Special Section: Conscientious Objection in Healthcare: Problems and Perspectives

The Cost of Conscience

Kant on Conscience and Conscientious Objection

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Abstract: The spread of demands by physicians and allied health professionals for accommodation of their private ethical, usually religiously based, objections to providing care of a particular type, or to a particular class of persons, suggests the need for a re-evaluation of conscientious objection in healthcare and how it should be regulated. I argue on Kantian grounds that respect for conscience and protection of freedom of conscience is consistent with fairly stringent limitations and regulations governing refusal of service in healthcare settings. Respect for conscience does not entail that refusal of service should be cost free to the objector. I suggest that conscientious objection in medicine should be conceptualized and treated analogously to civil disobedience.

Keywords: conscience; critical conscience; conscientious objection; civil disobedience; Kant

Introduction

Refusal of service by professionals on private moral (conscientious) grounds regularly occurs in the medical profession, sometimes publicized and sometimes not, but it is not subject to any professional or legal sanction, although medical associations usually have policies covering conscientious objection.[1] Although the brunt of conscientious refusal of service by healthcare professionals has, to date, been borne by women seeking services related to contraception and abortion, the spread of demands by physicians and allied health professionals for accommodation of their private ethical, usually religiously based, objections to providing care of a particular type, or to a particular class of persons, suggests the need for a re-evaluation of conscientious objection in health care and how it should be regulated and responded to. I begin with some examples of what I take to be two distinct kinds of conscientious action by health professionals in the course of their duties.

1) "In the United States, Carla sought an abortion of an early pregnancy, a procedure that first required the removal of a large uterine mass shutting off her colon and bladder. Her doctor refused to perform the procedure because of risks to the pregnancy. Forced to find another provider, the delay cost Carla her uterus and $40,000 in medical bills. Another American woman was not so lucky. Nineteen weeks pregnant her membranes ruptured early and she became septic. But because the foetus still had a heartbeat, the ethics

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committee at St Mary's hospital denied her an abortion. For ten days the patient lay dying in the Intensive Care Unit. By the time the foetus expired, the woman had developed pulmonary disease and is now oxygen dependent for life."[2]

2) Simon Horsfall, the owner of the only pharmacy in an outer suburb of an Australian country town, slips a note into every oral contraceptive pill packet he dispenses pointing out that he accepts the teachings of the Catholic Church and is opposed to artificial contraception. The note reads in part: "If your primary reason for taking this medicine is contraceptive then it would be appreciated that, in the future, you would respect our views and have your OCP (oral contraceptive pill) prescriptions filled elsewhere." The pharmacy also refuses to stock condoms and the morning-after pill.[3]
3) "A Brisbane hospital is refusing to discharge an asylum seeker toddler who has been recovering from burns, in a bid to prevent the Turnbull government from returning her to immigration detention at Nauru. In a statement, a spokesperson from Lady Cilento Children's Hospital said it was treating a 12-month-old girl from Nauru who "will only be discharged once a suitable home environment is identified," as was the case with every child who presented at the hospital. "All decisions relating to a patient's treatment and discharge are made by qualified clinical staff, based on a thorough assessment of the individual patient's clinical condition and circumstances, and with the goal of delivering the best outcome," the spokesperson said.[4]
4) "[Australian Medical Association] President Professor Brian Owler has accused the federal government of trying to intimidate doctors and other health workers from speaking out about the treatment of asylum seekers being held in immigration detention centress. The AMA Pesident has mounted a strongly worded attack on controversial provisions in the Government's Border Force Act aimed at gagging whistle-blowers amid mounting claims that many detainees—including children—have been sexually and physically abused while in custody. Professor Owler said doctorswere … morally obliged to advocate for the welfare of their patients, and the new laws—which threaten up to two years' imprisonment for unauthorised disclosures—placed them in an invidious position. "As doctors, we have an ethical and moral obligation to speak out if we have concerns about the welfare of our patients, whether it be the treatment of an individual or whether it be at a system level," he said".[5]

In these cases, the professionals claimed moral or religious authority for refusing to comply with the law, or refusing to provide a professional service in the course of their employment. We might cheer for the professionals in some of these cases and condemn them in others, but policies on conscientious objection cannot be formulated on the basis of agreement or otherwise with the moral position of the objector. Is there a principled way of distinguishing between them that could guide a policy on conscientious objection?

