Special Section: Conscientious Objection in Healthcare: Problems and Perspectives

Conscientious Objection and "Effective Referral"

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Abstract: Complicity in an immoral, and even criminal, activity, such as robbery or murder, is itself regarded as involving responsibility for those acts. What should the position be of health professionals who are expected to participate in actions that they believe are morally wrong? Professional responsibilities may clash with private conscience. Even referring a patient to someone else, when what is in question may be assisted suicide, or euthanasia, seems to involve some complicity. This is a live issue in Canada, but similar dilemmas occur elsewhere. Physicians and others should not be coerced into involvement of any kind in what they regard as wrong. Such coercion goes against the very principles of liberal democracy. Conscience matters. Reasonable accommodation should be given to those whose moral judgment may be at variance with prevailing professional norms. Moral questions should still be given weight within medicine, and disagreements respected. Dedication to the promotion of human welfare should be paramount, but it should be recognized that there may be different visions of what such welfare consists of.

Keywords: conscience; referral; complicity; assisted dying; moral disagreement; exemptions; reasonable accommodation

The Problem of Complicity

Two bank robbers enter a bank, armed and seemingly prepared for violence. They start to seize cash but a bank clerk makes a break for it to raise the alarm. "Shoot him; I can't," shouts one robber to the other. The clerk is shot in the back by the second robber and killed, but both robbers are later apprehended. This seems to be a good case for them being found equally guilty of murder, whether the reason for the first robber not shooting was that his gun had jammed or that he could personally not bring himself to kill somebody in so cold-blooded a way. Both men were equally involved in a conspiracy. Certainly, it is hard to see much difference from a moral point of view between killing somebody and shouting to somebody else to do it for you. The intention is the same; namely, that somebody be killed.

This raises the whole question of complicity in, and shared responsibility for, actions that some may find morally objectionable. It is often held in medical ethics that respect for somebody's conscience is important; but that it is met by simply allowing medical professionals not to participate directly in practices they view as morally wrong. Even this much can be contested, in that some would hold that it is part of the duty of health professionals, at least in a National Health Service, to abide by the law, and to provide publicly agreed-upon services. Professionals should not, it will be said, let private opinions intrude into their public duty. Rights of conscientious objection that appear to allow the arbitrary opting out of public duties seem to undermine the possibility of a consistent delivery of a service that the public might have a right to expect.

The contrast between private and public already sets up the right to make a conscientious objection in a contentious manner. The suggestion seems to be that the views of one practitioner can be set aside in the interests of the will of the majority.

Cambridge Quarterly of Healthcare Ethics (2017), **26**, 32–43.

doi:10.1017/S0963180116000633

The stress on public reason and political philosophy, popularized by John Rawls, has the immediate effect of concentrating on the agreement of the majority and on what is accepted as reasonable in the public sphere. Private opinions that diverge and may not easily be reconciled with publicly acceptable norms can be set aside as idiosyncratic. The idea of conscience can be seen as essentially private, and irrelevant to public discussion. What cannot gain majority acceptance, or perhaps be scientifically verified, can be dismissed as a matter of personal "values." That immediately discounts the possibility that claims about what is right or wrong, good or bad, may themselves be claims to truth about the human condition, rather than the mere expression of personal attitudes and preferences. If we truly respect the beliefs of those who see something wrong in certain practices, particularly when human life is at stake, we cannot dismiss them out of hand.

Recent developments, particularly in Canada, put the question of a private conscience firmly on the political stage. In 2015, for example, the College of Physicians and Surgeons of Ontario issued a new policy approved by their Council.[1] It proved controversial in that, although it respected the right of physicians not to participate in medical practices of which they disapprove, for reasons of conscience or religion, it demanded that they make an "effective referral" to other physicians who would provide the service. An effective referral was defined as "a referral that is made in good faith with a view to supporting, not frustrating or impeding, access to care." This begs an important question as to what constitutes proper "care." It assumes that the view of the majority, perhaps as expressed in legislation, defines what good care must be. The implicit assumption is that conscience may be an inconvenient fact about an individual, but gives no information about what really ought to be done.

