Science et Esprit

Science et Esprit

PHYSICIAN CONSCIENCE

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Volume 75, Number 2, May–August 2023

URI: https://id.erudit.org/iderudit/1098990ar
DOI: https://doi.org/10.7202/1098990ar

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Publisher(s)

Collège universitaire dominicain, Ottawa

ISSN

0316-5345 (print)
2562-9905 (digital)

Explore this journal

Cite this article

Sweet, W. (2023). PHYSICIAN CONSCIENCE. *Science et Esprit*, *75*(2), 237–251. https://doi.org/10.7202/1098990ar

Article abstract

In a number of jurisdictions in Europe and in North America, and particularly in Canada, the introduction and expansion of the conditions under which a patient may request euthanasia or assisted suicide – what is called, in Canada, 'medical assistance in dying' (MAiD) – has led to an increased concern about whether a physician may ethically refuse to perform such procedures – or, indeed, any legal medical procedure that lies within her practice. I argue that a physician may, sometimes, ethically refuse to perform such medical procedures. I begin with a clarification of some key terms: 'acting on conscience' (sometimes called conscientious objection), health, medicine, and 'the duty of the physician.' I then present some arguments to show that a physician is bound to provide medical care only under conditions entailed by or consistent with the aim of medicine. I consider some objections to this claim, and, then, show why these objections fail.

Science et Esprit, 75/2 (2023) 237-251

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In a number of jurisdictions in Europe and in North America, and particularly in Canada, the introduction and expansion of the conditions under which a patient may request euthanasia or assisted suicide – what is called, in Canada, 'medical assistance in dying' (MAiD) – has led to an increased concern about whether a physician may ethically refuse to perform such procedures – or, indeed, any legal medical procedure that lies within her practice. Some have argued that the obligation of physicians to provide patient care requires those who have the requisite medical competencies to provide procedures such as MAiD or, if they decline to do so as a matter of conscience, provide effective referrals to physicians who will.[1] Some, however, have gone further, to argue that all physicians who have been trained in the procedures or have this competency within their practice, should be willing and ready to provide it, and that refusals to do so based on conscience cannot apply.[2]

In this paper, I argue that a physician *may*, sometimes, ethically refuse to perform a legal medical procedure that lies within her practice. To do this, I begin by clarifying some key terms: 'acting on conscience' (sometimes called conscientious objection), health, medicine, and 'the duty of the physician.' I then present some arguments to show that a physician is bound to provide medical care only if, in her judgement, it meets the aim of medicine, namely treatment of disease and promoting patient health.[3] Next, I consider some objections to this claim, and, finally, show why these objections fail.

I. Clarification of terms

First, then, and before looking at arguments for ethical refusal to perform certain medical procedures, some terms need clarification.

To begin with, we need to give some thought to what "the aim(s)" of a physician – i.e., of a 'practitioner of medicine' – might be. A brief survey of

1. For example, Clarke 2017.
2. See, for example, Stahl and Emanuel 2017; Giubilini 2017; and Shanawani 2016.
3. In this paper, I leave aside the question whether activities such as performing abortions, MAiD, etc., are"treatments."

major medical dictionaries indicates that 'medicine' is "the art and science of the diagnosis and treatment of disease and *the maintenance of health*,"[4] "The art and science of *maintaining health*; recognising, understanding, preventing, diagnosing, alleviating, managing and treating diseases, injuries, disorders and deformities in all their relations that affect the human body in general,"[5] and the "*active maintenance of health* and the prevention and treatment of disease and illness."[6] Since medical dictionaries reflect at least a consensus, is not a normative view in the field, it is reasonable to say that the aim of medicine, therefore, is health.[7]

What, then, is 'health'? According to the World Health Organization, health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,"[8] and, more broadly, "the extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment."[9]

From the preceding brief descriptions, then, since the aim of medicine is health, the aim and the duty of a physician is to promote and maintain health – i.e., physical, mental, and social well-being through, for example, the management and treatment of illness and disease.

