (Klocksien, 2012, p.285). If things go worse for me in the possible world where the event takes place, then the event is harmful.

This comparative account does justice to our intuitions in the paradigm cases I mentioned. Why am I harmed if one of my limbs is lopped off, if I’m turned down for a job, if I suffer intense pain, if I’m thrown in jail? Because things go measurably worse for me than if my limb had been left attached, if I had been given the job, if I’d been spared the pain, if my freedom had not been curtailed.

Now, in certain edge cases, this account can clash with our intuitions. There’s the ‘overdetermination problem’, in which I’m struck by two bullets at once, and the related ‘preemption problem’, in which I’m struck by bullet 2 an instant after I was killed by bullet 1; in both cases, the comparative account of harm seems to suggest that none of these bullets actually harm me.<sup>45</sup> A third scenario, the ‘non-identity problem’, proposed by Parfit (1984, p.358), points out that there are possible situations in which it’s not clear what comparison we are supposed to make. But the fine details of preemption, overdetermination and non-identity are rabbit holes I don’t need to dive down.<sup>46</sup> My only reason for wanting to define

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<sup>45</sup> Worries about overdetermination and preemption in the comparative account of harm mirror analogous worries in other areas of philosophy where comparative counterfactual explanations are invoked. For a classic exposition of such an account in the philosophy of causation, including an attempt to address the overdetermination problem, see Lewis (1973); for a more recent discussion, see Schaffer (2007).

<sup>46</sup> Should the reader want to dive down them: real-life examples of these problems are discussed in Coady (2002) and Hensel (2005); an attempt to shore up the comparative account of harm is Klocksien (2012); some attempts to find alternative accounts are Shiffrin (2000) and Harman (2009).

'harm' is so that I can go on to argue that forcing doctors to act against their moral beliefs risks harm to them. And the kinds of harms I have in mind here are the kinds that fit squarely in the middle of our intuitive understanding of harm: pain, psychological trauma, loss of self-esteem, damage to future occupational wellbeing and so on. These are not mysterious edge cases which give rise to conflicting intuitions and philosophical puzzles. They clearly count as harm under the comparative account, because they are instances of things going worse for the doctors in question than they would otherwise have gone. But they also clearly count as harm under the other plausible accounts of harm I've mentioned, such as Shiffrin's or Harman's (see footnote 46). In short, whichever account of harm we choose, if it's to be worth its salt, we can be sure that the ill effects sometimes suffered by doctors when they are forced to act against their moral beliefs will always count as harms.

So, for present purposes, I don't need to adjudicate between the different specific accounts of harm according to how well they deal with puzzles that will never actually arise with respect to doctors' moral objections. Instead, I need a *general* way to understand harm that is neutral about which (if any) of these different specific accounts is right. For this, I turn to Joel Feinberg. In his book *Harm To Others* (1984, especially p.49 onwards), and in subsequent work (1985, 1986), Feinberg proposes the following account:

[Harm] must lead to some kind of adverse effect, or create the danger of such an effect, on its victim's interest. [...] It is a necessary element in all harming, then, that it have an effect on someone's interests. The term 'interests' is best left undefined here, except to say that interests are distinguishable components of a person's good or well-being.

(Feinberg, 1986, p.146)<sup>47</sup>

Like the comparative account of harm, Feinberg's account — let's call it the *damage-to-interests* account — does justice to our intuitions at least on the straightforward cases. If my

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<sup>47</sup> Feinberg's account of harm actually has two elements. The first is damage to interests, which I include in the quotation here, and the second is wrongful violation of rights, which I omit. This is not intellectual sneakery, though. This second element is included by Feinberg because he believes it necessary for an understanding of Mill's harm principle, i.e., for the purposes of limiting the state's right to constrain individual liberty. Feinberg goes on to point out that this second element is not relevant to "a broader, ordinary sense of 'harm' in which that word refers to any state of adversely affected interest, whatever its cause. In that broader sense, people are often harmed by microbes, unforeseeable eruptions of nature, innocent actions of other persons, and actions of other persons to which they have freely consented. These are all examples of nonwrongful setbacks to interest, or 'harms that are not wrongs' to those who suffer them. If the word 'harm' as it occurs in Mill's harm principle had that broad sense, it would be quite implausible" (1986, p.146). For my purposes, I intend to adopt this broader sense of harm, and thus I set aside Feinberg's second element about wrongful violation of rights and focus simply on damage to interests.

interests are distinguishable components of my good or wellbeing, then they are clearly damaged if I lose a limb, fail to get a job, suffer intense pain, or get thrown in jail. These events set back my wellbeing in obvious ways.

So is Feinberg's account another rival to the comparative account or either of the alternatives I've mentioned? No. It is too high-level and too vague to be a competitor, because it deliberately leaves the meaning of 'interests' open. It's compatible with the comparative account because it can be sensibly argued that it's in my interests for things to go well for me, and so if a particular event makes things go worse for me than they otherwise would, that event is damaging to my interests.<sup>48</sup> Equally, it's compatible with the autonomy-based account, because it can be sensibly argued that it's in my interests for there to be no significant conflict between how I rationally will my experiences to be and how they actually are. Finally, it's compatible with the intrinsically-bad-states account, because it can be sensibly argued that it damages my interests for me to be put in intrinsically bad states such as pain, discomfort, disease and so on.

So I propose to adopt Feinberg's general damage-to-interests account of harm — not because it's superior to more specific accounts, or solves the problems they face, but because it doesn't go there. We can agree with Feinberg that harm is damage to interests, and as long as we leave the meaning of 'interests' vague, we can encompass the uncontroversial kinds of harm that are relevant to our discussion while sidestepping the controversies that are not relevant.

#### *Pro tanto and overall harm*

Just as we can make a distinction between an act's having *pro tanto* moral significance and *overall* (or all-things-considered) moral significance (Ross, 1930; see also p.46 in the present thesis), we can make a similar distinction between acts that are *pro tanto* harmful and *overall* (or all-things-considered) harmful.

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<sup>48</sup> In the same way, the damage-to-interests account makes no progress in addressing the problems of overdetermination, preemption, or non-identity. For instance, since it's unclear how being killed by either bullet makes things go worse for me than they otherwise would, it's correspondingly unclear how these events damage my interests.

Briefly, an act is pro tanto harmful if it incurs at least some harm, or to put it another way, if it has a harmful feature. By contrast, an act is harmful overall if, weighing up all its pro tanto harms and pro tanto benefits, the balance tips towards harm.<sup>49</sup>

In ordinary language, we use the word ‘harm’ in either sense, and sometimes both simultaneously. For instance, if I say that having my leg removed is harmful to me, I might mean that in both the pro tanto and the overall sense. If my leg is lopped off by a chainsaw-wielding maniac in the street, this will be pro tanto harmful to me according to any plausible account of harm: the pro tanto harms involved are not just considerable pain and inconvenience at the time, but also (probably) longer-term limiting of opportunities and a measurably reduced quality of life. Such an incident, I expect, will also turn out to be harmful to me overall, since these pro tanto harms will probably be accompanied by relatively few compensatory benefits. On the other hand, while many of the same pro tanto harms will also apply if my leg is amputated by a surgeon with my consent — after all, if I lose a leg, I lose a leg — in this case the benefit of preventing the spread of gangrene may well outweigh them, and if so, the amputation will not be harmful to me overall, despite the pro tanto harms involved.

## II. Non-experiential harm

Consider a situation in which a doctor might take part in a particular procedure — aborting a foetus, say, or helping a patient to commit suicide. As I’ve already said, if the doctor has sincere moral objections, forcing her to take part anyway risks harm to her. It may cause her psychological pain and anguish at the time, as she unwillingly performs an act which is deeply wrong by her lights. This anguish may in turn lead to a loss of self-respect which might have more long-term consequences, affecting her relationships with others and her attitude towards her career. In the most severe cases, a doctor may feel unable to continue

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<sup>49</sup> This way of presenting the issue assumes that it’s possible, at least in principle, to weigh up harms and benefits by assigning numerical values and disvalues. I assume the coherence of this account — at least as a metaphorical way to assess harms and benefits— without argument. For more discussion on this, see Feinberg (1985, chapters 2 and 3; and 1986, pp.146-147). Note that this arithmetical account implies neither that we do in fact literally assign numerical values to real-life harms and benefits (either consciously or unconsciously), nor that every set of harms and benefits has a single objectively correct set of numerical assignments.

practising medicine, thus negatively affecting her quality of life in many different, tangible ways.

As I've said, these are all unambiguous, unmysterious harms. They are clearly damaging to the doctor's interests in various ways. But the question I want to consider now is this: Is there a further type of harm, independent of these assorted negative experiences, which we should add to the list as well — namely, *non-experiential* harm that results directly from, or perhaps even consists of, acting in a way that one considers to be immoral?

If it's real, then this kind of harm is obviously at play here, because then a doctor who participates in a procedure which goes against her moral beliefs is harmed in (at least) two distinct ways: firstly, from the negative experiences she suffers as a result of participating in the procedure, and secondly, from the fact that she does something wrong by her own lights. If this is right, then the possibility of this second type of harm will add more weight to doctors' moral objections when we come to weigh them against possible harms on patients and society. And there may even be cases where the *only* plausible kind of harm suffered by a doctor is the harm that he suffers from acting immorally.

Harms in the first category — consisting of negative experiences suffered as a result of participating in a procedure — are, as I've said, unambiguous and uncontroversial. Call harms like these *experiential* harms. (I use the term somewhat differently from Dworkin (1993), for whom the main contrast between “experiential harms” and “critical harms” is the kinds of interests that those harms damage.) And call harms in the second category, those which befall the doctor directly as a result of acting against her beliefs and independently of her experiences, *non-experiential* harms.

So are there such things as non-experiential harms? The question sometimes arises in debates about the philosophy of punishment, where some writers have insisted that the notion non-experiential harm is necessary to account for some kinds of punishment that we feel are justified (e.g. Hershenov, 2010), or when discussing whether something can plausibly damage your interests after you've died (e.g. Grover, 1989).<sup>50</sup> And I don't deny

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<sup>50</sup> In philosophy, posthumous harms are a prominent category of putative non-experiential harms: see, for instance, Partridge (1981); Luper (2004); Tomasini (2017). But in what follows, I don't discuss these types of harms in any detail. As it happens, I think much the same objections apply to this notion as those I

that the notion has some up-front appeal. It sounds plausible, initially, to suggest that acting against my moral beliefs is intrinsically harmful to me. And this also seems compatible with the general account of harm as damage to interests which I adopted in the previous section: if my interests include acting in accordance with my own moral beliefs, as also sounds initially plausible, then it's damaging to my interests (and thus harmful to me) to act against my own moral beliefs.

But I'm not at all sure that this initial plausibility can be correct. To be honest, the more I think about it, the more puzzling I find the whole broad notion of non-experiential harm. In particular, I struggle to understand what the *harm* in non-experiential harm is actually supposed to be. Of course I grant, in the case of the doctor, that additionally to all the experiential harms suffered there is *the bare fact* that the doctor is being forced to act against her moral beliefs. But a bare fact need not entail a harm. Equally, of course I grant that it's *a shame* if a doctor is forced to act against her moral beliefs; from an objective perspective, it would be better if that never happened. But something's being a shame does not entail a harm either. Frankly, it seems to me that a suitably broad and all-inclusive notion of experiential harm, which includes all kinds of psychological distress and negative emotions, already has all the bases covered. I just can't get my head around what's supposed to be added by the further notion of *non-experiential* harm.

### *Prudential importance*

General bafflement is not an argument, so here is an argument. The notion of non-experiential harm seems to violate a crucial definitional element of harm: that we should *care* about it. Ben Bradley puts it like this:

[Any] analysis should entail that harm is something worth caring about in prudential deliberation. Harm is the sort of thing we should try to avoid; if we have an analysis of harm such that one might reasonably be indifferent concerning whether an event of the sort described in the definiens takes place or not, we should reject the analysis.

(Bradley, 2012, p.395)

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advance against supposedly unexperienced harms to living people. But I don't need to go there. If it turns out I'm wrong, and that the only non-experiential harms are posthumous harms, then I can live with that. There is zero overlap between posthumous harms and the kinds of harms that can plausibly be used to justify granting moral weight to a doctor's objection. Whether or not a dead doctor can be harmed, their death makes it difficult for them either to accede or to object to a medical procedure, or indeed to continue to practise medicine.

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Call this the ‘prudential importance principle’. It basically says that harm is something we rightly care about, and any adequate account of harm must not make this caring mysterious. Importantly, this doesn’t just mean that we should care *in general* what harm is and when people are harmed; it doesn’t just mean that the existence of harm matters (morally, to the world). It’s saying specifically that *I should care about harm to me*, and that this principle is part of what any account of harm must explain.

If the prudential importance principle is right (and I take it that it is), the challenge for the proponent of non-experiential harm is not just to explain why I should care about supposed ‘harm’ that I don’t actually experience; it’s to show *how it’s even possible* to care about anything that I don’t experience. After all, caring about an effect on me presupposes awareness of that effect at least to a minimal degree. It seems flatly impossible for me to care about an event that doesn’t register on my stream of experience at all, never mind for it to play a role in my decision-making.

Suppose my friend considers it immoral to eat eggs (even free range eggs). He is not allergic to eggs or anything like that; he just finds the idea of eating them morally wrong. One day, I sneak a tiny amount of egg yolk into my friend’s coffee, and unwittingly he drinks it. Is he harmed by this? Well, I grant that, *if* he had realised my trick, *then* he would have felt bad (an experiential harm of non-zero magnitude) because he would have known that he acted against his moral belief. But this is hypothetical, and we can rule it out by fiat: suppose my friend in fact never realises, and I never own up, so he goes to his grave without ever discovering what happened. In this case, my friend suffered no ill effects either physical or psychological, nor were any of his projects and goals affected by the bare fact that he unwittingly acted against his belief. In short, *things went exactly the same for him* as they would have done if I hadn’t played my trick.

In this case, I’m afraid I simply can’t see how eating egg yolk damaged my friend’s interests, even though it was something that he had a moral objection to. The moral I draw from this analogy is that it’s not harmful for someone to act against his beliefs, apart from the experiential harms I’ve already granted.

I can think of some possible objections to my drawing this moral.

- **Objection 1.** People simply *do* care about non-experiential harms. People care if they have acted against their moral beliefs, and not just because of the unpleasant experiences involved. They care because they don't want to do things that they judge to be immoral.

I have two responses to this. Firstly, I grant that people do indeed care about not doing things that they judge to be immoral. But this doesn't imply that they care about avoiding non-experiential harm, such as might be incurred by acting against their beliefs. It might just be that they care about avoiding wrongdoing. Someone who cares about avoiding wrongdoing will try not to perform actions which he believes to be wrong — that is, *avoiding wrongdoing* will be of prudential importance to him when deciding what to do — but that gives us no reason to think that *avoiding non-experiential harm* is of prudential importance.

Or, secondly, suppose what I've just said is mistaken. Suppose that someone who cares about avoiding what he believes to be wrongdoing actually does so not because he wants to avoid wrongdoing, but rather because he cares about avoiding non-experiential harm to himself. The new puzzle is then to say *why* he should care about that. For the concept of non-experiential harm to satisfy the prudential importance principle, it's not enough to show that we *do in fact* care about non-experiential harms; rather, it must be shown *why we are right* to care about them. As I said a few moments ago, any account of harm which leaves that mysterious is inadequate. So, even if it's true that people *do* care about avoiding non-experiential harm, that does nothing to address the mystery of why they *should* care about it.

- **Objection 2.** It might not be non-experientially harmful to do something which one *happens to consider* immoral (like eating egg yolk), but it *is* non-experientially harmful to do something that actually *is* immoral (like assisting a suicide).

I *might* concede, reluctantly, that it would be harmful for someone to perform an act whose immoral nature is obvious, purely on the grounds of that act's immorality, even if it was otherwise harmless. (I'm not at all sure about this, but let's grant it for the sake of argument.) But, when we talk about doctors' objections to controversial medical procedures, this is irrelevant. We aren't talking about acts whose immoral nature is accepted

by all concerned; we're talking about acts which are judged to be acceptable by society at large but as unacceptable for an individual doctor. As I said when I set out my fundamental rule (p.43 of this thesis), the moral status of controversial medical procedures is just that: controversial. Any argument claiming to demonstrate that it's harmful to a doctor to perform that act must not rely on the act's supposed immorality as a premise. Therefore, for the notion of non-experiential harm to help the doctor's case, the claim would need to be that she is harmed by performing an act which *she considers* immoral, without prejudice to its actual moral status. So this objection fails to establish anything useful.

- **Objection 3.** The egg yolk analogy is unfair because it describes a situation where someone is *unknowingly* forced to violate his moral beliefs (and never discovers this fact). Perhaps in this specific case it's hard to see how the person was harmed. But when it comes to doctors taking part in morally controversial procedures, there is nothing unknowing about it. Doctors who assist patient suicides or perform abortions never do so in ignorance. It's forcing someone to *knowingly* violate his moral beliefs that's harmful.

This objection is also misplaced. I've already granted that forcing someone to violate his moral beliefs can be harmful. That's not at issue. What's at issue is what constitutes that harm. I claim that it's constituted solely of the harmful *experiences* that the person suffers as a result of his actions. The rival claim is that there is some further, *non-experiential* component of harm that consists of the person's acting against his moral beliefs.

The point of the egg yolk analogy was to test this claim by constructing a situation in which all the uncontroversial experiential harms were removed, and the simplest way to do this was to stipulate that the victim was unaware of the fact that he had acted against his beliefs, thus removing any possibility of experiential harms. The question is whether, in that situation, we are still tempted to say that the victim was harmed. My instinct is to answer 'no'. If the objector agrees with me that the victim is *not* harmed in the case where he violates his beliefs unknowingly, but that he *is* harmed in the case where he violates his beliefs knowingly, then this suggests the objector in fact also rejects the notion of non-experiential harm and is instead focusing on the experiential harm suffered by someone who knowingly acts against his beliefs.

- **Objection 4.** It's nonsense to claim that I shouldn't and can't care about events that have no impact on my experience. In fact it's perfectly common to care about those events. For instance, I might feel depressed or anxious when I hear on the news about dozens of civilian deaths in a distant war, or when I see a passer-by across the street kick a puppy. These negative emotions are still harms to me, even though I haven't personally experienced the events that triggered them.

Of course I accept that the negative emotions occasioned by witnessing or hearing about depressing situations are indeed harms. But those negative emotions are experiential harms, because they are things I experience. The objector needs to find an example where I am unambiguously harmed by an event *notwithstanding* experiential harms like negative emotions. Examples where I feel bad because I learn a particular piece of information about the world are no help.

- **Objection 5.** Surely some things can affect me in a negative way without my ever being aware of them. If you steal a penny from my wallet every week for twenty years, I may never notice, but depriving me of that money is still harmful to my interests. That is a non-experiential harm.

No, it isn't. A suitably rich understanding of ordinary experiential harm has this base covered, too. Suppose that you steal a penny from your neighbour every week, and he never notices that you're doing so. He goes about his life entirely oblivious to the theft. Suppose, further, that after many weeks of this, your neighbour wants to buy a train ticket to visit his grandmother in the next city, but he doesn't have enough money to do so. As it happens, the amount of money he needs for the ticket is exactly the total amount of money you have stolen from him so far, unbeknownst to him. So he has been harmed by your theft, even though, to coin a phrase, the penny never drops. But this is not a non-experiential harm. The harm he experiences is not being able to visit his grandmother. He doesn't have direct experience of the *cause* of the harm, because he is oblivious of your theft from me, but he certainly does have direct experience of *the harm itself*: he sits at home in sad frustration rather than taking the train.

We can consider a variation on this example where I'm prepared to bite the bullet about non-experiential harms. Suppose you steal a penny from your neighbour every week, but

he's wealthy enough that he goes to his grave without this ever making a discernable difference to him: he can still afford to pay for whatever he needs in life, including visiting his grandmother whenever he likes. In this example, he never learns about your theft and it never makes any difference to his interests at all. In this case, I say that your neighbour is indeed *unharmed* by your theft. But this is not a difficult bullet to bite. I'm not saying that your theft was morally right, or that it's fine to steal money from people who won't notice. Nor am I saying that, if your neighbour had discovered your plot on his deathbed, he would have been happy about it. I'm simply saying that, as things turned out in this particular case, the theft didn't harm him.

While discussing posthumous harms (a discussion of which I set aside in footnote 50), Dorothy Grover (1983) brings up another version of this objection:

One would deny the possibility of posthumous harm, if one assumed that people are harmed only if they suffer experientially. This will not persuade many that posthumous harm is impossible. For according to this theory, a person who is carelessly given a drug that turns him into a 'vegetable' would not suffer harm, if the victim was at no time aware of what was happening.

(Grover, 1983, section 3.1, p.339)

Again, the right response seems to me to be that there *is* experiential harm here, even though the victim doesn't realise its cause. Just as in the case of your neighbour who is unable to visit his grandmother, the drug victim's experiences are markedly different from how they would otherwise have been, and this is what constitutes the damage to his interests, even if he doesn't identify the cause of that damage — either because he was unaware of the drug or because he is unable to process that thought afterwards anyway.

### *Harmless rape and harmless trespass*

There is another way to object to my rejection of non-experiential harms, and that is to deny the prudential importance principle in the first place.

It's possible to make this objection very simply. The objector could simply say, 'I am convinced that one suffers a non-experiential harm from acting against one's moral beliefs. If this means that the prudential importance principle must be rejected, then I reject that principle'.

In his 2012 paper, Bradley seems to allow for this when he adds to his statement of the principle: “Or, more cautiously: we should either reject the analysis or give up on the idea that harm is an important concept in prudential deliberation” (p.396). This suggests that an account of harm might be so persuasive that he might rather give up the principle that we should care about harm than give up the account. (Interestingly, in his written version of an unpublished talk on harm (2011) which was the progenitor of this paper, Bradley does not allow for this alternative. And if there is an account of harm which denies the prudential importance principle and which would be sufficiently persuasive for Bradley to go along with it, he does not mention it in either document (2011, 2012). In fact, notwithstanding his own expressed caution, he uses the principle of prudential importance to rule out some accounts of harm and support others.)

Nonetheless, this objection is coherent, and hard to respond to, since it presents no argument for choosing one horn of the dilemma over the other; it simply says that we should be prepared to make the choice. But the drawback to rejecting the prudential importance principle is that, as I’ve already said, the principle has very strong intuitive support. It seems intuitively obvious that harm is the kind of thing we rightly care about, and that any account of harm which renders this mysterious is plainly inadequate. Of course, intuitively obvious claims can be false. But if you want to deny what seems intuitively obvious, the burden of argument rests with you to give an account of why your alternative is so strong that it is better to contradict our intuitions than deny the alternative.

Is there such an account? There is, though it is an account which I think will ultimately be unsuccessful. To present it, I need to take a detour into the small and eccentric philosophical literature on so-called ‘harmless rape’.

‘Harmless rape’ is a distasteful term, but thankfully also a misleading one, since there are no writers (I’m aware of) who sincerely defend the claim that rape can be harmless. Rather, the question at issue is how to account for our strong intuition that *rape is always harmful*, given that it appears to be possible to construct a hypothetical situation in which the nature of that harm is hard to identify:

A victim may be forever oblivious to the fact that she was raped, if, say, she was drugged or drunk to the point of unconsciousness when the rape was committed, and the rapist wore a condom. [...] Then we have a victim of rape whose life is not changed for the worse, or at all, by the rape. [...] She has no feelings about the incident, since she knows nothing of it.

Indeed the story has no perspective dimension for the victim, except possibly a hangover in the morning; otherwise the victim's life goes on exactly as before.

(Gardner & Shute, 2007, p.5, quoted in Spina, 2010, p.499)

Gardner & Shute add "for complete insulation" that the rapist himself is killed by a bus immediately after performing the act, so there is no difference to his prospects either.

An analogous example comes from Arthur Ripstein, who imagines a 'harmless trespass':

Suppose that, as you are reading this in your office or in the library, I let myself into your home, using burglary tools that do no damage to your locks, and take a nap in your bed. I make sure everything is clean. I bring hypoallergenic and lint-free pajamas and a hairnet. I put my own sheets and pillowcase down over yours. I do not weigh very much, so the wear and tear on your mattress is nonexistent. By any ordinary understanding of harm, I do you no harm.

(Ripstein, 2006, p.218)

Both Gardner & Shute and Ripstein have in their sights the politically-oriented 'harm principle', derived from Mill (1859) — loosely, the principle that political power may only be used to restrict individual freedoms where failure to do so would incur harm. They want to ask: If we accept the harm principle, why is it right for us to outlaw unexperienced rape and unexperienced trespass? But their examples will do for my purposes too.

So, both the unexperienced rape and the unexperienced trespass can be construed as counter-examples to the prudential importance principle. Are the victims in these strangely contrived stories actually harmed, despite having no experience of that harm? If so, then non-experiential harms are possible after all. And if non-experiential harms are possible, then the prudential importance principle, for all its intuitive appeal, is misguided. There *are* harms which we can't care about in prudential deliberation, namely, particular cases of rape and trespass which never get discovered and cause no negative experiences. This doesn't show that a doctor who acts against her moral beliefs is harmed by virtue of doing so. But it does appear to remove the barrier to that claim that I have been urging, namely, that there is no such thing as a non-experiential harm because there can't be a harm to me that I ought not to care about.

And the point can be pressed further. If Gardner & Shute's unexperienced rape were indeed 'harmless', then this would have a certain unsavoury consequence. Just as my egg yolk analogy was supposed to factor out the uncontroversial experiential harms that obviously derive from acting against one's moral beliefs in order to focus on its supposed non-

experiential harms, so the unexperienced rape example is supposed to factor out the uncontroversial harms that obviously derive from being raped in order to focus on its supposed non-experiential harms. But if this exercise reveals that there *are* no non-experiential harms, then this implies that the only harms that a victim suffers in the ‘ordinary’ instances of rape are the experiential harms: according to this view, all that’s harmful about rape is the victim’s suffering. And the unsavoury consequence is that taking this position arguably undermines much of that suffering by condemning it as irrational. This is because, if someone is raped, much of the experiential harm they suffer is due to the *feeling* of violation — of having been severely harmed in a fundamental way. If we deny the reality of that harm and insist that all that’s harmful about rape is the psychological suffering the victim experiences, then we appear also to dismiss those very experiences as irrational.

Discussing restitutive theories of justice, David Hershenov (2010) makes this point with regard to infidelity: “The harm is there before the recognition of it. There would be nothing to be indignant about if there were not first a non-experiential harm” (p.38). And an objector could press the same point with regard to requiring a doctor to act against his moral beliefs. If we argue that the only harm the doctor suffers in this situation is the experiential harm that derives from a belief that he has been non-experientially harmed by acting against his beliefs, but we deny the reality of this non-experiential harm (as I have been doing), then we dismiss those negative experiences as irrational too.

Indeed, the case against my denial of non-experiential harms appears to be even clearer in the case of the objecting doctor than in the case of the rape victim. When someone suffers rape (of the real-life type, not the hypothetical unexperienced type), she is likely to be severely experientially harmed in multiple ways, including physical pain and long-lasting fear. These harms, at least, can’t be undermined by denying the underlying non-experiential harmfulness of the rape itself. But in the case of the objecting doctor, there are often no such attendant experiential harms. A doctor is not physically injured by taking part in a procedure to which he has personal moral objections. In most cases, the *only* kind of harm the doctor suffers is the psychological harm that derives from a belief that he has been non-experientially harmed by acting against his moral beliefs. When we deny the reality of this non-experiential harm, we apparently condemn *all* of the negative experiences the doctor suffers as irrational.

Taken together, these points constitute a clear objection to my claim that there is no such thing as non-experiential harm. I have two responses to it.

The first response is to question the conclusion that this objection invites us to draw. Suppose that denying the reality of the non-experiential harm suffered by a doctor when he acts against his beliefs does indeed mean that we judge his negative experiences to be irrational. So what? What exactly does this show? Does it show, for instance, that those negative experiences in fact don't incur genuine harm in the way they would if they were rational? Does it show that we should give those negative experiences less weight when decide how to respond to the doctor's objections than we would if they were rational? I don't see that anything like this follows. If a particular act produces experiences of psychological anguish, self-doubt and loss of self-respect in its victim, then those horrible experiences don't magically stop counting as harmful, and therefore stop mattering, if we call into doubt the rationality of the link between the act and the experiences. To establish that an event is harmful, it sets the bar far too high to demand an all-things-considered, defensibly rational connection between the event and the harm. Rather, all that's needed is a simple causal connection. If one day I jump out at you from an alley when you're calmly walking down the street and momentarily frighten you, you might complain afterwards that the momentary fright was an experiential harm. You would be perfectly right about that, and it wouldn't make my actions any less harmful if I argued that you should not have been scared because you know I'm your friend and would never hurt you, or because nobody would attack you in the street in broad daylight, or because I knew all along that you were irrationally jumpy about these things. A harm is a harm, whether the victim rationally 'ought' to experience it or not; calling a harm 'irrational' does not lessen its importance.

In case my first response fails to convince, here is a second response. In the case of the rape victim, the objection claims that many of the victim's negative experiences are made to seem irrational by denying the reality of rape's non-experiential harmfulness. We might concede this point and still question how well this conclusion transfers to the case of the objecting doctor. Unlike the rape victim (supposedly), the doctor's harmful experiences need *not* be based on a belief that he has been non-experientially harmed. The doctor suffers harm for a simpler, more obvious reason: *because he believes he has acted wrongly*. It's the plain belief that he acted wrongly, not the philosophically complex belief that he suffered non-experiential harm, that gives rise to the objecting doctor's moral anguish.

So I concede that it would not bring much comfort to say to a doctor after he participates in a procedure to which he has moral objections, ‘Don’t worry — you shouldn’t feel bad! There is no such thing as non-experiential harm, so you haven’t in fact inflicted any harm on yourself by virtue of acting against your moral beliefs!’. After all, even if he accepted the claim about non-experiential harm, this would not magically make his negative experiences disappear. But what *might* bring some comfort would be if the doctor somehow came to believe that what he did was not in fact wrong after all — that his moral judgement about the wrongness of the procedure was misplaced. And the objecting doctor might well concede this hypothetical point: he might well say, ‘Yes, I admit that my feelings of anguish are contingent on my moral beliefs being correct, but as long as I’m confident that they are correct, I will continue to suffer anguish’.

### *Irrelevance of the whole discussion*

To summarise what I’ve just said: I believe that a suitably rich understanding of ordinary, common-or-garden *experiential* harm — including both physical and psychological effects, with all other discernable damages to interests — is enough to account for all the harm there is. The concept of a harm that floats free of real-life impact, never experienced by anyone, strikes me as unaccountably strange.

But in case what I’ve said has failed to convince, here’s my final line of defence: for our purposes, it’s unlikely to matter. I concede that there are some philosophically interesting situations, such as when someone’s lifelong interests are thwarted after their death, where the question of whether non-experiential harm is real is a big deal. But the question of harm inflicted on a doctor by forcing him to act against his personal moral beliefs is not one of those situations. If a doctor is forced to suffer deep psychological distress because of his experiences, there is plenty of experiential harm to go around. As I just argued a moment ago, it seems unlikely that much of that experiential harm is predicated on the doctor’s belief that he has been non-experientially harmed; it seems far more likely that it is predicated on the doctor’s belief that he has simply acted wrongly, or that a wrong act has been committed, or that things will go worse for him as a result of his actions. And, even if some of that psychological distress really *is* predicated on the doctor’s belief that he has been non-experientially harmed — well, that belief is real, and really harmful to him, whether its premise is accurate or not.

### III. Degrees, thresholds, and the continuum of harm

In my introductory chapter, I conjured up a story about a doctor who abandons a patient in order to move her illegally parked car. My claim then was that, although her reason for refusing to treat the patient was a genuine moral belief which others might well share ('I ought not to park my car illegally'), it seems clear that it doesn't warrant the kind of moral weight that justifies abandoning a patient. To put it briefly, I suggested that the harm that the doctor would suffer if she ignored that belief in this case is unlikely to be significant enough to want to accord her belief moral weight. And indeed, throughout this chapter, I've been referring to 'significance' as a kind of threshold: if violating a belief would cause someone 'significant' harm, then that belief deserves 'significant' moral weight; otherwise, it doesn't.