Many have little patience with the refusal of some professionals to do what could be regarded as part of their job. Perhaps as a matter of practical politics, if not of principle, they should not be coerced into doing what is repugnant to them, because they may not do it very well. It seems better to avoid trouble and to let them pass on the duty to a colleague. The attitude that the professional must be prepared to refer the patient to an unobjecting physician is fairly widespread. If too many physicians are unwilling to do that, it will be difficult to provide the service. One article on the subject suggests[2] that "where a colleague is not reasonably available, or...the patient's vital interests are at risk, then the objector must provide the contested service." The writers consider that complicity admits of degrees, so that referring patients to somebody else implicates physicians less than if they perform a particular service themselves. Our bank robber example, however, might suggest that that is not a clear-cut issue. In any case, it is accepted that there is still complicity in what may be seen as a horrendous evil by some physicians; however, the obligation to provide the service must, it seems, in the end prevail.

The writers have a simple solution for those with a tender conscience who might resist such coercion. Just because the professional obligation remains, they say of a physician who is reluctant to engage in certain procedures[3]: "She can, just as she freely joined, freely leave the profession." They further add that "by remaining, the professional must accept that sometimes, patients come first." That remark, however, continues to beg the question at issue as to what is in a patient's interest. It is easily made when conscience seems a mere matter of personal preference,

rather than a source of moral insight into particular issues. In contentious ethical cases, what is difficult is not that I may be coerced into doing something I may not feel like doing or want to do. The issue is not about me. It is about whether what is proposed is ethical, and that should be about whether it really does further the interests of the patient. The argument is not about making people do things they do not want to do. It is about what it is to flourish as a human being, and that carries implications about how humans should be treated. Whether the question is, for example, the availability of contraception to 12-year-old girls, or the performing of an abortion, different conceptions about what is good for people can come into play. Such conceptions may be independent of any religious views, and cannot be dismissed as irrelevant.

Nowhere is this more the case than in a current issue of great ethical dispute, the provision of assisted dying, whether through assisted suicide or voluntary euthanasia. Physicians who have dedicated themselves not only to the avoidance of human suffering, but also to the preservation of human life, may find that being called on to be involved in the deliberate ending of a life is as reprehensible as any shooting by a bank robber. It would seem to them to be deliberate killing—murder—and that crosses a line that many physicians feel should never be crossed. The idea that human life is expendable in this way could to some seem to change the focus of medicine.

This is not the place to expand on the complex issues involved here, particularly those posed by a collision between the utilitarian desire to minimize suffering, and the deeply entrenched moral view that human life is intrinsically valuable. There are honourable arguments on both sides and the ethical issues around them are undeniably contentious. That this is so, is precisely the point. This is an area of sincere moral disagreement, very often stemming from different worldviews. They each deserve not only to be heard, but to be respected, and respecting them means taking their argument seriously. A democratic society depends not only on majority opinion, but also the reasoned reflection of all its citizens in coming to that judgment. Extinguishing the views of the minority on the grounds that they have lost an argument is hazardous. It does not only cause political unrest, but also shuts off a source of moral strength and wisdom for the future. Just because we may not agree with someone else does not mean that they may still not have important insights to offer. They may even change our minds in the future.

Conscience and "Assisted Dying"

The archetypal example of conscientious objection that has, over the years, gained acceptance is that of objection in time of war. Conscientious objectors have often engendered resentment in wartime on the grounds that they are shirking the proper defense of their country. For that reason, their duties as citizens have had to be reconciled in some way with their reluctance to do what they regard as intrinsically wrong; namely, take another human's life. Although their judgment may be questioned by many, however, particularly in times of national peril, their stance still points to the essential value of human life and is a salutary reminder that no one should ever hold human life to be unimportant. A nation would be the poorer without those willing to take such a stand in time of war, even if most people feel deeply that those who do that are wrong.