Finally, what is it to 'act on conscience'? Conscience has been understood in different ways, particularly in ethics, but one sense that is generally relevant to medicine – and, again, is recognized in medical literature – is that it is "the moral, self-critical sense of what is right and wrong"[10] and "the exercise and expression of a reflective sense of integrity, constitutive of reflection about the relationship between a specific course of action and a particular idea of the self and one's integrity."[11] I would re-express this slightly, as follows: that conscience is 'a judgement or an intellectual process of careful deliberation to determine what should be done or avoided in a concrete situation, involving objective practical principles known in us, as well as having a good will, practical experience, and as much relevant information as possible.' (While the term 'conscience' may also sometimes be understood as 'feeling deeply' or

4. *Dortland's Illustrated Medical Dictionary* 2012, p. 1119 (emphasis mine). See also *Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health* 2003.

5. Segen 1992 (emphasis mine).

6. *Tabers Cyclopedic Medical Dictionary* 2021 (emphasis mine).

7. There is, admittedly, ongoing discussion of the aims or goals of medicine in the scholarly literature. See, for example, Boorse 2016.

8. Preamble to the Constitution of the World Health Organisation, entered in force on 7 April 1948.

9. World Health Organisation 1984 / 1986. This description seems consistent with more recent definitions – e.g., "the capability of individuals, families, groups and communities to cope successfully in the face of significant adversity or risk" (Vingilis and Sarkella 1997).

10. *Mosby's Medical Dictionary* 2016, p. 425.

11. *Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health* 2003, p. 1100.

a 'personal moral code' or a subjective intuition, these would all be versions of moral subjectivism, and so have little normative role in ethics.) An act of conscience, then, is to act on that judgement. Conscience has long been regarded as a fundamental freedom and basic right, and has been explicitly recognised in many declarations and bills of rights.[12] 'Conscientious objection,' therefore, would be to object to or refrain from following a particular rule or acting in a certain way, based on a judgment of one's conscience.

Given this brief description of key terms, let us turn to the arguments, and begin to see why one might argue that a physician should be able, ethically, sometimes to refuse to perform a legal medical procedure that lies within her practice: because some medical procedures may not have health as their aim; because the judgment of what is appropriate treatment is a professional, medical judgment of the individual physician concerned; and particularly because physicians are enjoined to have this 'moral, self-critical sense of what is right and wrong' as part of their practice, and so must be allowed to exercise it. Physician conscience is part of practicing medicine ethically and, moreover and more profoundly, is an instance of the integrity and dignity of all human beings. I begin, then, by looking briefly at a recent article on physician conscience and, subsequently, build on it to develop further arguments for the ethical legitimacy of physician conscience.

II. Arguments

One argument for recognizing the role of conscience and 'conscientious objection' in medicine is that, as Christopher Cowley argues in a recent article[13], "there is a link between conscientious objection and the ideals of medicine that deserve respect"[14] – and, Cowley adds, that critics "err in seeing conscientious objection as no more than a self-serving non-moral aversion."[15] Cowley writes that the practice of medicine is not just a job or a service, and that the decision to seek to become a physician is often not just a choice or preference of one job among many possibilities. It is a vocation or calling wherein one has a deep

12. For example, in the Universal Declaration of Human Rights (UDHR) of 1948, the International Covenant on Civil and Political Rights (1966), as well as in national constitutions and bills of rights in countries such as Germany, Canada, and India, among many others. It is implied in the First Amendment to the Constitution of the United States, and appears explicitly in various drafts of that amendment (Sweet 2009, p. 5). See also Sweet 2022 and Schinkel 2007. Charles Malik, one of the principal architects of the UDHR, saw that conscience was not necessarily religious. Conscience is, more broadly, an 'inward freedom.' Malik held that "The human person's most sacred and inviolable possessions are his mind and conscience, enabling him to perceive the truth, *to choose freely* [emphasis mine], and to exist." United Nations, UN Doc. E/CN.4/SR. 14.