In other words, there seems to be a *threshold* of harm. It seems that we can draw a line on the 'harm continuum' somewhere, and say that all harms that lie beyond this line deserve to be accorded significant moral weight, while the rest don't.

But I now want to make the claim that there's actually no need to draw the line at all, at least at this stage. Why? Well, where there are degrees of harm, from the trivial to the severe, there are also corresponding degrees of moral weight, from the trifling to the weighty. So (I propose) we don't need to legislate for a 'significance' threshold of harm, saying that only harms that surpass this threshold are worthy of moral weight. Instead, we should simply say that *all* potential harms have moral weight — and the degree of weight we grant to each one simply corresponds to the degree of harm that would be caused if it was violated. We should assign a large moral weight to an objection based on a belief that, if violated, would cause someone (a doctor, in this case) great emotional agony, and a small moral weight to one that would cause a moment or two of discomfort.

By the way, my view that all harms matter puts me at odds with Mark Wicclair again. Wicclair argues that considerations offered are sometimes not just outweighed but actually *completely cancelled* by opposing considerations. He thinks, for instance, that a moral belief has zero moral weight as a reason for respecting an objection if that belief lacks "consonance with the values of medicine" (Wicclair, 2000, pp.216-217; I considered this in detail in the previous chapter). He also thinks that tolerance has zero moral weight as a reason for respecting an objection when it clashes with considerations such as patient autonomy or

informed consent (something I will discuss in the next chapter). Now, I can see why Wicclair would have to make these claims *if it were true* that a reason for respecting an objection were completely cancelled by opposing considerations. But I have just argued that we need not accept that cancellation claim. Rather, it's perfectly coherent to say that the fact of a doctor's objection *always* carries some moral weight. The exact weight it carries will depend, of course, on the strength of the objection, the risk and gravity of harm to the doctor if it's violated, and (if what I say in my next chapter is right) the extent to which that objection represents a position that ought properly to be tolerated. But — and this is the important point — its weight will not be zero, because *all else being equal* we may as well respect it. As I said in chapter 3, and as even the most stolid opponents of conscientious objection concede, surely *some* moral objections can be accommodated when this would result in no harm, or perhaps incredibly trivial harms, elsewhere.

The advantage of my position over Wicclair's is that we don't have to make an ad-hoc list of opposing features that, when present, are supposed to cancel the moral weight of the doctor's objection. We can simply say that the objection always has moral weight in itself, and the question then becomes: in any given situation, is that moral weight outweighed by the opposing considerations?

Yes, this will mean that we are bound to assign some moral weight even to trivial harms, such as the suffering of my hypothetical doctor who feels bad about her parking violation. But, in my view, this is appropriate. We should not shy away from assigning non-zero but relatively low degrees of moral weight to minor harms. As long as the *degree* of moral weight we assign to each harm is proportionate to its severity — that is, as long as trivial harms have correspondingly trivial moral weights — all will be well. And we don't lose anything this way. Remember that we are anyway going to weigh these harms against the harms that would be caused to others (e.g. patients) if we allowed the doctors in question to act on their beliefs, and we will use the outcome of this weighing process to determine whether we should actually let that happen. And that process, if we do it well, will ensure that the most trivial harms are easily outweighed even once acknowledged, while more serious ones are given due consideration and might win through if we judge them to be weightier than rival considerations. If we want to, we will still be able to say, for instance, that the opposing moral weight of acting in the interests of the patient will always (or almost always, or often) be greater than that of respecting the doctor's objection — not because the

moral weight of the doctor's objection is reduced to zero, but simply because patients' interests are always (or almost always, or often) morally more important.

This brings me back to a point I made at the end of my introductory chapter about my approach so far. When I say that some objections have moral weight, I'm simply saying that they have features which *count in favour* of making allowances for them. This is not an entirely trivial claim (it stands in opposition to the claim that doctors' moral objections are not even relevant) but it is not as significant as all that. I'm saying that some objections have 'pro tanto' moral significance, but not necessarily that they will be decisive in the final analysis.

And this is why, for all I've said in this chapter, I don't think I have actually addressed a real-life fault line between proponents and opponents of conscientious objection by doctors. Even the most stalwart defender of doctors' rights will concede that there are *some* more or less trivial objections which ought not to be granted in the final analysis because they are outweighed by the needs of patients, professional duties, or the justifiable expectations of society (I showed this with my car parking example). And equally, even the most stalwart opponent of allowing doctors' personal moral beliefs to affect the care they offer will grant that *some* moral objections can be accommodated when this would result in no ill effects, or perhaps incredibly trivial ill effects, elsewhere; this was Savulescu's point in the quote I offered in my introductory chapter (p.47 of this thesis).

Harm is harm, and the fact that it has moral weight ought not to surprise anyone. If requiring a doctor to violate her belief would cause her harm, then this fact has some degree of moral weight, be it large or small. The important question is: should we, at the end of the day, insist that the doctor does as she's told, or allow her to demur because of her personal beliefs? To answer this question for any particular situation, we need to weigh the harm inflicted by forcing her to act against her beliefs against other morally relevant considerations, such as patients' rights. The disagreement between, say, Wicclair and Savulescu is not about whether some particular doctors' beliefs are of a particular kind that rises to the threshold level of *significant* moral weight; the disagreement is about the *relative* moral weights to be assigned, which will determine the outcome in each individual case. I will confront this disagreement later in my thesis. But before I do, there's another factor I want to introduce: that of tolerance.

# Chapter 4:

## Tolerance

At the end of the preceding chapter, I concluded that doctors' moral objections to controversial procedures often have moral weight because of the potential for harm to be caused if doctors are forced to act against those objections. This means that we should at least consider making allowances for those objections, even when we don't agree with the beliefs that lead the doctors to object.

In this chapter, I want to present a second possible reason for making such allowances. My suggestion is that questions about moral conflicts, which include questions about doctors' moral objections, are closely related to questions about *tolerance*<sup>51</sup> — questions that more usually arise in a political context than in the context of medical ethics. The simplest formulation of the argument I want to make in this chapter is as follows:

1. Respecting doctors' objections is an instance of tolerance.
2. We should be tolerant.

Therefore, we should respect doctors' objections.

So I start this chapter with a detour away from medical ethics to skim the surface of the philosophy of politics and say exactly what I take tolerance to be, as a general concept. Drawing on conceptual analyses of this notion, I consider in detail how its boundaries should be drawn, and I show that the question of doctors' objections in medicine falls clearly within those boundaries. That's enough to establish my first premise.

I then turn to my second premise, that we should be tolerant. At first glance, at least from a liberal perspective, this seems just obvious; but appearances are deceptive. I consider the so-called 'problem of tolerance', which points out difficulties with the claim that we should be tolerant and some possible solutions to those difficulties. In the course of examining these

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<sup>51</sup> Or, equivalently, 'toleration'. The two terms are used interchangeably and with roughly equal frequency in literature on the subject. For clarity, and because a quirk of the English language means the only available term for the opposite practice is 'intolerance', I'll stick to 'tolerance'. But when I quote other writers talking about 'toleration' or switching freely between the two, I assume without argument that they mean the same thing.

solutions, I also discuss what each of these solutions would imply for the connection I drew between tolerance as a political notion and tolerance specifically of doctors' objections — a connection that is not always straightforward, once these solutions are taken into account. Nonetheless, my conclusion at the end of the chapter is that there are good reasons to be tolerant in general, and that this also provides a defensible basis for granting moral weight to doctors' objections.

By the way, I'm somewhat loose about what I mean when I say that discussions of tolerance 'more usually arise in a political context'. If we wanted to sharpen this up, it would be as well to distinguish between two related meanings of this claim: (1) discussions of tolerance mostly arise in relation to questions that are generally thought of as political, such as the way we organise our society and the power relationships between different parts of it; (2) discussions of tolerance are mostly conducted by those who work in the (more or less well-delineated) field of political philosophy, as opposed to medical ethics or another area. But I don't think this is an important issue for my purposes, because when I say that tolerance might apply just as well in the context of doctors' objections as in the political context, I mean to make *both* the claim that (1) tolerance is not just about societal organisation and power relationships, but also about how we interact with other individuals including doctors; *and* the claim that (2) medical ethicists as well as political philosophers can fruitfully make use of the concept.

### *Tolerance is not harm*

Before I proceed, I want to clarify one conceptual point about my project in this chapter.

When I say that tolerance is a reason to respect doctors' objections based on moral beliefs, I don't say that this is simply because failure to tolerate would be harmful to doctors. Of course, in many situations this is likely to be true. But saying "we should tolerate objecting doctors because it might harm them if we don't" would just be a repeat of the argument I made in the previous chapter, only with my previously favoured phrase "respect doctors' objections" replaced with "tolerate objecting doctors". If that was the whole story, then there would be no need for me to write this current chapter at all.

But no. The argument I now want to make is completely separate from the one I made in the previous chapter, and it has nothing to do with harm considerations. My argument in

this chapter will be that tolerance would be a reason to respect doctors' objections, separately from any other reason, even if there was no risk of harm. In what follows, I will of course discuss reasons *why* I think this is the case. They are reasons to do with the general good of society and the medical profession, and the kinds of things that we should be interested in protecting. But among those reasons you will not find a reference to the risk of harm to doctors.

## I. Tolerance as a general concept

Loosely speaking, 'tolerance' is the act of putting up with someone else's belief or practice even though one morally disapproves of it. (But wait: Does it have to be *moral* disapproval? Might one's disapproval be more a matter of taste, or of a visceral reaction? I postpone my discussion of this until later in the chapter.)

As I said a moment ago, the philosophical study of tolerance has mostly been the domain of political philosophy. In this context, discussions of tolerance tend to focus on the question of whether, and to what extent, society at large ought to tolerate the dissenting beliefs and practices of minority groups, such as religious and cultural subgroups, within that society. (But wait: What is the appropriate object of tolerance? Is it peoples? Beliefs? Practices? Again, I postpone this discussion until later in the chapter.)

Now, of course this political context is an obvious and important application of the general concept of tolerance. But what I want to show in the first part of this chapter is that *it's just one application*. Tolerance does not arise exclusively or necessarily in the domain of politics. Rather, wherever there's moral disapproval — that is, wherever people are faced with other people's beliefs and practices which they find morally reprehensible — they must decide how to react to those beliefs and practices, and specifically, whether or not to tolerate them.

This is hardly a controversial suggestion; in fact, I think it follows easily from the uncontroversial loose definition of tolerance I presented a moment ago. Sometimes, writers on the subject acknowledge this generality, but then narrow their focus to the political context with or without explicitly acknowledging this move. In his classic article on tolerance, for instance, Bernard Williams makes a gesture in the direction of generality,

pointing out that it's not just those who have the power to make laws who are in a position to be tolerant:

Toleration is a matter of the attitudes of any group to another and does not concern only the relations of the more powerful to the less powerful. It is certainly not just a question of what laws there should be. A group or creed can rightly be said to be 'intolerant' if it would like to suppress or drive out others even if, as a matter of fact, it has no power to do so.

(Williams, 1996, pp.18-19)

Even so, Williams's broadened concept of tolerance is still inherently political — it's about the relationship of groups or creeds to one another within society. Samuel Scheffler goes further in the direction I want to recommend:

Although some continue to regard tolerance as being, in view of its asymmetrical character, a limited virtue at best, many others have, in effect, reinterpreted the idea so that it is understood to apply symmetrically to groups and individuals of differing size, strength, and power. Each of us is called upon to tolerate everyone else. It is this notion of toleration, rather than the asymmetrical or hierarchical one, that most contemporary liberal thinkers mean to be endorsing.

(Scheffler, 2010, p.315)

On Scheffler's understanding of tolerance, if I refrain from commenting when I disapprove of the inconsiderate behaviour of the man opposite me on the train who spends the entire journey talking loudly on his mobile phone when I'm trying to work on my thesis, I'm being tolerant. This doesn't imply any particular cultural affiliation, group membership or political standpoint on my part or on his. Nor, in deference to Williams's point, does it imply any particular power relationship between the two of us: I have no legal or organisational authority over the inconsiderate phone user, and there is no particular cultural right on my part to intervene, since it's perfectly legal and more or less socially acceptable to make phone calls while on the train. In other words, it's not a political issue at all, in the sense of being linked to formal power relationships in society. (Informal power relationships, yes, maybe; but this is sociological, not political.) Yet for all that, my forbearance is an act of tolerance, simply because I am quietly putting up with a practice of which I disapprove.

This broadening of the concept of tolerance beyond the political sphere is what licenses my next move. Recall the question on which my research is focused: What allowances, if any, should we make for doctors who have moral objections to controversial medical practices? This question can, I propose, usefully be framed as one of tolerance on the part of society at large. The belief or practice in question is the morally-based objection by doctors to their

participation in a legally authorised procedure. And the question being asked is whether society should be *tolerant* of such objections, permitting and accommodating them; or *intolerant*, seeking to overrule them and compel those who hold them to act against them, or subjecting them to penalties if they refuse to do so.

To outline the *prima facie* case for regarding this as an issue of tolerance, it will be helpful to have an example in mind, so here it is. Doctors in the UK, and many other countries, are sometimes asked to provide sexual health and family planning services to their patients, or to provide their patients with access to such services. Suppose a same-sex couple asks their general practitioner for these services. Suppose, further, that the GP has a deeply-held moral conviction that sexual relationships between same-sex couples are morally wrong, and in turn that for him to provide the services would be to endorse, or even to encourage or further, a morally wrong state of affairs, which would itself be wrong. On the basis of this belief, the GP refuses to provide the requested services.

Here we have a situation in which society permits a particular practice, namely, the provision of sexual health and family planning services to people in same-sex relationships by healthcare professionals. And doctors have professional duties, underpinned by professional regulations, to provide appropriate healthcare services to their patients. Because the couple in our example are the doctor's patients, the doctor has, on the face of it, a professional duty to provide these services. But, by virtue of the fact that the patients are in a same-sex relationship, providing these services in this case is something of which the doctor disapproves.

Now, I said that the question of tolerance arises wherever people are faced with beliefs and practices of other people of which they (morally) disapprove. In this example, there are two clear instances of such disapproval. The first, the more obvious, is on the part of the doctor towards the patients whose relationship he finds morally reprehensible. Should he act on this disapproval — perhaps by refusing to provide sexual health and family planning services? Or should he mute his qualms and provide the services as requested? (And, if the latter, does this count as 'mere' tolerance, or would the doctor be actively supporting or facilitating what he considers to be an immoral state of affairs?) This is an interesting and important issue, not least for the doctor himself, but it's not the one I want to consider for

now — though I will have more to say later about what kinds of responses would count as tolerant and intolerant in this situation.

The second instance of disapproval in this example, and the one which interests me here, is on the part of *society at large* towards the objecting doctor, as expressed in the laws and professional expectations that society imposes. I've already said that the provision by medical professionals of sexual health services to same-sex couples is permitted in the UK and other countries: not only is it not outlawed, but it's encouraged as a positive public health measure. And there is also legislation intended to guarantee equal treatment of all citizens irrespective of characteristics such as sexual orientation.<sup>52</sup> There is enforceable professional guidance, maintained by a statutory regulator and underpinned by law, establishing a doctor's professional duty of care to patients irrespective of patients' sexual orientation, lifestyle choices or personal beliefs, and irrespective of the doctor's own personal beliefs.<sup>53</sup> One of the intended functions of this guidance is to enable everyone to receive appropriate medical treatment on an equal basis and free from discrimination by healthcare providers on the grounds of characteristics such as sexual orientation.

Note that it's not enough for our purposes that society simply *permits* doctors to offer their services to everyone. After all, society *permits* lots of things — mowing your lawn in the winter, for instance — without implying any degree of moral disapproval of people who choose not to do so, and thus without any suggestion that non-mowers would be proper objects of tolerance. In order for the question of tolerance to arise, there must be not just *permission*, but the intention that doctors *should* provide sexual health services to everyone

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<sup>52</sup> In 2010, the UK replaced assorted anti-discrimination legislation since the 1970s with a single Equality Act which protects citizens from discrimination on the grounds of certain 'protected characteristics', one of which is sexual orientation. Discrimination on these grounds is illegal at work, in education, as a consumer, when providing and using public services, and in various other situations.

<sup>53</sup> Medical practice in the UK is governed by primary legislation, principally the Medical Act 1983 as subsequently amended. Under sections 2 and 5 of this Act, the General Medical Council (GMC) is empowered and to determine the standards of conduct and competence required for membership of the register of medical practitioners which it maintains. The GMC issues professional guidance which defines these standards (most recently GMC, 2013; accompanying supplementary guidance to the current revision of the guidance has been published since 2007). Duties imposed on doctors by this guidance include making patients' care their first concern; acting in the best interests of patients; respecting patients' beliefs; and not allowing their own (the doctor's own) personal views to compromise patient care. The GMC also provides a regulatory framework, underpinned by statute, by which practitioners who consistently fail to meet these standards can be sanctioned and ultimately removed from the register.

equally — for instance, if doing so is a component of fulfilling more general professional duties, such as providing appropriate care to patients. In the UK and for the practice we're considering, this intention is specifically expressed as a component of the regulation that lays out a doctor's professional duty. For other practices and in other jurisdictions, it may be laid down in statute or case law, or simply be a part of widespread cultural expectation. However it's expressed, it's this intention that a doctor *ought to* do something as part of his duty that implies a corresponding negative judgement towards failure to do it, and it's this negative judgement that raises the question of whether to *tolerate* such failure.

To sum up, the argument I've been developing so far is that the question of tolerance — most commonly discussed in a political context — in fact arises whenever someone disapproves of someone else's belief or practice and is faced with the decision of what to do about that disapproval. Specifically, I have argued that the question arises for society at large when a doctor refuses to provide a given service as part of his medical practice, when that service is legally permitted and when there is an intention on the part of society, expressed in law, professional guidance or general cultural expectation, that he should provide it.

## II. Constraints on the concept of tolerance

So far, I've been working with a loose definition of 'tolerance': the act of putting up with someone else's belief or practice even though one disapproves of it. All kinds of beliefs and practices, and all kinds of disapprovals, arguably fall under that loose definition.

In the context of political philosophy, the concept of tolerance has been analysed in some depth and its boundaries have been drawn quite carefully. While I don't intend to go through every detail of this analysis, I now want to bring out some proposed constraints on what counts as 'tolerance'.<sup>54</sup>

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<sup>54</sup> The most thoroughgoing analysis in recent years is that of Cohen (2004). I draw on Cohen's article at several points in what follows.

*Tolerance implies negative moral evaluation*

I've already said that, to be in a position to tolerate something, you first must disapprove of it. Not only is it obviously nonsensical to talk about the possibility of tolerating something which you endorse, it's also odd to talk about the possibility of tolerating something which you don't give two hoots about. It would be strange for me to claim that I 'tolerate' my neighbours hanging out their washing in the back yard, when in fact I don't mind in the least whether they do it or not. Tolerance is not nonchalance (Wall, 1998, p.3).

Moreover, I think the negative judgement implied by tolerance has to be genuine moral disapproval and not just dislike. This isn't a universally-accepted element of the concept; Nicholson (1985, pp.160-161) stipulates it, but other writers (e.g. Cohen-Almagor, 1994; McKinnon, 2006) follow Warnock (1987) in allowing for an alternative "weak" sense according to which it's appropriate to say that you can tolerate something based solely on personal preference:

Often one would think oneself tolerant if one refrained from criticizing something that one disliked, hated or regarded with varying degrees of distaste. I am tolerant if one of my daughter's boy-friends wears sandals with his suits or a stock with his tweed coat, and I not only make no mention of this outrage, but actually express myself pleased when they announce their intention of getting married. [...] In the weak sense, I am tolerant if I put up with, do not forbid, things which it is within my power to forbid, although I dislike them or feel that they are distasteful. In the strong sense I am tolerant only if I put up with things which it is within my power to prevent, even though I hold them to be immoral.

(Warnock, 1987, pp.126-127)

I don't dispute that it's common in everyday speech to apply the concept of 'tolerance' in the weak sense too, to cover matters of personal preference and taste as well as moral disapproval; Warnock certainly seems to be clear on her forbearance regarding the suits-and-sandals combination, much to the relief, I'm sure, of her daughter. But, for the purposes of my argument here, I want to focus exclusively on the *moral* element of tolerance. So I mean to exclude Warnock's weak sense, an attitude towards a merely *disliked* belief or practice, and focus on the strong sense, an attitude towards a *morally disapproved-of* belief or practice. My main reason for this deliberate narrowing is that I want to go on to

discuss how tolerance can be morally valuable, and this question is clearest, I think, when what's being tolerated is something which one regards as immoral.<sup>55</sup>

Limiting questions of tolerance to cases of moral disapproval isn't a problem for my central claim. I have already argued that the laws, regulations and professional expectations governing medical practice imply an expectation on the part of society at large that doctors (morally) should provide their professional services equally, in the best interests of patients, without regard to their own personal moral views or the views, characteristics and lifestyle choices of patients. If this is right, then they also imply moral disapproval of those who flout those laws, regulations and professional expectations by refusing to do so. Of course, I hope it goes without saying in the present context that, by pointing out this disapproval, I don't mean to claim that society should definitely *act* on that disapproval — for instance, by censuring doctors who object to particular practices. I merely mean to claim that, when it decides whether or not to act on its disapproval, this is a question of tolerance.

*Tolerance implies a legitimate interest*

There's another potential widening of the concept of tolerance which I want to bring up in order to reject it. These are situations where one puts up with a disapproved-of belief or practice, but one really has no right to disapprove of it in the first place.

Fletcher (1996) suggests, correctly in my view, that my reluctance to intervene in my neighbour's TV viewing habits, whether I dislike or even disapprove of them, can't properly be described as tolerance because the question is none of my business in the first place:

Even if I disapprove of her taste and style of life, I am not in a position to be either tolerant or intolerant of the way she lives. Calling my hands-off attitude a matter of tolerance cheapens the virtue and arrogates too much power to myself.

(Fletcher, 1996, p.158)

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<sup>55</sup> By the way, for what it's worth, I'm tempted to think that tolerance can only have moral value in situations where what's being tolerated is something which one regards as immoral. There is no particular objective moral value, it seems to me, in Warnock's 'tolerance' of her future son-in-law's dress sense, which is a response to nothing more weighty than her own style preferences — preferences which are themselves morally neutral, I take it. But Horton (1996) disagrees: "In some cases, it remains appropriate, as Warnock argues, to see tolerance of what is merely disliked as a straightforwardly moral virtue. The most obvious instances would be those in which people have a right to impose their likes or dislikes but choose not to" (p.23). There are difficulties with Horton's position, I think, but I won't pursue the argument here.

Again, I don't pretend that there is universal agreement that it would be an error to widen the concept of tolerance to include these situations. In fact, I think we *do* sometimes naturally want to use the word 'tolerance' to describe situations where my objection to the practice in question is hard to justify, or my right to intervene is dubious. And the question of which of other people's practices properly count as "my business" and which don't is an interesting question in its own right, depending at least in part on my views about the moral wrongness of the practices in the first place, and the general right or duty of people to intervene in other people's affairs.

But I'm content to exclude these disputed cases by fiat, simply because I want to focus the discussion on situations where the tolerator clearly *does* have a legitimate interest regarding the actions of those who are tolerated. Few people would dispute that society has a legitimate interest in the medical services available to its citizens. After all, if it didn't have such an interest, the whole practice of professional regulation by government would be improper. As before, I'm not saying this interest implies that society ought never to make allowances for doctors' moral objections. I'm merely saying that, when it decides whether or not to make these allowances, this is a question of tolerance.

*Tolerance is about moral evaluation, not simply morality*

The question of whether someone has a legitimate interest in something is *not* a question about whether that thing is actually right or wrong. This means that the question of whether a person's attitude towards a practice is one of tolerance, intolerance or something else does not involve the question of whether that practice is actually right or wrong. It merely involves the question of whether the person disapproves of it. This is an obvious point, but one that is important to keep in mind.

Suppose I disapprove of my friend's habit of boiling a full kettle of water every time she wants a cup of tea (I think it is wrong to waste energy in this way), but I boast that I am tolerant of it. It would not be an objection to my boast to argue that there is in fact nothing wrong with my friend's habit. Be that as it may, the fact is that *I disapprove of it*: in my judgement, there *is* something wrong with it. This judgement may be wrong — my disapproval may be misplaced. But that doesn't affect the fact that I am, nevertheless, being tolerant when I decline to act on it.

The same is true of society's attitude to doctors' moral objections, and this is an important point. Suppose a doctor refuses, on grounds of her personal moral convictions, to take part in an assisted dying procedure (in a country where the procedure is legal). And suppose society decided to make allowances for such refusal, for instance by providing a legal guarantee that a doctor would not be prosecuted or otherwise disadvantaged by refusing. If someone claimed that society was being tolerant of conscientious refusal, it would not be an argument against this to insist that society should never have disapproved of her refusal in the first place (e.g. because assisted dying is wrong, so the doctor was quite right to refuse). The relevant issue when determining if society's permissiveness towards refusal counts as tolerance is not whether that refusal is wrong, but whether society morally disapproves of it. Without this point, the overall argument from tolerance that I develop in this chapter would fall foul of my fundamental rule, outlined at the end of chapter 1 (p.43 of this thesis) — it would use the morality of an act as a premise.

*Tolerance is tolerance of beliefs and practices*

This is another area where everyday usage would benefit from a little clarification. The issue here is what kind of things can properly be the object of tolerance. In everyday conversation, we commonly refer to tolerating all kinds of things: people, groups of people, cultures and ways of life, to name a few.

So far, I've talked exclusively about tolerating 'beliefs and practices'. I will continue to do so. But this is only for consistency, and I don't mean to suggest that it's in any way misguided or incorrect to talk about tolerating other categories of things. Rather, I mean my convenient phrase 'beliefs and practices' to be interpreted broadly enough that it covers all the categories of things that can properly be objects of tolerance.

My only substantive claim in this regard is that it will always be possible to translate talk about tolerating a particular thing (a person, a culture, or whatever) into talk about tolerating either a particular belief or a particular practice. For instance, when we talk about tolerating a person or group of people, we could just as easily (and equivalently) talk about tolerating the way those people *behave* — in other words, their practices. And when we talk about tolerating a culture or way of life, we can translate this, I claim, into talk about

tolerating the beliefs embedded in that culture or way of life, and the behaviours they give rise to.

In his editorial introduction to a collection of essays on tolerance, David Heyd makes exactly the opposite move:

We do not tolerate opinions and beliefs, or even actions and practices, only the subjects holding disliked beliefs and the agents of detested actions... Only human beings can be the object of restraint based on respect, which is required by the idea of tolerance.

(Heyd, 1996, p.14)

But, despite appearances, I'm going to stick my neck out here and suggest that there is no fundamental disagreement between Heyd and myself. On my reading, Heyd doesn't claim as a *definitional* fact about tolerance that its object must be human beings, any more than I deny this. Rather, I read Heyd's intended approach as a pragmatic one: he wants to remind us that, when we talk about tolerating people's beliefs and practices, it will help us to remember that the basic reason we ought to do so is because they are the beliefs and practices of moral agents whom we acknowledge to be deserving of "restraint based on respect", independently of our judgement of the beliefs and practices in question. In the same way, my focus on beliefs and practices is also intended to be expository, not to make any claim about the 'proper' way to talk about tolerance. I certainly don't mean to preclude the argument that what makes tolerance worthwhile is its grounding in respect for other individuals, or to reject as nonsensical claims of 'tolerating people'.<sup>56</sup>

#### *What counts as 'putting up' is vague*

There's one final issue I want to consider. I said that someone is tolerant when they *put up with* a belief or practice of which they disapprove. Well, what counts as 'putting up'? A range of complexities lurk beneath this broad phrase, and I want to briefly draw attention to them.

The main complexity is that one man's admirable restraint is another man's objectionable interference. To adapt an example of Horton's (1996, p.28), suppose I disapprove of the sale

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<sup>56</sup> After all, it can sometimes be perfectly natural to talk about tolerance in this way. For instance, to the (limited) extent that the authorities in 1930s Germany tolerated minorities such as the Jewish population, it seems right to say that it was *the people themselves* who were being tolerated, not the things they did.

of pornography (and suppose I argue that I have a legitimate interest, in that I believe the sale of pornography damages the fabric of society or something). There are various ways this disapproval might play out. I would clearly be ‘putting up’ with the practice, in the relevant sense for the purposes of defining tolerance, if I suppressed my views completely, never breathing a word about them either in public or private. And I would clearly *not* be ‘putting up’ in the relevant sense if I routinely firebombed shops where I found pornographic materials to be on sale. But between these extremes lies a broad spectrum of possible behaviours. Am I ‘putting up’ if I miss no opportunity to grumble quietly about the widespread availability of pornography, but this is the extent of my activism? Am I ‘putting up’ if I encourage my friends to boycott shops which sell pornographic videos, and to support political candidates who promise to regulate such sales more strictly? Am I ‘putting up’ if I actively seek out opportunities to campaign publicly against pornography? And, to change perspective for a moment, would we regard a *society* as ‘putting up’ with the sale of pornography if it required vendors to obtain a licence in order to sell it? What about if it restricted its sale only to certain heavily-regulated outlets? What if it outlawed the sale of pornography, but declined to prosecute those who broke the law?

As these few examples show, what counts as ‘putting up’ is, to some degree, a subjective matter. Whether or not it applies in any given situation depends on other variables which are themselves open to debate, including the morality of the belief or practice in question and the degree of intervention in that practice to which one would otherwise be entitled, if one were not restraining oneself. If you think pornography is a deep social evil which society is perfectly entitled to ban outright, you will no doubt regard even a relatively restrictive regulatory framework as ‘putting up’ to a notable degree. But if you think the state has no business interfering with matters like these, you might regard even the lightest-touch regulation as failing to ‘put up’.

And if the concept of ‘putting up’ is vague, then the concept of tolerance must be vague too, since the former is a part of the definition of the latter. Indeed, this seems to be true both historically and contemporaneously. Our understanding of tolerance can change over time, and in different political contexts. John Locke’s famous *Letter Concerning Toleration* of 1689 is a landmark exposition of the liberal argument for widespread tolerance. But his primary

concern is to end religious persecution, and in this vein he interprets tolerance as excluding force, while actively encouraging evangelism:

I would not have this understood as if I meant hereby to condemn all charitable admonitions and affectionate endeavours to reduce men from errors, which are indeed the greatest duty of a Christian. Any one may employ as many exhortations and arguments as he pleases, towards the promoting of another man's salvation. But all force and compulsion are to be forborne.

(Locke, 1689, p.31)

I'm not sure how many modern liberal thinkers would praise the tolerance of an individual who dedicated his life to reducing others' religious "errors" through constant haranguing. When Steven Wall, for instance, talks about 'tolerance' three centuries later in terms of restraining one's disposition to repress others, he defines repression broadly enough that it includes "repress, persecute, harm, offend, insult, etc" (1998, pp.63-64) — which would rule out most of what Locke thinks acceptable.

In the same vein, we may disagree about what kind of response from the doctor in my earlier example would count as tolerant and what would count as intolerant. The extremes are clear: it would clearly be tolerant for the doctor to swallow his objections and dutifully provide sexual health services in exactly the same way as he would for a heterosexual couple, while it would clearly be intolerant for him to call security and have the couple escorted from the surgery as soon as they darkened his door. But the middle ground is still up for grabs. Suppose the doctor explains that his moral objections to the patients' sexual practices make him unable to provide sexual health services, and suggests that they consult another GP. Someone who shared the doctor's views on homosexuality might regard this as a reasonably tolerant response, but someone who was concerned to defend equal rights for same-sex couples might criticise it as intolerant.

It seems to me to be a plain truth about the concept of tolerance, and not really a big deal, that judgements can vary on whether a response to a belief or practice counts as tolerant or intolerant to the same extent that judgements can vary on the invidiousness or otherwise of the belief or practice itself, and on the right of the tolerator to intervene if he wanted to. In fact, this vagueness helps to explain why there is quite vociferous disagreement, for instance, about whether it's tolerant or intolerant of society at large to require doctors to refer patients for abortions elsewhere if they refuse to perform the abortions themselves for personal moral reasons — a topic I will take up again in chapter 6. But that's not to say that

there are no clear instances of tolerance or intolerance, or indeed possible *degrees* of tolerance, according to which we can agree, for instance, that allowing refusal but requiring referral is *more tolerant* than disallowing refusal in the first place, even if we disagree about whether it is tolerant *enough*.