Each side of the argument about assisted suicide and euthanasia insists on something important. All human life matters, and it should be repugnant to end any life too easily. Human suffering is also of moral importance and must never be disregarded. At the very least, proper palliative care is essential. The problem is how to balance these two objectives, and when solutions vary, little is achieved by assuming that concern for the patient's interest is only the property of one side of the debate. Further, if a mere consumer-oriented view arises that the patient's autonomy and right to choose overrides everything else, the ethical judgment of physicians, in this case all of them, is being put aside. The question is again being begged, by assuming that the patient's judgment and preferences are all that matters. The issue becomes particularly confused when this takes place through an appeal to rights, which themselves are thoroughly ethical concepts. It sometimes seems as if all ethical judgments are made to be subjective, and the preserve of each individual, in the name of a view of rights. However, such rights can only claim authority if they have an objective, or interpersonal, validity. Subjectivism then seems to be validated through appeal to a particular view of what is important morally from an objective perspective. The contradiction is obvious.

This all came to the fore in 2015 with the judgment of the Supreme Court in Canada, *Carter v. Canada*.[4] Assisted suicide is a vexing and controversial issue in many countries, and a subsidiary issue must be whether its legality should be decided in the courts or in a parliament. In the United Kingdom in September 2015, the House of Commons by a three to one margin decisively rejected the legalization of assisted suicide. In Canada, however, the Supreme Court put aside all precedents and ruled in favor of decisions about assisted dying[5] by "competent adults who seek such assistance as result of a grievous and irremediable medical condition that causes enduring and intolerable suffering." It reasoned[6] that the right to life does not create a "duty to live," and that a patient's dignity and autonomy must be respected. In effect, the autonomous choice of an individual is made the fundamental good, more important than the good of life itself. Clearly the Court has come down on one side of a complicated philosophical debate. To summarize two of the various possible positions in play, a liberal will maintain the absolute priority of individual choice, whereas, to take another example, a believer in natural law will maintain that certain actions, such as the deliberate ending of human life, are intrinsically evil.[7]

It is the role of a pluralist democracy to allow such issues to be debated, and to provide mechanisms that determine what should be done. Making personal autonomy the central criterion is one way of leaving controversial issues to individual decision. Whatever seems right and good to a person is so for them. The subjectivism of this is clear; however, it suggests that even if someone's moral view about what is good is thought to be a matter only for that person, it has to be respected. A moral conscience is important to someone who is a subjectivist about morality, even if it is thought that such views or preferences tell us nothing about the world, but only say something about the person's moral integrity. The emphasis on autonomy and dignity that leads to the approval of an issue such as assisted dying must also lead us to respect the demands of anyone's moral conscience, in whatever direction it leads.

The emphasis on autonomy and dignity as ends to be pursued must be far from any subjectivist notion, as it lays down standards that are meant to apply to everybody. My autonomy does not give me a right to ignore the right of others to

autonomy or dignity. Appeals to such rights, like all appeals to human rights, assume the existence of objective standards that all must accept. The exercise of conscience implies the obligation to respect the conscience of others. This inevitably leads back, in the case of moral disagreement, to discussions about what is intrinsically good and right. It is the cornerstone of all democracy to foster and cherish everyone's views about this. Decisions about what has to be done must be made. That does not mean that the consciences of those on the other side of the debate can be held to be of little account. Minorities can become majorities, and democracies flourish when received opinions are questioned so as to be reinforced or replaced.

One line of argument in this context, is to juxtapose the obligations of a profession with public responsibilities with what are alleged to be the private preferences of individuals. Jonathan Montgomery writes[8] on the conflict, as he sees it, between personal and professional ethics, and between what he terms "personal belief" and "public roles." He sets up as an exemplar[9] "the principles explored in the case of civil registrars who have objections to the evolution of legal definitions of marriage." This is hardly a happy precedent, as in such cases[10] principles of conscience are often simply trumped in the courts, in a manner that has aroused great controversy, but that is in the interest of implementing the demands of public policy. The balancing of deeply held convictions of what is good and bad for society with publicly agreed-upon policies cannot be properly dealt with by ignoring the former. There should be room for reasonable accommodation[11] of conscience. Not all claims of conscience can be accepted, if we are to live together, but that does not mean that none should be, particularly in matters of life and death. When, too, Montgomery contrasts[12] "personal moral agency" with "the special status of professionals," he must remember that professions gain their authority not only because of technical expertise, but also because of their grounding in a moral outlook. Professions without a moral anchor will be a danger to their society, and in the end will lose respect. Bankers provide a recent example of this process.