In this article, I will examine Kant's account of conscience and moral obligation and his remarks on professional role responsibilities and public goods, to consider what protection the exercise of conscience requires and deserves in the medical context. I will suggest that failures to comply with directives on the grounds of professional role morality such as is seen in the case of the medical professionals

who break the law to reveal conditions inside detention centers provide an interesting contrast case to service refusal to patients on the grounds of private or religious conscience. What is most striking is that in one kind of case the cost of conscience is born by the professionals whereas in the other, the cost is largely borne by the patient. I will argue on Kantian grounds that the provision of cost-free conscientious refusal of service unfairly privileges the private ethical views of healthcare professionals over those of the patients they serve, and I will suggest a mechanism to redress this imbalance while respecting well-formed conscience.

Which Conscience?

Forcing a person to violate his or her conscience seems intuitively wrong. Respect for a person demands that we respect that person's conscientiously held views. However, we need to question whether conscience in all its forms is equally deserving of protection and accommodation in the professional sphere. Clearly not just any moral view a professional might hold is thought to be deserving of such accommodation. A physician with very sincerely and deeply held racist views would not be entitled to refuse service on the basis of race. This suggests that there are normative standards that the conscientious objector needs to meet in the formation of his or her conscience and against which the deliverances of that person's conscience may be measured.

According to a number of philosophers (e.g., Allen Wood[6]), accounts of conscience fall into three broad divisions, which may also represent different aspects of conscience. The first two of these are: *moral knowledge* and *moral motivation*. Knowledge theories see conscience as a source of moral knowledge. Our conscience tells us what is right or wrong. But how? Conscience may be taken to be the direct voice of God within. Or it may simply represent the moral standards inculcated in childhood by parents, teachers, and houses of worship. Motivation theories focus on the prickings and proddings of conscience. Conscience motivates us to act in accordance with our judgements of right and wrong. To act against conscience is uncomfortable and leads to feelings of guilt. Moral knowledge and moral motivation theories, therefore, seem to go together. A reflexive negative emotive response to an action may be taken by the agent as a veridical indication that the proposed action is wrong.

The view of conscience as involving these two elements chimes with evidence from psychology that suggests that conscience requires the internalization of conduct norms, and that it manifests in moral emotion and rule-compatible conduct. A study of the development of conscience in children found that: "The structure of conscience was remarkably stable over time. The coherence between Moral Emotion and Rule-Compatible Conduct factors increased as children grew older."[7] Measures of conscience included resistance to temptation, complying with moral norms without surveillance, intensity of guilt feelings, and reparation.

However, there are obvious problems with privileging rather than challenging conscience based on the elements of claims to moral knowledge plus moral motivation. Many evil acts are done out of a firm belief in their rightness. Consider slavery, apartheid, genocide, and the Inquisition. At least some perpetrators were acting "in good conscience."

This suggests that more is required of conscience than conviction if it is to deserve protection. A.C Garnett argues that the first two aspects of conscience can

function quite uncritically. He thinks it is particularly dangerous when people invest their emotional reactions with moral authority and this "emotive element" inhibits critical activity. This leads to the third view of conscience: *reflection theories,* or as Garnett calls it *critical conscience*. These are views that prioritize moral considerations in reflection, and stress the need for reasoned moral judgment and critical examination of moral ideas.[8]

I now turn to Immanuel Kant's view of conscience, which I suggest combines a motivation account with a critical account. It thus escapes the objections to accounts that characterize conscience as an infallible inner voice. By a Kantian account, the kind of conscience that deserves respect requires a *conscientious* and *autonomous* moral agent capable of rigorous self-examination and impartial judgment. Characterizing conscience in this way has important implications for questions about how and when to accommodate conscience in healthcare settings.