### *A revised definition of tolerance*

Based on all the considerations I've outlined above, here is a revised definition:

- One is tolerant to the degree that one puts up with someone else's belief or practice, even though one disapproves morally of that belief or practice and would otherwise have at least some right to intervene (e.g. to criticise, prevent or attenuate the belief or practice).

It will be clear from the foregoing section that this is a fairly narrow definition of the concept of tolerance. Other definitions with wider scope are perfectly possible, especially in everyday talk. But I've deliberately chosen to narrow my focus only to putting up with a belief or practice (not a person or culture), where there is moral disapproval (not mere personal dislike), and where the tolerator would otherwise have at least some right to intervene (not where it's none of their business). Although I have already argued that this circumscribing of the concept does reflect everyday usage at least to some degree, nothing in the rest of my argument relies on that claim. If you prefer, you can take this as a purely stipulative narrowing: notwithstanding how the term is used in other contexts, when I use the word 'tolerance' (and related words) from now on, I mean it in this specific, restricted sense.

Under this definition, I submit, the question of how society should react to doctors' objections is a question of tolerance.

### **III. Why should we be tolerant?**

Having come up with a working definition of tolerance, the million-dollar question is why we should actually *be* tolerant. Without a clear answer to this question, my claim later in the chapter that respecting doctors' objections counts as tolerance is not much use as an argument for actually respecting those objections.

Bertrand Russell (1940) famously observed that the first difficulty with many philosophical problems is “simply to see that the problem is difficult” (p.9), and that might seem to be the case here. For those of us accustomed to liberal twenty-first-century societies which value, or aspire to value, both individual autonomy and cultural diversity, we might think it just *obvious* that we ought to tolerate other people’s beliefs and practices — and correspondingly hard to imagine what kind of argument could lead us to doubt it.

To start to dispel this impression, the first point to make is that the value of tolerance has not always been quite so obvious. Historical attitudes to religious diversity, for instance, were rather different:

By the end of the 18th Century it had come to be accepted in most of Western Europe that every decent society must embrace some principle of religious toleration. But as late as the 16th Century most Europeans, I think, regarded it as self-evidently false that it was desirable to tolerate significant differences of religious opinion.

(Curley, 2004, p.48)

Of course, that was then and this is now. Societies change their moral outlooks over time — maturing, we like to think, and coming to recognise new moral truths that previously eluded them. So perhaps we shouldn’t worry too much about what our 16<sup>th</sup>-century ancestors thought. It would be a pretty feeble argument against the obviousness of the evil of slavery, after all, that there was a period of history when its evil went unrecognised.

But an appeal to modern values is not enough to solve the difficulty, because the case against tolerance (as opposed to, say, slavery) seems to be based on moral principles which ring just as true for us today as they did five hundred years ago. The problem is simply that it’s hard to see why we should tolerate anything of which we disapprove. As David Raphael puts it:

To disapprove of something is to judge it to be wrong. Such a judgement does not express a purely subjective preference. It claims universality; it claims to be the view of any rational agent. The content of the judgement, that something is wrong, implies that the something may properly be prevented. But if your disapproval is reasonably grounded, why should you go against it at all? Why should you tolerate? Why, in other words, is toleration a virtue or a duty?

(Raphael, 1988, p.139)

The difficulty summarised by Raphael might explain why one does not have to look too far, in the modern world, to find analogues of the 16<sup>th</sup>-century outlook. For instance, tolerance of outward criticisms of conservative religious worldviews is often viewed as undesirable by

those who hold those worldviews (Clark, 2007), and even more liberal religious codes often include an overt principle that the nonbelief of others is regrettable or bad, and should be challenged or ‘witnessed to’ — a principle that is sometimes played out innocuously, and sometimes more forcefully. Really, in order to throw doubt on the value of tolerance, all you need is a combination of two claims which are both uncontroversial ingredients of at least some mainstream religious worldviews: *exclusivity* (‘this set of religious claims is true and certain others are false’) plus *moral obligation* (‘it is morally right to believe true religious claims and morally wrong to reject them’). And these two claims can often be derived from other equally uncontroversial elements of believers’ worldviews. For instance, if God’s will is a universal moral imperative, and God wills that we accept him, then there is an argument to be made that rejection of him is morally wrong and should be discouraged. Equally, if the universe is set up such that unbelievers will be made to suffer for their stance, for instance by being sent to hell, then trying to convince them to change that stance might be seen as not only morally obligatory but also maximally compassionate.

From a secular perspective too, it’s far from clear why it should be morally desirable to tolerate beliefs and behaviours that deviate from what we consider acceptable. After all, there are many possible ways of behaving which we might judge as immoral, and for most of them we would regard any suggestion of tolerance as entirely misplaced. Modern societies, no matter how liberal, don’t adopt a tolerant attitude towards murder or larceny. Instead, we try our best to prevent them, and punish those who perpetrate them. Given this, why should we tolerate *any* activity or way of life which we think of as morally bad?

Another way to characterise the same problem is as a dilemma. It’s easy to put up with something of which you don’t disapprove — in fact, I’ve already said that this doesn’t count as tolerance at all. But then, if you *do* disapprove of something, it’s hard to see how tolerance can be a more appropriate response than interference. As a basic principle of ethics, if bad things are happening, we should surely do what we can to stop them, all else being equal<sup>57</sup> (Raz, 1986, p.401). So it seems that, for *every* belief or practice, either tolerance is ruled out by definition (because we don’t disapprove in the first place) or it is inappropriate (because we do). This dilemma leads Bernard Williams to his famous pithy

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<sup>57</sup> Here, I intend “all else being equal” to include such qualifications as “provided that interference will not cause more harm than good”, and “provided that interference is not ruled out by some other duty or moral requirement”. See the quote from Herman in the following section.

observation about the problem of tolerance, subsequently quoted in nearly every philosophical discussion of the problem:

Toleration, we may say, is required only for the intolerable. That is its basic problem.

(Williams, 1996, p.18)

Naturally, there is a long tradition of attempts to solve this problem in the context of political philosophy.

### *The peace-and-harmony account*

One of the most common proposals, developed by Williams himself among many others, is the virtue of tolerance is not intrinsic but instrumental. The idea here is that tolerance is some kind of compromise: when it's of moral value, this is true not because we ought to value it in itself, but because it turns out to be the optimum way to balance the value of trying to prevent wrong with other considerations which we also perceive to have value. Here is Herman's account of what's really going on when we tolerate:

One accedes to the continued existence of something one objects to either because its continued existence contributes to something else one values or because the costs of interfering with it are too high.

(Herman, 1996, p.61)

The most common proposal for "something else one values" is the good of "a peaceful and harmonious society" (Scheffler, 2010, p.313). So, as a shorthand, let's call this the peace-and-harmony account. This account plays out as follows. Suppose we judge as immoral a particular belief or practice which is adhered to by others. Absent any other considerations, it seems to us that the belief or practice ought to be prevented on the grounds of its immorality. But this is not the only morally relevant factor. Not everyone agrees with us about the immorality of the belief or practice, and in fact others value it. So, if we try to interfere, we will very likely generate conflict. Not only does conflict risk harm to individuals (a risk we may or may not be willing to take, on balance), but, if the belief or practice in question is very deeply valued, if it is tightly intertwined with cultural identities, and if opinions are sharply divided as to its moral status, then the conflict that arises might be acute or even intractable, and this will then endanger something else we value: a stable, peaceful and harmonious society. So (from our perspective) we now have two valuable ends which appear to be in conflict: (1) preventing immorality and (2) preserving social harmony. In this situation, the argument goes, we can be justified in prioritising (2) over (1)

when the consequences of neglecting (2) are somewhat worse than the consequences of neglecting (1). That is, in some situations, we can set aside our disapproval for the beliefs or practices in question — we can *tolerate* those beliefs and practices — in order to keep the peace.

And for those sympathetic to the peace-and-harmony account, there may well be a further, related reason to prefer social harmony over interference: if we endanger peace and harmony, our intolerance may come back to bite us in the form of repression or conflict. This consideration is pragmatic rather than moral. We are not the only members of our society to be faced with the question of what attitude to adopt in the face of others' beliefs and practices which we find morally reprehensible. Others with different moral outlooks from our own may face exactly the same difficulty with respect to *our* beliefs and practices. If *we* want to be tolerated by *them*, then, it's strongly in our interest to try to bring about a society in which, in general, people tolerate each other — this is as much to our own benefit as to the benefit of those with whom we disagree. The desire for social harmony made possible by tolerance is as much self-interested as it is morally enlightened. To summarise: be tolerant, the pragmatist says, because tolerance is the only way to secure the kind of society that makes it possible for us all to have the kind of life we want.

Before I go on to consider whether the peace-and-harmony account is a good solution to the problem of tolerance in its own terms, let me first reiterate that this question matters for the question of whether tolerance is a useful concept in the context of doctors' objections. If the account I've just presented is correct — that is, if it turns out that the only way we can justify tolerance as a virtue is by reference to its value in preserving peace and harmony — then I think this will severely compromise the usefulness of tolerance when applied to medicine, for two reasons.

The first reason is that, so long as policies are made with reference to general public opinion and taking into account the views of the medical profession in general, moral objections to any given legalised practice are only likely to affect a minority of doctors, so the general damage inflicted on society by deciding not to tolerate them will be accordingly small. Certainly, I can think of no examples where doctors' objections to legal medical practices, specifically, have led to *general* social disharmony. I suppose we might generate something *analogous* to social disharmony, perhaps 'unrest in the medical profession', but unless the

medical profession is conceived as the bedrock of our society, this hardly seems to be a strong enough factor to outweigh the competing attraction for society of preventing moral wrongs.

The second reason, moreover, is that there is an important difference between politics and medical ethics which undermines the attempt to draw an analogy here. In the political arena, the potential for conflict depends substantially on the fact that the dissenting minority (the group whose beliefs or practices are disapproved of) have no alternative but to suffer intolerance if they are unwilling or unable to give up the relevant beliefs or practices. Resigning from society is rarely an option.<sup>58</sup> But in the medical context, there is always an alternative which preserves one's conscience and sidesteps any further difficulty: one can resign as a doctor. So about the worst possible outcome of societal intolerance of conscientious refusal in medicine is the resignation of a number of doctors. This may indeed be highly undesirable for many reasons — it may cause pain to the doctors in question as well as impacting on the availability of medical care (Imbody, 2009) — but, at least in the present context, it is unlikely to lead to rioting in the streets.

So, if the peace-and-harmony account I've just outlined is right, then we may need to look elsewhere for a useful account of why we should tolerate doctors' objections. Therefore, the big question is: is the peace-and-harmony account the right one?

As it happens, I don't think it is. Here is why.

First, it seems to me that there is no guarantee, in any given political situation, that the balance of value will come down clearly on the side of preserving peace and harmony. Yes, we might concede that tolerating some beliefs or practices would be more likely to engender the harmonious society that we value than not tolerating them. But this admission does not by itself guarantee that tolerance would be justified in the final analysis. We judge many beliefs and practices to have sufficient *negative* moral value that it would be better to try to prevent them, and to hell with social harmony. In these situations, the instrumental justification for tolerance fails. This failure would be uncontroversial if a subgroup or culture wanted to practise slavery, eugenics or human sacrifice, for instance. Even in the

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<sup>58</sup> At least, not in the modern era. For an interesting perspective on the political environment which led to the departure of the Puritan pioneers from England in the 17th century, see Bremer (1995).

most liberal or conflict-averse societies, few people would advocate the value of social harmony over trying to prevent these practices, even if they conceded that peace and harmony was indeed more likely to result from tolerating these practices than from trying to prevent them. And there are plenty of beliefs and practices — religiously segregated schooling, for instance — whose moral value is more controversial and where the balance between morally-motivated intervention and deference to social harmony is harder to strike. Yet it's precisely these controversial areas where the appropriateness of tolerance is most in question, because it was the perceived relative disvalue of these beliefs and practices that first made us doubt the value of tolerance as opposed to interference. In short, the peace-and-harmony account only has weight where we're prepared to agree that the disvalue of the practices we find objectionable is sufficiently small to be outweighed by the value of peace and harmony — and, given the nature of the debate about such practices, this is certainly not a given in every case.

Second, if tolerance is all about preserving peace and harmony, then it ceases to be a recommended course of action in situations where a case can be made that it isn't linked to peace and harmony in the first place. This can happen if we fear that tolerating a particular belief or practice — for instance, the rise of political extremism — might also lead to social disharmony if left unchecked, or indeed where the belief or practice in question itself represents a source of social disharmony. In those cases, we may prefer the conflict that we expect to arise from intervention to the conflict that we expect to arise from tolerance. Now, we may be prepared to bite this bullet and agree that tolerance is not appropriate in these cases. But an associated bullet is harder to swallow: tolerance *also* ceases to be attractive in situations where conflict is inevitable or likely to continue anyway, whether we tolerate or not. In such situations, the instrumental account implies that we may as well try to prevent the practices we find immoral anyway, since essentially we have nothing to lose!

Third, and most worryingly, tolerance ceases to be *at all* attractive on this account when adherents to the belief or practice in question are much less powerful or influential in society than those who object to their activities, meaning that the chances of intolerance coming back to bite the oppressors are quite low. Scheffler makes this latter point effectively:

In particular, if one group in a pluralistic society becomes substantially more numerous and powerful than the others, the members of the ascendant group may feel that they can accomplish more through intolerant policies than they can by adhering to a regime of

toleration. The cost to them of suppressing dissent, they may feel, would be minimal and the gains significant. Under these conditions, instrumental considerations may not suffice to tilt the balance of reasons in favor of toleration.

(Scheffler, 2010, p.317)

This seems to me to be a fatal objection, since it essentially rules out the value of tolerance in situations where a powerful ruling majority is in a position to repress and quash a minority of which it disapproves, for instance through the use of overwhelming force. Yet it's precisely these situations, it seems to me, where we feel the need to invoke the value of tolerance as all that stands between a powerful ruling elite and evils such as rapid cultural expansionism and the brutal repression of minorities. By modern standards, the *pax romana* was not really a *pax* at all.

Fourth, there are further complications arising from tolerance which cast doubt on its credentials as an instrumentally valuable practice. Perhaps surprisingly, some writers — including some self-identifying political liberals — have suggested that there might even be *liberal* grounds to question its value. For instance, Thomas Scanlon (2003) points out that adopting what looks like a cost-free live-and-let-live outlook can in fact bring long-term disadvantages to tolerators, if failing to challenge an attitude of which one disapproves can lead to that attitude becoming more influential in the society in which one lives, and thus reduces one's own freedoms. And Barbara Herman (1996) argues that widespread tolerance, often regarded as a progressive value, can in fact be socially conservative in two respects: (1) when a tolerated practice is undesirable, the doctrine of tolerance allows it to continue to flourish, insulated from the disapproval of others (p.60); and (2) when the tolerated practice is harmless or positive and ought to be acknowledged or embraced, the doctrine of tolerance conversely allows general *disdain* of the practice to persist unchallenged, thus discriminating unfairly against those who are tolerated (p.61).

If these observations are right, then tying tolerance to peace and harmony considerably narrows the scope of situations in which tolerance would be recommended. This is clearly not a good result for those of us who want to value tolerance.

But it's not the worst of it. In fact, I think the social harmony account gets things altogether backward. When we think of situations in which an overwhelmingly powerful cultural or political majority successfully quashes a relatively powerless minority, we don't tend to think, 'Well, that's one way of achieving peace and harmony! Well done!'. Instead, we tend

to criticise the oppressors, precisely because it seems clear to us that tolerance would have been a morally more appropriate option *regardless* of the effectiveness of oppression. In fact, it seems to me that the greater the power imbalance — that is, the easier it would be for the powerful majority to achieve social harmony in intolerant ways, and therefore the less social harmony comes into the equation — the more virtuous we would judge tolerance to be. Imagine a hypothetical society that's so powerful that it can completely exterminate every shade of dissent from within its borders, leaving alive only those citizens who completely and sincerely sign up to society's dominant values. It seems obvious that this would achieve peace and harmony, but equally obvious that it would be morally abhorrent.

If this is right, then tolerance can't simply be an instrumental virtue on the road to achieving peace and harmony. It must have something else to recommend it. So the fact that the peace-and-harmony account does not transfer well from the political to the medical context is not a great concern, because the peace-and-harmony account is not very effective even in the political context.

As a kind of postscript to this discussion, it's worth noting that the weakness I've just described for the peace-and-harmony account is going to be a weakness suffered by *any* solution which paints tolerance as an instrumental virtue rather than an intrinsic one. As soon as we retreat from the claim that tolerance is valuable in itself to the attenuated claim that it simply contributes to an independently valuable end — that is, as soon as we say its value is instrumental and not intrinsic — we back ourselves into a corner where we are forced to recommend tolerance only in a limited set of circumstances, namely when it appears that (a) the value of tolerance outweighs the value of interference, and (b) tolerance is the most effective way to achieve the end in question, as opposed to, say, oppression. And this is an undesirable corner to be in, because it's simply not how we think of tolerance, either in the political or the medical context. If there are good reasons why we ought to respect doctors' rights to object to a procedure which we find morally dubious, at least some of these reasons must surely be about respect for the objection itself, and not simply about sitting on our hands and preserving a beneficial societal arrangement. Like it or not, we *do* think of tolerance as being intrinsically valuable, something whose intrinsic value is to be at least weighed against other considerations. And this is just as true in the medical arena as in the political one.

This conclusion represents bad news and good news for my main argument in this chapter. The bad news: If preserving peace and harmony is not a reason to tolerate in general, then I haven't yet identified a reason to tolerate in general, so I'd better keep looking. The good news: If preserving peace and harmony is not a reason to tolerate in general, then it doesn't matter that there appears to be no good way to extend the peace-and-harmony account into the medical arena in order to make tolerance apply there.

### *The personal autonomy account*

The next justification for tolerance that I want to consider is that it is an appropriate way to respect the personal autonomy of those with whom we disagree. The idea here is that individuals ought to be free to live out their own moral choices, which implies that we ought to tolerate their doing so:

The agent's thought is this: 'This other agent has a sinful and disgusting way of life and engages in sinful and disgusting practices. However, it is nobody's business to make him, force him, induce him, or (perhaps) even persuade him to take another course. It is up to him — his morality is in his own hands.' It is as a particular consequence of all this that political power should not be used to constrain him.

(Williams, 1997, p.38)<sup>59</sup>

Conscience is the fundamental commitment to be moral: the fundamental commitment to respect others. People of conscience owe each other, first and foremost, respect for their consciences. Without conscience, no morality is possible. To have a conscience is to commit oneself, no matter what one's self-identifying moral commitments, to respect for the conscience of others. This is tolerance.

(Sulmasy, 2008, p.145)

We need not delve too far into the back story for this justification of tolerance to see that it has relevance to the question of doctors' objections. Doctors are citizens of society. If society ought not to subject its citizens to intolerance with respect to practices of which it disapproves, then it ought not to subject doctors to that intolerance with respect to their moral objections. So to the extent that respect for individual autonomy is a reason to tolerate anyone's beliefs and practices, it is a reason to tolerate doctors' moral objections.

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<sup>59</sup> This isn't Williams's own position, but rather a gloss proposed by him as one of two possible interpretations of a remark by Nagel; Williams calls it a moral interpretation with political implications, and contrasts it with a rival interpretation which is purely political. He goes on to criticise the moral interpretation on several grounds, and argue that his purely political interpretation is more successful. For my purposes, I need not go into the details of this discussion.

Is this a good argument? Well, one point to make in response is that the principle of autonomy cuts both ways. If doctors' objections are to be tolerated out of respect for their autonomy as moral agents, then patients' autonomy also plays a part, and of course these two considerations can sometimes conflict. The potential for conflict doesn't undermine the potential relevance of the individual autonomy account as an explanation of why doctors' moral objections should be tolerated, all else being equal. But it does remind us that such tolerance is not the end of the story. That's why the question of how to resolve the conflict between doctors' interests and patients' interests will become my main focus in the following chapters.

Another point is that this argument is rather close to a position I discussed in chapter 2 (p.56 of this thesis), that a reason to respect doctors' objections is simply because they are free individuals like the rest of us, and therefore are entitled to choose to act according to their own preferences. I gave this claim short shrift earlier, pointing out that the nature of a profession — indeed, of any job — is that one commits to certain responsibilities, thus curtailing one's personal freedoms somewhat. The same response applies here. We might indeed want to tolerate people's moral views out of simple respect for their personal autonomy. But we must also understand that a person's autonomy can be constrained by many things, including when that person voluntarily signs up for a profession like medicine which comes with a list of obligations and responsibilities in exchange for financial and other compensations. Whether that list of obligations and responsibilities should include 'participating in procedures even if you feel they're wrong' is an open question. But the question is not settled simply by asserting the basic personal autonomy of the doctor.

### *The cultural-value account*

Here's another proposal. The reason we should tolerate different groups' beliefs and practices, even if we disapprove of them, is because those beliefs and practices are part and parcel of different cultures or ways of life, and those cultures or ways of life are themselves valuable and worthy of respect.

There's more than one way to fill in the details here, depending on what we think the criteria are by which we judge whether a culture has value and whether that value is intrinsic or representative of some higher good. Some writers (e.g. Musschenga, 1998) have

argued that cultural diversity has intrinsic value, and therefore (so long as certain other conditions are satisfied) it's worthy of tolerance. Others point to the complexity of multiple cultures as representative of a valuable feature of human society, such as the creative process by which such cultures arise:

That explains why we think it a shame when any distinctive form of human culture, especially a complex and interesting one, dies or languishes. [...] We try to preserve cultures we do not especially admire, because they embody processes of human creation we consider important and admirable.

(Dworkin, 1993, pp.72 & 75)

Still others seek to ground tolerance of cultural diversity in broader conceptions of 'the good life'. Drawing on the work of Will Kymlicka (1991), the legal philosopher Alon Harel (1996) addresses the particularly thorny question of whether we should tolerate ways of life that themselves engender *intolerance*. He argues eloquently that the protection of particular cultures and ways of life, even intolerant ones, is important because these cultures give rise to communities of shared values which in turn provide the necessary social context for individuals "to live in accordance with their freely-made choices" (p.115). Taking this social context as an important component of individual well-being, Harel argues that the state thus has a duty to tolerate and protect such ways of life as a component of its duty to promote citizens' well-being:

Intolerant views, opinions, or values can be an aspect of a wider net of opinions and sensibilities that, taken together, form a distinctive style or way of life. [...] The complex cluster of values and practices that comprise a particular way of life cannot be interfered with by the state without undermining the integrity of that way of life.

(Harel, 1996, pp.116-117)

Suppose for a moment that Musschenga, Kymlicka, Dworkin and Harel are all broadly right, and the reason we should value tolerance is because of the value (intrinsic or otherwise) of different cultures or ways of life. Where does this leave us with respect to tolerating doctors' objections?

When I discussed the peace-and-harmony account a moment ago, I conceded that it didn't translate well to the medical context but argued that this didn't matter because its usefulness as an account of why we should tolerate even in the political context was dubious. For the cultural-value account, my approach is different. Instead of challenging the account on its own terms, I will argue that it actually translates quite well to the medical context — and so, if it's the right account for the value of tolerance, then so much the better for my argument.

The most obvious way to translate the cultural-value account to the medical context is simply to apply it literally in cases where this makes sense. When a doctor has a moral objection to a particular practice, this objection might be based on his own cultural (ethnic, religious) way of life. If that way of life has independent value, then tolerance of it means tolerance of the behaviours implicit in it, and that might include refusal to take part in certain procedures. For instance, a doctor who objects to assisted dying may point to his belief that only God has the moral authority to dispose of life — a belief that is part of his wider religious worldview; a doctor whose religious beliefs include a prohibition on consuming alcohol may raise an objection to treating those suffering from alcohol-related illnesses (Wyatt, 2009); and so on. Part of *what it means* to tolerate different ways of life is tolerating doctors' objections arising from them. This is the claim, at least; in what follows I consider some arguments against it.

Does this mean there can be no value in tolerating doctors' objections which *don't* arise directly from such ways of life? After all, a doctor may object to a practice like abortion because he judges it to be immoral, without relying on any distinctive cultural or religious backdrop as his basis for that view. And I certainly admit that, where there's no such backdrop, there can be no *literal* application of the cultural-value account.

But here I want to switch to a different argument: in the absence of a literal backdrop of this type, there may still be an *analogous* backdrop. In the place of a literal cultural (ethnic, religious) basis for tolerance, I substitute a relevantly similar one: the medical profession itself.

This is only an analogy. I'm not claiming that a professional edifice like medicine *literally is* a valuable culture or way of life in the political sense, and deserving of tolerance for that reason. That would simply be another direct application of the original account, and one that would require a substantial amount of work to avoid looking tenuous. Rather, I'm claiming that the kinds of considerations that lead Dworkin and Harel to argue that culturally-grounded beliefs and practices are worthy of protection in a political context can equally well be applied to the *professionally*-grounded practice of doctors' objections, thus giving rise to an analogous case for tolerance.

Precisely what these considerations are depends on which account we subscribe to. Echoing Dworkin, we might propose that the medical profession's value derives from the fact that it

is an edifice with independent value because of its history, complexity and distinctiveness. Echoing Kymlicka and Harel, we might identify its contribution to the good life of society as its valuable features. We might even suggest that the medical profession has intrinsic value, or there may be other reasons to value the constitutive traditions and values of medicine. But however we spell out the details, the idea is that — just as the constitutive traditions and values of a religious or cultural community (ostensibly) deserve our tolerance because the protection of those communities is valuable to society — so the constitutive traditions and values of the medical profession (ostensibly) deserve our tolerance because the protection of that profession is valuable to society. The medical profession is similar enough to a culture to make sense of the value of tolerance according to an analogy with cultural-value account.

As empirical evidence for this claim, I would point out that objecting doctors do in fact often point to the medical profession as grounding their moral objections in precisely this way. In chapter 1 (p.24 of this thesis), I brought up the case of objections based on professional norms and duties — that is, cases where the reason a doctor gives objecting to a practice is that to participate would violate a moral duty incumbent upon her *by virtue of her adherence to a particular shared set of values*, namely the values of the medical profession, the most commonly cited example being ‘Do no harm’. I pointed out there that an interesting question arises in situations where a doctor might have no *personal* moral objection to a procedure (e.g., she might think assisted dying is sometimes permissible) but might nonetheless believe that the values of the medical profession require her to object (e.g., she might think *doctor-assisted* dying is impermissible). I debated whether this really counted as a personal moral judgement, given its reliance on values derived from a code of conduct, but I concluded that a doctor who cites professional duties when refusing to perform a procedure does indeed make a moral judgement of the following sort: that *she ought to allow* the constraints of her profession to outweigh what might otherwise be an appropriate course of action.

In these cases, I submit, what is actually going on is that the doctor is pointing to the values of the medical profession to explain and justify her objection *in precisely the same way* as she might point to the values of her religion or culture. Rather than insisting that we directly respect her individual moral decision in this particular case, she’s insisting that we respect her general choice to live her life according to a code that is itself worth respecting,

including a higher and more general set of values according to which it would be wrong for her to take part in this particular procedure.

This account also helps to explain why some campaigners are keen to emphasise that their moral objections to (say) abortion are based on the medical profession's traditions and values, rather than simply pointing to what they see as the negative moral status of abortion. They claim that, to the extent that a doctor's objection is grounded in the traditions and values of his profession, it ought to be tolerated, and that this moral obligation can be recognised and acknowledged even by those who do not themselves agree with the objection — including, crucially, the society which has chosen to permit the controversial practice in the first place.

And looking at tolerance in this way can illuminate another tricky issue. Much of Harel's paper is concerned with the question of whether there can be a good reason to tolerate specifically *intolerant* beliefs and practices (he cites as an example the principles of Orthodox Judaism which dictate an inferior social position for women and the immorality of homosexuality). The question is interesting because it describes a paradox which a heterogenous society faces: if we are committed to tolerance, does that require us to respect others' *intolerance*? Harel's answer is a qualified 'yes': to the extent that intolerant beliefs and practices form an essential and indivisible part of a group's culture or way of life, and that culture of way of life is itself valuable, society ought to tolerate those intolerant beliefs and practices.

By the way, I haven't gone into any detail about *why* Harel thinks a particular way of life, especially an an intolerant one, is worth protecting in its own right. In brief, his answer is: because of the social context such a way of life provides for the meaningful choices of individuals within it, and these meaningful choices are themselves of value. This means that Harel's recommendation of tolerance is not unqualified:

First, it is necessary to show that the intolerant practice is indeed an integral part of a way of life. Second, it must be shown that the way of life as a whole is a valuable one. It is certainly possible that some intolerant practices are integral parts of ways of life that are not valuable and hence need not be protected. The difference between one's attitude toward such practices as those of fundamentalist religious groups, on the one hand, and those of the KKK, on the other, can be explained by the claim that whereas the former are valuable (although they might contain repugnant values and practices), the latter lack any value.

(Harel, 1996, p.117)

It seems to me that there is an obvious connection between this question and the question of whether society should tolerate doctors' objections to controversial practices. As I discussed earlier, there are *two* instances of disapproval at play in the example of the doctor who refuses to participate in a particular procedure: one on the part of the doctor towards performing the procedure, and the other on the part of society towards the doctor on account of her refusal. In the example I gave of providing sexual health services to same-sex couples, the doctor is (arguably) intolerant with respect to her patients' sexuality if she refuses to provide the services. The question then facing society is whether or not to tolerate this intolerance. A framework like Harel's, according to which intolerance ought to be tolerated only if it is an inextricable component of the general worldview of the culture whose general body of beliefs and practices is of independent value, may well provide a fruitful way to approach this issue.

### *The pillar-of-society account*

In a recent paper, Daniel Sulmasy (2017) develops an argument for respecting doctors' objections based on the nature of professional discretion. His thesis is that, since medicine is a profession and not just an occupation, to fail to grant moral weight to doctors' objections unnecessarily restricts the latitude that doctors ought to have to decide what services to provide to their patients — their “discretionary space”, in a phrase borrowed from Pellegrino (1977):

Because of these moral and intellectual differences between professions and other occupations, individual practitioners of a profession are granted wide latitude in their decisions about what to do on behalf of those that they serve. [...] Society has an interest in promoting good medicine, and, therefore, society has an interest in granting physicians the wide discretionary space that is required to make medical practice excellent.

(Sulmasy, 2017, p.24)

Sulmasy points out that, on a practical level, this discretionary space is what allows doctors to choose to specialise in a particular area of medical practice, motivated by intellectual interest, aesthetic taste or “moral commitment to improving the lot of patients with such disorders [for example] because of memories from childhood of a thyroid operation gone wrong in a loved one” (p.24). Such specialisation allows for the obvious benefits of professional excellence and increased personal commitment. This part of Sulmasy's argument seems uncontroversial to me. Society would be impoverished if all doctors were forced to be general practitioners. Indeed, the ability for individual doctors to avoid areas of

practice which risk conflict with their personal moral beliefs is often cited as a solution to the conflict by those who oppose making allowances for those beliefs.

But Sulmasy goes on to propose that the proper “discretionary space” should extend to allowing clinicians to make moral decisions about which procedures they choose to participate in, even when those procedures fall within the defined boundaries of their chosen areas of specialisation. His main argument here is that moral decisions are ubiquitous in medical practice:

Moreover, sometimes physicians refuse to perform interventions that fall within the scope of their own chosen practice parameters. As with other professional judgments, these professionals should be afforded wide discretionary space in making such judgments, which are driven by complex admixtures of technical and moral considerations. [...] Because these professional judgments are both technical and moral in all cases, it seems even more important to respect and protect a wide discretionary space for physicians regarding ethically controversial interventions. Precisely because there can be no a priori legislation of each and every medical decision, society has a deep interest in cultivating practitioners of conscience. This is in the interest of patients.

(Sulmasy, 2017, pp.25-26)

Now, Sulmasy’s argument here is intricate, and there are at least three different strands to it.