In Canada and elsewhere, when decisions are made about "physician assisted dying," it must be part of the democratic process not only to listen to dissenting voices, but also to realize that with fundamental moral issues, particularly about life and death, the losing side in the debate must not be compelled to do something that it regards as utterly wrong. In the case of the Canadian Supreme Court, there is a cursory reference at the end of their judgment[13] to the fact that "a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief." The court concludes that the rights enunciated in the Canadian Charter of Rights and Freedoms will need to be reconciled. They leave this to legislators and regulators.

One contribution to the debate was sketched by a team of academics from philosophy and law who tried to deal with the moral and legal dimensions of conscientious refusals in healthcare. They recognized [14] a right "to decline to provide legally permissible and publicly funded health services if providing their services violate their freedom of conscience." The sting comes in the next sentence. We are told of physicians who "in such situations…must make a referral to another healthcare provider who is willing and able to accept the patient and provide the service." Such effective referral may seem, however, to make the physician complicit in what is euphemistically called "the service." This hearkens back to the bank robber scenario. Is the robber shouting "Shoot him!" any less guilty of killing

than the accomplice who pulls the trigger? Are physicians who ask colleagues to assist patients to die, perhaps even by deliberately killing, any less guilty because they have apparently kept their own hands clean? If physicians who refer feel complicit, and their conscience forbids them to act accordingly, that should be a major factor in the situation.

The subjectivism, even incipient nihilism, that we have remarked on, is apparent in the approach being suggested to Colleges of Physicians and Surgeons. Physicians, it is said, must never suggest that their own moral views are more important than those of their patients, nor, more significantly, should they be allowed even to express them. It is stated,[15] in language that is becoming more common, that "physicians must not communicate or otherwise behave in a manner that is demeaning to the patient to the patient's beliefs, lifestyle, choice or values." Physicians are not allowed to talk freely to their patients about the ethical issues involved. Their views, it seems, may be an idiosyncrasy that may be tolerated but are by definition irrelevant to the interests of the patient. Physicians must be silenced. It is a parallel situation to the more general demand that religion, and religious influence, be driven out of the public square.[16] However, conscience covers an even wider category than religion. There is no reason why it should be assumed that anyone who sees human life as intrinsically valuable, and not to be destroyed, necessarily believes that for religious reasons. For some, it could be the cornerstone of a humanist philosophy.

The Coercion of Conscience

Many think that the obligation to refer fully respects conscience. The proposed policy, however, often does not stop there. There may be times and places when, for various reasons, there are no other physicians or others who are ready and able to do what is necessary. What should happen then? The proposed policy is clear that as the delivery of the publicly agreed-upon "service" is a priority, it must be made clear[17] that "physicians must provide the patient with all health services that are legally permissible and publicly funded." Physicians' consciences are then to be ignored in pursuit of public policy. The draft proposals explain[18] that "this obligation holds even in circumstances where the provision of health services conflicts with physicians' deeply held and considered moral or religious beliefs." The whole tenor of the proposal is to refuse to take seriously the objections of physicians to whatever procedure is being forced. It is presupposed that once rules have been set or laws have been enacted, they have to be enforced without exceptions, using coercive means if necessary. The brushing aside of serious conscientious objection never makes for good law in a free society. A solution might be to write exceptions into a professional rule, or law, before it is passed. In this case, however, the general message is reinforced by the ensuing statement that "failure to meet the obligations set out in this policy constitutes professional misconduct," and that as a result, physicians will be subject to discipline. Those who refuse to toe the line may lose their jobs, which betrays a lack of any genuine respect for conscience. The refusal to take a reluctance to refer seriously is but part of a more general dismissal of conscience when recognizing it becomes inconvenient.

This is a common view. An article on conscientious refusal in healthcare makes this crystal clear, when it declares[19]: "Where the dictates and prescriptions of religion make demands upon the faithful that would be dysfunctional in the particular

professional setting, and where a particular individual feels unable to deviate from those prescriptions, it does not seem unreasonable to require of her that she practice a profession that can more easily accommodate the demands they place on her." Anyone with a conscience that diverges from current fashions in the medical profession has, it seems, no place in medicine. Ethical judgment must be placed on one side to deliver whatever the law permits.