13. Cowley 2016.

14. Cowley 2016, p. 364.

15. Cowley 2016, p. 359.

conviction that one ought to care for and help others by doing what one can to treat disease and to promote and maintain health.[16] Moreover, being a physician is not a normal '9 to 5' job where one 'clocks in and out.' It involves more than fulfilling a contract for which one receives remuneration and promotion, and it has additional responsibilities. Cowley points out,

> some doctors (…) see their job as the *restoration* of health, as far as possible. [For example, when it comes to Physician Assisted Suicide,] [t]hey may reluctantly admit that the autonomous patient has a moral right to commit suicide (…). But as *doctors*, they will say that assisting such a suicide contravenes the ideal of medicine – an otherwise eminently plausible ideal – with which they identify.[17]

So, given their understanding of medicine and the ideals of the practice of medicine, and "out of respect for their concept of medicine" as the restitution of health, Cowley concludes that the conscience and views of these doctors "deserve accommodation,"[18] i.e., they should be allowed ultimately to determine how they will practice medicine, and, as the case may be, refuse to perform certain medical procedures.

Cowley also seems to offer a second argument – though he does not explicitly separate it from the preceding – that the recognition that "medicine is not a normal job"[19] brings with it a recognition of the importance of physician judgement – that the "well-established principles of clinical judgement and discretion" leave it "for the doctor to decide"[20] what is the most appropriate treatment. For example, when it comes to Physician Assisted Suicide (PAS), Cowley writes, it is up to the physician "whether PAS is or is not the most appropriate 'treatment' (…). Under the principle of medical discretion, therefore, the doctor can refuse to provide the PAS, and instead offer different treatments,"[21] such as palliative care and, if requested, palliative sedation.

Cowley acknowledges that some individuals may claim that they have a right to treatment, however he rejects this. He writes that people have a right *to attention*, but that it is up to the physician alone to determine *the treatment*. This is, to my mind, an important distinction. For example, suppose that I have congestive heart failure and I ask my physician for a heart transplant. I have, presumably, a right to be given attention – getting an appointment with her, discussing my condition, and so on. If, after examination, my physician determines that a transplant is the appropriate treatment or course of action, I may be put on the waiting list, etc. But if my physician judges that it is *not* the appropriate treatment, or at least not at this time, then she is not violating

16. Cowley 2016, pp. 361-362.
17. Cowley 2016, p. 363.
18. Cowley 2016, p. 362.
19. Cowley 2016, ibid.
20. Cowley 2016, p. 363.
21. Cowley 2016, ibid.

any so-called right to treatment, and she is under no obligation to put me on the transplant list.

Cowley concludes, then, that given the distinctive if not unique character of the 'vocation' of the physician, and given that medical judgement about treatment is part of the practice of medicine, physician conscience should be respected – specifically, that there is an "option of conscientious objection in medicine."[22]

It is, however, not all that clear that the need for allowing the exercise of physician judgement is sufficient for 'conscientious objection.' There need to be, then, other and stronger arguments to support physician conscience.

First, I would go further than Cowley about the issue of accommodating a physician's understanding of 'the nature of medicine.' It is not just because some physicians "understand" the aim of medicine as "the promotion of health" that their view merits respect. This is too subjective. It is that the nature of medicine itself traditionally has been (and is in documents such as ethics codes, statements from the World Health Organization, and so on) 'aiming at health and the treatment of disease.' It is not just that we should 'tolerate' a personal conception of medicine coming from some individuals who feel called to a particular profession; it is what medicine traditionally has aimed at, and is still generally regarded as aiming at. Thus, the physician who acts on her conscience and declines to perform a "medical" procedure may be doing so because *it is simply not part of medicine* to do so, not just because it is not part of how she "understands" medicine.

A second argument can be drawn from the importance of recognizing the physician as a moral agent. It is by no means a new argument that all individuals have a right, and perhaps even an obligation, to act in ways that enable their development as moral agents and to develop basic virtues,[23] and this is also something that is recognized in codes of ethics and professionalism such as that of the Canadian Medical Association.[24] For individuals to have the opportunity to develop that agency, they must be authors of their own moral action. Thus, the profession of medicine must respect the physician as a moral agent, particularly within their sphere of practice.