The first strand is the analogy he seems to want to draw between the freedom of doctors to choose their clinical speciality and the freedom to choose which operations to perform *within* that speciality. I said a few moments ago that the ability of doctors to specialise, and thus deliberately avoid procedures which might cause them moral qualms, is uncontroversial. This decision can be based on doctors’ personal tastes and preferences, their perceptions of their own skills, or indeed their moral views about the kinds of procedures associated with each speciality. Sulmasy seems to want to say that, by the same token, we should permit doctors *within* a speciality to decline to perform (pp.24-25). If this is intended as a simple argument about consistency — ‘if we allow the first, we should allow the second’ — then it seems rather feeble to me, for at least two reasons:

- The whole point about choosing (freely) to specialise in a particular area is that you undertake to perform a specific function. That speciality comes with a set of responsibilities and obligations. So long as those responsibilities are reasonably predictable, then it seems to me the argument actually runs the other way: your commitment to the speciality implies *more* of an obligation to perform procedures that are part of that speciality, not less. (It’s like choosing to become a doctor in the

first place: you don't have to do it, but if you do, you accept that certain obligations come with the role, and thus you are *more* obliged than an average citizen to participate in medical procedures, not *less*.)

- The difference between choosing your general speciality and choosing whether to perform a particular procedure for a particular patient is that in the latter case, but not the former, a patient's wellbeing may be on the line. If you decide not to train as a thoracic surgeon because you don't want to perform emergency blood transfusions, then no patients will suffer as a result, provided enough other doctors are willing to become thoracic surgeons instead. But if you are a thoracic surgeon and you decline to perform an emergency blood transfusion for a patient admitted to A&E right now, that patient might well suffer a worse outcome as a result. (And if this is not the case — if no patients' interests will be damaged on the occasion when you exercise your objection — then there's no issue in the first place.) So the analogy between choosing to specialise in general and refusing to participate right now is a weak one.

A second distinguishable strand of Sulmasy's argument is about the interests of patients. Sulmasy makes the case that it's clearly in the interests of society to "cultivate practitioners of conscience" among doctors, because an inseparable part of being a good doctor is making day-to-day moral decisions about patients' interests. This is a strong and important argument, and it's one I'll consider in much more detail in chapter 5, in the context of whether doctors' judgements about patients' interests should take priority over society's judgements about those interests, especially where I discuss the claim that the medical profession is intrinsically a moral one (starting at p.153 of this thesis). (Sneak preview: my conclusion there will be that, while moral judgements are indeed a part of a doctor's role, there is no particular reason to prioritise a doctor's moral judgements over conflicting moral judgements on the part of society or individual patients — and indeed that there will be occasions when we are justified in overruling a doctor's views in favour of others.)

The third and final strand of Sulmasy's argument is the most interesting to me right now. Rather than being about the interests of doctors and patients, it's about *tolerance* as I've understood it in this chapter. Sulmasy maintains that one reason we should consider making allowances for doctors' personal moral beliefs is because it accrues political benefits to society to have a medical profession whose members have "wide discretionary space".

Indeed, although he doesn't say so explicitly, it seems to me that a consequence of Sulmasy's position is that there might be occasions when we might judge a doctor's conscience-based objection to be deleterious to his patient's interests, but still want to protect the doctor's right to object as a matter of general policy because of the wider benefits to society of adopting that policy.

So what are these political benefits that Sulmasy thinks will accrue if we tolerate doctors' personal beliefs? This is linked to his view of the special political role played by the medical profession, and indeed professions in general:

A pluralistic, liberal democratic society needs to foster the independence of its professions if it is to flourish. To the extent that markets, the academy, the press, religions, other private associations, and the professions all thrive as vibrant institutions, independent of the government and the other institutions, each can keep the other from becoming too dominant and each can independently (and all collectively) contribute to the common good. Democracies go awry when there is too much power concentrated in the hands of one, such as markets, or the government, or a particular religion. [...] Because of the complex nature of the moral and medical decisions that professionals must face, society has an abiding interest in fostering an independent professional culture that attends to conscientious practice, and an interest in respecting the consequently wide discretionary space that must be afforded to individual practitioners.

(Sulmasy, 2017, pp.25-26)

Call this the 'pillar-of-society account': we should allow doctors and other professionals wide discretionary space because that promotes their independence, and independent professions play an important role in preserving the institutional balance that keeps democracy functioning. What he has in mind here, I think, is the ability of a relatively independent and strong medical profession to resist sinister changes in society: unduly influential market forces can compromise patient care in favour of economic benefits, while an unduly influential state authority can potentially lead to patient-harming atrocities such as those recorded in Nazi Germany in the 1940s.

I agree with Sulmasy that this could indeed be an important reason to grant moral weight to doctors' objections. It seems both very plausible that a medical profession with wide discretionary space would be better equipped to resist such sinister changes than one in which doctors' moral views were routinely overruled, and obviously indisputable that such resistance would be beneficial to society as a whole as well as to the interests of individual patients. This is, then, another good reason to tolerate doctors' moral objections — as always, all else being equal.

#### IV. Objections to tolerance in the bioethics literature

Few writers have drawn substantially on considerations of tolerance to ground a recognition of doctors' moral objections in the way that I am doing here. Daniel Sulmasy is an honourable exception, and I have already discussed his views. But a few writers have mentioned tolerance as a possible approach — usually in passing, in order to dismiss it. So I deal with some discussion of the subject here.

##### *Wear, LaGaipa and Logue*

In a jointly authored paper from 1994, Stephen Wear, Susan LaGaipa and Gerald Logue consider the difficult case of withdrawing life-sustaining treatment at the patient's request, and consider various ways to apply the principle of 'tolerance of moral diversity' with regard to doctors who have moral objections to obeying that request.

Although Wear, LaGaipa and Logue are clearly writing about tolerance of doctors' objections, their approach is different from mine in at least three important respects. Firstly, they do not present specific arguments for tolerating, or respecting, doctors' objections. Rather, they present tolerance as the status quo, and their concern is then to show how some attempts to apply that status quo can "serve both sides [doctors and patients] poorly" (p.149).<sup>60</sup> Specifically, they suggest that one supposed application of a tolerant attitude, namely the imposition of a duty to refer, entails self-undermining difficulties:<sup>61</sup>

People in bioethics have been quick to recommend that in cases of conflict the physician should simply sign off the case and 'step aside'. This is not easily done psychologically or morally. Such a resolution also masks a number of more subtle, quite troublesome problems that conflict with the commitment to toleration and moral diversity that it is intended to support.

(Wear, LaGaipa & Logue, 1994, p.147, typo corrected)

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<sup>60</sup> When the authors do briefly (in their opening paragraph) allude to reasons why we should tolerate, they make two empirical claims. The first claim is that there is increasing moral diversity in our society. The second is that "we no longer share any common moral ground to which we might appeal for the adjudication of our differences" (p.147), which, following Engelhardt (1986), they call the "post-modern predicament". They make no particular attempt to establish or defend these claims, presumably because (again) their concern is to explore the limits of tolerance and its application, not to recommend or defend it.

<sup>61</sup> I will have much more to say about the duty to refer, and whether it is compatible with respecting doctors' objections, later in my thesis, especially in chapter 6.

Secondly, Wear, LaGaipa and Logue do not distinguish between *respecting* doctors' objections and *tolerating* them. That is, when they discuss whether we should tolerate doctors' objections to withdrawing treatment, they treat the phrase 'tolerate doctors' objections' as synonymous with 'permit doctors to object'; for them, the question 'Should we tolerate doctors' objections?' and 'Should we permit doctors to object?' are simply two different ways of phrasing the same question. By contrast, in this chapter, I've been using 'tolerance' to refer to the general principle that we should put up with beliefs or practices that we disapprove, and then arguing that, if we grant this general principle, this gives us one specific reason to permit doctors' objections, albeit a reason which may be outweighed by countervailing considerations. That is, I distinguish between tolerance (a general principle) and actually respecting doctors' objections (a specific application of that principle).

Thirdly, the authors assume throughout their article that the proper object of tolerance — or at least the one that's relevant in the case of doctors' objections — is *moral diversity*. While they don't explicitly define this concept, I think it's reasonably clear that they take it to mean something like 'coexisting moral beliefs and practices that are incompatible with one another'. This is not exactly the same as the phrase I used in my definition of tolerance, 'beliefs and practices of which we disapprove'.

It could be argued that these two phrases do in fact cover the same ground when it comes to moral beliefs and practices. Perhaps 'my neighbour has a moral belief different from mine' strictly implies 'I disapprove of my neighbour's moral belief'. But, putting that question to one side, my definition of tolerance anyway has wider scope than theirs in at least one respect: I also allow that *non-moral* beliefs and practices (of which we disapprove) can be objects of tolerance. For the purposes of my conception of tolerance, what matters is not whether someone's belief's or practice is moral in nature; what matters is simply the fact that we disapprove of it. The most obvious instances of non-moral beliefs and practices which I claim should be tolerated are cultural ones. A distinct, culturally-embedded belief or practice, such as all men having beards, need not have a moral component in order to be worthy of tolerance.

This might seem like an unnecessarily pedantic difference to highlight between my position and that of Wear, LaGaipa and Logue, given that doctors' moral objections are the subject

under discussion, and moral objections *do* obviously originate in moral beliefs. But in fact I think this difference is worth highlighting, because I wouldn't want my account to be conflated with theirs in this respect. I rely on other accounts — the ones I presented in the preceding section — to explain *why* moral diversity is worth tolerating. One account I presented, the cultural-value account, cited the valuable features of different cultures as what makes moral diversity worthy of tolerance. And, importantly, there is no requirement for these valuable features themselves to be moral in nature.

In fact, I actually think it would be very hard to defend Wear, LaGaipa and Logue's claim that moral diversity *in itself* has value and is thus worth tolerating. I can see no value in the plain fact that different people hold different (incompatible) moral beliefs. Quite the opposite, in fact: it seems to be a definitional fact about the concept of morality that it would be better if everyone held, and acted on, the *same* moral beliefs, provided, of course, that they were the right ones. Moral diversity, in itself, is something to be regretted insofar as it entails deviation from true moral beliefs among at least some people. And that's why, if we are going to tolerate moral diversity nonetheless, we need an independent account of why we should do so. Wear, LaGaipa and Logue provide no such account, but I have attempted to do so with the cultural-value account: diversity in beliefs and practices, including both moral and non-moral ones, should be tolerated when those beliefs and practices are manifestations of cultures whose independent value we recognise.

### *Wicclair's objections*

In the course of canvassing different potential accounts for respecting doctors' beliefs, Mark Wicclair (2000) mentions Wear, LaGaipa and Logue and then raises objections specifically to tolerance of moral diversity as a reason to respect objections. I've already argued that Wear, LaGaipa and Logue don't in fact *propose* tolerance of doctors' objections, but simply present its widespread acceptance as a jumping-off point, so I think it's wrong to suggest that Wicclair is directly criticising these authors. But Wicclair's three objections are nonetheless clearly aimed at something like the project that I have been developing in this chapter, so they deserve some attention.

One of Wicclair's three objections is easily ruled out of court:

In effect, the appeal to tolerance of moral diversity substitutes one question (Why should moral diversity be tolerated?) for another (Why should appeals to conscience in medicine be

recognised?). It may well be that the answers to these questions are related, but the objective of this paper [Wicclair's] is to present an answer to the second one.

(Wicclair, 2000, pp.211-212)

This may be a reasonable complaint to make about Wear, LaGaipa and Logue's presentation, since (as I said a moment ago) their objective is not to answer either of these questions, and they do indeed treat the two questions as largely equivalent. But it is not an objection to my argument in this chapter, since my claim is that the questions can usefully be interpreted as distinct, and that the answer to the first provides an independent justification for an answer to the second. I hope this is clear from what has gone before in this chapter.

Wicclair's other two objections merit more discussion. First, he argues that an appeal to moral diversity in defence of one's right to act according to one's own moral beliefs can undermine itself:

Suppose Dr K believes that it is morally wrong for *any* physician, including one who believes there is an ethical obligation to honor Mr S's wishes, to discontinue cancer therapy. Then Dr K would not accept the principle of toleration of moral diversity. Dr K might not be intolerant in this respect, but if she were, then, paradoxically, she would not accept the principle that is cited to justify recognizing her appeal to conscience. *Others* might still seek to offer such a justification by appealing to the principle of toleration of moral diversity. But if Dr K were to reject that principle, then she, and anyone else who does not accept it, cannot consistently cite it as a reason for recognizing conscientious objection.

(Wicclair, 2000, p.211, emphasis in original, typo corrected)

This is an interesting complaint. Wicclair gestures towards an important feature of many moral beliefs: that they are, in the view of the person who holds them, supposed to be *universalisable*. That is, my belief about the morality of another person's act doesn't vary according to that other person's own beliefs about the morality of doing so. If an act is wrong simpliciter, it's wrong for everyone. If I believe that it's wrong simpliciter to withdraw cancer therapy treatment from a patient, this means I believe it's wrong for *anyone* to do so.

This issue of universalisability is, as Wear, LaGaipa and Logue identify, a particular difficulty when it comes to imposing a duty to refer. But I will postpone my discussion of compulsory referral until chapter 6. For now, the question is whether Wicclair is right that the universalisability of moral beliefs undermines doctors' appeals to tolerance. While he admits (correctly, I think) that universalisability need not be a feature of every moral belief,

he argues that, when it is, it represents intolerance on the part of the doctor and thus prohibits him from consistently invoking tolerance as a justification for respecting his objection.

I disagree with this latter claim for two reasons.

Firstly, just because a doctor thinks his moral belief about a particular procedure is universalisable, that doesn't necessarily imply he is intolerant of others. It is perfectly consistent for the doctor to (a) refuse to perform a procedure such as withdrawing life-sustaining treatment on moral grounds, (b) believe that the procedure is equally wrong when another person performs it, and (c) be prepared to put up with other people performing it according to their own consciences, *precisely because* he subscribes to the principle of tolerance. Indeed, as I have already argued, this 'putting up' is what tolerance *is*. A precondition of a tolerant attitude towards a belief or practice is that one disapproves morally of that belief or practice. If moral disapproval of others performing it was enough to categorise one as *intolerant*, as Wicclair seems to suggest, then tolerance would be flatly impossible in the way I have defined it in this chapter.

Secondly, suppose that a doctor *is* in fact intolerant of others' moral beliefs, in that he *both* believes a procedure is wrong whoever performs it *and* would like to prevent others from performing it. As I said, this need not be the case, but suppose now that it is. Then I accept Wicclair's insistence that the doctor can't consistently invoke the principle of tolerance as a reason for respecting his objection while rejecting the same principle in his attitudes towards others. But I would suggest that, in this case, he does not need to do so. This doctor already has a perfectly good argument to justify respecting his objection: that the procedure he objects to is morally wrong, and he should not be forced to perform acts that are morally wrong. That simple argument is enough to ground both his objection and his request that he be allowed to refuse to participate. For him, the question of tolerance need not come into it at all.

By contrast, the people who *do* need to rely on the principle of tolerance are those who may not share the doctor's belief that the procedure is morally wrong, but nonetheless have to decide how to respond to his objections. These people — health service managers, regulators, policy-makers, judges, and ultimately voters — are the ones who must decide whether to make allowances for such objections or to overrule them. Of course, these people

may decide, rightly or wrongly, not to tolerate intolerant views. But even if they do take this stance, this need not be simply because the person who holds those views cannot consistently ask them to be tolerant.

Finally, Wicclair raises this objection:

Taken to an extreme, toleration of moral diversity would imply that physicians never are morally obligated to follow ethical standards that they reject. Although professional guidelines and hospital policies may allow physicians to refuse to participate in forgoing life-sustaining treatments for reasons of conscience, they rightly do not permit conscientious refusal with respect, say, to informed consent or confidentiality. Surely, a defense of conscientious objection in medicine is not acceptable if it requires absolute ‘value neutrality’ (or ‘value agnosticism’) and is incompatible with upholding any ethical standards. Whereas value neutrality is sometimes recommended as a goal for *governments* in pluralistic liberal-democratic states, it is not an appropriate goal for medicine.

(Wicclair, 2000, p.211)

I’m not quite sure what Wicclair is getting at with this objection. If he is saying that tolerance always implies value-neutrality, then this strikes me as confused. It is perfectly consistent to hold a particular set of values while also tolerating those who depart from that set of values. We can quite consistently uphold one set of ethical standards as the right ones, which logically implies a wish that others might universally accept those standards, and still tolerate those who do not. In fact, my main argument in this chapter expresses a hope that an attitude of tolerance towards those who depart from our values will itself *follow* from our values, if our values include cultural diversity or individual autonomy.

On the other hand, perhaps the reason Wicclair mentions value-neutrality in this passage is to argue that a commitment to tolerance (and thus value-neutrality) gives us no way to draw the line between what to tolerate and what not to tolerate. This seems to be the point of his observation that we don’t tolerate doctors’ objections to informed consent or patient confidentiality. Since we don’t tolerate objections to these things, he seems to be arguing, tolerance can’t be the reason we respect other objections, such as to abortion.

But in that case, Wicclair’s criticism can’t be right, because its sweep is far too broad. If Wicclair is saying that tolerating objections to *something* would require us to tolerate objections to *everything*, then this undermines not just the value of tolerance in medicine but the value of tolerance more broadly, including in the political context. Wicclair seems to accept this implication of his view when he remarks that value-neutrality is indeed sometimes “recommended as a goal for governments”. But it isn’t. Even the world’s most

liberal societies are not value-neutral. The most liberal and democratic societies imaginable still have some clear values: liberalism, for instance, and democracy. They generally value the rule of law, and individual freedoms, and human flourishing. They often devote considerable effort and resources to protecting themselves and their core values against countervailing influences such as religious extremism and totalitarianism. They tend to have strong prohibitions against a wide range of independently morally prohibited acts, such as murder, rape and torture. Indeed, as I argued a moment ago, a commitment to tolerance is itself a value, one which many liberal societies wear proudly on their sleeves.

So I disagree with Wicclair. Tolerance *cannot* require absolute value-neutrality, or else no society has ever been, nor will ever be, tolerant. Rather, tolerance admits of degrees, and can coexist alongside acceptance of a particular set of values. In fact, as I've already argued, it logically requires acceptance of a particular set of values in order to count as tolerance at all. To deny this is to confuse moral disapproval with intolerance, and in the course of doing so, to make any kind of tolerance definitionally unachievable.

Moreover, if Wicclair is right that tolerance is a bad account of why we should respect objections because "taken to an extreme" it fails to provide any way of drawing the line between those we should respect and those we should not, then this criticism surely applies not just to tolerance but to virtually any account of why we should respect doctors' objections. For instance, the account I developed in the previous chapter, based on harm to doctors, also fails to provide a way to draw such a line. "Taken to an extreme", the harm account suggests that any requirement we impose on doctors which might harm them in any way should be grounds for allowing objection. But this is obviously not plausible, because we wouldn't permit doctors to opt out of our expectations about patient confidentiality or informed consent on the grounds of harm to them, either. And tellingly, Wicclair's criticism could also be applied to his *own* account of why we should respect objections, which I discussed at length in chapter 2 (starting at p.57 of this thesis). This is the claim that we should respect objections that are based on doctors' core moral beliefs. But surely, "taken to an extreme", this claim would imply that we should allow doctors to object to anything that goes against their personal moral beliefs, regardless of the content of those beliefs or the implications of allowing refusal.

Wicclair would be quite right to reject this supposed difficulty with his core moral beliefs account. Indeed, tellingly, he spends a great deal of time in several different articles showing how his account *does* in fact make subtle distinctions between the different moral weights we should assign to different objections, according to the ‘coreness’ of the beliefs on which they are based (e.g. Wicclair, 2000, p.221). And he seeks to add a further constraint, that an objection must be based on values consonant with medicine (see p.74 of this thesis). Now, I have observed in previous chapters that I find both these claims of Wicclair’s (that respect for objections should be grounded on core moral beliefs, and that the values on which objections are based must be consonant with the values of medicine) problematic. That observation stands. But, be that as it may, my point here is that Wicclair himself clearly recognises that his own core moral beliefs account need *not* be “taken to an extreme”. That is, while the account provides a consideration in favour of respecting objections when it applies, it does not by itself guarantee that the objection in question should be allowed to prevail.

Indeed, there’s no reason why we should expect it to. As I argued at the end of the preceding chapter (p.100 of this thesis), it would be odd to demand of a reason to do X that it must always completely outweigh competing reasons not to do X, or else not be acceptable as a reason at all. One good reason to stay at home when I’m supposed to go to work might be that I have the early symptoms of a cold. This is still a good reason to stay at home, even if I ultimately decide to ignore my symptoms and go to work anyway because I have an important meeting that day. It would not be reasonable to insist that having a cold can *never* be a reason to stay off work simply because in some circumstances it is outweighed by countervailing considerations.

Of course, Wicclair’s core moral beliefs account is not undermined by the complaint that it would be unacceptable when “taken to an extreme”. But then neither is my tolerance account. The fact that we all agree tolerance can *sometimes* be outweighed as a reason to respect a doctor’s objections — for instance, in cases where patient autonomy or informed consent would be put at risk — doesn’t rule out its usefulness as a legitimate reason for respecting objections. Just as Wicclair is perfectly within his rights to refine his ‘core moral beliefs’ account by pointing out circumstances in which its force is blunted by countervailing considerations, so am I with respect to my tolerance account.

## V. Tolerance as a foundational premise

I have argued that we should grant moral weight to doctors' objections because we should be tolerant. That is:

1. Respecting doctors' objections is an instance of tolerance.
2. In general, we should be tolerant.

Therefore, we should respect doctors' objections.

Some parts of this argument have been more rigorously defended than others. In this chapter, I've defended premise 1 as well as I can, but premise 2 somewhat less comprehensively. When I presented three possible accounts of *why* we should be tolerant in general — the peace-and-harmony account, the cultural-value account, and the individual autonomy account — I discussed the merits of each of these accounts to some extent, and I criticised the peace-and-harmony account the most strongly, as a result of which I rejected peace and harmony as a justification for tolerance. But I certainly didn't say as much as could be said about these accounts, and whether they are really good solutions to the so-called problem of tolerance — a problem that threatens the obviousness of premise 2 by challenging us to say why tolerance isn't actually a really *bad* idea. For more discussion of the problem of tolerance and whether it can be 'solved', I happily direct the reader to the literature on tolerance in political philosophy, to which I've made extensive reference in this chapter. But it's no surprise that, like many controversies in philosophy, the literature reflects no happy consensus on the correctness of any proposed 'solution'.

This leaves a potential weakness in my argument. Someone unsympathetic to my cause might claim that I have failed in this chapter to establish that we should respect doctors' objections *because* we should be tolerant. Rather, at best, all I've shown is a hypothetical claim: we should respect doctors' objections *if* we should be tolerant. And I have failed to thoroughly establish and defend the antecedent.

I suppose I must concede this. But if my argument is going to rely on some unargued-for foundational premise or other, I could do a lot worse than the claim that people should tolerate each other in general. I pointed out earlier that the obvious value of tolerance might not have been a good starting-point for an argument at every point in history, or from every cultural perspective. But I think most of the people at whom my research is directed —

policy-makers, managers, clinicians, citizens of modern liberal democracies — would see it as a good starting-point today. If necessary, so be it.

As I said at the outset, the claim that tolerance is a reason to grant moral weight to doctors' objections is independent of my claim in chapter 3, that we should grant moral weight to doctors' objections because failing to do so risks harm to them. These two claims are complementary: they provide two different, independent reasons to grant moral weight to doctors' objections. But, as I have also been at pains to point out, they are not absolute conclusions. I said in chapter 3 that the risk of harm to doctors, while important enough a consideration that it gives objections moral weight, is not the only consideration. And the same applies to tolerance. By saying that we ought to tolerate doctors' objections, I don't mean to imply that such tolerance must automatically translate into granting doctors the right to refuse participation. Tolerance, like avoiding harm, has limits. Life is complicated. In nearly every situation where a doctor objects to participating in controversial procedures, other factors will weigh against that objection. In what follows, I will look at what those limits are.

# Chapter 5:

## Patients' interests

In the last couple of chapters, I presented two complementary answers to the question of what gives doctors' moral objections moral weight. Whether this counts as progress depends on your starting-point.

To a philosopher, even the simple claim that doctors' objections have moral weight may not be entirely obvious, and even if it is, accounting for the source of that moral weight counts as genuine theoretical work. From that perspective, I have made definite progress.

But when clinicians, health service managers, policy-makers and patients face difficulties arising from moral objections in medicine, their starting-point is rarely the question of whether such objections are worth considering at all. Rather, the presumption is that they do indeed make at least some demands on us — that is, they have at least *pro tanto* moral significance — and the real question is how best to balance those demands against other morally significant, but conflicting, considerations, such as patients' interests, justice, the prevailing moral view of society at large, or what-have-you.

From this perspective, all the work I've done so far has just been philosophical positioning — answering the easy questions and ignoring the hard ones. Only now am I at the point where I can actually engage with the hard questions of conflict and balance.

### I. The conflict between moral objections and patients' interests

Let me first set up the problem very simply. Here are two principles, each of which has strong appeal:

1. **Respecting moral objections:** Doctors' moral objections to participating in a given procedure have moral weight.
2. **Acting in the patient's interests:** Doctors ought to provide appropriate medical services in a way that furthers the patient's interests (or 'best interests': I assume that the two terms are equivalent, and I prefer the shorter one).

I submit that we have *pro tanto* reason to assent to both these principles. The first is the conclusion which I hope has been established by the foregoing chapters; I'll talk about the second in some detail in the remainder of this chapter. The problem, then, is what to do when the two are in tension — that is, when it's impossible to fully satisfy both.

Obviously, such a tension is not always present. It only arises in situations where a doctor's duty to act in the patient's interests involve her performing some action which conflicts with her moral views. One would hope that few doctors find themselves in situations like this day in, day out, at least when practising public medicine voluntarily in peacetime in relatively liberal countries. But such situations *can* arise from time to time in medical practice, more or less frequently depending on the area of practice under consideration, and especially when a controversial new medical procedure is legalised (I mentioned many examples of such situations in chapter 1). In these situations, principle 1 pulls in the direction of respecting doctors' moral objections and principle 2 pulls in the direction of not doing so. So we need a way to resolve the tension in order to determine what expectations we should place on doctors.

What do I mean by 'interests'? Like Feinberg, whom I quoted on p.85 of this thesis, I am content to leave the answer to this question a little vague, and simply say that something is in my interests if it furthers my total wellbeing in some way.<sup>62</sup> One clear component of patients' interests, for instance, is in receiving timely and effective treatment appropriate to their medical needs. But the phrase can also be interpreted more broadly to cover more

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<sup>62</sup> UK primary legislation is also content to leave the exact definition of 'interests' to the courts. Even the Mental Capacity Act 2005, which depends on the concept of 'best interests' for nearly every one of its provisions, only offers very sketchy advice about what these mean or how to determine them if a person is unable to express them for himself: "consider, so far as is reasonably ascertainable, (a) the person's past and present wishes and feelings, [...] (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) [most helpfully of all!] the other factors that he would be likely to consider if he were able to do so" (UK Government, 2005).

general and indirect interests of both individual patients and patient populations as a whole, examples of which include:

- **Accommodating patients' desires:** Patients have an interest in having their desires about their own treatment taken into account and accommodated, when those desires are based on full information (Moulton & King, 2010).<sup>63</sup>
- **Facilitating informed consent:** Patients have an interest in being provided with the maximum available information about the benefits and drawbacks of all available treatments, so that they can make well-informed decisions about their own care (Manson & O'Neill, 2007).
- **Avoiding unjustified discrimination:** Patients have an interest in not suffering unjustified discrimination. Doctors should set aside their own views of a patient's identity or lifestyle when providing care (Vicol & Gergely, 2011).
- **Just distribution of resources:** Patients have an interest in our ensuring, as far as possible, that appropriate healthcare resources are justly distributed among all entitled patients, based on each patient's need (Culyer & Wagstaff, 1993).

For the sake of argument, I assume that each of these examples is straightforward and widely accepted. In fact, each of my examples has a whole weight of philosophical literature behind it, and none is entirely uncontroversial; the single reference I've provided for each example above points to what I believe to be a good overview of the issue in question. But the complexity under the surface doesn't concern me here. I only intend these to be *examples* of the kinds of interests that might conflict with a pro tanto right of doctors to have their moral objections recognised, over and above the obvious interests patients have in receiving timely, effective and appropriate treatment. No part of my argument in this chapter relies on the ultimate success of any one of them.

Again, hopefully none of these principles will *always* be in tension with the principle of respecting doctors' moral objections. Sometimes — usually, one would hope — the doctor is able to discharge her day-to-day responsibilities without compromising either her moral

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<sup>63</sup> In an extended essay arguing against the principle of beneficence in medicine, Veatch (2000) maintains that patients' desires about their own treatment are not only a key component of their interests, but also the only reliable proxy available to doctors for determining the nature of most other components. I have a little more to say about this on p.171 of this thesis.

beliefs or any of the principles listed above. But each of them can give rise to tensions in at least *some* situations. For instance, the principle of ensuring just distribution of resources seems to conflict with the principle of respect for moral objections where a doctor's refusal to participate in a controversial procedure will lead to uneven treatment of patients, either because some but not all doctors offer a particular treatment, or because a single doctor refuses to offer the treatment to all patients on an equal basis. And the principle of facilitating informed consent seems to conflict with the principle of respect for moral objections when a doctor is reluctant to make a patient aware of treatment options of which she (the doctor) disapproves, such as the availability of certain sexual health services to same-sex couples. The existence of these conflicts is, of course, the main source of the moral and practical difficulty which is my focus throughout this thesis.

### *Professional and moral obligations*

One further principle that's commonly cited to weigh against a doctor's right to object — but that I didn't mention in my list of examples above — is that of a perceived professional or moral obligation for the doctor to ignore his personal moral qualms (Meyers & Woods, 1996). We might say, 'I recognise your objection to offering this procedure to this patient, but you have an overriding obligation to do it anyway'. Such an obligation might be attributed either to *professional* considerations — 'the medical profession places an obligation on you to offer this treatment to this patient, never mind your objection' — or to *moral* considerations — 'it would be wrong of you not to offer this treatment to this patient, never mind your objection'.

Perceived professional and moral obligations are important, and, as I say, commonly cited in cases where doctors object to particular procedures. So why didn't I list them as a principle above? Because simply saying that a doctor has an *obligation* to act in a particular way is not yet, in itself, to give a *reason* for him to act in that way. It's only an assertion that there *is* such a reason. If you ask me why you shouldn't break a promise, what you want from me is some account of what the source and nature of the obligation is. If I respond, 'Because you have an obligation not to break your promises', this is really just the same as saying, 'Because you shouldn't break your promises'. It may be true, but it's vacuous; it doesn't yet say *why* you shouldn't break your promises.

If you and I both acknowledge the obligation, then we may not need to go into detail about its source or nature. But if we disagree about it, simply asserting the obligation won't help us to understand or resolve our disagreement. Indeed, professional or moral obligations are frequently cited in support of *both* sides of the disagreement. If we try to encourage a doctor to ignore his personal beliefs on the basis of his perceived obligation to do so, the doctor might perfectly well reply, 'Actually, it seem to me that I have an obligation *not* to offer this treatment to this patient — that's why I object to it in the first place'. (I discussed this at length in chapter 1.) This assertion also gets us nowhere.

So when I assert an obligation in the face of your disagreement, I owe you an account at least of what that obligation consists of. Ideally, I should also be able to give you an account of where it comes from, whether it stands up to close examination, whether it does indeed conflict with other obligations in the way it appears to, and (if so) whether and how those conflicts might be resolved. In the current context, what that means is that I can't just say, 'The reason you should ignore your personal objection to this procedure is that you have an obligation to do so'. Even if that's true, it's an empty assertion.

## II. Consensus on prioritising patients' interests

What do we do when patients' interests and doctors' objections are in tension?

There is an apparently easy answer to that question. A near-universal maxim in modern Western medicine is that doctors should always *prioritise patients' interests*:

Good doctors make the care of their patients their first concern.

(General Medical Council, 2013a, paragraph 1)

Doctors may practise medicine in accordance with their beliefs, provided that they [...] do not deny patients access to appropriate medical treatment or services.

(General Medical Council, 2013b, paragraph 4)

A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

(American Medical Association, 2001)

Where it is available and approved by NICE [the body that authorises individual interventions for availability in the UK National Health Service], patients are entitled to timely, clinically-indicated care or treatment that is provided in a supportive, sensitive and non-judgmental manner. The legal right to such care and treatment is enshrined in the NHS

Constitution. Doctors seeking to exercise a conscientious objection must take care not to undermine this right.