When there is a difficulty in providing a particular service because of the number of physicians refusing to participate, that fact itself must be significant. Laws that are passed that are unenforceable because of conscientious objection are not only ineffective. There also must be something wrong with a society requiring a practice repugnant to many who have to put it into effect. They are the ones who know at firsthand what is involved. The notion that physicians should be coerced into doing what they regard as immoral, on pain of being forced out of their profession, demonstrates how easily conscience can be dismissed. Degrees of complicity become irrelevant.

This high-handed approach indicates why those who object to effective referral are given short shrift. Accommodation is regarded as an administrative expedience to avoid trouble. No real moral weight is given to moral objections to what is being required. If a physician's objections to assist somebody in dying, whether through suicide or outright euthanasia, can be set aside if circumstances demand, other moral objections will clearly be ignored. When someone can be required to kill, objections to complicity in other procedures through passing a patient on to another physician will be regarded as frivolous.

Instead of a recognition that there is a basic clash of moral vision here, the deliverances of private consciences are regarded as matters of idiosyncratic preference and ultimately of no public concern. If it becomes expedient not to accommodate them, they can be ignored in pursuit of an apparent greater good. Professional bodies, or state institutions, can legitimately compel people to do what they believe to be wrong and punish them if they refuse. When what is being required is seen in some people's eyes as murder, we have reached a strange state of affairs.

Many people are contemptuous of so-called "slippery slope" arguments in matters that are morally contentious. People may be required to do something against their conscience, but perhaps it only marginally implicates them in whatever they regard as wrong. Then they are asked to be further involved, and finally they end up totally implicated. It will always be difficult to know where a line is to be drawn, and the temptation is to think that each small step does not matter. Our opening example, however, indicates how one does not actually have to kill to be fully implicated in killing. In a conspiracy to murder, others are drawn in and have to bear responsibility. It is hard not to sympathize with those who refuse absolutely to be drawn into any such process from the very beginning. When criminal activities, such as robbing banks, are involved, that is obviously wise. However, the same problems arise in medical areas, which are complicated precisely because, unlike ordinary criminality, different views of what is good and right are involved. Particularly because there is honest disagreement in such areas, it is vital that each side respect the other's stance. One must be sensitive to the feeling among some professionals that they are being unreasonably and inexorably drawn into a process of which they disapprove. The problem is at what stage it is legitimate and proper for such a professional to say, "I will have nothing to do with this."

Two possible objections can be made to such a stance. The first is to brush it aside, saying that there must be one law for all, and it must be obeyed. After the trauma of twentieth century totalitarianism on both the left and right political wings, the dangers of this need not be stressed. Subordinating conscience to the demands of the state can quickly lead to the horrors of the concentration camp. Even without such apocalyptic warnings, the idea of one law for all raises problems. The year 2015 saw the 800th anniversary of Magna Carta, a document seen as the antecedent of many basic freedoms. Its influence on English law has been profound, and it has been even more explicitly venerated in the United States. The whole purpose of the document was to demonstrate that no one, however powerful, not even the monarch, should be above the law. Exceptions in favor of an individual or group, might then seem to contravene basic axioms of justice. Things, however, are not so simple. When those in power over-rule conscience, even through the administration of law, that act could in itself undermine the basis of the rule of law, the purpose of which is to prohibit the use of arbitrary power.

The first clause of Magna Carta safeguards the freedom of the English church, and was an undoubted precursor of more modern notions of freedom of religion and conscience. The charter itself establishes the rule of law by, from the very first, placing limits on its reach. The idea of "exceptions" and "accommodations" in the law so as to favor the role of conscience might already suggest a priority of law over conscience that it should not claim. The law should be regarded as having intrinsic limitations rather than being in the business of making gracious and sometimes arbitrary concessions. Even if there should be one law for all, and not alternative legal systems such as that of sharia law, there is ground that the law should not too readily trespass on, constituted by the rights of conscience.

Another objection to the idea of the priority of conscience over law is trickier to deal with. Not everything can be claimed to be a deliverance of conscience. Law would undoubtedly break down in the society if anyone could opt out of anything on grounds of conscience. It has, for example, long been recognized that whereas conscientious objectors might reasonably refuse to be directly involved in killing in time of war, they cannot refuse, for example, to pay taxes, on the grounds that some of them might be used to pay for weapons and armies. A line has to be drawn somewhere. Even if conscience is respected in cases of profound moral principle, not every whim or reasoned objection can be accommodated.