Kant's Account of Critical Conscience

Although Kant is often stereotyped as a hyper-rationalist for whom emotions were largely a distraction from duty, this is misleading. Moral feeling plays a constitutive role in Kant's account of moral agency. Indeed, at first glance, Kant appears to hold a simple motivation theory of conscience.

For Kant *conscience* is one of the moral feelings that lies: "at the basis of morality, as *subjective* conditions of receptiveness to the concept of duty" He argues that "any consciousness of obligation depends upon moral feeling to make us aware of *the constraint present in the thought of* duty."[9]

Without moral feeling (including conscience) duty could not motivate us, and if a person cannot be constrained by thoughts of duty then that person could not reach the threshold for moral agency: that person would in Kant's terms be "morally dead." He says "conscience is not something that can be acquired, and we have no duty to provide ourselves with one; rather every man, *as a moral being*, has a conscience within him originally" (my emphasis).[10]

Therefore, according to Kant, conscience is fundamental to moral agency. Without it, morality has no force. It is conscience that warns the agent before he or she makes a decision that might violate duty and that prosecutes them afterwards. When conscience acquits the agent of wrongdoing he or she is relieved of the anxiety and discomfort of a bad conscience. However, Kant clearly rejects the view that such feelings of discomfort and relief are the source of *moral knowledge* saying: "we no more have a special sense for what is (morally) good and evil than for *truth*"[11] Rather, it is the process prompted by the feelings that is key to Kant's view.

According to Kant, "conscience is practical reason holding man's duty before him for his acquittal or condemnation." It operates as an internal courtroom; man finds himself "observed, threatened…and kept in awe (respect coupled with fear) by an internal judge; and this authority watching over the law in him is not something he himself (voluntarily) makes but something incorporated in his being?"[12] As Allen Wood explains it, "Conscience is always a reflection on one's actions in which the issue, as in a criminal court is guilt or innocence." Within the internal courtroom that Kant speaks of, "both the accuser and the defender within us must be seen as articulating their arguments on explicit grounds, and the verdict of the judge must equally be a reasoned one."[13]

If we are acquitted in this internal courtroom then, Kant says "as far as guilt or innocence is concerned" nothing more can be required of us.[14] This endorsement of the supremacy of conscience in guiding conduct, however, must be seen in the light of what is required of agents in the formation and testing of moral principles. Kant notes that it is incumbent upon the agent to "*enlighten his understanding in the matter of what is or is not* duty"[15] (my emphasis). This is a continuous and central task for moral agents, and requires the application of critical reason and "[i]mpartiality in appraising oneself in comparison with the law."[16] The Kantian view thus stresses *moral autonomy* and what personality psychologists term *conscientiousness*. Conscientiousness is one of the Big Five personality traits and is characterized by planning, persistence, self-control, and responsibility. Conscientiousness seems to require rational reflection and the capacity to step back from one's impulses, and is consistent with developmental accounts of conscience in which early inhibitory control is clearly linked to conscientiousness in later life.[17] In sum, Kant rejects a knowledge account of conscience. Although he accepts that conscience has a crucial motivating or feeling aspect, he argues that good conscience requires rigorous critical reflection.

What are the implications of this view of conscience for the issue of conscientious objection in healthcare settings? To tease this out, I turn first to Kant's view of professional role responsibilities and of the legitimate restrictions that can be placed on role occupants, and then apply this to the case of service refusal by healthcare professionals.