(British Medical Association, 2013)

In the bioethics literature, too, failure to prioritise a patient's interests over one's own is frequently identified by critics as what goes wrong when doctors decide to act on their objections:

Someone who places his own interests above his patients' departs from medicine's standard of altruism and violates a crucial tenet of medical ethics that every physician is duty bound to observe.

(Rhodes, 2006, p.78)

The settled view of much of the medical profession appears to be that, whatever reasons we might have for granting moral weight to doctors' personal objections (and I have argued that there are two good ones, namely risk of harm and considerations of tolerance), those reasons are outweighed by the obligation to prioritise patients' interests.

Taken at face value, this seems to be a very strong principle. Although it doesn't say that a doctor's personal beliefs can *never* be respected, it does seem to limit the occasions when they *can* be respected to occasions only where they don't conflict at all with patients' interests. In every other situation, doctors' personal beliefs must come second to the interests of patients. Indeed, the GMC's assertion that "good doctors make the care of their patients their first concern" implies that those who put any other considerations — including their own moral beliefs — above the interests of patients in any given situation are simply not good doctors. (This is essentially the consistent position of ethicists Udo Schuklenk and Julian Savulescu, two of the most vigorous opponents of conscientious objection in recent years, whom I cite several times in this thesis.)

Intepreted this way, this rule makes patients' interests a trump card and dismisses all other considerations as irrelevant. But I think there are two good reasons to suspect that such a unsubtle, absolutist interpretation is not quite the right way to think about things — and, indeed, not what's intended by the authors of the guidance I quoted above.

The first reason is that it's inconsistent with the law in many jurisdictions, and indeed with much of the rest of the guidance issued by regulatory authorities. If prioritising patients' interests were a trump card, the GMC (for instance) could have stated this in a sentence and that would be the end of the matter. In fact, much of the detailed guidance in publications

such as ‘Personal Beliefs and Medical Practice’ (2013b) consists of specific instructions about how and when other considerations, such as the doctor’s own beliefs, can also affect decision-making: for instance, in the event that a doctor refuses to offer a particular controversial procedure to a patient, the GMC permits a degree of inconvenience to that patient so that other options or referral can be arranged. Such arrangements would be ruled out, and thus the detailed guidance would be superfluous, if the rule about prioritising patients’ interests was supposed to be interpreted in an absolute way.

The other reason for rejecting an absolutist interpretation is a logical one: we would not be tempted to apply the same interpretation to other areas of professional activity. The GMC’s rule about doctors making patient care their “first concern” is not just aimed at moral objections; it’s supposed to cover all areas of a doctor’s professional activity. Yet the GMC wouldn’t expect a doctor to put himself in mortal peril, or threaten the wellbeing of other people, or bankrupt himself, in order to maximise a patient’s interests. As Robert Veatch puts it:

In spite of the uniformity of commitment to this platitude, it is becoming increasingly clear that no one really believes literally that the physician should always act so as to do everything that will benefit his or her patient. [...] For example, quite a number of patients would have their interests served best if their personal physician stayed with them in their homes twenty-four hours a day, yet no one ever advocates that they do so.

(Veatch, 2000, p.702)

If the admonition to prioritise patients’ interests is not intended as an absolute rule in other areas of regulated professional practice, then why should we take it as an absolute rule in the context of moral objections either?

So while prioritising patients’ interests is clearly regarded as important by regulatory authorities, to be weighted heavily when considering what to do, it can’t be intended as an automatic trump card. In at least some situations, there is room for manoeuvre. This kind of manoeuvre could take one of two forms:

- One might try to square the circle by maintaining a commitment *both* to prioritising patients’ interests (in general) *and* to respecting doctors’ objections (in general). I consider how this could be done in a moment.
- A compromise could be found which allows the interests of both sides to be respected to a degree, while still ensuring that patients’ interests are not impacted to too great a degree. I consider this option in detail in the next chapter, on referral.

### III. Rejecting the framing of the problem

An interesting way to defend doctors' rights to act on their objections while preserving the commitment to prioritising patients' interests is to argue that these two requirements don't actually conflict as often as might be thought. The idea here is that, in at least some cases, when a doctor objects to participating in a legally permitted procedure because of her moral beliefs, she is not seeking to prioritise her own interests over the patient's; rather, her view of *what is in the patient's interests* is simply different from the prevailing view of society.

For instance, a doctor who refuses to accede to a request (or court order) to withdraw life-sustaining treatment from a patient in a permanent vegetative state need not say, 'I refuse to participate in this procedure because I believe it's morally wrong, even though that means I am failing to prioritise the patient's interests in this case'. She might instead say something like, 'I refuse to participate in this procedure because I believe it's not in the patient's interests to have treatment withdrawn, even though that means I disagree with the court's view (or the prevailing view of society) about what is in the patient's interests in this case'.

This approach turns the basic problem on its head. Rather than characterising the objecting doctor as an individual who (nobly or otherwise) finds herself unable to act in the interests of patients because of her moral beliefs, it instead characterises her as the *defender* of patients' interests against countervailing pressures that would undermine it. This is a strong position because, rather than rejecting a principle that most find convincing (the priority of patients' interests), it relies on that very principle to derive a right to object.

I think this is indeed how many objecting doctors see themselves. For instance, the UK's Catholic Medical Association relies heavily on this position in its response to the GMC's consultation on draft guidance on moral beliefs in 2012. In one part of its response, it asserts that to say a treatment is morally wrong is to say that it is damaging to patients or others.<sup>64</sup> Based on this claim, it rejects the supposed conflict between a doctor who refuses to participate and the interests of the patient:

If a conscientious objection forms part of a doctor's integral world view on an issue, compelling them to comply with the provision of a treatment which they believe to be

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<sup>64</sup> The response is not clear on the interesting question of why it thinks moral wrongness and harm always go hand-in-hand in this way. Is it harmfulness that makes a practice wrong, or is it wrongness that makes it harmful?

*inherently morally wrong and therefore damaging to the patient or to others who will be adversely affected* will inevitably also adversely affect the doctor over time.

[...]

The phrase [in the GMC's draft guidance] referring to the denial of patients' access to 'appropriate medical treatment' implies that if a doctor exercises a conscientious objection, when they cannot support a treatment option in an individual circumstance *or because it is inherently harmful*, that doctor must lack objective judgement and the patient is assumed to have selected an appropriate option by virtue of selecting it.

(Catholic Medical Association, 2012, responses to qq. 1 & 5; emphasis added)

A similar argument is developed at length by Stephen Genuis in his provocatively-titled article 'Dismembering the ethical physician' (2006). According to Genuis, the act of exercising a moral objection is often an attempt to withstand external pressure to act *contrary* to the patient's best interests as perceived by the doctor. Such pressure may come about because of patient wishes, legal requirements, professional guidelines or societal expectations; but in all these cases, Genuis argues, to give into external pressures diminishes the doctor's professional integrity because the doctor then gives up her prime professional responsibility to determine and then prioritise the interests of the patient.

But it can't be the case that a doctor's judgement about a patient's interests *always* take priority over society's judgement, because there are instances where society clearly has not only a right but a duty to overrule an objecting doctor in favour of society's conception of the interests of the patient. Consider, for instance, a hypothetical situation in which a patient has suffered severe blood loss and will die if an emergency blood transfusion is not performed. We obviously would not, and should not, permit the only available doctor (I stipulate 'only available doctor' to avoid clouding the issue with questions about the possibility of referral) to refuse to save the patient's life simply because he believes that a blood transfusion can never be in someone's interests for moral reasons — if the doctor is a strict Jehovah's Witness, for instance.<sup>65</sup> Whatever other reasons we may have for sympathising with the doctor — because we want to tolerate his beliefs, or because we want to avoid harm to him — there is, I submit, no room for disagreement here about who is the

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<sup>65</sup> The question of how to treat Jehovah's Witness patients who refuse blood transfusions has received plenty of attention; Gohel et al (2005) outlines what is and is not regarded as acceptable for (most) Jehovah's Witnesses in this context, and Trzciński et al (2015) discuss practical examples. But there are also doctors and nurses who are themselves Jehovah's Witnesses, for whom the question of individual conscience arises when treating patients. Kipnis (2006) offers a brief discussion of this issue. By including this example, I don't mean to take a position on whether or not doctors who hold these particular beliefs are suitable candidates for the medical profession in the first place.

appropriate judge of the patient's interests. The patient's interests lie squarely in receiving life-saving treatment, and the doctor's dissenting judgement ought to be overruled. If commentators like Genuis and the Catholic Medical Association would go along with this assessment in obvious cases like this — as I trust they would — then the logic of their argument in defence of doctors' consciences does not go all the way, and it falls to them to say why. Neither does so.

On the other hand, it also seems clear that doctors' judgements about patients' interests *should* indeed take priority over society's at least sometimes. For one thing, doctors have a simple but significant advantage with respect to understanding a patient's interests: *they know the patient*. Patients are not a homogenous population for whom best practice for all is guaranteed to correspond to best practice for each. A general recommendation (formulated on the basis of reliable scientific evidence, resource availability or moral consensus) may imply that treatment A is the most appropriate course of action in general for patients with condition X, but that doesn't mean that a doctor will always be mistaken to judge that a particular patient with condition X might best have his interests served by being offered treatment B instead, or treatment C, or indeed no treatment at all. Indeed, treatment guidelines generally include an implicit or explicit acknowledgement of this fact, usually allowing for doctors to use their own judgement about each individual patient rather than slavishly following general recommendations and evidence. Doctors are able to acquire more information about the circumstances, needs, interests and desires of their individual patients than any politician, administrator, health economist or ethicist can possibly aspire to, simply because they can draw on direct personal contact with those patients.

Naturally, I don't claim that doctors are *always* the best judges. Doctors are human, and as liable to error as the rest of us, and society may rightly want a way to overrule individual doctors' judgements in cases like these. But still, if we need a rule of thumb to answer the question 'Whose judgement should we trust on clinical issues?', there are good reasons to prefer the doctor's judgement over others'.

So here's the problem. When it comes to determining patients' interests, it can't be a universal rule that a doctor's judgement always takes priority over society's — hence my Jehovah's Witness example. But it also can't be a universal rule that society's judgement always takes priority over the doctor's — hence my points about patient access and special

insights. So what is the distinguishing principle here? How do we know when to allow a doctor to plead patients' interests when he refuses to do what society expects?

To answer this question, let's look more closely at the motivation of some hypothetical doctors. In the case of my Jehovah's Witness doctor, it's his personal moral (religious) beliefs that underpin his judgement about the patient's interests when it comes to blood transfusions. (Gardner et al, 1997, p.58: "Who would benefit if the patient's corporal malady is cured but the spiritual life with God, as he sees it, is compromised?") But imagine, instead, a different hypothetical doctor who is not a Jehovah's Witness. He has no *moral* objections to transfusions, and indeed accepts that the procedure is frequently in patients' interests. But he nonetheless believes for some other reason that *this particular* patient's interests would not be best served by receiving a transfusion. Perhaps the doctor knows something about the patient's personal medical history that leads him to believe that a transfusion would do more harm than good. Perhaps he observes that the nature of the trauma suffered by the patient would make the transfusion procedure unacceptably risky. Perhaps he has reason not to trust the cleanliness of equipment available to him right now, or the competence of the staff who would assist, or the quality of blood stocks on hand.<sup>66</sup> Whatever the reason may be, our hypothetical doctor has some reason to doubt that the *general* beneficial effects of blood transfusions (for patients with clinical needs somewhat like this patient's clinical needs) will apply to *this* patient in *this* situation, right here, right now.

This second doctor's objection to the procedure is not a directly moral one but based on his clinical judgement (see p.24 of this thesis for more discussion of the distinction here). In fact, that's my point. In each case, a doctor refuses to provide a treatment which might otherwise be recommended because of his judgement that the treatment is not in the patient's interests. But, when we compare the two cases, the obvious difference is that the Jehovah's Witness doctor's judgement is based on his *moral* beliefs about questions of right and wrong, while the other's is based on his *clinical* beliefs about matters of medical fact.

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<sup>66</sup> Or perhaps he knows something about the patient — that *the patient* is a Jehovah's Witness. The issue of the patient's *own* view of his interests is the elephant in the room here, one to which I will return shortly.

This is relevant because doctors have an important domain of expertise, namely the domain of clinical medicine. When it comes to making judgements about what's in an individual's (clinical) interests, doctors are often better equipped than lay people, policy-makers and health economists, because of their specialist training, their experience, their direct contact with the individual concerned, and the wealth of information available to them, all of which is linked to the profession of which they are members. That's why, in cases like these, it often makes sense to prefer the doctor's judgement over society's: they are often better judges of patients' clinical interests — a fact generally recognised in law and guidance, which acknowledge the ability and even responsibility of the doctor to make individual, patient-by-patient judgements rather than slavishly following society's policy-based and evidence-based recommendations as to the best course of action.

But it's much more difficult to argue convincingly that a doctor's expertise extends to the domain of general *moral* judgements. If there is such a thing as 'moral expertise' at all — and we might well doubt that (Caplan, 1989) — certainly nothing about a doctor's training or experience confers any claim to that title. Yes, doctors often have privileged access to information that's *relevant* to making moral judgements about clinical situations, and as I've just said, their training and experience may equip them to interpret that evidence more effectively than most non-doctors. But when it comes to discerning right and wrong, and being accurate in the way they make such discernments, doctors have no better claim to expertise than the rest of us:

It is as though being a skilled cyclist made one adept at making judgments about whether or not to cycle on the pavement. It does not. Nor do clinical skills, however important, enable one to make ethical decisions about how, when and whether to apply them. In both cases, what is required is ethical judgment, something quite different from the exercise of a technical skill.

(Brecher, 2011, p.996)

Of course, doctors' decisions in reality are a bit more complicated than I've just described. When it comes to judging patients' interests, doctors are expected to take into account not just clinical and moral factors but also a range of non-clinical factors such as the patient's own priorities and wishes (see p.147 of this thesis, and footnote 62, for an overview of how this works in the UK). To save argument and reduce the need for guesswork, I don't take a position on whether doctors are better or worse than laypeople on average at correctly assessing and weighing up these non-clinical factors. But, even if they are better, that still

doesn't imply that doctors have special expertise in making their own *moral* judgements about patients' interests.

### *Training and experience*

I've just argued that good clinical judgement does not imply good moral judgement. Here is a likely response: even if that's true, it would be odd to say that the two are mutually exclusive. Rather than throwing up our hands and declaring that doctors can't be trusted with moral judgements, we could — and, indeed, we do — work to try to develop good moral judgement in doctors *alongside* their clinical skills. For one thing, ethics is an important element of the medical curriculum in most countries (Goldie, 2000), where medical students are specifically required to reflect on moral dilemmas that arise in the course of medical practice, learn techniques for weighing up competing factors in morally complex cases, and understand the nature and limits of the doctor's role. Surely the whole point of this element of medical training is to try to make doctors' moral judgements a little more skilled than they might otherwise have been. Equally, it might be argued that experienced doctors who have confronted practical moral dilemmas many times during the course of their careers may have developed more finely-honed skills in addressing and resolving those dilemmas than an average member of the public, not to mention policy-makers, regulators and the like. And if this is the case, then maybe we *ought* to allow doctors' judgements about patients' interests to trump society's judgements, even if those judgements are based on controversial personal moral beliefs.

Interestingly, Stephen Genuis, whom I quoted earlier, appears to be fundamentally cynical about whether any degree of training or experience can improve a doctor's skill in making moral judgements. One might expect this cynicism about our ability to "engineer" individually ethical doctors to be a premise in an argument that careful regulation and ethical supervision is necessary in the medical profession. But in fact Genuis goes in exactly the opposite direction. He strongly criticises what he calls "the sequelae of authoritarian guidelines" (2006, p.234 — "sequelae" is his favourite word), enforced by "innumerable bioethical faculties, ethics committees and conduct codes" (p.236) and "authorities who exert power to elicit choices that contravene personal values" (p.235). His point seems to be that doctors should be free to make individual decisions based on their own consciences, rather than supervised and directed by such authorities.

I will have much more to say about Genuis's argument shortly. For now, I'm willing to grant for the sake of argument that a combination of medical training and clinical experience *might* successfully bring about noticeable improvements in a doctor's moral judgement.<sup>67</sup> Even so, I don't think this is enough. That's because, when we say that a particular doctor has 'good moral judgement', we might be ascribing to him either of two different qualities:<sup>68</sup>

1. **Skill in analysing and processing morally difficult situations.** That is, the doctor is better than average at discerning the relevant moral factors that apply in a situation, weighting and prioritising those factors to reach a conclusion, and understanding the legal responsibilities and practical requirements of the profession.
2. **Accurate moral beliefs about controversial topics.** That is, the doctor's beliefs about controversial practices are more likely than the average person's to coincide with moral truth, so he or she is more likely to be right about the moral value of practices like euthanasia, abortion and so on.

Now, it seems to me that the *first* of these two qualities might well be promoted and developed in doctors through medical training and clinical experience. That's all well and good. But it's the *second* of the two qualities which we would need to ascribe to a doctor if we were to give priority to that doctor's controversial moral judgements about patients' interests over other people's. And I don't think that the second quality is something that can in fact be reliably instilled in doctors through training or experience.<sup>69</sup>

I have three reasons for thinking this:

- First, if medical training and clinical experience *did* instil the second kind of skill, then we'd expect to see more agreement on controversial medical questions among doctors than among the general population, since more of them would tend to have beliefs that coincide with moral truth. As a matter of fact, there appears to be no

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<sup>67</sup> There have been some attempts to measure this impact: for instance, Self et al (1989); Seehouse (1991). For two comprehensive literature reviews on the effectiveness of medical ethics teaching, see Eckles et al (2005) and Campbell et al (2007).

<sup>68</sup> See Eckles et al (2005, p.1150) for a brief discussion of the "virtue/skill dichotomy" in ethical teaching.

<sup>69</sup> Bleich (2002, p.257) makes a similar claim, but doesn't defend it.

such consensus. Two random doctors are as likely to disagree over their personal moral beliefs in controversial areas as two random laypeople.<sup>70</sup>

- Second, more tellingly, even if this could happen, how could we possibly know? Suppose for a moment that medical training and clinical experience *did* improve someone's personal moral beliefs on controversial issues. Or suppose that a particular doctor just so happened to be a natural moral saint, with all-'correct' personal moral beliefs. In either case, how would we know that? How can we, as a society, recognise superior moral beliefs without comparing those beliefs to an accepted moral standard and identifying that they coincide with that standard? And the whole point of *controversial* beliefs is that there is no such accepted standard.
- Third, to be frank, I find it hard to imagine what kind of medical training or clinical experience could possibly be *expected* to 'improve' a doctor's moral beliefs about something controversial — whether homosexual partners should have sex, for instance — such that those beliefs would become more reliable determiners of judgements about patients' interests.

Having made those points, two quick clarifications are in order.

The first clarification: Recall again that I'm talking specifically about *moral* beliefs influencing judgements about patients' interests. I've already granted that a doctor's *clinical* beliefs can rightly supersede those of others — and of course I fully acknowledge that clinical beliefs can develop and improve through medical training and clinical experience. For instance, if a doctor came to believe that abortion had more dangerous consequences for a particular type of patient than is widely recognised, I would have no objection to his drawing on that belief to make judgements about patients' interests and holding out against the prevailing view of society. This seems to me a legitimate part of the doctor's role, for which he is empowered by his training and experience.<sup>71</sup> But my argument is about personal

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<sup>70</sup> In a fun empirical study, Schwitzgebel & Rust (2013) assess whether training in ethical theory actually improves moral behaviour at all, by studying the ethical behaviour of academics working in philosophical ethics with those of other groups. Sadly, "on no issue did ethicists show unequivocally better behavior than the two comparison groups" (p.293).

<sup>71</sup> Perhaps needless to say, I'm not committed to the view that a doctor's clinical judgement must always be allowed to prevail over society's. I'm not interested in this question anyway. My point is just that there are often good reasons to think it ought to, unlike the case of moral judgement.

moral beliefs, not clinical ones. What it would take to convince me that I'm wrong in this — i.e., that it *is* justified for a doctor to draw on controversial personal moral beliefs — would be a demonstration that a doctor's particular beliefs about moral issues are more likely to deliver an accurate judgement of a patient's interests than the prevailing moral view of society at large. And I don't think this can be the case, no matter how much training and experience the doctor has received.

The second clarification: Of course I'm not denying that doctors can develop and change their personal moral beliefs over the course of their medical training and clinical experience. Nor am I denying that training and experience can be important influencing factors in such change. Of course this can happen: indeed, I argued earlier in this thesis (starting on p.58) that deeply-held moral beliefs, while somewhat resistant to change, can evolve gradually or change fundamentally in the light of significant experiences. What I'm saying is that there is no reason to think that such experiences are more likely than other processes to produce moral beliefs about patients' interests that we ought to trust over the beliefs that prevail in society at large, for the reasons I've given.

To summarise, when is it appropriate to prefer a doctor's judgement over society's judgement of a patient's interests? My answer is: when that judgement is in a domain where we have reason to think the doctor has specific expertise, such as the domain of clinical medicine. Meanwhile, in domains where we have *no* such reason to grant the doctor special expertise, such as the domain of moral judgements, we correspondingly have no reason to allow the doctor's judgement of the patient's interests to overrule society's judgement. In short, doctors' assessments of patients' interests are entitled to be held in special esteem when they relate to clinical matters, but not when they relate to moral matters.

As I emphasised at the very start of this chapter, this is not to say that we should necessarily force the doctor to act against his moral beliefs in such a situation. I am only considering the question of whether we should allow a doctor to invoke his judgement of patients' interests to justify his refusal, and I answer that question with 'no'. This says nothing about other reasons why we might want to allow doctors to refuse — in particular, about those reasons which relate to how the doctor himself might be affected, such as the considerations of harm and tolerance I've already outlined.

### *Genuis and the conflation of clinical and moral judgements*

I mentioned earlier an essay by Genuis (2006) in which he argues that we should indeed allow doctors' judgements of patients' best interests to justify their objections, even when those judgements are based on the doctors' personal moral beliefs on controversial issues.

One interesting feature of Genuis's argument is that it's not always clear whether he wants to talk about clinical judgements, moral judgements or both. At the outset, the long list of sample dilemmas he provides under the title "Ethics in collision" (p.233) are certainly of the moral type, without obvious clinical elements.<sup>72</sup> Similarly, in his conclusion (p.237), he refers to "actions or procedures felt by individual practitioners to be *morally* inappropriate" (emphasis added).

But this moral focus does not persist through the main body of the essay. When Genuis sets out his stall for allowing decision-making autonomy among doctors, it seems less clear that he succeeds in sticking to the moral side of the moral/clinical divide:

Proceeding in a fashion that the physician sincerely believes is right, acting in a manner thought to be in the best interests of the patient, or refusing to participate in any action or procedure considered harmful to the wellbeing of the patient, can be ethical even if it does not coincide with the patient's request or establishment guidelines. In fact, if the treatment in question is detrimental, its application would clearly be unethical, and "doctors would be obliged to refuse to co-operate".\*

(Genuis, 2006, p.236; reference marked \* discussed below)

Of the three acts listed at the start of this passage, the first ("proceeding in a fashion that the physician sincerely believes is right") is clearly intended to describe a doctor making a moral judgement rather than a clinical one. The second and third are less clear. We might want to give Genuis the benefit of the doubt, given his up-front insistence that moral factors are what interest him. But in fact his supporting quote at the end of the passage (marked \* above) is from Jackson (1994), an article which discusses when it is appropriate for a paediatrician to participate in an unproven oncology treatment. The occasion when "doctors would be obliged to refused to co-operate", according to Jackson, is when they judge a procedure likely to be *clinically* detrimental to a patient. This choice of supporting

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<sup>72</sup> One exception is "Should a primary practitioner adhere to clinical practice guidelines he suspects are harmful to patients?", where it's not clear what kind of "harm" is meant. More on this in a moment.

quote leads me to suspect that, at least by the end of this passage, Genuis is arguing that doctors may (indeed, must) rely on their beliefs about the *clinical* harm that may be inflicted on patients through when weighing up treatment options and making judgements about patients' best interests.<sup>73</sup>

At one point he seems cynical about whether the clinical/moral divide is even a useful practical concept:

Decisions to decline management in accordance with a patient's expressed wishes or authoritarian guidelines are rarely the simple result of a philosophical ideology or religious belief; *health considerations* and medical ethics are usually central to such decisions. A refusal to accede to a requested intervention often results when the physician deems the intervention to be unwise, deleterious, or damaging. [...] The ethical physician necessarily desires to achieve the optimal long term health and wellbeing for the patient and consequently makes clinical decisions to the best of his/her ability in accordance with this objective.

(Genuis, 2006, p.234, emphasis added)

Genuis is surely right that clinical and moral considerations frequently exist side-by-side as component parts of the same complex decision. I suspect he may even be right that doctors sometimes fail to see a distinction between the two kinds of consideration: perhaps, sometimes, patients' interests are just patients' interests, and doctors simply don't distinguish between elements of their decision-making that depend on clinical judgements and elements that depend on moral ones. But my focus is on how society should respond to such a situation. And I've argued that it's clear that doctors have a claim to special clinical expertise, but unclear that they have any claim to special moral expertise. So it seems to me that, even if doctors don't draw the distinction between these two, we should — for the simple practical reason that we need to give special weight to doctors' judgements about patients' interests when they are in the clinical domain and not when they are in the moral domain.

To be fair, Genuis does admit that doctors can be wrong in their moral judgements, and concedes that "authoritarian guidelines" (p.234) may still be necessary. But he rails against those same guidelines when they seek to overrule doctors' individual moral judgements

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<sup>73</sup> I suppose there is potential for confusion here. When Jackson talks about what would be "appropriate" for a doctor to do, she of course means 'morally appropriate'. So, in a way, these are all moral decisions. But what's at issue is whether those moral decisions about how doctors should act are based on judgements about the patient's clinical interests or (doctor-judged) moral interests. Jackson is clearly talking about the former.

because, he thinks, becoming “subservient to administrators and bean counters” (p.236) compromises integrity, professionalism and morale, and counts as intolerance — all factors I considered earlier in this thesis. (He also argues that allowing disagreement to flourish is the way the medical profession has always grown and developed — an argument I don’t consider here, but one which is not a million miles away from Sulmasy’s argument for tolerance which I considered on p.132 of this thesis.) But, surprisingly for such a strongly-worded essay, Genuis makes no effort to suggest how this difficulty can be resolved. His best suggestion is that authorities must pursue a “healthy and judicious tension” (p.237) between the need for regulation and respecting doctors’ moral freedoms — which seems perfectly reasonable until we recall that Genuis’s version of this “tension” is one which never asks a doctor to compromise on their moral beliefs. It seems to me that this suggestion gets us absolutely nowhere.

#### **IV. The doctor as engineer**

My argument in the foregoing section is that doctors are in a privileged position when it comes to making judgements about patients’ *clinical* interests, but not when it comes to making judgements about patients’ *moral* interests. But an objection to that argument has its origin in ideas set out by Robert Veatch:

One of the impacts of the biological revolution is to make the physician scientific. All too often he behaves like an applied scientist. The rhetoric of the scientific tradition in the modern world is that the scientist must be ‘pure’.

(Veatch, 1972, p.5)

Jeffrey Blustein (1993) elaborates Veatch’s account of ‘the doctor as engineer’, suggesting that there are two possible ways in which this might be taken. The first way is the more straightforward: the doctor sees himself as “only an applied scientist, a technician of the body” (p.292), whose job is simply to perform his role with as much *technical* skill as he can, as might a plumber or a hairdresser, while standing apart from any questions of patients’ interests. The second is a little subtler: rather than detaching himself entirely from the realm of morality, the doctor instead makes a general moral decision, namely that it is morally appropriate for him always to defer in interest judgements to another authority such as the law, clinical or professional governance, or the wishes of the patient (p.293).

Now, as both Veatch and Blustein suggest, these attitudes aren't really defensible. For a start, the analogy with other professions is shaky at best. Without intending to belittle the professional activities of plumbers or hairdressers, the activities they carry out in the course of their day jobs rarely have grave moral consequences. A hairdresser may well be justified in focusing solely on applying her technical skill as best she can to implement the hairdressing-related requests of her client, safe in the knowledge that — however unwise she privately judges those requests to be — the worst that can result for the client is an embarrassing haircut. If this is deleterious to the client's interests, it is so only in a relatively mild way. By contrast, the activities carried out by doctors as part of their day jobs do frequently and unavoidably have grave moral consequences. Patients' interests can be greatly furthered or greatly injured by the choices their doctors make. For this reason, it doesn't do for a doctor to focus entirely on technical proficiency and simply wave away questions of morality and interests as above their pay grade.

The point is that doctors are patently *not* just engineers. For reasons I've rehearsed at length, they do (and must) perform actions all the time that have a heavy moral import. The model of 'doctor as engineer' is indefensible because medicine is an inherently moral profession (Curlin, 2007; Mirus, 2012; Sulmasy, 2017).

Indeed, the very decision to absolve oneself of the responsibility to make judgements about patients' interests — whether that decision is taken unconsciously, as in Blustein's first version of the engineering model, or consciously, as in his second — is *itself* a moral act, the moral equivalent of sticking one's fingers in one's ears and shutting one's eyes, an act for which we can reasonably hold people responsible. As Blustein points out, "one cannot block moral responsibility for one's professional activities merely by selectively focusing on the technical proficiency with which they are carried out" (p.292).

So I agree that the model of 'the doctor as engineer' is mistaken. So far, so good. But doesn't this then give rise to an objection to the claim I've been making so far in this chapter? After all, if I reject 'the doctor as engineer' — that is, if I maintain that medicine is an inherently moral profession, if doctors' professional activities have an impact on patients' interests, if doctors rightly shoulder some responsibility for their activities — then surely, for all those reasons, I was wrong a minute ago to argue that we have no special reason to prefer a doctor's moral judgements over society's? I can't consistently maintain that a doctor bears

moral responsibility for the impact of her actions on patients' interests, *and* claim that she should defer to society when it comes to judging what those interests are and how best to further them. That would amount to forcing the doctor to take responsibility for her actions while denying her any choice over whether to perform those actions. And it is a basic tenet of fairness that one can't be held responsible for actions about which one had no choice (Brown, 2006).

My response to this objection is that it gets things the wrong way around. Of course I accept that a prerequisite for holding someone morally responsible for the consequences of an action (or at least its foreseeable consequences) is that the action was in some sense freely chosen by him. There's something obviously defective about forcing someone to perform an undesirable action and then blaming him for the consequences. But the objection I've just outlined seems to want to run the chain of reasoning in the other direction. Doctors are definitely responsible, it seems to say, for their actions; and this means that we had better not force them to take those actions against their will, because that would unfairly land them with moral responsibility for actions over which they had no choice. This is muddled. The *reason* doctors (like the rest of us) are ordinarily responsible for their actions is precisely *that* they choose those actions in some sense freely and with a degree of confidence in likely outcomes. It follows that, to the extent that we relieve a doctor (or anyone) of his ability to choose an action freely, we also take relieve him of moral responsibility for his part in it. Yes, it would be unfair to try to hold someone responsible for an action over which we allowed him no choice — but the reason it would be unfair to do so is because *there can be* no responsibility for such an action, and thus to try to blame him for it would be unjust. In other words, the rule is not, 'Make sure you allow an agent freedom to choose over all actions for which he must bear responsibility' — this makes no sense. It is, rather, 'Make sure you don't try to hold an agent responsible for any action over which he had no choice'.

The upshot of this is that, to the extent<sup>74</sup> a doctor is *compelled* to act in a way that he believes is deleterious to a patient's interests (because his beliefs are overruled by society or by

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<sup>74</sup> I say 'to the extent' because, of course, the strength of the compulsion makes a difference, because in most circumstances the doctor has various 'nuclear options' such as resignation available to him (which I discuss in my final chapter).

deference to the patient's beliefs), he does not bear moral responsibility for any genuinely interest-damaging consequences of that act.<sup>75</sup>

*The doctor as engineer: when and how?*

Let's bring these threads together. I have just presented in quick succession two different claims. First, I dismissed as mistaken the model of 'the doctor as engineer', a doctor who, like a hairdresser, focuses exclusively on the technical aspects of his profession because he views the moral aspects as above his pay grade. Second, I suggested that a doctor is relieved of moral responsibility to the extent that he is compelled (e.g. by society) to act against his judgement.