A third – and, on my view, the principal – argument for the ethical relevance of physician conscience focuses on the activity of a physician. Now, it is important to distinguish between the 'profession' of medicine and the

22. Cowley 2016, p. 359.

23. For example, Kant recognises that, for a person developing his good will, if he is to be logically consistent, all human beings must be given an opportunity to develop such a will. Thus, Kant writes: one should "Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end." Kant 1964, p. 96. [AK. IV 429].

24. See, for example, the list of virtues, responsibilities, and commitments enumerated in the Canadian Medical Association Code of Professionalism and Ethics.

'practice' of medicine. For most of human history, the practice of medicine has not been licensed. While there was, for example, in many places in 'the Western world,' a code or oath (such as the Hippocratic Oath) that, in a sense, governed medicine, there was no licensing and enforcement mechanism until about the 16th century,[25] and even then not systematically. One can, and perhaps should, talk of 'the practice of medicine' as distinct from 'the medical profession' (i.e., being licensed).

What is it to 'practice medicine'? It is not just a matter of being able to engage in certain activities that promote health and treat diseases. It is to engage in "the art and science of medicine,"[26] and this means in light of certain values, principles, and virtues.[27] These values are recognized explicitly in medical codes of ethics, such as the *Canadian Medical Association Code of Ethics and Professionalism*.[28] These values, which govern and should influence medical practice, include "the wellbeing of the patient"; to "prevent or minimize harm"; "dignity" and "respect [for] the equal and intrinsic worth of all persons"; the "autonomy of the patient"; "integrity"; "personal health and wellness"; ensuring "meaningful co-existence of professional and personal life"; and "physician health and wellness." Thus, physicians are instructed to: "Act according to your conscience"; "cultivate (…) physical and psychological safety"; "communicate information accurately and honestly"; show "civility"; "never participate in or condone (…) any form of cruel, inhuman, or degrading procedure"; support patient empowerment; and fulfill a "duty of confidentiality," "of loyalty," and of "non-abandonment [of] the patient."[29]

To be a physician, then, is not simply being able to perform certain kinds of medical services and interventions, as a mechanic would "service" an automobile. It is to perform these services within a broader context of values, principles, and virtues, and to show professional and personal integrity, in a way that respects one's dignity.

This notion of 'integrity' is key to the practice of medicine and, more broadly, to acting ethically in general. Integrity is not, *pace* Cowley, 'a desire not to "feel guilty."'[30] This is to trivialize integrity. One definition of integrity, found in the *Code of Ethics for Registered Nurses* (Canada), is: "adherence to moral norms that is sustained over time. Implicit in integrity is soundness,

25. In the United States, states began to license physicians starting in the 1800s. See Chaudhry 2010, p. 1657. Among the earliest such licensing institutions in Europe were The Royal College of Physicians in London (1518), The Royal College of Physicians in Edinburgh (1681), and The Royal College of Physicians in Ireland, founded in Dublin in 1654.

26. See the *CMA Code of Ethics* (2004/2015 version).

27. Sweet [forthcoming].

28. *CMA Code of Ethics and Professionalism* (2018).

29. *CMA Code of Ethics and Professionalism* (2018).

30. Cowley 2016, p. 360.

trustworthiness and the consistency of convictions, actions and emotions."[31] This emphasis in integrity on "consistency" is not just that one is expected to act consistently in one's professional work, but that one acts in a way that is consistent with or coherent with *other* values – such as the dignity of the patient and of the physician. For integrity means "the state of being whole, entire, or undiminished."[32]

Integrity is essential to the practice of medicine, and is recognized, for example, in the codes of ethics of various medical and health care professionals.[33] Yet this is not just integrity in 'professional' activity, independent of the rest of one's moral life. While many values in the CMA Code focus on responsibilities to others, integrity emphasizes a responsibility to oneself *and* to others; all of us, including physicians, are ethically required to seek to be people who are 'whole.' It is difficult to conceive how there can be a genuine integrity where one's professional values are different from one's personal values. Forcing one to separate the values of one's profession from a 'personal' endorsement and commitment to them is not acknowledging or respecting that person's integrity.