Conscience, Enlightenment, and Professional Role Responsibilities

In his essay *What is Enlightenment?*[18] Kant considers the conditions under which a society may progress toward enlightenment. He argues that progress depends on the free use and protection of public reason and debate. All adult members of a society have the right and the responsibility to engage in public debate, particularly on matters about which they have some special expertise. However, he draws a sharp distinction between the public use of reason and what he terms the private use of reason. Kant argues that private use of reason—in the context of a particular civil post or office—"may quite often be narrowly restricted." He says "we require a certain mechanism whereby some members of the commonwealth must behave purely passively, so that they may…be employed by the government for public ends."[19]

Kant's example here of a public good is the military. Soldiers must obey orders. They cannot argue about strategy in the field, or the protection of the commonwealth is at risk. Disagreements over military strategy and policy must seek other forums. Similarly, we cannot as private citizens withhold our taxes because we do not agree with the uses they are put to. We can, however, vigorously debate tax policy and suggest alternative proposals. However, it is Kant's discussion of the clergyman with doctrinal disagreements that is most relevant to conscientious objection in healthcare settings, and that is where his position becomes clearest. The clergyman who has doubts about church teachings is nonetheless: "bound to instruct his pupils and congregation in accordance with the doctrines of the church he serves *for he was employed by it on that condition …he is not and cannot be free as a priest* (my emphasis)."[20]

In this private context—a priest with his flock or a physician with his or her patient—the employment of reason is restricted to the appropriate delivery of the service and governed by precepts internal to that institution or profession. One's conscientious disagreements should not enter into one's private professional interactions with patients or parishioners who are entitled to expect the appropriate service delivery, but should be kept for professional and public fora."Conversely, as a scholar addressing the real public through his writings, the clergyman making public use of his reason enjoys unlimited freedom to use his own reason and speak in his own person."[21]

Freedom of conscience, then, is not the freedom to deny service or to demand accommodation from others; it is the freedom and indeed the obligation to argue one's views in the public arena or in discussion with fellow professionals as scholars and citizens, and Kant is resolutely opposed to any move to restrict such freedom. He thinks we cannot achieve enlightenment by binding others to our views through rules, legislation, or doctrines that do not permit the expression of disagreement or doubt. Kant says: "One age cannot…put the next age into a position where it would be impossible for it to extend and correct its knowledge …This would be a crime against human nature, whose original destiny lies precisely in such progress."[22]

For Kant, the requirement on us to enlighten our understanding through the continuous exercise of reason is stringent. *Only* then does conscience have a firm and defensible basis. But *even* then it does not entitle us to special accommodation in the conduct of our professional duties. In particular, it does not entitle us to refuse to perform the duties assigned to enable the delivery of public goods while enjoying all the benefits of employment.

Conscience and Integrity

This hard-line view on conscientious objection raises an immediate issue. Is not the requirement to check one's conscience in at the door an assault on the integrity and moral autonomy of the health professional? We surely do not want physicians to be passive instruments of their employers. They need to be ethically engaged and to refuse to compromise their standards at the whim of an employer. The Nazi doctors should have refused to experiment on their patients. Physicians working for government departments should not compromise their professional assessment of a person's level of disability to meet their employer's target of reducing the number of people on disability benefits. Physicians in detention centers should continue to speak out about the disastrous health and developmental outcomes caused by prolonged detention.

In my view, these kinds of examples, potent though they are, rely on blurring the distinction between conscientious refusal of service to the patient on the basis of one's private moral views, and conscientiously refusing to carry out a directive or act in accordance with a law that would require the health professional to act in a way that is clearly *contrary* to his her professional role responsibilities to prioritize the medical interests of the patient. In the second kind of case, the employer often also seeks to restrict the capacity of professionals to engage in public debate about the objectionable practice (as in the case of medical professionals working with immigration detainees in Australia or physicians working for insurance companies), thereby violating their freedom of conscience

even on Kant's restricted account of what is required for the free exercise of conscience in professional settings.