Now, these different claims are not in themselves contradictory. It is consistent to maintain that (a) a doctor is morally responsible for his free actions, and (b) when those actions are not free, that responsibility evaporates. But the complication is that, earlier in this chapter, I argued that doctors' judgements about patients' interests should not be held in special esteem when they are based on moral (rather than clinical) matters. If I advocate forcing doctors to do what society decides in these circumstances, and if I also claim that doctors are absolved of moral responsibility in such situations... then am I not tacitly *endorsing* the 'doctor as engineer' model?

The first point to make in response to this is that I have *not* advocated forcing doctors to do what society dictates in these circumstances. I have simply ruled out doctors relying on arguments about defending (their view of) patients' interests in order to justify acting against society. As I've been at pains to argue, there are *other* important reasons why we might want to respect doctor's objections: the two I have highlighted are considerations of harm and considerations of tolerance. So it is not true to say that, whenever a doctor's objection to a practice is based on an assessment of a patient's moral interests, even when that assessment is correct, that objection should automatically be overruled. That's not my position.

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<sup>75</sup> As always, I'm still talking specifically about the *moral* elements of the act. If the doctor's performance is *technically* wanting — for instance, if he carelessly messes up an operation and leaves a patient with a lifelong disability — there may still be moral responsibility to shoulder.

The second point to make is that the situation is more complicated than that. I admit that there are *some* circumstances in which I advocate forcing doctors to do what society decides, regardless of their own moral beliefs about patients' interests. So does this mean I subscribe to 'the doctor as engineer'? My answer is: mostly no, but in some limited circumstances, yes.

It is an obvious caricature to suggest that doctors should never have any discretion to apply moral judgement, and that they should always be shorn of moral responsibility in their professional lives. There are many areas where doctors do indeed rightly have discretion in how to act, and therefore bear responsibility for the moral consequences of those actions. In their daily practice, doctors must choose which interventions to pursue and which to neglect; they must present appropriate options to patients and guide them in decision-making; they are certainly the primary channel, and sometimes the only channel, by which information about clinical options and societal limitations reaches the patient at all. Moral discernment and moral judgement are implicit in all these activities; Savulescu & Schuklenk (2017) make this point particularly vigorously. And I would certainly maintain, with Blustein, that it is not open to a doctor deliberately to abdicate responsibility over any of these actions so as to focus exclusively on the non-moral aspects of his role (this was Blustein's second version of the engineering model). It's no good for a doctor simply to declare that moral responsibility is above his pay grade. Even when such a declaration is sincere, it has a whiff of defensive self-delusion about it. So, in all these ways, I affirm that medicine is an intrinsically moral profession, and I firmly reject 'the doctor as engineer' as a model.

But there is, I believe, a narrow set of circumstances in which a doctor might be justifiably relieved of moral responsibility, namely, the situations in which his moral beliefs about the patient's interests are not shared by the other actors in the situation — society or the patient — and the disagreement is otherwise ineliminable. These are the kinds of difficult situations which I've been discussing: the doctor has a strong moral view that treatment X is morally wrong because it goes against the patients' interests, but the prevailing view of society is that treatment X is morally appropriate or to be recommended, and no amount of rational debate or sincere soul-searching by either party can close the gap. In these situations, it will be obvious to all concerned, no matter what each party's positions on treatment X, that *something has to give*. When sincerely held, diametrically opposed moral views imply

opposite courses of action, it is a matter of simple logic that there is no way to respect everyone's moral view equally. *Someone* is going to have their beliefs set aside whichever option we choose, and whether we like it or not:

The problem of conflict between values is ineliminable. In practice, it needs to be fairly — perhaps democratically — resolved even if that goes against some parties' values. The supposition that conflict can be resolved to the satisfaction of the parties involved, whatever their own values might in fact be, is either sincere but naïve or — worse — awesomely disingenuous.

(Brecher, 2011, p.997)

My point is simply that it is not defensible to argue that the actor whose beliefs are set aside must never be the doctor. And if someone wanted to insist that this demotes the doctor to the status of engineer in at least that small number of scenarios, then they may be right. Sadly, I can see no way around that.

### *'Only following orders'*

I acknowledge that the argument I've just expressed is a difficult, perhaps controversial, position to take. Since the days of the Nuremberg trials, the defence 'I was only following orders' (legally, 'respondeat superior') has been regarded with suspicion. Contrary to what I've just argued, a common take-away message from those and similar episodes in modern history is that an agent is *not* absolved of responsibility for morally reprehensible actions simply because he acted under instruction or compulsion, or because the authority to carry out those actions lay outside himself (International Law Commission, 1950, principle IV). Under this view, we are expected to refuse to follow orders that would lead to moral outrages. If we accede to such orders — no matter how *understandable* our immoral actions become, in a psychological sense — we can still be held morally responsible for what we do, either as if we had done those actions entirely voluntarily, or at least in some attenuated sense that takes into account the degree of involvement of outside agents.

We don't have to look too far for contemporary examples of this way of thinking. On several occasions in the past century, state government officials have refused on grounds of conscience to implement rulings by the US Supreme Court, including to implement school desegregation in 1954 (Patterson, 2001) and permit interracial marriage in 1967 (Wardle, 1998). In 1992, a US medical director testified that he would refuse to obey a court order to remove a patient's feeding tube because of his personal moral objections (Bleich, 2002). In

2015, the US Supreme Court declared same-sex marriage to be a constitutional right, striking down prohibitions across many states (Yoshino, 2015). In September of the same year, Kim Davis, a county clerk in the state of Kentucky, was jailed for refusing to issue licences to same-sex couples in open defiance of the new law. The leader of her supporters' group, a Baptist pastor, told the Associated Press that "we have to stand before God, which has higher authority than the US Supreme Court" (Jonsson, 2015). In other words: we are held to a higher standard than simply acceding to lawful (earthly) authority, and the duties of a sincere moral agent are not satisfied simply by following (earthly) orders. For the conscience of Kim Davis and her supporters, 'I was only following orders' does not wash.

Obviously, this principle can't be absolute. There are orders and orders. If an evil scientist implants a remote-control device in Kim Davis's brain and issues commands that compel her to sign marriage certificates automatically, the responsibility for any immoral actions lies squarely with the scientist and not with her. Most people would have the same intuition about her blamelessness if a terrorist instead held a gun to her head, or the head of a loved one, and ordered her to implement the law on pain of death. There is no bright line between what level of coercion counts as 'compulsion', thus absolving me of responsibility, and what counts as 'following orders', thus leaving me (arguably) morally responsible for my actions. But the fact remains: if we believe acting under compulsion entails moral responsibility in at least some circumstances, then a doctor can argue that, at least in those circumstances, he ought not to acquiesce to the expectations of society when his personal moral beliefs deliver a different verdict about the patient's interests.

Is this a good argument? I don't think so. As I've already argued, in situations where a doctor has a personal moral objection to a procedure which others consider to be in the interests of the patient (and not otherwise morally objectionable), there is *simply no way* to satisfy everyone's interests. If we allow the doctor to demur on the basis of her beliefs, we deny the patient treatment which we believe is in the patient's interests. If we compel the doctor to participate, then we compel her to violate her own moral beliefs in doing so. When neither option recommends itself as 'the' uncontroversially moral thing to do, we may well look for another way to break the deadlock (which is what the first part of my thesis was about) — but, crucially, we must acknowledge that no solution will leave unscathed the interests of everyone concerned.

And it's important to note that this response should be persuasive even to someone who would argue that one still bears moral responsibility for actions which are performed under coercion (that is, someone who rejects the 'I was only following orders' defence). Either one remains responsible for acting wrongly even when coerced, or one does not; but either way, violation of conscience is unavoidable for at least some actors in cases of otherwise ineliminable conflict. For this reason, a disagreement about what counts as patients' interests does not lend much support to a doctor's refusal to participate, whether or not we consider 'I was only following orders' to be a useful defence against moral responsibility.

## **V. Paternalism**

There may seem to be an elephant in the room here. So far, I've been presenting the question of who is better equipped to make judgements about patients' interests as if it was a simple dichotomy: either trust the doctor or trust society. But this way of framing the issue looks too simplistic. After all, there's an important voice missing in the picture I've just painted: the voice of the patient. Surely the patient himself is also well equipped to assess his own interests — provided that he understands his situation, is well informed about the available options and the implications of each option, and is capable of weighing up all those factors together with his own beliefs and desires.

Indeed, a strong emphasis on the patient's views and judgements about his own interests, and his right to have those views respected, is now ubiquitous in the rules governing medical practice in most of the world's liberal democracies. In England and Wales, for instance, both common law and statute require that patients' "best interests" are determined with reference to patients' own views on the matter, with specific rules about how to handle situations in which patients lack the capacity to come to such views themselves, or to communicate them (UK Government, 2005). And many writers have regarded this strongly anti-paternalistic turn as the most prominent development in medical ethics in the twentieth century. In his assessment of the state of medical ethics in the year 2000, Robert Veatch characterises the view that it's a doctor's job to pursue her own understanding of the patient's wellbeing as "the Hippocratic slogan", and argues not only that this principle has already been substantially undermined but that it will be "relegated to the ash heap of history" (p.702) in the next hundred years.

There are many interesting questions about patient autonomy and paternalism, and many articles and books have been written (and no doubt many more have yet to be written) to address these questions.<sup>76</sup> Questions include: What exactly do we mean by ‘patient autonomy’ and ‘paternalism’? What we should do when a doctor’s view of the patient’s interests — clinical, moral or both — conflicts with the patient’s own view? What is the nature and role of doctors’ special expertise? How should we address difficult cases where the patient’s capacity to judge or communicate his views is ambiguous? How should we respond to the views of child patients? To what extent we should take into account the views of third parties such as the patient’s family or other representatives? And there are many more.

But my research is not about these questions. My research overall is about *doctors’* views, not *patients’* views, and my focus in general has been on how society should respond when doctors have moral objections to controversial medical procedures. In this chapter specifically, I’ve been discussing situations where there’s a conflict between the doctor’s view of the patient’s interests and society’s view of those interests. In such a situation, the patient’s views — and the views of other interested parties — may align with the doctor’s, with society’s, both or neither, but they are not the object of my concern.

This is not to say that the patient’s desires, moral views and opinions about his clinical needs aren’t important in these situations. As I’ve just said, there is a consensus that they are hugely important. But the reason I believe I’m justified in ignoring them, or at least setting them aside, is that — in law, in medical practice, and in common sense — they are not definitive. I know of no jurisdiction where a doctor is required by law or professional regulation always to act exactly according to the patient’s demands, at least demands for treatment (refusals of treatment are a different matter). And even if such a requirement were to be imposed in some hypothetical future jurisdiction — that is, if society’s view of appropriate treatment *always* aligned with the patient’s view — we would still face the question of what to do when doctors refused to comply with the requirement because it conflicted with their own judgement.

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<sup>76</sup> A good starting-point is Pollard (1993).

Every day, every doctor makes numerous judgements — conscious and unconscious, weighty and trivial — about what medical interventions are appropriate to the patients in her care. Those patients' own views about their interests should weigh heavily in such judgements. But at the end of the day, she must decide for herself whether or not to participate. That decision point is separate, and downstream, from the judgement of patients' interests. And it's that decision point which is the focus of my research, because when it comes to moral objections, that's where the rubber hits the road.

# Chapter 6:

## Referral

In the previous chapter, I cited a general consensus among authorities that we should prioritise patients' interests over other considerations. At first glance, I argued, this appears to rule out permitting doctors to object to procedures on the basis of their own moral beliefs at least in situations where the patient has an interest in undergoing the procedure. Later in the chapter, I examined a possible way to square the circle by allowing doctors to object without thereby compromising patients' interests.

In this chapter, I consider a second possible way to square the circle: allowing doctors to act on their objection to a procedure only if they accept an associated duty to refer the patient for treatment to another doctor who does not hold the same objection. Like the proposal I considered in the previous chapter, this proposal begins by granting the principle of prioritising patients' interests, but then seeks to establish some wriggle room by saying that causing a certain amount of inconvenience to the patient, in this case by referring the patient to another doctor in order to make allowances for a doctor's objection, doesn't count as failing to prioritise patients' interests.

This proposed solution is far from purely theoretical. A general requirement to refer in cases of objection is included in the American Medical Association's *Principles of medical ethics* (2001), as well as the UK General Medical Council's guidance about doctors' personal beliefs:

If you have a conscientious objection to a treatment or procedure that may be clinically appropriate for the patient, you must do the following: [...] Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you. If it's not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made — without delay — for another suitably qualified colleague to advise, treat or refer the patient.

(General Medical Council, 2013, paragraphs 12 & 13)<sup>77</sup>

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<sup>77</sup> By the way, this paragraph in the guidance doesn't constitute a general conscience-based refusal clause in the UK because the GMC also maintains an overriding duty to act in the interests of the patient (see p.150 of this thesis), and paragraphs elsewhere in this and other doctors' guidance specify numerous situations in which doctors' personal beliefs are *not* permitted to affect their clinical conduct. It does,

In the same vein, when jurisdictions have legalised controversial medical procedures, they have frequently written provision for referral in the case of objection into the legislation. When Belgium and the US state of Oregon legalised doctor-assisted suicide, they included an explicit referral clause (Flemish Association of General Practitioners, 2003). A similar implicit provision exists in Dutch case law (Hendin, 2002).

Provision for referral also exists in many jurisdictions where abortion is legal, including the UK, many other European countries, and at federal level in the US.<sup>78,79</sup> The World Medical Association's Declaration on Therapeutic Abortion also allows for referral:

If the physician considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of medical care by a qualified colleague.

(World Medical Association, 1970, article 6)

The nature of the intended solution to the conflict of interests between patient and doctor is clear. The patient's interests are preserved insofar as he is still able to benefit from the treatment in question. At the same time, the objecting doctor's beliefs are respected insofar as he is not obliged to participate in the treatment as long as he can arrange for another doctor to stand in (Frader & Bosk, 2009). It is, potentially, a neat solution for all concerned.<sup>80</sup>

But there are two big challenges to this potentially neat solution. The first challenge is the argument that it doesn't actually solve the problem for patients: referring a patient for

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however, mean that the GMC is more permissive than the British Medical Association (2013), which holds that doctors only have a right to conscientious objection where this is already provided for in law.

<sup>78</sup> For a description of conscientious objection provision in doctor-assisted suicide regulation in Belgium, Oregon, the Netherlands and Switzerland, see Lewis and Black (2012, pp.24 and 34). For a survey of abortion laws in many European countries, see Gissler et al (2012). For an outline of provision for conscientious objection and referral in EU and neighbouring countries, see Heino et al (2013). Fiala and Arthur (2014) also provide a brief but well-referenced survey of the laws governing refusal and referral for sexual health services in many Western countries.

<sup>79</sup> The legal position in the UK that allows doctors to refuse to participate in abortion has arisen through a combination of primary legislation (Abortion Act 1967), secondary legislation and case law. It applies in England, Wales and Scotland, but not in Northern Ireland, which is governed by separate provisions.

<sup>80</sup> Analogous provision is sometimes made when it's the code of conduct of a medical institution, rather than the moral belief of an individual doctor, that prohibits a patient from receiving a particular treatment. In these cases, the patient can be transferred to a different institution which does not have the same restriction. Bleich (2002, pp.253-255) enumerates several such cases.

treatment by another doctor is likely still to damage the patient's interests in a significant way. The second challenge is the argument that it doesn't actually solve the problem for objecting doctors: referring a patient for treatment by another doctor is likely still to violate the doctor's beliefs in a significant way. In this chapter, I will consider each of these challenges in turn.

## **I. Does referral really protect the patient's interests?**

The referral solution depends on the claim that we can avoid damaging a patient's interests in benefiting from a particular procedure by allowing for referral. But it is disingenuous to pretend that referral has *no impact whatsoever* on the patient's interests. In what follows, I outline three kinds of possible impacts on patients' interests: delay and inconvenience, making treatment impossible, and dissuading reluctant or vulnerable patients. I make no claim that this list is exhaustive, merely that it is indicative of the broad areas of impact.

### *Inconvenience and delay*

When a patient presents herself to a doctor for consultation or treatment, it is (all else being equal) in her interests that she receives the treatment which would benefit her as straightforwardly and soon as possible. If a doctor refuses to provide the treatment and instead refers the patient to another doctor, this is deleterious to the patient's interests at least to the extent that she is inconvenienced. This inconvenience may take the form of simply having to walk down the corridor to the next doctor's room, or it may be more serious.

If a delay is introduced because of the need for referral (waiting for a willing doctor to become available, for instance), this may have an impact on the patient's long-term experience of recovery, or on the treatment's chance of success. Even if neither of these occurs, in many cases the delay will at least prolong her experience of whatever unfavourable symptoms led her to seek medical treatment in the first place.

It's interesting to note that the issue of inconvenience and delay is often prominent in real-life debates about accommodating moral objections. When two Catholic midwives objected — ultimately unsuccessfully — to supervising a ward in which abortions took place, much

of the case seemed to turn on this issue: the unsuccessful midwives argued that “the number of abortions on the labour ward at our hospital is in fact a tiny percentage of the workload, which in turn could allow the accommodation of conscientious objection with minimal effort”, while a representative of the Royal College of Midwives claimed exactly the opposite, that accommodating this type of objection would disadvantage women seeking abortion and put unnecessary pressure on colleagues (BBC News, 2014).

### *Making treatment impossible*

In some cases, the line between inconvenience and outright denial of treatment can be crossed. This can happen, for instance, when introducing delay would render treatment completely inaccessible, or completely ineffective, or both. This may occur, for instance, in the case of irreversible illness, where a delay might mean that a patient’s condition worsens to the extent that some treatments cease to be practicable or permissible (for instance, doctor-assisted suicide may be ruled out if the patient’s mental capacities degenerate beyond the point where they can meet the psychological requirements mandated by law to consent to such a procedure).

Another clear example of this can be found in the case of emergency post-coital contraception (the ‘morning-after pill’):

The refusal of a pharmacist to fill a prescription may place a disproportionately heavy burden on those with few options, such as a poor teenager living in a rural area that has a lone pharmacy. Whereas the savvy urbanite can drive to another pharmacy, a refusal to fill a prescription for a less advantaged patient may completely bar her access to medication.

(Cantor and Baum, 2004, p.2010)

Here, Cantor and Baum are talking about pharmacists’ moral objections to fulfilling a prescription for the morning-after pill. But it’s as easy to imagine the only local doctor refusing to issue a prescription as it is to imagine the only local pharmacist refusing to fulfill one.

Discussing elective abortion, Heino et al (2013, p.232) report that the line might already have been crossed in several European countries, including Italy, Portugal and Austria, simply by dint of so many providers refusing to provide services that the services become effectively unavailable. According to Heino et al, entire regions of Austria reportedly had no willing providers in 2011. Nordberg et al (2014, p.2) raise the same concern about sparsely

populated regions of Norway, and Minerva (2015) about large parts of Italy. In 2017, mainstream European media picked up in the problem: according to one commentator, “if you want to get an abortion in Sicily, the best way to get it is to jump on a plane” (Paravicini, 2017) — assuming, of course, that you can afford the flight.

Finally, in a study of jurisdictions where doctor-assisted suicide is legal, Penney Lewis and Isla Black describe the various “substantive requirements” mandated by law in these jurisdictions in order for assisted suicide to be permitted (for instance, that a second doctor also consents, that the patient has been provided with adequate information and is judged to have weighed it sufficiently, and so on). They then consider ways in which it might be made more difficult for these substantive requirements to be met, and to be seen to be met, and remark:

One might hypothesise that the more substantial the relationship between physician and patient, the easier it is for the physician to assess whether the substantive requirements are met, and the more likely that assessment is to stand up to prospective scrutiny (by a consultant) and retrospective scrutiny. However, in the presence of conscientious objection, the patient may not be able to establish a sufficiently substantial relationship with a new physician, particularly in cases involving terminal illness. No robust comparative data exist to support this hypothesis.

(Lewis & Black, 2012, p.11)

### *Dissuading reluctant or vulnerable patients*

Allowing for referral can give rise to a third kind of difficulty. There are patients whose past experiences, social background or other personal circumstances mean that approaching a medical professional is a significant step, putting them far outside their comfort zone.<sup>81</sup> For such patients, seemingly routine practical processes — such as referral to a different doctor, a request to return on a different occasion, or even a simple discussion about rights and wrongs (Card, 2007) — can become significant barriers to successful treatment (Stephens, 2017).

A reluctant or vulnerable patient’s discomfort is amplified if the patient’s condition or the treatment sought is one to which stigma is attached, either in society at large, among the patient’s own social group, or even just for the patient herself. Indeed, the patient may

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<sup>81</sup> For a high-level survey of many socioeconomic and other factors that may influence patients’ trust in medical professionals, see Pearson & Raeke (2000) — though the authors’ main finding is quite well summarised by their article’s subtitle, ‘Many theories, few measures, and little data’.

already have had to overcome significant personal qualms before she even arrived in the doctor's consulting room. And, of course, all these factors are more likely to apply in the case of a morally controversial procedure than for routine consultations.

Now, if the first response of the first medical professional encountered by such a patient is to terminate the consultation because of his belief that the treatment is morally wrong (either in itself or because of the particular circumstances), eventual treatment can be severely jeopardised — the patient may simply decide to back out of the whole affair. Equally, if the patient and the doctor have known one another a long time and built up a degree of trust, this relationship can be damaged by a sudden need for referral, with the moral judgement it implies. With some patients, this will be the case no matter how kindly and professionally the doctor's moral judgement is delivered,<sup>82</sup> and no matter how smooth the administrative process of referral to a willing provider subsequently proves to be.

For very many thoughtful clinicians, the duty of care in patients' interests is an overridingly important consideration. The impact of society's policy towards conscientious objection on the doctor's ability to fulfil that duty is a significant consideration. But, as I have indicated, this consideration can cut in both directions. In the previous chapter, I explored in detail the merits of the claim that the right for objecting doctors to resist compulsion from society is central to their ability to fulfil those duties. By contrast, the two considerations I have just described (dissuading patients and making treatment impossible) suggest that accommodating conscientious objection can have a negative impact as well as a positive one.

### *Balancing interests*

For the reasons I've just outlined, we should not imagine that imposing a duty to refer on an objecting doctor completely removes the potential for negative impact on the patient's interests. On the contrary, when a patient seeks treatment and is instead referred to another

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<sup>82</sup> Interestingly, British Medical Association guidance (2013) asserts both that "doctors should not share their private moral views with patients unless explicitly invited to do so" and that "doctors or other health professionals seeking to exercise a conscientious objection may need to discuss the matter with their patient, explaining, for example, their reasons for referral to another practitioner". This apparent contradiction aside, the BMA does highlight the need for a "sensitive" approach to such discussions, especially with patients who are "in a particularly vulnerable position".

provider, the degree of negative impact ranges from the minor (inconvenience) to the major (jeopardising or completely ruling out effective treatment). It is not zero.

Does this mean that allowing referral is a bad idea, and we should always require doctors to participate in controversial procedures, regardless of their moral beliefs? Not necessarily. I pointed out in the previous chapter (starting on p.150) that we should resist the urge to be absolutist about prioritising patients' interests. Patients' interests count, but doctors' interests count too. We may choose to weight one category of interests more heavily, but that does not mean entirely disregarding the other.

The duty to refer is best seen as an attempt to balance these two sets of interests. If referral provides a defensible way to avoid forcing the doctor to participate in a treatment she judges to be immoral (which is a big 'if', as I'll go on to discuss shortly), then my arguments from chapters 3 and 4 indicate that that would be a valuable thing, all else being equal — and we should weigh its value carefully against the disvalue of any negative impact on patients' interests to determine whether, in the last analysis, referral is a moral option.

This means that the decision whether to allow referral in any given situation will depend on a balancing act between the interests of patients in receiving appropriate and timely treatment, and the interests of doctors in not being forced to act against their deeply-held moral beliefs. Sometimes the balance will tip clearly towards allowing refusal and referral — for instance, when the inconvenience of referral to the patient is minor but the psychological damage of compulsion to the doctor would be major. In other situations, the balance will tip more clearly towards disallowing refusal and referral, and instead requiring the doctor to act in the patient's interests and against his own moral beliefs — for instance, when the impact of referral on the patient would be major.

In short, the answer to the question 'Can patients' interests still be served adequately if we allow referral?' is an apparently unhelpful 'Sometimes'. This might not look like very helpful advice for policy-makers and legislators, who might reasonably hope for something a little more specific. But, drawing on the difficulties I've already outlined, I think it *is* possible to be more specific about ways in which potential damage to patients' interests can be reduced or minimised so as to tip the balance of considerations towards allowing referral. For

instance, referral is less damaging to patients' interests, and thus morally more appropriate, in situations where:

- **delay is minimised:** where consultation and treatment by another doctor is readily available, and the process of referral does not mean a longer-than-usual wait for the patient
- **alternative treatment is readily accessible:** where willing alternative providers are nearby and available
- **referral does not negatively impact the patient's eligibility for treatment:** where legal or clinical pre-conditions for treatment can be just as readily met after the process of referral
- **treatment remains clinically effective:** where there is no appreciable difference in treatment outcomes or recovery times after the process of referral
- **patient experience of negative symptoms is unaffected:** where the process of referral does not imply a significant lengthening or worsening of unpleasant symptoms for the patient
- **the patient is unlikely to be dissuaded or psychologically damaged by referral:** where the patient is not reluctant or vulnerable in the ways I've described, and where the likelihood of referral for certain treatments, or the fact that such treatments are not available, has already been advertised by the objecting provider<sup>83</sup>

Many of these ameliorating factors are already provided for in specific legal or regulatory provisions for referral, including in UK law and guidance. (For a concise example, see the policy statement on conscientious refusal by the College of Physicians and Surgeons of Saskatchewan, 2015, paragraphs 5.3 & 5.4.) Some other ameliorating factors on the list, while not listed specifically in legal or regulatory provisions, are implicit in those provisions, especially the requirements to prioritise patients' interests and to provide patients with appropriate treatment (GMC, 2013, paragraphs 4 and 13).

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<sup>83</sup> McLeod (2008) attributes to a personal communication with Rebecca Kukla the following point on pre-advertising a refusal to perform a conscientious procedure by displaying signs in waiting rooms: "The problem with this solution, however, is that it does not guarantee that the women who enter these waiting rooms and who want abortions will know where to go to get them. Also, prospective patients who have no need for abortion services may conscientiously object to the content on the signs and feel that they cannot attend the relevant clinic, even though they have few other options for healthcare" (2008, p.43, note 3).

Again, I don't claim that this list of ameliorating factors is exhaustive. But I suggest that, in situations where most or all of these factors clearly apply, and in the absence of other significant factors that would damage patients' interests, the balance tips towards allowing doctors to refer when they have moral objections; this is a satisfactory solution which does not damage patients' interests unacceptably. Equally, where few or none of these factors apply, the balance tips towards requiring doctors to provide treatment directly, since allowing referral would damage patients' interests unacceptably. And where only some of these ameliorating factors apply, or to a limited extent, or where there are other factors at play that might damage patients' interests in case of referral, the balancing act between harm to doctors and harm to patients is more delicate. Here, the obvious advice is for doctors and managers (and, I suppose, courts where necessary) to take each decision on a case-by-case basis and weigh up the impact of allowing or disallowing referral on both doctor and patient.

This is not quite as banal a piece of advice as it may sound. Firstly, the factors I've just laid out point to a strategy for approaching such decisions: wherever possible, maximise the number of ameliorating factors that apply, and try to adjust the balance so that referral is less damaging to patients' interests. Secondly, where this is not possible, I have already outlined (in chapter 5 of this thesis) a key guiding principle for making such decisions: *patients' interests should be prioritised*, meaning not that they should always trump doctors' interests but rather that they should be weighted more heavily when considering a balance of interests. If the clash of interests between doctor and patient is both irreducible and finely balanced, this will mean resolving the issue in favour of the patient.

This means that there will be some situations in which it's not possible to allow a doctor to refer, and thus some situations where prioritising patients' interests means compelling doctors to act against their beliefs. I argued in chapter 3 of my thesis that doing so harms doctors. I also argued in chapter 4 that it is an intrinsically intolerant position, inasmuch as it not only fails to respect individuals' deeply-held personal moral beliefs, but in fact forces them to act directly against those beliefs. So my conclusion here is indeed that there are times when we should act in a way that we know is intolerant and harmful towards doctors.

This is a potentially unsettling conclusion, and one whose implications I will discuss at greater length in the final chapter of my thesis.

## II. Does referral really protect the doctor's interests?

In the previous section, I asked whether allowing referral could still do justice to the duty to prioritise patients' interests. Now I turn to a different question. If we *require* a doctor who objects to a procedure to refer the patient, do we adequately protect the *doctor's* interests? The argument I will be considering here is that, far from protecting doctors from having to violate their beliefs, imposing a duty to refer seems to miss the point altogether.

Here's the problem. If I refuse to participate in (say) doctor-assisted suicide, I do so because I believe the procedure to be morally wrong. This in turn implies that I believe it's morally wrong for *me* to participate in that procedure. If the law allows me simply to refuse to participate, then my personal conscience can remain clear — in the same way that I don't feel my conscience is impugned by the fact that other people sometimes commit murder, much as I judge murder to be morally wrong. (As Smart & Williams famously put it, "Each of us is specially responsible for what he does, rather than for what other people do" (1973, p.99).) But if the law forces me to refer the patient to another doctor for the express purpose of having that procedure performed, or indeed whom I have good reason to believe will perform the procedure, then it looks like *I myself* am morally complicit after all — just as I would be morally complicit if I knowingly helped to arrange for a murder to happen, even if I didn't pull the trigger myself. In other words, requiring me to refer if I object didn't do its intended job of absolving me of moral responsibility (Blustein, 1993, pp.307-308; Schuklenk, 2015, p.ii).

As a representative of Pharmacists for Life put it vividly in an interview with a *Washington Post* journalist in 2005:

That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does'. What's that saying? 'I will not off your husband, but I know a buddy who will?' It's the same thing.

(Stein, 2005, p.A01)

Other commentators have presented this argument as exposing an inconsistency, or at least an arbitrariness, in any law which both allows doctors to refuse to participate and requires

them to refer, as if it were only possible to have a moral objection to the former and not the latter:

Imagine a personal secretary of Josef Mengele fending off criticism of her role in arranging for more concentration camp prisoners to be delivered for use in lethal experiments, protesting: ‘You can’t criticize me, I merely typed the letters’.

(Jackson, 2006, p.48)<sup>84</sup>

If it is not morally permissible to perform a non-emergency abortion, then, absent special circumstances, it is not morally permissible to refer the mother on directly or indirectly for a non-emergency abortion, or to play any part in assisting this referral process. [...] This means that it is unsatisfactory to legislate that nobody may be legally obliged to participate in the treatment (understood as by the courts) for a non-emergency termination of pregnancy while simultaneously insisting that some may be legally obliged to refer people on for such a termination: many of those that have a conscientious objection to participating in a non-emergency abortion will also have a conscientious objection to referring on for such an abortion.

(Hill, 2010, p.347)

Both Jackson and Hill propose to resolve the inconsistency by changing the law so that it recognises a refusal to refer as well as a refusal to participate: “the conscience clause should be extended to cover any kind of co-operation in the wider process” (Hill, 2010, p.348). But, of course, it’s perfectly possible to resolve the problem in the other direction. Responding to Hill, Whiting (2011, p.2007) points out that the apparent inconsistency could be fixed just as easily by eliminating permissible refusal as by expanding it to cover referral. Whiting mentions this by way of criticism of Hill’s position, but there is no shortage of commentators willing to bite this bullet and prohibit both refusal to participate and refusal to refer:

In fact, objectors often see no moral difference between doing an act and allowing it. [...So,] we propose that healthcare providers be prohibited from a blanket right to refuse to perform or refer for abortion or dispense contraception for personal or religious reasons. [...] Institutional [conscientious objection] should be completely prohibited for health systems and businesses that serve the general public.

(Fiala & Arthur, 2014, pp.19-20)

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<sup>84</sup> This contribution is interesting because it brings up the question of what counts as participating in a procedure. Specifically, Jackson seems to find it self-evident that typing letters implies moral culpability (a position that others have rejected, and that was specifically at issue in the case of *Janaway v Salford Health Authority*, 1988). I discuss this issue in more detail in chapter 1 (p.16 of this thesis, and many of the following pages).