Integrity, then, is or seeks a wholeness or consistency in oneself. Integrity requires being the author of one's moral conduct (i.e., autonomy), acting in a way that is consistent with one's obligations and moral values, and being ready to take responsibility – and, in doing so, standing up for one's values and, ideally, exhibiting and articulating how one acts on one's obligations. This may involve acting courageously, 'setting a standard,' and supporting others.

A person of integrity, then, is not simply one who has certain opinions or personal preferences, but who must determine and articulate *for oneself* these principles and values – i.e., what Charles Taylor calls one's 'core convictions,' those convictions around which one centres one's life and which are important or central to the meaning of one's life – *and* to act on these convictions.[34] In other words, one must have an opportunity to form, and act on, one's *conscience*. Having the ability to form one's conscience is essential to integrity.[35]

Integrity and conscience, then, are not matters of merely making choices, but of who a person is. A violation of one's wholeness, one's integrity – so that a person is 'just follows orders' and takes the line of least resistance – is forcing one to surrender one's 'authorship' of moral conduct.

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31. *Code of Ethics for Registered Nurses*, p. 49, citing Burkhardt, Walton, and Nathaniel 2010.

32. "Integrity," *Dictionary.com* [n.d.].

33. For example, see *Code of Ethics for Registered Nurses*, p. 7, 16, 23.

34. See Taylor and Maclure 2011, p. 96.

35. This idea of conscience, required if one is to be true to oneself, is not just a 'Western' idea. It is suggested, for example, in the text attributed to Confucius called *The Analects*: "What is called a great minister is one who serves his prince according to what is right, and when he finds he cannot do so, retires." [*The Analects*, Book XI, Hsien Tsin, Chap. XXIII]

The importance of integrity and conscience is supported by the most recently revised codes of medicine and professionalism. While codes by themselves are not, of course, absolute, they are an indication of where the profession of medicine stands – and the CMA Code, for example, insists that a physician show integrity, act according to one's conscience, and ensure the meaningful co-existence of professional and personal life. It does not, moreover, say that society can force a physician to act against what medicine aims at, or even against the understanding of many physicians of what medicine aims at. Thus, out of respect for a person's integrity, one should seek to accommodate, and even celebrate, a physician's integrity.

The value of the dignity of the physician is also relevant here. To oblige one to act against or in violation of one's conscience and one's medical judgment, is not just to undermine one's status as a moral agent. It is to treat the person as an object. At the core of dignity is the notion that one is not to be used merely as a means, merely as a thing, but always as an end in oneself. To not recognize the conscience of a person, and to require her to act without reference to, or against her conscience, is a violation of her dignity. Recognizing physician conscience is part of recognizing a person's dignity.[36]

III. Objections

A number of authors have challenged this view, insisting that there should be no 'conscientious objection' in medicine.[37] Julian Savulescu, for example, writes that "When the duty is a true duty, conscientious objection is wrong and immoral. When there is a grave duty, it should be illegal. A doctors' conscience has little place in the delivery of modern medical care."[38] He concludes that "Doctors who compromise the delivery of medical services to patients on conscience grounds must be punished through removal of licence to practise and other legal mechanisms"[39] and, further, that "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."[40]

What arguments can one offer for this view? I want to look at *four* arguments – four arguments mentioned, directly or indirectly, by Savulescu, but also repeated in various forms by others[41]: that conscientious objection in medicine is unjust, inconsistent, violates a physician's 'commitments,' and

36. See Malik in United Nations 1947 (UN Doc. E/CN.4/SR. 14). See Sweet 2009.
37. Savulescu 2006. See also Giubilini 2017; Schuklenk 2015.
38. Savulescu 2006, p. 294.
39. Cowley 2016, p. 296.
40. Cowley 2016, p. 294.
41. See note 36, above.

goes against what physicians are supposed to do. The argumentation provided by Savulescu, however, is sometimes unclear, and requires some unpacking.