This point of view was trenchantly expressed in a historic case concerning polygamy brought before the United States Supreme Court in the nineteenth century. Ruling against the practice of polygamy by Mormons, allegedly in accordance with their religious faith, the court famously said[20]: "To permit this would be to make the professed doctrines of religion superior to the law of the land and, in effect to permit every citizen to become a law unto himself." However, the idea of one law for all can make some ready to coerce conscience on any issue. Many would suggest that allowing effective referral is itself to give too much respect to conscience. Physicians are not being forced to commit murder, but are simply being asked to pass the problem on so that the will of the majority in a society can be carried out. This, however, can be re-phrased into saying that physicians are not being asked to kill but to ensure that others do so for them. The moral responsibility for what happens would still appear to be shared.

Moral responsibility, however, cannot spread indefinitely. Arranging homicide or suicide might seem to some to be as evil as actually killing somebody. Is, however,

the secretary who sends out a notice making an appointment for a consultation on the issue also morally implicated? Some secretaries may feel they are, but any responsibility for the content of any consultation could hardly be theirs. Indeed, issues of patient confidentiality might suggest that it is none of their business. If they work for an abortion clinic and object to abortion they may certainly be in the wrong job; however, it is outrageous for the principle of exclusion from jobs to be extended to the practice of medicine as a whole. An ethical cleansing of the medical profession, sending the message that physicians should not have a moral conscience that fails to conform to majority professional opinion would seem to be dangerous.

There have been growing limitations on the exercise of conscience in the medical profession. The current stress on human rights in practice seems to leave little room for its exercise, even though conscience is supposedly protected in all human rights documents. In the case of medicine, the emphasis often appears to be on the patient's values, rather than those of the physician. Such talk of values appears to be the way in which morality is referred to nowadays, but the implicit distinction from facts, and the idea that "values" inevitably belong to somebody quickly removes the argument from questions about truth. The issue is no longer about what is really in a patient's interest but rather, as we have seen, becomes an exercise in discovering the subjective preferences of an individual, and perhaps weighing them against those of others. If subjective whims are in question, that may be reasonable. The physician certainly has no rights over the patient. If, however, the question is what is actually good for the patient, the physician's views may not be so irrelevant. These disputes often arise from very different conceptions of the status of the reasons being given for a conscientious refusal to do something. If morality is simply a matter of the adoption of subjectively valid "values," it cannot claim any public justification.

The Extent of Reasonable Objection

Even if it is accepted that conscience must be respected, there will still be an issue about how far conscientious objection can extend. Effective referral will seem to many to be a principled way of providing for a proper delivery of a service while not making people participate directly in something of which they disapprove. Indeed the nature of the practice to which they object may itself be morally contested. Physician assisted death, whether through euthanasia or assisted suicide, unambiguously involves the ending of human life. That is its avowed purpose. The same certainty does not pervade arguments about when human life begins; that is, whether at conception, birth, or some point in between. A recent appeal in the United States had the plaintiffs claiming that a fundamental freedom is the right to refrain from taking human life. As the Federal Appeals Court noted, part of the issue was that the plaintiffs, in objecting, as pharmacists, to providing certain emergency contraceptives, did so because of religious beliefs about the beginning of human life, which can themselves be disputed. Significantly the court quotes[21] with approval a lower court as saying: "There is no doubt about the consequences of assisted suicide: here there is doubt." That may suggest the conscientious objection to participation in assisted suicide may sometimes gain more traction in law than objection to forms of contraception, and even to abortion.

The plaintiffs, in this case, were content to allow what they termed "facilitated referrals,"[22] saying that they "are a reasonable accommodation for objecting

pharmacies because facilitated referrals do not jeopardise the timely delivery of prescription medication." The court disagreed saying that "the immediate delivery of a drug is always a faster method of delivery than requiring the customer to travel elsewhere." Whatever the arguments about the effectiveness of such referrals, it seems surprising that those who believe a practice is wrong are happy to "facilitate" it, as long as someone else provides the service. The notion of facilitation implies an element of moral responsibility. Perhaps pharmacists eager to escape such responsibility could claim they have no responsibility in the matter. That, they could say, belongs wholly to the physician making the prescription or the customer in their choice of what to buy. Once involvement in the chain required to deliver a service becomes a moral issue, the place one has in the chain becomes less relevant. At each stage, it could be then argued, there is some level of complicity.