May (2005) raises a similar objection to requiring referral, and Schuklenk professes sympathy with doctors who find referral as objectionable as participation because, in fact, “this compromise is anything but a compromise” (2015, p.ii).

This apparent inconsistency is a problem. In what follows, I discuss five attempted solutions, respectively by the American and Canadian Medical Associations, by Rebecca Cook & Bernard Dickens, by Jeffrey Blustein, by Demian Whiting, and by Carolyn McLeod. Finally, I present my own response to the objection, which is not so much a solution to the problem as a constructive suggestion about how to approach it.

### *The AMA and CMA’s solution*

The American Medical Association, in the part of its Code of Ethics entitled ‘Physician exercise of conscience’, makes the following suggestion:

In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

(American Medical Association, 2016, section 1.1.7)

And the Canadian Medical Association gives practically identical advice to doctors who object to performing or referring for abortions:

You should also indicate that because of your moral beliefs, you will not initiate a referral to another physician who is willing to provide this service (unless there is an emergency). However, you should not interfere in any way with this patient’s right to obtain the abortion. At the patient’s request, you should also indicate alternative sources where she might obtain a referral.

(Blackmer, 2007, p.1310)

In other words, you don’t have to offer a referral, but you do have to offer a referral for a referral — a piece of advice described by McLeod & Downie (2014) as one of many “further and deeper mysteries” (p.ii) inherent in conscientious objection guidance in Canada. It strikes me, too, as rather optimistic. Will there really be many doctors whose personal beliefs lead them to refuse both to participate in a procedure and to refer a patient to another provider for that procedure, but who are then quite comfortable with supporting patients to self-refer for the procedure? (‘I don’t kill people myself, and I can’t tell you about the guy down the street either — but here’s where you can find a list of registered hitmen so you can make the arrangements yourself.’) It seems to me that a doctor whose moral

outlook provides for no distinction between (1) performing a procedure and (2) referring for that procedure is hardly going to be freed from his quandary by an even more subtle distinction between (1) arranging for the patient to obtain the procedure from another provider and (2) “offer[ing] impartial guidance to patients” about how to make such arrangements. It’s hard to see how introducing one additional link to the causal chain after the objecting doctor’s intervention is going to make much difference to anyone.

Maybe I’m being unfair. Maybe there are some doctors whose consciences would be protected by precisely this carefully-circumscribed degree of involvement; after all, it is official AMA and CMA policy, so presumably it was not plucked out of nowhere. If so, then more power to them: as I will argue at length in my final chapter, we shouldn’t rule out useful practical compromises on the basis of philosophical nitpicking. But the writers I’ve already quoted in this section are not among them, because their central point is that, once you admit that moral responsibility extends beyond directly performing a procedure and into other parts of the causal chain which lead to that procedure being performed, being an essential link in the middle of that chain is as problematic (or nearly as problematic) as being at the business end. So, for the objections I’m considering in this section, the AMA’s and CMA’s solution is no solution at all.

### *Cook & Dickens’s solution*

Another straightforward attempt to throw out the objection to referral is proposed by Rebecca Cook and Bernard Dickens:

Clinicians who have already established professional relationships with their patients have an obligation to refer them to alternative sources of care if they do not intend to offer particular services. Referrals of this sort do not constitute participation in any procedures agreed upon between the referred patient and the physician to whom the patient is referred. If, for instance, the second physician were to counsel or treat the referred patient negligently or unlawfully, the referring physician would not be a participant in the negligence or illegality. Similarly, the referring physician does not participate in the treating physicians’ fee.

(Cook & Dickens, 2006, pp.337-338)

This argument is somewhat elliptical, but however it’s spelled out, it’s pretty flimsy. Firstly, Cook & Dickens rely on the claim that the referring doctor does not actually “participate” in the treatment provided by the treating doctor. This is a narrow view about the definition of “participation” that is at least controversial, as I discussed at length in chapter 1 of this thesis

(starting at p.16). But, even if we grant this definition, Cook & Dickens's argument only delivers the intended conclusion — that referral for a procedure avoids moral culpability — if we understand it to rely on the further implied premise that one is only morally responsible for actions in which one directly “participates” (as they understand the term). And this premise seems vulnerable to straightforward denial. The whole point of the objection I'm considering in this section is that a doctor who refers a patient to a colleague with the intention that the colleague provides a particular treatment *is* morally responsible for doing what he does (referring), whether we rule such an act inside or outside the scope of the word “participate”.

Cook & Dickens present not so much an argument against this objection as a flat denial of it. But their denial lacks plausibility. There are certainly many other situations in which we would naturally say that someone bears a share of responsibility for a morally significant act, even though he doesn't “participate” in the narrow sense proposed by Cook & Dickens. For instance, under the criminal law, if I act in such a way as to make it possible for my friend to commit a crime “as by command, advice, instigation or concealment” (Berg, 1996) — even if I'm not actually present — I can be punished alongside my friend as an accessory to that crime. (These are the criteria in UK criminal law; other jurisdictions have similar provisions.) Equally, while we may not exactly heap the same praise on a billionaire philanthropist whose lavish donations keep a lifesaving medical ward open as we might on the staff of the ward itself, it does seem obvious that the donor deserves *some* credit for the patients whose lives are saved. (I suppose it remains open to Cook & Dickens to say that ordering or helping with a crime, or donating money, should be included in the scope of “participation” while referring should not. But then their definition looks even more arbitrary.)

By way of analogy, Cook & Dickens suggest that we wouldn't hold the referring doctor responsible if the treating doctor acted “negligently or unlawfully”. But what makes this claim plausible is the assumption that (in the case of negligence) the referring doctor doesn't know, or at least doesn't have reason to expect, that his colleague would subsequently act in this way. If it emerged that a doctor had deliberately referred a patient for treatment to someone he knew to be a charlatan, a criminal or a routinely careless doctor, it would be hard to escape the conclusion that the referring doctor *had* acted wrongly after all. So knowledge (or at least reasonable expectation) is a crucial factor here. And in the case of

referral for a controversial procedure, of course, the referring doctor knows full well what the procedure involves: that is the whole point of making the referral. So the analogy fails.

Cook & Dickens's last point is that the referring doctor doesn't receive a share of the treating doctor's fee. I guess the idea here is that, because no money changes hands, this indicates that we don't in fact hold the referring doctor responsible. But this seems irrelevant to me, for four reasons:

- First, in many healthcare systems, doctors are paid a salary rather than billing patients for each procedure, so there is no specific 'fee' related to that patient in the first place.
- Second, where doctors *are* paid per procedure, it is in fact perfectly normal for the referring doctor to charge a fee for the consultation that results in referral, even if not for the subsequent procedure. Referral consultations are not done *pro bono*.
- Third, I can see no reason to tie up the question of moral responsibility with the question of whether one receives a fee, or a share of a fee. After all, if work is not paid for, it is not thereby also made responsibility-free. Doctors surely have the same set of professional and ethical responsibilities towards their patients regardless of their payment arrangements.
- Fourth, even if the rules or conventions about doctors' fees in a particular jurisdiction indicate that society *does not* apportion responsibility to a referring doctor, this hardly lends weight to the moral argument that we *should not* apportion such responsibility.

Finally, for my purposes, there is a further problem with Cook & Dickens's position. Even if their argument were entirely successful, it would establish only that referral was not morally dubious. We might, I suppose, try to infer from this conclusion that doctors *ought not to be* harmed by being forced to refer (for some suitably nuanced definition of 'ought'). But we certainly couldn't infer that doctors *are not in fact* harmed by being forced to refer. I pointed out in chapter 3 that the harm suffered by a doctor who's forced to act against his moral beliefs is not dependent on the correctness of those beliefs. A doctor who has a deeply-held moral belief that referral for a controversial procedure is wrong will still be harmed by being forced to act against that belief, even if the belief is wrong. So, even if we accepted everything Cook & Dickens say, we wouldn't have a solution to our problem.

I conclude that it won't do simply to assert, as Cook & Dickens do, that someone who does not "participate" in a procedure (according to their narrow interpretation) is thereby free of responsibility for referring a patient to undergo that procedure. If there is a way to defend the practice of referral as a solution to moral conflicts in healthcare, Cook & Dickens have not provided it.

### *Blustein's solution*

A substantial part of Jeffrey Blustein's influential (1993) essay about conscientious objection deals with the issue of referral. Blustein considers several different accounts of why it may be morally acceptable to refer a patient for treatment, even for a doctor who objects to the treatment itself. Among the several accounts of which he approves, he identifies a common theme: *integrity-preserving compromise* on the part of the referring doctor.

The kind of compromise that Blustein identifies is not, as one might expect, between the differing moral views of the doctor and of society, but rather between two of the doctor's own moral views. According to Blustein, while a doctor may believe that a particular procedure is morally wrong, he may also believe that "it is not the business of public institutions [...] to enforce specific, controversial moral or religious conceptions" (p.310).<sup>85</sup> And, if this is the case, then the doctor might well reflect as follows:

Transferring the patient [for treatment] can be justified on the basis of a distinction between the values to which I may appeal in the conduct of my own professional life and those to which I may appeal as a practitioner within a public institution.

(Blustein, 1993, p.310)

With this proposal, Blustein proposes a strict delineation of a doctor's moral beliefs into two categories: those that can appropriately govern the sphere of his personal professional conduct, and those that can appropriately govern the sphere of his conduct as a practitioner, representative or agent of a public institution. A doctor who acts according to Blustein's recommendation accepts a specific moral principle, namely that at least some of the personal moral values which he applies to his own actions ought not to be shared by public

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<sup>85</sup> Actually, Blustein mentions approvingly two different doctors' motives for referral: (1) that it is not the business of public institutions to enforce specific moral conceptions; (2) that the moral sincerity of people who disagree with the doctor's own views must be acknowledged. I don't discuss (2) here, but much of what I say about (1) could apply to (2) also.

institutions, and thus should be left at the door. This is why it may be consistent for him to refuse to perform a particular procedure himself, while consenting to refer a patient to another provider whom he knows will perform that procedure, since in the latter case, but not the former, he acts as a representative of a public institution whose business is not to enforce a specific moral or religious conception; and thus, Blustein argues, the moral integrity of the referring doctor is preserved.

This seems like a consistent defence of referral, at least for doctors who work in public institutions such as the UK's National Health Service. (Whether doctors in private practice can reason in the same way is an interesting question. Perhaps Blustein would regard the medical profession itself as a public institution, regardless of the administrative arrangements in any given country; see also Wreen, 2004.) But it will clearly only work for a doctor who accepts the premise that some personal beliefs should be left at the door in favour of the neutrality of the public institution. And to accept that principle, the doctor must first accept the moral principle that the moral duty to protect the neutrality of the public institution should take precedence over the moral duty not to participate in a practice that one considers immoral. (May, 2005, points out that principled compromise is only possible in this kind of situation.)

I expect there are some doctors who will accept this latter principle — but there are others who will not. Where a doctor's objection to a controversial procedure stems from a moral attitude that's more fundamental (by his lights) than his belief in the neutrality of the public institution, then Blustein's compromise isn't much use. And very many objections stem from these kinds of fundamental moral attitudes. Religious convictions are the most obvious example: a committed Christian may well say, 'Of course I can see the value of neutrality of the public institution, but a divine command clearly takes precedence over that'. The same is true for many non-religious motivations: someone who believes very deeply that her role as a medical professional is to protect human life is unlikely to allow her commitment to neutrality in public institutions to overrule that belief, even though she does indeed also hold that commitment.

It might be objected that I'm being too pessimistic here. While there are some doctors who stubbornly stick to their guns and refuse to compromise on their personal convictions for reasons like Blustein's, aren't there very many others, religious or not, who *are* in fact

willing to set aside their personal convictions in service of the higher value of the neutrality of the public institution of medicine — and to do so with moral integrity, as Blustein points out? And if this is right, then isn't Blustein's suggestion a useful one, even if it doesn't work in every single case?

In response to this objection, I offer the following defence of my pessimism. Yes, there are many doctors, probably the majority, who are willing to do that. But we aren't talking about those doctors. Rather, both Blustein and I are talking specifically about *refusals to refer* here. That means that we are already talking about a small minority of all doctors, namely those who (1) have a deep-seated personal moral objection to a legal procedure in which they are professionally expected to participate; (2) do not accept that their duty as a medical professional is to set that personal objection aside and participate in the procedure anyway; and (3) also have a personal moral objection to the compromise position that they should refer the patient to another doctor in order to avoid having to perform the procedure themselves. When we consider *this* specific subset of all doctors, I don't think it is overly pessimistic to worry that many of them will be unimpressed by Blustein's suggestion — a suggestion which once again asks them to leave their personal values at the door in the interests of preserving the neutrality of the public institution for which they work. As I discussed at length in chapter 2, the kinds of personal moral objections that lead to refusals to participate in controversial medical practices very often stem from the deepest, most fundamental aspects of the person's worldview, aspects that are closely linked with personal identity and self-conception. That's what brings such doctors to struggle with the requirement to refer in the first place. I honestly doubt that many of this specific subset of doctors will be impressed by Blustein's advice.

### *Whiting's solution*

Responding to Hill (2010), Demian Whiting<sup>86</sup> characterises the problem of referral as primarily one of consistency: isn't it inconsistent for the law to allow doctors to refuse to *perform* controversial procedures, but not to allow them to refuse to *refer* for those procedures? Furthermore, he takes Hill to be arguing that the law ought to allow individual doctors to act with moral consistency — that is, if X and Y are morally equivalent, and the

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<sup>86</sup> Demian Whiting was a supervisor of this thesis.

law allows doctors to refuse X for moral reasons, it should also allow them to refuse Y for moral reasons.

On this, Whiting disagrees with Hill. Drawing on John Stuart Mill's (1859) characterisation of the purpose of the law as primarily to minimise harm, he argues that allowing moral consistency was never an objective of the law in the first place:

This is because allowing people to exercise moral consistency might sometimes fail to minimize harm or be in the interests of society at large. Crucially, it might be the case that allowing an individual to do X will impact negatively on other people's interests to such a degree that it cannot be tolerated by law even though it may be the case that doing X is for an individual morally equivalent to doing Y and doing Y is something that the law should allow. [...] That the law might not allow some doctors to exercise moral consistency drops out as largely irrelevant because the law was never really concerned about making that a priority anyway.

(Whiting, 2011, p.1007)

A quibble: there's a difference between saying (1) that the law should be consistent, and (2) that the law should allow people to act with moral consistency. My reading of Hill is that he only claims (1), but Whiting reads him as claiming (2) too, and the first part of Whiting's reply argues that Hill is wrong to think that (2) is true. While I think Whiting is successful in showing that (2) is false, or at least need not be true under one decent conception of the purpose of the law, I don't think Hill is claiming (2) anyway.

But this is only a quibble, because it seems to me that the disagreement between Hill and Whiting in fact turns not on (2) but on (1). Hill clearly thinks that the law is inconsistent if it allows doctors to refuse X but forbids them from refusing Y, but Whiting replies that this appearance of inconsistency is mistaken:

Of course, on a *superficial* understanding of the law it might appear arbitrary that the law allows, for instance, refusal to abort but not to refer, but in this paper it has been argued that on a *deeper* understanding of the law there is no arbitrariness present in the law. This is because the law seems entirely reasonable and justified in the light of what it sets out to do, namely to ensure that harms are prevented or minimized.

(Whiting, 2011, pp.1007-1008, emphasis in original)

Whiting's argument for this is that minimising harm, which is the primary purpose of the law according to Mill, sometimes involves drawing a distinction between two acts that would be otherwise morally equivalent. In the case of controversial medical procedures, Whiting argues that we might legitimately *both* seek to minimise harm to doctors (of the kind I discussed in chapter 3) by allowing them to refuse to perform a procedure, *and* seek

to minimise harm to patients by requiring doctors to refer patients for controversial treatments if they themselves refuse to perform them. And this might in fact be the best way to minimise harm across the board, even if it means drawing a superficially arbitrary distinction between performing and referring when these would otherwise be morally equivalent.

I can see a possible objection. Whiting's position depends on the premise that referring a patient really does occasion less total harm overall than the alternatives.<sup>87</sup> This means that the total harm occasioned to both doctor and patient by a regime of compulsory referral must be less than that occasioned by allowing doctors to refuse to refer, or by compelling doctors to perform procedures to which they object. (If this isn't the case, then the law is being arbitrary just for the sake of being arbitrary, and Whiting's argument fails.) Now, there are two different sources of harm from which an objecting doctor (**D**) might suffer:

- D**<sub>compulsion</sub> being forced to perform the controversial procedure (as I argued in chapter 3);
- D**<sub>referral</sub> being forced to refer for that procedure (as I suggested earlier in this chapter).

Equally, there are two different sources of harm from which a patient (**P**) might suffer:

- P**<sub>referral</sub> being referred for a procedure rather than having the procedure right away;
- P**<sub>refusal</sub> possibly being denied the procedure altogether, or finding it more difficult to secure.

Suppose, plausibly, that each of these harms has a value greater than zero: that is, each one is harmful at least to some extent. Now, Whiting wants to say that less harm is occasioned in total in his preferred scenario — if we allow doctors to refuse to perform procedures but require them to refer — than in other possible scenarios. Yet in Whiting's preferred scenario, *both* the doctor and the patient are harmed: the doctor by being forced to refer, and the patient by being referred rather than treated immediately. So the total harm is  $D_{referral} + P_{referral}$ . In other scenarios, only one of these two actors is harmed. Since Whiting's

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<sup>87</sup> For a word or two about the coherence of the arithmetical account of harm, see footnote 49 on p.87 of this thesis.

claim is that his preferred scenario minimises harm across the board, he is committed to the premise that the total amount of harm suffered by doctor and patient here ( $D_{referral}+P_{referral}$ ) is less than the harm that would be suffered by the doctor alone ( $D_{compulsion}$ , if objecting doctors were forced simply to perform the procedure) or by the patient alone ( $P_{refusals}$ , if objecting doctors were allowed to refuse both performance and referral).

And not everyone would accept that  $D_{referral}+P_{referral}<D_{compulsion}$ . I've already quoted claims that "objectors often see no moral difference between doing an act and allowing it" (Fiala & Arthur, 2014, pp.19-20), and "it's the same thing" (Stein, 2005, p.A01). Of course, saying that two acts are perceived as morally equivalent by the actor is not quite the same as saying that they are equally harmful to the actor. But if (as seems likely to me) much of the harm inflicted on the doctor is of the type I discussed in chapter 3, namely psychological distress suffered by someone who believes that he is being forced to act immorally, then it seems likely that a doctor who sees administering treatment and referring for treatment as morally equivalent will also suffer an equivalent amount of harm in each case: that is,  $D_{referral}\approx D_{compulsion}$ . If this is right — if requiring a doctor to refer is potentially just as harmful to him as requiring him to perform the procedure in the first place, even before we take harm to patients into account — then  $D_{referral}+P_{referral}$  must be greater than  $D_{compulsion}$ , since  $P_{referral}$  is greater than zero — and Whiting's argument fails to show why we should prefer requiring referral over simply forcing doctors to swallow their objections.

How good is this objection? There are a few possible replies. One is that, while a doctor may well insist that it's just as bad for him to refer a patient for a procedure than to perform that procedure himself ( $D_{referral}\approx D_{compulsion}$ ), at least referral spares the doctor the *experience of performing* the procedure. And that might make a crucial difference to the degree of harm the doctor suffers. For some controversial procedures, such as performing an abortion (which is the procedure Whiting has in mind), withdrawing life-sustaining treatment, or assisting with a suicide, the experience of actually performing the procedure against one's moral beliefs may inflict significantly more psychological damage than would the more mundane experience of simply completing a referral form or verbally recommending that the patient consults a colleague, even if the doctor believes, in the abstract, that the two

things are morally equivalent.<sup>88</sup> In these cases, we might plausibly expect that requiring referral inflicts less harm overall than requiring performance:  $D_{referral} < D_{compulsion}$ .

For other controversial procedures, such as providing sexual health services to same-sex couples or issuing a prescription for the morning-after pill, the experiences of referring and performing the act are more similar. On the assumption that there's nothing *intrinsically* psychologically damaging to the actor about the simple act of writing words on a prescription form (after all, this is a routine procedure for most doctors), any harm inflicted in the case of controversial procedures must therefore derive mostly or entirely from the actor's negative judgement about the moral status of the specific prescription being written. For a doctor who judges performance and referral to be morally equivalent, it's hard to see how the harm inflicted on both doctor and patient in the referral case could add up to less than the harm inflicted only on the doctor in the performance case. So it seems that, in these cases,  $D_{referral} \approx D_{compulsion}$  after all, and Whiting's argument is not so strong.

A final thought. One issue missing from the foregoing discussion is how the various different harms are weighted, and specifically the view that patients' interests should be weighted more heavily than doctors' interests (see chapter 5 of this thesis). If this is right, then it follows that harms to patients should also be weighted more heavily than harms to doctors: to put it crudely, faced with the choice of inflicting an equal amount of harm on either a patient or a doctor, we should prefer to inflict it on the doctor. When comparing the total harm inflicted in two different scenarios, *referral* and *refusal*, this imbalance should be taken into account.

This is true, but it won't help Whiting's case. In fact, it makes it more difficult to sustain. Recall that, for Whiting's account to work, it must be true that less total harm is inflicted when doctors are required to refer than when they are required to swallow their objections and perform the procedure to which they object: that is,  $D_{referral} + P_{referral} < D_{compulsion}$ . But if harms to patients are to be weighted more heavily, this can only increase the left-hand side of the calculation, making it less likely for the maths to come out in Whiting's favour.

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<sup>88</sup> I will have more to say about the importance of the doctor's perceptions of harm in my final chapter.

To summarise: Whiting proposes that the primary purpose of the law is to minimise harm overall, and that this justifies allowing doctors to refuse to participate but requiring them to refer, even these two acts are morally equivalent in themselves. But Whiting can only be right if the total harm to doctors and patients combined is less in the case of requiring referral than it would be if we simply disallowed all objections in the first place. For some doctors and some procedures, this is plausibly the case, but since the claim of many opponents to compulsory referral (including Hill himself) is that it is equivalent to simply disallowing objections, it seems likely that the harm inflicted is in fact at least similar in both cases.

### *McLeod's solution*

Like Jackson, Hill and May, all of whom I quoted above, Carolyn McLeod (2008) believes that allowing refusal but requiring referral fails to resolve the issue of doctors' objections. Her specific focus in this paper is healthcare workers' objections to abortion, but as she writes on pp.31-32, she intends her argument to have broad relevance to other controversial procedures.

McLeod argues that we should in general require referral, and we should not allow doctors to refuse to refer. Her argument for this is easily stated: there is a morally justified norm of the medical profession which entails that doctors ought to refer patients for legal but controversial procedures, and we should not allow doctors to refuse to act in accordance with that norm. She concedes that this may not be the only basis for requiring referral, but argues that it is the "most important" (p.39). (In fact, her arguments here suggest to me that she believes it is not only the most important criterion but also the fundamental one, in that the others depend on it.) She argues that this view delivers the correct verdict in three example cases:

- **It rules out objections to uncontroversial medical procedures.** Wicclair (2000, p.16) describes a hypothetical doctor who believes that patients deserve pain, and thus objects to giving pain relief (I discussed this example on p.74 of this thesis). McLeod points out that we "would be appalled if the profession allowed individual physicians to object" in this case (p.39 of her article), and that this is consistent with the requirement to comply with a morally justified norm of the medical profession, namely that pain should be alleviated.

- **It permits objections to corrupt medical norms.** Since McLeod's principle only requires doctors to comply with morally justified norms, it remains open to doctors to object to norms which are *not* morally justified. This provides an easy reply to the point that doctors surely must be allowed to object when they are asked by an authority to act immorally — for instance, when doctors were expected to participate in human experimentation under the Nazi regime. Under McLeod's principle, doctors are always justified in resisting such demands because the norms from which they follow are not morally justified.
- **It rules out objections to referral for abortion.** In the controversial case of elective abortions, McLeod argues that objecting doctors should be required to refer because allowing them to refuse would violate several morally justified norms: "respecting [patients'] autonomy, honoring their trust, and being beneficent toward them" (p.36).

How good is McLeod's principle? Well, it seems to me that the principle is well equipped to handle the first two uncontroversial cases above: providing pain relief (where it delivers the correct verdict that we must *not* allow refusal) and following corrupt norms (where it delivers the correct verdict that we *must* allow refusal). But these are the easy cases.

A more important test is how well it deals with referral for procedures that are actually controversial. In such cases, it's all very well to say, as McLeod does, that referral for a controversial procedure is morally required and that refusal to refer violates morally justified norms. But the problem is that doctors who believe that abortions are immoral (perhaps because they believe abortions entail killing actual or potential people and can't be justified with reference to the autonomy rights of pregnant women) will hardly be convinced that they nonetheless ought to refer patients for such a procedure on the basis of McLeod's argument — which is why the difficulty arises in the first place. Doctors who judge a procedure to be immoral are unlikely to agree either that professional duties ought to override moral considerations, or indeed that duties such as acting in the patient's interests are satisfied by referring her for the procedure at all. Quite the opposite: many opponents of, for instance, abortion would classify any professional expectation to refer in these cases as morally illegitimate and corrupt, and conclude that McLeod's principle mandates their principled objection.

In other words, *even if a doctor accepts McLeod's principle*, that doctor's view about whether he is required to refer a patient for a controversial procedure will depend on his prior assessment of that procedure's moral permissibility. But it's definitionally true that those doctors who are faced with the decision of whether or not to refer a patient for a procedure to which they object themselves are the ones who already judge the procedure to be morally impermissible. So the practical value of McLeod's principle appears to be zero.

In essence, the problem for McLeod here is very similar to that faced by Wicclair's and Magelsson's proposals, which I discussed in chapter 2 of this thesis. By insisting that a norm must be morally justified in order to provide a foundation for principled referral by objecting doctors, McLeod's solution only succeeds by overlooking the fundamental disagreement over which norms are in fact morally justified and how clashes between them should be resolved.

If that was all there was to say about McLeod's solution, then I would consider it refuted. But there's a crucial further step. McLeod herself anticipates the objection I've just presented, grants it, and maintains that it doesn't undermine the usefulness of her principle. In fact, she is perfectly explicit about the connection between disallowing refusals to refer for a procedure and the moral permissibility of that procedure:

We know already that the refusals contravene norms about not abandoning patients, respecting their autonomy, honoring their trust, and being beneficent toward them. [...] I interpreted these norms in such a way that they require access to abortions for women in unwanted pregnancies. One would have to show that these norms so interpreted are morally justified in order to prove using [my principle] that physicians cannot refuse to refer patients for abortions. Of course, the above norms so interpreted are only morally justified if abortion itself is morally permissible. Thus whether objectors can refuse to make referrals for abortion ultimately depends on whether abortions are morally permissible. Just so we're clear: that is my thesis.

(McLeod, 2008, pp.41-42)

As such, McLeod takes a firm position on the question of requiring doctors to act against their moral beliefs. Responding to the objection that her principle asks too much of doctors by making this demand, she writes:

The proper response to this objection is to note that [my principle] only expects this much of a physician whose conscience is misguided. [...] Surely, in their practices, physicians ought not to be able to follow their consciences when the voice of their conscience misleads

them. There is too much at stake for patients to allow wholesale freedom of conscience among physicians.

(McLeod, 2008, p.40)<sup>89</sup>

This makes McLeod's argument importantly different in both scope and conclusion from the superficially similar arguments of Cook & Dickens and Blustein. Unlike those writers, she doesn't aim her argument at individual objecting doctors. She makes no attempt to convince those who object to a controversial procedure that they should (by their own lights) refer. Rather, her argument is that referral is *objectively* morally required for procedures which are themselves morally justified, and thus that we (society) ought to oblige doctors to refer in those cases, never mind what the doctors themselves think.

In chapter 1 of this thesis, I mentioned that one possible solution to the problem of how to respond when a doctor objects to a controversial procedure would be to assess the morality of that procedure, and use that to judge whether the doctor's objection was well-founded. I ruled out trying for this solution, and decided instead to look for an approach which remained neutral about the morality of the procedure: that was the fundamental rule I introduced on p.43. But McLeod is highly pessimistic about the prospects for this kind of approach. She thinks that the problem of doctors' objections is very unlikely to be solved without resorting to moral arguments about the procedures they object to.

For now, then, I will put McLeod's solution to one side. It doesn't obey my fundamental rule: it doesn't point to a way to respond to doctors' objections to controversial procedures which can be recognised by people on both sides of the controversy. But I will return to this issue in the final chapter of my thesis, when I will consider what to do with those doctors whose objections are still standing when the fundamental rule fails.

#### *A note on theoretical defensibility and practical usefulness*

I've just criticised a number of different proposed solutions to the problem that requiring referral fails to do what it sets out to do, which is to protect doctors from having to act against their personal moral beliefs.

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<sup>89</sup> Remember that McLeod is talking about *referral* here. She makes clear elsewhere that she would only support requiring a doctor to *perform* a controversial procedure if referral was impractical for some reason, such as the reasons I described in chapter 6, starting on p.176 of this thesis.

But am I, along with Hill, Jackson and the rest, just missing the point? While philosophers argue over whether or not compulsory referral is a defensible compromise between patients' interests and doctors' interests, invoking concepts such as the weighting of harms and the neutrality of public institutions... out in the real world, aren't doctors availing themselves of the opportunity to refer every day? Doesn't the empirical fact that both doctors and patients broadly seem to regard referral as a satisfactory compromise between conflicting interests trump the philosopher's complaint that it really shouldn't be?

I have two things to say in response to this. The first is that I'll yield somewhat in the final chapter of my thesis, when I take off my philosopher's hat to discuss some more practical approaches to resolving these kinds of conflicts.

But my second response is to mount a tentative defence of philosophical reasoning in this context. Yes, I appreciate that the practical usefulness of an position might be independent of its theoretical defensibility — but I think we should be careful about accepting this point unquestioningly. Of course there's the obvious point that it can be independently illuminating and interesting to explore the theoretical foundations of any practical arrangement, and to challenge any confusions we expose. But even setting that aside, just because many people regard a particular practice as solving a moral problem, that doesn't mean that the problem is in fact solved. Even if *every single doctor* was convinced that referring patients for objectionable procedures absolved them of all moral blame, they might all be wrong about that; and if so, there would still be some value in pointing out their error.

Suppose we invented a magic pill that would automatically remove all feelings of guilt from the person who swallowed it. Would we simply issue a supply of these pills to every doctor harbouring qualms about any controversial medical procedure, and consider the problem of doctors' consciences solved? No — because, as I argued in my first chapter (especially around p.23), when we legalise a controversial procedure, the problem facing us is not just how to deal with the moral objections of those doctors who disagree. It's how to do it in a morally acceptable and tolerant way, respecting, as far as possible, the individual moral agency of the objectors. I've argued elsewhere that this isn't always possible, not least because patients also have interests and society has a duty to defend those interests too. But

magic pills, moral placebos and conceptual tricks are broadly to be avoided — even if they would in fact help doctors to carry out their duties without moral qualms.

My point is simply this. The possibility that those doctors who accept referral as a conscience-preserving compromise are wrong to do so is worth exploring, not only for academic interest, but in the interests of *those doctors*, who have a right to know. At the end of the day, we may still decide that referral is a useful measure, regardless of its theoretical defensibility; this is one theme I will explore in my final chapter. But we can't make that judgement call unless we ask the questions.

### **III. A new way to approach the question of referral**

Requiring objecting doctors to refer is often presented as a compromise between the doctor's interest in not being forced to perform a procedure she considers immoral, and the patient's interest in receiving the treatment he needs. As I've shown in this chapter, the usefulness of that compromise is debatable — hence why it has received so much attention from writers with an interest in doctors' consciences.

But I also think it's a mistake to approach the problem of referral as if it were a specially unique problem, as most writers do. Instead, the question of whether we should force a doctor to refer a patient for a procedure strikes me as just another instance of the more general question about whether we should force a doctor to participate in *any* procedure to which they have a moral objection. In other words, we should see compulsory referral as *just another controversial medical procedure*, in the same category as abortion, withholding and withdrawing treatment, or any one of the many other examples I listed in chapter 1.