First, Savulescu says that conscientious objection "introduces inequity and inefficiency." It is inefficient because, he claims, a physician who refuses to provide a medical service that is "legal, beneficial, desired by the patient, and a part of a just healthcare system"[42] obliges those requesting that service to "shop among doctors to receive [that] service to which they are entitled." This, Savulescu writes, wastes resources and, thereby, is inefficient. It is also inequitable, he writes. Since some patients will not 'shop' around, and may not know that they can shop around, he concludes that they are being treated inequitably.[43]

Such an argument is opaque and question-begging. Not only are inefficiency and inequity vague concepts here – inequity suggests treating people differently for arbitrary reasons, and there is no support for this in Savulescu's example – but it is not clear that 'efficiency,' for example, is always a relevant or a positive value. At the very least, the moral weight of efficiency or inefficiency depends on another principle. For some, it may be more efficient to put suffering people to death than to treat them, but it is far from obvious that this 'efficiency' is ethical. Similarly, the fact that some patients may seek to consult another physician while others do not, does not entail that those who do not have been treated inequitably. Further, even if it can be established that the majority in a society is indifferent or opposed to certain acts of conscience, it does not follow that 'minority rights' or the reasonable claims of the few do not trump the views of the majority. Sometimes, one is ethically obliged to defend values such as the dignity and integrity of minorities. Indeed, Savulescu himself later concedes as much. For he writes that, "When a doctor's values can be accommodated without compromising the quality and efficiency of public medicine they *should*, *of course*, be accommodated."[44] That he writes that conscientious objection in such a context "should, of course" be accommodated is striking. This suggests that *some* (minimal) 'shopping around' and some (minimally inconvenient putative) 'inequity' are ethically allowable even on his own terms.

Second, Savulescu says that conscientious objection is inconsistent. He suggests that it leads to cases where a physician simply prefers personal values and self-interest over the values of, and obligations to, the practice of medicine. Yet the illustrations that Savulescu gives do not show that there is an inconsistency between what a physician is (according to medical standards or medical practice) supposed to do – e.g., 'provide care' – and what conscientious objection putatively allows her to do, sc., *not* 'provide care.' Nor do they

42. Savulescu 2006, p. 295.
43. Savulescu 2006, ibid.
44. Savulescu 2006, p. 296, emphasis mine.

show that a physician cannot – according to longstanding medical practice – appeal to 'self interest and self preservation' in refusing to treat a patient, and that conscientious objection is precisely that – simply a matter of self interest and self preservation.[45] The putative inconsistency is, rather, that to act on one's conscience is 'inconsistent' with the fact that "society has deemed patients are entitled to treatment"[46] that the physician refuses to provide. This is 'inconsistent,' however, only if medicine is defined as 'providing all those services to patients of which that society approves' – and this is implausible for the reasons outlined at the beginning of this paper.

A third objection to physician conscience is that appealing to conscientious objection violates a physician's professional commitments; Savulescu writes that "To be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system"[47] – that if one is a physician, then one must provide such services. So, Savulescu suggests, refraining from providing a certain legal service, one is acting against the commitments that are part of being a physician.

I have argued against this objection earlier in this paper. There is, I pointed out, more to being a physician than being one who performs "medi-