It can be too easily assumed that passing on what may be regarded as dirty work to somebody else involves escaping responsibility. The United Kingdom Supreme Court seems to assume that. In 2014, when delivering a unanimous judgement about participation in abortions, Lady Hale on behalf of her fellow judges said,[23] "It is a feature of conscience clauses generally within the healthcare profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional's duty of care towards the patient. Once she has assumed care of the patient, she needs a good reason for failing to provide that care."

This begs the question again, taking it for granted that there is a clear answer to what it is to provide care. Most medical professionals would think that it does not just involve giving the patient what the patient wants. It may, however, not always be obvious what is needed instead. When the ending of life is at stake, there may well be reasonable doubt about what "proper care" involves, let alone difficulty about who it is that is to decide what a duty of care involves.

In the abortion case, what was at issue was how close participation had to be to provide a defense of conscientious objection. Was the general supervision and support of staff participating in the termination process itself tantamount to participation? Presumably hospital managers of a hospital that conducted abortions were not participating in the process, any more than were caterers providing meals for the patients. Lady Hale said robustly[24] that "'participate' in my view means taking part in a hands-on capacity." However, that kind of direct involvement may provide too narrow a criterion. It is not surprising that the court saw no problem in demanding effective referral. If "nonparticipants" can arrange for someone else to act on their behalf, that would absolve the bank robber who got his colleague to fire the gun. There has to be a middle path between saying that anyone involved in the running of the hospital is responsible for everything that goes on within its walls, and saying that no one has any responsibility for a process unless they are involved hands-on at the end.

We have remarked on how one of the problems about the edicts of conscience is that they are by definition subjective simply because they belong to a person. Whether or not others feel the same compunction, and indeed whether or not they ought to, it will remain true that this person at this time cannot do something simply because it is felt to be wrong. Whether it is wrong or not, and whether the example of such a person ought to sway others, remains to be seen. If one does not believe that morality is a matter of subjective feeling or arbitrary emotional

reaction, we may all be given pause for thought by such an example. Even so, the fact that it is at the least subjectively valid should mean that it is of extreme importance to the individual concerned.

Claims for exemption, or apparent special treatment, by some may always be regarded with suspicion. The sincerity of beliefs has always to be tested. However, if it is clear that someone is seriously committed to a moral principle of fundamental importance, such as issues concerning life and death, what kind of society will think it proper to indulge in coercion? The answer must be that only totalitarian societies will take such action. Democratic societies must be dedicated to individual liberty. They cannot indulge in coercion without threatening the principles on which they are built. The way forward is through forms of democratic decision-making that accept the existence of minorities. The latter may, by definition, not get their way, but that does not mean that they should be persecuted out of existence. In the case of medical professionals, facing issues about the value of human life and death, they should continue to have, and to nurture, a moral conscience. It would be a sad day if people with such consciences felt that they could not enter the field of medicine, let alone be forced to leave it behind. Medical professionals can never allow themselves to be regarded as mere purveyors of whatever service their customers demand, or merely reflect the fashions of the day. They have to be allowed to follow their own informed judgments about what is right.

When that conscience leads people to feel that they are complicit in actions that they believe to be wrong, particularly killing someone, it has to be respected. We must recognize that a day when healthcare professionals would be required neither to exercise such a moral conscience, nor perhaps, even to have one, would be a grim one for medicine. It may already have come in some European countries, if physicians are not entitled to refuse to perform abortions.[25] When someone not only believes strongly that something is wrong but that a course of action inevitably leads to it, it is rational to refuse to have any part in it. Asking a colleague to do something that one is not willing to do oneself must still be to take responsibility for what happens. Sheltering behind somebody else might even seem to be the action of a hypocrite. It is hardly surprising that those who are so unsympathetic to the rights of conscience that they see nothing wrong in requiring referral also see nothing wrong in making physicians themselves do what they find repugnant if there is no one available to whom they can refer the patient.