If this is right, then there are two separate questions to be answered about compulsory referral, as with every other controversial procedure. The first question is whether it's a practice that we want to allow, which is to say, whether it's a practice that we want to add to the list of professional duties we expect doctors to fulfil. If society answers 'yes' to that first question, then the second question is: what do we do about doctors who object? This chapter has been concerned with answering the first question. My answer is that referral can indeed provide a useful way for some doctors to act in accordance with their personal

beliefs and thus avoid unnecessary harm, though its usefulness in this regard is also importantly limited.

As for the second question, the perspective I've just proposed gives an obvious answer to the question. As policy-makers, we should give those who hold moral objections to compulsory referral exactly as much leeway as we give those who hold moral objections to, say, terminal sedation. How much leeway is that? Well, my answer to this question is the one I've been developing throughout the rest of my thesis. The dual considerations of harm (chapter 3) and tolerance (chapter 4) mean that, all else being equal, overruling doctors' sincere moral objections is a bad idea — and that suggests we should allow doctors to refuse to refer. But the consideration of patients' interests (chapter 5) means that in some circumstances, which I've spelled out, we ought to overrule those objections nonetheless. This means that, like the other controversial practices I've considered, referral ought sometimes to be compulsory, and at other times not.

# Chapter 7:

## Next moves

The preceding six chapters have focused on the moral question of how we should respond when doctors hold personal moral objections to controversial medical procedures. Most notably, I've argued that there are some circumstances in which doctors' sincere personal moral objections can rightly be overruled by society because they are outweighed by countervailing considerations. I stand by this conclusion, but at the same time I recognise that it can be problematic.

For the final chapter of a philosophical thesis, then, a conventional approach is to consider the practical implications of what's gone before, perhaps asking how my proposed conclusion should be implemented in law, or who should be responsible for enforcing the problematic rules or making the case-by-case judgements it requires.

In my final chapter, however, I want to do something a little different. I want to ask, and propose answers to, the following questions:

1. Where would the decision to overrule an objecting doctor leave that doctor?
2. How might we, as a society, try to manage that situation so as to minimise the harm inflicted on the objecting doctor?

The second of those two questions might seem strangely familiar. After all, I've just spent 80,000 words or so debating the question of how to manage doctors' moral objections when they clash with society's expectations, and I've come to some concrete conclusions about that. Now it might seem that I am suddenly asking the question all over again, and in a less sophisticated way.

But the impression of *déjà vu* is mistaken. The rest of my thesis has asked, and tried to answer, the question of whether society should allow a doctor to refuse to perform a procedure which she finds morally objectionable. In this chapter, we're at the next stage. The question now is what *else* we should do in cases where we've decided to give a negative reply to that first question and find some doctors still unwilling to accept that negative reply. At this point, the main solution I've been considering in preceding chapters, namely

allowing individual objecting doctors some moral autonomy with regard to controversial issues, has already been ruled out. The question now is what options remain open to the objecting doctor, and how we, society at large, might try to handle the fallout.

## **I. Next moves for doctors**

Consider the case of a doctor who objects morally to some controversial procedure. (As usual, it doesn't matter what the procedure in question is.) And suppose that the validity of objections like his has been recognised and acknowledged, but then, after a thorough and genuine process of deliberation which includes weighing up the factors that this thesis has discussed, the objection has been overruled — either in the general case by lawmakers or regulators, or, in the case of this specific doctor, by those who have direct responsibility for his day-to-day management. In short, this doctor is expected to perform the procedure despite his misgivings.

The question is: now what? What can the doctor's next move be?

### *Good grace*

When a controversial procedure is legalised, but a doctor refuses to participate for moral reasons, one common response from those who don't share the doctor's moral qualms is to say that she ought to accept the rules with good grace, swallow her moral objections, and perform the procedure after all. After all, unless she rejects the general right of relevant authorities to regulate her conduct, then it seems too much for her to demand not just that her views are adequately taken into account when making decisions on the permissibility of treatments, but also that the resulting decisions should always go in her favour. When all is said and done, the debate has to end somewhere, and you can't win them all (Cowley, 2016).<sup>90</sup>

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<sup>90</sup> Cowley (2016) attributes his summary of this argument to Schuklenk (2015), but I can't find anything in Schuklenk's article that has much in common with it.

But to say that ‘doctors ought to accept the decision with good grace’ is itself to make a moral judgement, the result of weighing up two competing moral claims. Very roughly, they are:

1. When all is said and done, a doctor ought to act according to the expectations of the relevant legitimate authorities in carrying out her professional duty.<sup>91</sup>
2. A doctor ought not to perform this procedure (because it’s morally wrong).

And to say that a doctor ought to accept the decision with good grace is to judge that she should weight **1** more heavily than **2** in her deliberations — that is, she should allow the duty to obey legitimate authorities to supersede the moral requirement not to act wrongly. But this conclusion is not instantly obvious. Both claims are likely to have some moral weight in the mind of the doctor, and there is no guarantee that the doctor will judge the wrong occasioned by failing to fall in line with the expectations of legitimate authorities to outweigh the wrong occasioned by failing to perform a particular procedure. Indeed, it seems likely that at least some doctors who felt strongly enough to register a personal moral objection to a particular procedure in the first place will also feel strongly enough to come to the opposite conclusion: when all is said and done, that the duty not to act immorally by their lights, **2**, outweighs the duty to follow instructions, **1**. (This is a similar line of argument to that in chapter 6, p.189, when I discussed Blustein’s proposed solution to the problem of referral.)

Religious convictions can provide one context in which this judgement might be made. I’ve already mentioned one such real-life, non-medical example: that of the Kentucky clerk who refused to perform same-sex marriages in 2015, arguing that “we have to stand before God, which has higher authority than the US Supreme Court” (page 169 of this thesis). Clearly, if an employee believes that there’s a divine being whose fiat prohibits a particular procedure, she’s very likely also to believe that this divine being constitutes a higher source of moral authority than whatever earthly institution is trying to get her to perform the procedure. In that situation, it seems that the only moral option for her, by her own lights, is to disobey society’s instructions.

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<sup>91</sup> These claims could clearly be fine-tuned. For instance, we might want to specify certain characteristics that define which authorities are relevant and legitimate (Edmundson, 1998).

Note that this needn't amount to a wholesale rejection of earthly authority. She need not think, for instance, that earthly regulators and governments have *no* right to specify expectations for citizens' or employees' conduct, nor that such expectations have *no* moral weight. That would be a very radical claim, amounting to something like (earthly) anarchism. Rather, her claim is likely to be the much less radical one that, in the end, no earthly regulator or government can overrule divine authority. According to this way of thinking, both sources of authority have weight, but when they conflict we should break ties in God's favour. As John Locke put it, "Obedience is due in the first place to God, and afterwards to the laws" (1689, p.33).

An interesting consequence of all this is that someone might reject the entirety of what I've said prior to this chapter and still find what I say in this chapter useful. Even if you're not at all convinced that society *ever* ought to overrule doctors' objections, the fact remains that this does sometimes happen, rightly or wrongly. Given this fact, it is still useful for someone who (like most of us) is not in a position unilaterally to rewrite the law of the land to consider how doctors might respond to the status quo and whether there are practical ways to soften the blow for them.

Note, also, that this conflict need not necessarily be conceived as a clash between secular and religious authority. My example of a doctor prioritising the latter over the former is just one possible scenario. There are at least two other possibilities. The first possibility is one in which God doesn't come into the equation at all: a doctor may judge, on an entirely secular basis, that the moral reasons (by his lights) not to perform a particular procedure outweigh the moral reasons to obey society's insistence that he should do so. The second possibility is the converse: the debate may happen *entirely* in religious terms. In some jurisdictions, the authorities which regulate citizens' behaviour may be religious in nature, either officially or *de facto*; and, even in an officially secular state, one can imagine individual legislators reflecting on their personal religious beliefs, or praying for divine guidance, before voting on whether to legalise a particular procedure or to recognise doctors' objections. Wherever there is a conflict between a doctor's personal moral beliefs and the expectations of authority, we have a problem. The conflict in question can perfectly well be religious vs secular, religious vs religious, or secular vs secular.

### *Would-be martyrs*

We can generalise the above argument. Suppose a particular doctor's moral principles determine that she should value the preservation of patients' lives above all else, and therefore that she should never participate in an act of killing. Because of those moral principles, she refuses to participate in procedures that count as killing (to her), such as doctor-assisted dying or abortion.

Is there anything at all we could say to this doctor to convince her that she ought to participate in those procedures? It seems not. If she literally values the preservation of patients' lives *above all else*, then pointing out other considerations to her will make no difference. She will not be impressed by arguments about legal or professional duties, because she believes that protecting patients' lives is more important than either of these. Nor will she be impressed by arguments about patient autonomy or public duty or minimising harm. And proposed compromises such as Blustein's will leave her cold (page 189 of this thesis), because there is no conceivable alternative principle which she would value highly enough to make a compromise morally desirable. Indeed, the logical consequence of this doctor's position is would-be martyrdom, because she will, at the end of the day, prioritise her belief above even preserving her own life. (One would hope that uncooperative doctors are not literally threatened with death as a result of their moral objections. But to the would-be martyr, coercion of all kinds is ineffective, including the threat of dismissal or imprisonment.)

The intractability of this position is not widely appreciated in much of the literature on conscientious objection. In my experience, it is also not widely appreciated in practice. When I've discussed ethics with medical students, I've frequently encountered responses along the line of: 'Yes, of course I can see that this is *morally* the right thing to do, but it's not as easy as that — because in practice doctors have so many other considerations to take into account alongside moral ones, like patient wishes and the demands of the law. The real world is more complicated than just black-and-white morality'.

This sounds seductive, even obvious — but in fact it's based on a conceptual confusion. If you believe that, in practice, doctors have to try to balance 'moral' considerations against other kinds of considerations, you're making a kind of category mistake. Of course, there are many different considerations that doctors must balance when making difficult

decisions: practical, legal, professional and psychological, to name but a few. Such decisions are rarely simple; different considerations pull in different directions, and there are shades of grey. But moral principles are not just another kind of consideration to be thrown into the mix, adding just another complication to be weighed against the rest. To borrow a cliché, morality is part of the solution, not part of the problem. It is the method by which it becomes possible to sift the various descriptive considerations, judge which ones ought to take priority, and (one would hope) come to a conclusion about the right thing to do. Without morality, there would just be a whole load of descriptive considerations and no way to decide what to do.

Suppose you're faced with a dilemma as follows. Immanuel Kant is at your door, wielding an axe and demanding that you tell him where your dog is hiding so he can find and kill it. Your choice is to tell the truth about your dog's location, which will no doubt result in its grisly death, or to lie, which will send Kant away, frustrated. In this scenario, philosophical tradition has it that there are two conflicting pulls on your conscience: the consideration that to tell the truth will cause harm to your dog (and perhaps betray your duty of care), and the consideration that to lie will be an act of dishonesty. So how do you decide what to do? The answer is that you make a moral judgement. That is, you refer to your moral principles to judge which of those two considerations is morally more weighty in this situation, and that tells you what's the right course of action. In other words, your moral principles are your source of guidance, not an additional complication.

That is a deliberately crude characterisation. I said nothing about what the content of your moral principles might be or how they might be organised; I said nothing about whether the judgement should be situational or universal; I said nothing about how the process of weighing up actually happens. But I give the crude characterisation simply to illustrate what I mean when I claim that moral principles provide a source of normative guidance. They show you how to attach moral weights to descriptive considerations so as to produce judgements about how to act in response to those considerations. In fact, I think that's what your moral principles *are*: they are the things that translate descriptive facts into normative guidance. And if your principles tell you that the highest moral duty is to do X — that is, if you are a would-be martyr for X — then adding further considerations, no matter how many and how significant, can't possibly change your mind.

I said that the intractability of the doctor's position is not widely appreciated in the literature. Many attempts to address the question of conscientious objection in medicine, including many that I have quoted and discussed at length in this thesis, involve either introducing new considerations ('I know you value X for reasons A and B, but have you considered reason C, which suggests that not-X is valuable too?'), or proposing compromises ('I know you value X, but others believe that X is wrong, so we need to find a compromise'). But for the would-be martyr who values X above all other else, these are futile strategies. Literally nothing will change her mind. So this doctor is both persuasion-proof and coercion-proof. What is to be done?

## II. Softening the blow

To some, the answer is obvious. A doctor who refuses to carry out her duty, even after her objections have been properly taken into account, is guilty of dereliction of that duty and thus of conduct that is at best unprofessional and at worst maybe even criminal. Viewed this way, her position is analogous to that of the would-be conscientious objector who appeals to a tribunal against military conscription and loses his case but still will not submit to the decision (Fiala & Arthur, 2014); or, even more harshly, to the unrepentant criminal who refuses to admit that what he's done is wrong even after being convicted in a fair trial.

In an otherwise extended and philosophically sophisticated policy statement about moral objections in intensive care medicine, the American Thoracic Society devotes just two sentences to such end-of-the-line cases:

Situations may arise in which a clinician's [objection] cannot be accommodated, but the clinician nonetheless refuses to provide the medical service. In these circumstances the clinician may be subject to the institutional or legal consequences that apply to clinicians who refuse to provide a legal, professionally accepted, and otherwise available medical service.

(Lewis-Newby et al, 2015)

According to this view, there's only so far you can go in accommodating people: a line has to be drawn somewhere, beyond which dissent can't be tolerated. In short, would-be martyrs should expect martyrdom.

Naturally, we're not talking about *literal* martyrdom here. Membership of the medical profession is not compulsory, and the law doesn't view doctors who refuse to perform

controversial procedures as criminals. At the end of the day, if you can't do in good conscience what's expected of you in your job, you still have the option to resign and walk away with your conscience more or less intact (Savalescu, 2006; Schuklenk, 2015). Equally, a persistently insubordinate doctor could be subject to disciplinary proceedings, which might involve laying out conditions for a return to work, or a range of sanctions up to and including being barred from practice ('struck off').

Of course, career-ending alternatives are highly undesirable to all concerned. While there may be a few cases in which ending a persistently defiant doctor's career may be an unproblematic solution, there are surely many more cases in which to do so would be deeply sad and damaging all round. As I mentioned in chapter 1, p.33, every doctor who feels forced to resign over an issue of morality — or who goes to the wall for her moral beliefs and is sacked for non-compliance — is one less doctor able to contribute to the medical profession. Patients will suffer if the availability of generally good doctors is reduced. We should also not disregard the impact on the doctor herself whose career is cut short by such an event, and the impact on those who depend on her professional income, stability and happiness.

So, while disciplinary action or resignation are always options, they are usually bad ones. Of course, if we're faced with mostly terrible options, then it can be rational to choose a bad one. But, in what follows, I want to explore whether there is anything useful we can say to the objecting doctor whose personal moral objection we're not able to accommodate, which might help to soften the blow of compulsion and provide an alternative perspective according to which disciplinary action or resignation are not the only ways forward.

This is not so much about trying to find a way to persuade the doctor that she should toe the line — and this is anyway going to be impossible in cases like those I've just described. It's more about trying to find a way to make the situation less hard for her. Possible approaches to this include having a quiet, informal conversation in the workplace; providing a more structured forum for different perspectives to be aired; or even offering formal training on aspects of public healthcare policy such as diversity and non-discrimination.

In all of these cases, what it boils down to is that we, as policy-makers or managers, are putting her in an extremely difficult situation by overruling her sincere moral objections. Although we think that is justified, all things considered, we also recognise the harm that

our policy will inflict on her and we acknowledge that it would be better if she didn't have to suffer in this way. Arguably, we have a duty of care towards the doctor, since we are the ones requiring her to do something that we admit will harm her. So the question is what we can say or do to try to reduce this harm — without, of course, re-treading old ground about our decision to overrule the objection in the first place.

One might argue over the question of whether there's a moral duty on the part of the state or the employer to try to soften the blow of imposing morally challenging compulsion. But, even setting aside the question of professional ethics, surely basic human decency implies that if you are forcing someone to do something she finds unpleasant — or even if you just come into contact with someone who is really unhappy — you should take advantage of any opportunity to make her experience a bit less unpleasant. Even if we recognise that changing her mind is impossible, simple things like showing compassion, taking her perspective seriously and exploring different perspectives in a sympathetic way could all help to soften the blow.

### **III. Suggestions**

#### *Redirecting how the objection manifests itself*

There are various ways to respond to a conflict between what is expected of you by the law and what you believe to be right. Refusal to submit to the expectations of the law, through conscientious objection or civil disobedience, is one possible response, and the one that's been my main focus so far. But another is to obey the law while also campaigning for it to be changed.

Julian Savulescu and Udo Schuklenk argue vigorously for this response in a discussion about organ donation:

We have campaigned to change the law to an opt-out regulatory regime, permitting society to override family refusal and to prioritise organ donors in the allocation of scarce transplant organs. [...] The place of reasons and values in medicine is properly located in dialogue with patients, and in attempting to shape policy and law, as we have done in the case of changing the law around abortion, and euthanasia.

(Savulescu & Schuklenk, 2017, p.166)

And an AMA House of Delegates resolution from 2001 takes the same position:

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

(American Medical Association, 2001)

In contrast with a ‘put up and shut up’ attitude, this is more like ‘put up but work on it’. It allows the doctor, as a private citizen of a modern liberal democracy, to express his personal moral objections to a particular policy in as strong terms as he feels appropriate, and indeed to take concrete steps towards achieving political change via all the channels available to private citizens of a modern liberal democracy: political representations, public demonstrations, campaigning and so on. At the same time as taking advantage of these opportunities for political self-expression, we expect the doctor in his professional practice to obey the very rules to which he privately objects, at least until the campaign against those rules is effective in bringing about political change. From the perspective of the health service manager whose aim is to minimise harm to the objecting doctor while enforcing agreed policy, this approach has the advantage of channelling the doctor’s personal moral objection to a particular practice into legal and indeed arguably constructive activities, without reducing the availability of that practice, and thus without harming the interests of patients.

Savulescu and Schuklenk aim their argument against allowing conscientious objection at policy-makers. Can a similar argument usefully resonate with an doctor whose objection has been overruled? Perhaps. It depends, I think, on the psychology of the objection. If it was primarily about self-expression — about signalling one’s moral reservation in the face of societal pressures — then this alternative form of self-expression may be just as effective, or perhaps even more so, since it can be highly public. The suggestion may also strike a chord where the doctor’s refusal was primarily motivated by a desire to change the status quo (for instance, by motivating other doctors also to refuse, and eventually accumulating a critical mass to bring about a policy rethink); it could be argued that political campaigning is certainly the more appropriate, and maybe even the more effective, means to this end. Finally, for a doctor who is also deeply concerned about the negative impact on patients of his personal objection, this approach may recommend itself as a convenient compromise.

But I suspect there are also many objecting doctors who will be unimpressed by this suggestion. One complaint is likely to be that it misses the point about personal conscience.

For many, the reason they refused to participate in the objectionable procedure was to protect their own personal integrity, so that *they personally* did not have to perform an act which they judge deeply immoral (Smart & Williams, 1973, again). If this is right, then campaigning against the general rule that requires doctors to participate in that procedure (or against the legality of the procedure itself) is all well and good, but it hardly cancels out an individual's moral responsibility not to be party to an immoral procedure.

Furthermore, while some doctors might be happy to maintain a conceptual distinction between professionally mandated duties and private expressions of morality, others may feel the additional pain of personal inconsistency where those two conflict. Perhaps a man who pays lip service to the immorality of an act by night while consenting to perform that act by day offends more severely against morality than the man who just puts up and shuts up.

When it comes to promoting the interests of patients, this suggestion brings the additional complication that it requires a very strict and visible separation between a doctor's private activities and his professional duties. A same-sex couple seeking sexual health services might not feel that their interests are best served if those services are provided, however cheerily, by a doctor who spends his free time leading a vocal campaign against the reproductive rights of same-sex couples.

### *Challenging the effectiveness of refusal*

Can we usefully suggest to the objecting doctor that her refusal to participate will not in fact achieve the aims she has in mind, because of the way the world is, and so she should acquiesce?

For instance, suppose a hospital doctor objects to performing an abortion. We might point out that her refusal, and others like it, will not in fact reduce the number of abortions that take place. Indeed, fewer abortions in hospitals will simply mean more back-street abortions in more dangerous circumstances. (This was indeed the conclusion of a World Health

Organisation study in 2009.<sup>92</sup>) Analogous arguments might be made against refusals to participate in some other procedures.

As with the previous suggestion, this approach may be helpful in some contexts, but not all. If part of the objector's main motivations was to contribute to a reduction in the prevalence of abortions, then the claim that her refusal will not achieve that aim ought to be a relevant consideration. On the other hand, if her primary motivation was to protect her own personal integrity by refusing to perform an act she views as immoral, this approach is likely to fall flat.

### *Advocating referral*

I discussed the issue of referral at length in chapter 6. I return to it here, much more briefly, as a possible strategy to soften the blow to a doctor whose objection has been overruled. My suggestion is very simple indeed: if a doctor would be severely harmed by being forced to perform a procedure to which he objects, perhaps some of that harm could be alleviated by allowing him to refer the patient to another doctor rather than performing the procedure himself.

Yes, I argued at length in the preceding chapter of this thesis that a referral policy is not a straightforward solution to the problem of doctors' personal moral objections. But, as I said earlier, the question I was attempting to answer then was 'What should our policy be towards objecting doctors?'. Now, in this final chapter, my question has changed to 'What can we say to an objecting doctor to try to reduce the harm to them?'. And one thing we can say to them is, 'Perhaps you will not feel quite so terrible if you refer this patient to another doctor instead of performing the procedure yourself'.

If the doctor agrees with this suggestion, and finds the act of referral less personally painful than the act of participating in the procedure, then the philosophical arguments I made in chapter 6 are neither here nor there. The aim now is to reduce harm to the doctor, not to

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<sup>92</sup> "Legal restrictions on safe abortion do not reduce the incidence of abortion. A woman's likelihood to have an abortion is about the same whether she lives in a region where abortion is available on request or where it is highly restricted. [...] Providing safe abortion will prevent unsafe abortion" (Shah & Åhman, 2009, p.1149).

weigh up the conceptual arguments about whether a particular measure *rationaly ought* to be effective in doing so.

### *Rethinking the nature of the act*

One way to sidestep difficulties might be to try to explore the possibility that, contrary to appearances, there is no actual conflict between the doctor's beliefs and the duty being imposed by society. This can be a useful strategy because it avoids directly contradicting the doctor's beliefs, and instead simply suggests that they don't apply to this particular situation.

The clearest examples of this approach are in situations where there is disagreement about the moral significance of questions of life and death. For instance, suppose it has been determined that the best course of action is for a doctor to withdraw life-sustaining treatment from a patient in a permanent vegetative state, perhaps by disconnecting a ventilator. We can suppose that the patient's family and the hospital's ethics board are in agreement on this; we can even suppose that the patient previously put in place an advance directive to this effect. Suppose that, nonetheless, the doctor in question believes this to be immoral because it would count as an act of killing, and to her, killing is always wrong (either for anyone, or for a doctor, or for her personally). And suppose that we have decided that, in this particular case, the doctor's objection is to be overruled, an outcome that we judge likely to be harmful to her.

One way to try to address this is to introduce some ambiguity to the situation. We might say to the doctor: 'I recognise that you are opposed to killing. But to withdraw treatment from this patient would not in fact be an instance of killing. It would be an instance of allowing the patient to die by letting nature take its course. You may foresee the death of the patient, but you would not be causing it; you would merely removing an artificial mechanism by which life is sustained. So your conscience can remain clear: your objection to killing in fact doesn't apply to this situation.'

Whether this approach is successful or not will depend on many factors. It certainly has its limitations. There is a venerable literature on the difficulties associated with the doctrine of double effect (McMahan, 1994). And there are further philosophical complications around the interpretation of terms like 'letting nature take its course' (Feldman, 1998): What counts as 'nature'? Isn't virtually all modern medicine in fact an attempt to divert the course of

nature? Would it be acceptable to allow a patient to die for want of simple, albeit ‘unnatural’, antibiotics? The upshot of this controversy may well be familiar to the doctor in question, especially if her objection has a religious foundation, and in that case it might be that the doctor is unable to accept this recharacterisation of the situation. Withdrawing life-sustaining treatment *is* killing, the doctor might insist, and characterising the act as ‘letting die’ does not solve the problem.

Another potential approach would be to suggest that the situation is morally different from a straightforward act of killing because the patient has already permanently lost all higher brain functions. This might involve suggesting that it doesn’t count as killing if the patient is already in this state (thus preserving the doctor’s belief that all killing is wrong) or that killing in this particular situation is not morally wrong (thus challenging her belief). Again, the success of such a strategy will depend on the inclination of the doctor to accept that kind of argument, which may be dependent in turn on familiarity with both medical and philosophical debates about the definition of death (Holland, 2016; Youngner et al, 1999), or on her perspective on what ‘ordinarily’ makes killing wrong.

But there is at least a *prima facie* argument to be made that the moral status of an act that ends life by withdrawing life-sustaining treatment is different from that of an act that ends life by, say, putting poison in a healthy man’s cup. And that difference in moral status — whether it contributes to an argument that some life-ending acts are not really killing, or that some acts of killing are not morally wrong — may be enough to make the difference to some doctors.

There is another closely related approach available here. Rather than challenging the doctor’s categorisation of withdrawing treatment as killing, it may be productive to challenge the coherence of her objection. One argument might be that her objection to killing is impossible to sustain because there is no coherent definition of killing that includes the acts she objects to, but excludes other acts to which she has no objection, such as declining to treat a patient with the expectation that the patient will die as a result. The idea is that recognition of this incoherence might lead to the doctor’s rethinking her broader stance.

### *Invoking compulsion*

I considered in chapter 5 the usefulness of the ‘I was only following orders’ defence. There, I was interested in the question of whether objecting doctors might be able to take advantage of the suggestion that an act done under compulsion is not morally culpable in order to absolve themselves of moral responsibility. My conclusion on page 166 was:

To the extent a doctor is *compelled* to act in a way that he believes is deleterious to a patient’s interests (because his beliefs are overruled by society or by deference to the patient’s beliefs), he does not bear moral responsibility for any genuinely interest-damaging consequences of that act.

I humbly submit that this proposal might be of use here too. That is, we might say to an objecting doctor, ‘I understand that you believe this procedure to be immoral, and that it’s wrong for you to participate in it. But remember that you are not taking part in the procedure *freely*. You are compelled by the law of the land and the duties imposed on you by your profession. You have no choice but to comply, and in that situation, you are absolved of moral responsibility: ought implies can’.

Setting aside the philosophical complexities that I outlined in chapter 5, it’s an interesting empirical question whether this suggestion could work. Are people harmed less — that is, do people in fact feel less psychological distress — when they are *forced* to perform an act they judge immoral, compared to when they freely perform such an act? Does the reflection that ‘I couldn’t have done otherwise’ help at least to reduce some degree of guilt or pain?

## **IV. The moral-psychological switch**

For all the suggestions I’ve just made, it’s important to note that my aim is for practical utility, not for philosophical robustness. I haven’t tried to present watertight arguments for any of those suggestions, nor have I defended them against philosophical objections.

This has a number of implications. Firstly, the suggestions I’ve just presented are not only different in content and character from one another, but some of them might have mutually incompatible implications. If this approach seems somewhat scattergun, then so be it. Since my aim is to find several ways to soften the blow for objecting doctors, it would not be a surprise if different considerations resonate with different doctors. And since I’m looking for psychologically effective suggestions rather than pursuing philosophical robustness, I

won't be troubled by the complaint that some of my suggestions could be mutually incompatible. If a particular suggestion works for someone, then its usefulness is established. Its incompatibility with other suggestions (which might be equally effective for someone else) is neither here nor there.

Secondly, I recognise that some of these suggestions might be difficult to defend conceptually. That may limit their usefulness — but equally it may not. Features of philosophical robustness, like logical validity, empirical accuracy and ethical defensibility, were important earlier in this thesis when we were weighing up arguments for and against the accommodation of doctors' objections. But that time has passed. We're now at the last-resort stage of trying to find ways to soften the blow for doctors who might otherwise be driven to resign (or be struck off) because of the decisions we've made. If this is to be averted, then what we need are suggestions which have *psychological effectiveness* — that is, things we can say to doctors which might help them to find a way to stay in the profession and accept the decision that has gone against them, while avoiding or ameliorating the kinds of potential harms to them I outlined in chapter 3.

If this is so, then there might be a feedback loop here. Perhaps the availability of some of these 'pragmatic' strategies for reducing harm to doctors might count as grounds for refusing to accommodate doctors' objections in the first place? In other words, if we know that there are reliable ways in which a doctor can be required to act against an objection and the consequent harm can be reduced, perhaps that may tip the balance away from the doctor and towards the patient when deciding whether to accommodate the objection.

For sure, such an argument needs to be convincing enough that a thoughtful, morally sophisticated objecting doctor can recognise and accept it. But it does not need to pass the higher bar of philosophical robustness to which we tried to hold ourselves earlier. We are talking now not to the philosopher, but to the doctor, the policy-maker and the health service manager. If a particular argument is *convincing enough in practice* to reduce the harm that would otherwise be suffered, then its job is done — even if a deeper analysis might have exposed a conceptual hole in the argument. In a sense, I am taking off my philosopher's hat for the duration of this chapter, in the hope that some practical solutions might be easier to see when I'm not wearing it.

I hope this switch from the moral perspective to the psychological perspective comes across as usefully pragmatic, and not as cynical or devious. Importantly, I'm not suggesting that society should pursue compliance by finding ways to trick doctors into accepting superficially convincing arguments that, on careful reflection, they ought to reject. Rather, I'm trying to resolve the impasse between insistent authorities and objecting doctors by finding practical suggestions that some doctors themselves might be able to accept as helpful even if *both sides* acknowledge the possible philosophical shortcomings of those suggestions.

For instance, one suggestion I presented above is that a doctor may feel sufficiently less anxious about referring a patient for an abortion than about performing the abortion herself, *even if* in principle both she and we remain unconvinced that they are in fact morally different acts, a perspective I discussed in detail in chapter 6. That is a pragmatic compromise, and if it is philosophically shaky (as I have suggested), then its shakiness can be openly recognised by both sides without necessarily cancelling the anxiety-reducing effects of taking advantage of it. This is obviously less satisfactory than finding a philosophically robust shared moral principle that would bridge the impasse. But, given what has gone before, we are now at the point in the discussion where possible avenues for finding such a principle have been explored and most are dead ends. So a pragmatic solution that reduces the psychological harm to objecting doctors ought to be welcomed by both sides. We should not rule out, on sniffy philosophical grounds, helpful harm-reducing compromises.<sup>93</sup>

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<sup>93</sup> I'm grateful to Demian Whiting, one of my supervisors, for pressing this point in discussion.

# Some thoughts on the status quo

In this thesis, I argued first that there are good reasons to grant weight to doctors' personal moral objections to controversial procedures, and secondly that there are also countervailing considerations which must be weighed against those good reasons. Then I laid out various factors to take into account when trying to judge which way the balance might tip on any individual occasion. The upshot of all this is that, if I'm right, we will want to allow doctors to act on their moral objections in some circumstances, but not *all* circumstances. The decision will depend on the balance of factors at play in each case.

This is not a new conclusion. It more or less reflects the status quo in modern medicine, at least in most liberal Western societies. But that doesn't mean everything I've said so far has been pointless, for two reasons.

Firstly, as I hope I have demonstrated, the status quo itself is not settled. There are strong voices in the debate — in academia, public policy and wider society — arguing that we should respect doctors' objections more often than we do, perhaps even always. Other equally strong voices argue that we should respect them less often than we do, perhaps even never. When the status quo is itself controversial, a contribution which provides arguments in support of it can be just as significant as one which seeks to overturn it.

Secondly, when fundamental moral disagreements are this close to the surface of the policy landscape, even apparently simple changes can open unexpectedly huge sinkholes. For instance, in Canada, a recent Supreme Court judgement that legalised doctor-assisted suicide on constitutional grounds left politicians and healthcare workers alike scrabbling to reconstruct a consistent legal and moral framework for conscientious objection (Shaw & Downie, 2014; Trigg, 2017). When a part of the status quo collapses, an adequate understanding of how the rest of the structure holds together is vital to reconstruction. For that reason, even if all my conclusions are entirely conventional and apparently obvious, my work may nonetheless prove useful as an account of how those conventional and obvious conclusions have been built.

I hope I have made a useful contribution in both regards.

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