45. Savulescu writes that 'self interest and self preservation' are not sufficient grounds for conscientious objection – and here he is at least misleading, if not simply incorrect. First, it is true that a physician may have responsibilities that go beyond the responsibilities of an average employee, and that in such cases it means that a physician would have to engage in what for other people might be very risky – as a soldier or a lifeguard or a teacher might have certain responsibilities that entail certain risks or greater than average expectations. Still, there are limits to the risks that one might take, and codes of ethics are very clear about this. (Of course, one may well challenge these codes; my point is that this is how the profession sees itself, and if Savulescu wants to say that: '"to be a doctor is to be willing and able to" do X' – presumably, a descriptive claim – then one has to see what descriptive claims are, in fact, true about 'being a doctor.') Thus, among the descriptive claims found in codes of ethics, such as the CMA Code, are that a physician is one who [should] "Value personal health and wellness and strive to model self-care"; "Act according to [one's] conscience"; "Be aware of and promote health and wellness services, and other resources, available to you and colleagues in need"; "Seek help from colleagues and appropriate medical care from qualified professionals for personal and professional problems that might adversely affect your health and your services to patients," and so on – and not simply be ready to do all except what is "a grave risk to a doctor's *physical* welfare" (Savulescu 2006, p. 295, emphasis mine). Part of being a physician is to 'care for oneself.' Such 'self interest' is a good, 'secular' value.

Second, it may be that a physician puts herself into very risky situations – dealing in emergency situations where there is a risk to one's own life. But such actions are not necessarily part of one's "duty"; they may be supererogatory. Admittedly, if one has already assumed care for someone – i.e., that a patient is *her* patient – one may already have a *special* obligation to that *particular* person; the CMA code of ethics notes that there is a "duty of non-abandonment to the patient." Of course, even this duty is not absolute, and has its limits – e.g., a physician is obliged to provide services unless "these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship."

46. Savulescu 2006, p. 295.

47. Savulescu 2006, ibid.

cal interventions." There are values, including obligations to oneself, that one must respect, and these obviously bear on the when and how and to whom a treatment is offered. Moreover, even if one has an obligation to provide certain "appropriate medical interventions," who determines the appropriateness of the intervention? Normally, it is the attending physician herself; this is the issue of (autonomous) physician discretion and judgement, referred to earlier. Indeed, this is not 'conscientious objection'; it is professional medical judgement.

There is, however, one further important objection, which Savulescu only hints at, but which underlies his ultimate argument. His view seems to be that to be a physician is, fundamentally, to be a public servant. He would say – and indeed some opponents of conscientious objection would argue – that a physician is providing a public service and that "public servants must act in the public interest not their own."[48] Now, this claim is ambiguous. In one respect, the term 'public servant' means 'one who serves the public, i.e., who serves others in the community,' which a physician obviously does. But, in another respect, it means one who has a place in the public service; this is particularly the case in a healthcare system that is (entirely?) publicly funded. It seems that Savulescu sees the physician in this latter, and not primarily in the former sense. Thus, he concludes that, since the job of a physician (as noted above) is to provide a 'legal, beneficial, desired' service, to refuse to do so is to refuse to do what an employee is supposed to do – i.e., do what they were hired to do – and, this refusal, Savulescu claims, is not justifiable.

Here, Savulescu, intentionally or not, misses a key point: i.e., that the physician serves the public by being a physician and carrying out the duty of a physician, and not primarily by being a 'civil servant.' It is true that the physician, in a publicly funded health care system, has the obligations of an employee, but it is *as a physician*. How one works as a physician is not 'in one's own interest,' but is dependent on what it is to be a physician – and on the aim of medicine. Many physicians who work in a publicly-funded system, may be employees, *de iure* or *de facto*. But Savulescu conflates 'physician' with 'an employee trained in medicine working in a state-funded health-care system.' To illustrate this point, consider the following example. Suppose that you are a trained biology professor looking for employment, that there is no significant need of biology professors, but that those biology departments that are hiring professors hold that certain races or certain genders are inferior to others. You accept a position. What is your duty as a biology professor? Is it to teach biology, or to teach the racist and sexist version of biology preferred by your fellow biology professors? Presumably your duty as a biologist and as a biology professor is to teach what biology is, not racist or sexist views. Similarly, just

48. Savulescu 2006, p. 297.

as a biology professor should not be forced to teach a particular ideological view, so a physician should not be forced to provide services that she judges are inappropriate or wrong. The function or service of a physician is to be a physician, not to be a mere employee or public servant.[49]