We have seen how the persistent retort is that legally permitted services must be provided at all costs. Those indirectly involved cannot abstract themselves deliberately or by default. The British legal case about participation in abortions raises the crucial question as to what is to count as participation other than direct involvement. If a physician should not be expected to refer a patient against their principles, what if anything should they be expected to do? If actual referral implies complicity, should physicians still make available information about alternative sources of treatment? Might that itself, perhaps, constitute a form of referral? Patients need, it seems, to be connected with other physicians who are willing to help them as they would wish. If, however, I am a physician who objects to euthanasia or referral should I still be expected to provide a list of physicians who do not object? If I provide a list of vulnerable banks to a would-be robber am I not complicit even if I have no intention of going near the banks themselves or even profiting from any robbery? Even the provision of information may not be ethically neutral. Perhaps the answer to such problems is to say that it is the responsibility

of the appropriate authority to make information readily available for those who wish it, if the authority wants certain services to be used. Others should not do the job for that authority.

It should not be the responsibility of any professional to help someone on the first steps to something if they are not willing to go with that person the rest of the way. Slippery slope arguments point to real dilemmas. A simple refusal even to be slightly involved in what someone might regard as intrinsically evil prevents that person being sucked even further into the process. The demand that physicians be involved to a greater or to a lesser extent in what they regard as wrong goes against the principles of liberal democracy. It also poses fundamental questions about the role of medicine today. If it is no longer regarded as in any way a moral enterprise, rather than just a simple exercise of technical skill to provide customers with what they want, its future role in contributing to human welfare in a positive way must be put in doubt.

Notes

1. See News Release, March 6, 2015, College of Physicians and Surgeons of Ontario. Available at www.cpso.on.ca (last accessed 8 Oct 2015).
2. Huxtable R, Mullock A. Voices of discontent? Conscience, compromise and assisted dying. *Medical Law Review* 2015;23;242–63.
3. See note 2, Huxtable, Mullock 2015, at 251.
4. *Carter v Canada (Attorney-General),* 2015, SCCC 5.
5. See note 4, *Carter v. Canada* 2015, at 68.
6. See note 4, *Carter v. Canada* 2015, at 63.
7. For more on this see Trigg R. *Morality Matters*. Oxford: Blackwell;2005.
8. Montgomery J. Conscientious objection: Personal and professional ethics in the public square. *Medical Law Review* 2015;23(2):200–20.
9. See note 8, Montgomery, at 220.
10. As in the case of *Ladele*, dealt with by the European Court of Human Rights, in *Eweida and Others , v. United Kingdom* , Strasbourg, No 28420/10, 2013. For more on this case, see Trigg R. *Religious Diversity: Philosophical and Political Dimensions*, Cambridge: Cambridge University Press; 2014, at 182ff.
11. See note 10, Trigg 2014, at 182–3.
12. See note 8, Montgomery, at 220.
13. See note 4, *Carter v. Canada* 2015, at 132.
14. Downie J, McLeod C, Shaw J. Moving forward with a clear conscience: A model conscientious objection policy for Canadian Colleges of Physicians and Surgeons. *Health Law Review* 2013; 21(2):8–32.
15. See note 14, Downie et al. 2013, at 31.
16. See note 14, Downie et al. 2013, at 31.
17. See note 14, Downie et al. 2013, at 31.
18. See note 14, Downie et al. 2013, at 31.
19. Weinstock D. Conscientious refusal and professionals: Does religion make a difference? *Bioethics* 2014;28:8–15.
20. *Reynolds v. United States*, 98 U.S. 145 (1878).
21. United States Court of Appeals for the Ninth Circuit, *Stormans, Inc v. Wiesman*, No.12-35221, 2015, at 41.
22. See note 21, *Stormans, Inc v. Wiesman* 2015, at 23.
23. *Greater Glasgow Health Board v. Doogan* (Scotland), 2014 UKSC 68, at 40.
24. See note 23, *Greater Glasgow Health Board* 2014, at 38.
25. See Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. *The European Journal of Contraception and Reproductive Health Care* 2013;18(4):231–3.