Conclusion

If we are attentive to what terms, such as 'medicine' and 'health,' mean, what it is to speak of 'practicing medicine,' what it means to 'act on conscience,' and what 'the aim' and 'the duty of the physician' are, it seems clear that a physician *may*, at least sometimes, ethically refuse to perform a legal medical procedure that lies within her practice. I have argued, as Cowley appears to argue, that a physician is bound to provide medical care only if, in her judgement or understanding, it meets the aim of medicine, namely treatment of disease and promotion of patient health. I have also argued, however, that, regardless of one's "understanding" of the aims of medicine, if it is inconsistent with what 'medicine' means, or if it violates a physician's moral agency, or if it undermines a physician's professional judgment, or her integrity, or her dignity, she may ethically refuse to consent to performing such procedures. Some objections to this conclusion seem to focus on claims that refusing to perform presumably all legal procedures within one's competences, is unjust, is inconsistent, violates physician commitments, and is incompatible with the role of a physician as a 'public servant.' These objections, I have argued, are either too vague, fail to recognise the proper place of autonomous medical judgement, or misunderstand the role of a physician as a physician. It is clear, then, that a physician may sometimes – such as in the case of MAiD – ethically refuse to perform a legal medical procedure that lies within her practice.[50]

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49. I wish to make one final point; the term 'conscientious objection' is generally a misnomer. For example, refusal to provide MAiD is not to 'conscientiously object' because, first, in most if not all jurisdictions, there is no legislation that a physician must provide this. So for a physician to decline to yield to Savulescu's insistence that she perform procedures which she, for reasons of conscience, refuses to do, is not for her to 'object' to a law, for there is no such law; the refusal is simply an act of conscience. There is, admittedly, in some jurisdictions, a requirement that physicians who cannot, or who do not wish to perform certain procedures make an 'effective referral' to a physician who will – but this is a requirement of the licensing body, not of society or the state. What the ethical justification of certain Colleges may be for making such a requirement is unclear, but it cannot plausibly be that "society" demands it. More precisely, then, a refusal to perform or to refer is simply an act of conscience, just as any act or refusal to act is one that has a moral character.

50. I am very grateful to the two referees for this journal for their comments and suggestions.

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SUMMARY

In a number of jurisdictions in Europe and in North America, and particularly in Canada, the introduction and expansion of the conditions under which a patient may request euthanasia or assisted suicide – what is called, in Canada, 'medical assistance in dying' (MAiD) – has led to an increased concern about whether a physician may ethically refuse to perform such procedures – or, indeed, any legal medical procedure that lies within her practice. I argue that a physician may, sometimes, ethically refuse to perform such medical procedures. I begin with a clarification of some key terms: 'acting on conscience' (sometimes called conscientious objection), health, medicine, and 'the duty of

the physician.' I then present some arguments to show that a physician is bound to provide medical care only under conditions entailed by or consistent with the aim of medicine. I consider some objections to this claim, and, then, show why these objections fail.

SOMMAIRE

Dans un certain nombre de juridictions en Europe et en Amérique du Nord, et particulièrement au Canada, l'introduction et l'élargissement des conditions dans lesquelles un patient peut demander l'euthanasie ou l'aide au suicide – ce qu'on appelle, au Canada, « l'aide médicale à mourir » (AMM) – a mené à une inquiétude accrue quant à savoir si un médecin peut refuser éthiquement d'effectuer de telles procédures – et, en fait, toute procédure médicale légale qui relève de sa pratique. Je soutiens qu'un médecin peut parfois, sur le plan éthique, refuser d'effectuer de telles procédures médicales. Je commence par une clarification de quelques termes clés : « agir en conscience » (parfois appelé « objection de conscience »), santé, médecine et « le devoir du médecin ». Je présente ensuite quelques arguments pour montrer qu'un médecin n'est tenu de fournir des soins médicaux que dans des conditions entraînées par, ou compatibles avec, le « but » de la médecine. Je considère quelques objections à mon argument, et, ensuite, je montre pourquoi ces objections s'avèrent défectueuses.