Interestingly, and for reasons that cannot be fully explored here, accommodation for conscientious objection is only sought in the first kind of case.[23] Seeking special accommodation *in order to* perform one's role responsibilities would seem faintly ridiculous. I will focus here on two Kantian responses to the first kind of case—refusal of service on private moral grounds—and then argue that refusal of service on such grounds does violate the professional role morality of health professionals. I will also argue, with Kant, that imposing a cost on conscience is consistent with respect for conscience.

Artificial Conscience and Conscientious Objection

Wood points out that Kant makes a distinction between *reflective conscience*, which is impartial and reasoned, and "*artificial conscience.*" Garnett similarly argues that we should distinguish between traditional conscience (which can also be a source of unwarranted guilt) and critical conscience *or conscientiousness.* Artificial conscience (the internalized voice of society, religion, or convention) is bound, unfree, unenlightened, and, crucially, immature. In *What is Enlightenment?* Kant characterizes immaturity as "the inability to use one's own understanding without the guidance of another"[24] and sees it as abdicating one's responsibilities as an agent.

Religious beliefs are arguably the most common source of conscientious objection in healthcare. To the extent that health professionals passively accept religious doctrine as an unanswerable source of authority without critical reflection and without exposing their views to the rigors of public reason, their conscience is, in Kant's terms, artificial and not deserving of protection.[25] They remain unenlightened and non-autonomous. As Kant scathingly remarks: "It is so convenient to be immature! If I have a book to have understanding in place of me, a spiritual adviser to have a conscience for me…and so on, I need not make any efforts at all."[26]

Conversely some such physicians are active in what Kant calls private roles. They effectively impose their private views on people who are entitled to expect something else in this context. Critically, their objections to providing service need not be based primarily on considerations of the health and best interests of the patient but on moral and metaphysical views that are not essential to the role they occupy and that may be actively rejected by the patient. If physicians are permitted to refuse medical services at will by citing religious authority or personal moral conviction, the valuable social institution of which their employment is a part would be hamstrung in performing its role of providing a universal healthcare service to citizens, and the burden of delivering such care would be passed to other practitioners. The distinction between artificial conscience and critical conscience suggests that accommodation of conscientious refusal is not a condition of freedom of conscience. Freedom of conscience relies rather on the freedom to argue one's case and subject it to public reason.

Conscience and Epistemic Humility

Kant is clear that conscience does not deliver knowledge. We attain understanding through enquiry and the use of reason. As we have seen, for Kant, this is an

ongoing process and suggests the need for some epistemic humility and open-mindedness in the face of disagreement. The clergyman who has doubts about official doctrine can nevertheless teach them because: "what he teaches in pursuit of his duties…is presented by him as something …which he is employed to expound in a prescribed manner… He extracts as much practical value as possible for his congregation from precepts to which he would not himself subscribe with full conviction, but which he can nevertheless undertake to expound, since it is not wholly impossible that they may contain truth."[27]

Where reasonable people disagree, we should be prepared to listen to others, re-examine our own views, and consider that we might be wrong. In the medical context, epistemic humility plausibly requires the physician to respect that his or her moral views may not be shared by colleagues and, crucially, not be shared by patients. The demand for consideration for conscientiously held views works both ways: where there is disagreement between physician and patient on the moral permissibility of a lawful procedure, the morality internal to the professional role that makes patient autonomy a priority may be the determining consideration. Nevertheless, the cultivation of epistemic humility and open-mindedness cannot entirely resolve the problem. Some practitioners may still find that they cannot reconcile a service that they are called upon to provide with their conscience. What then? Kant appears to take a hard line.

Kant's priest has a duty of care to his flock and must meet their reasonable expectations of their priest. He argues that if the priest firmly believed that official doctrine was "opposed to the essence of religion" as he understands it, then he would have to resign, because he would be unable to perform his duties in good conscience.[28] Similarly, we are to assume that if soldiers or civil servants could not in conscience perform the duties assigned to them they should leave the service. Therefore, Kant rules out the idea that there should be any right to special accommodation of individual conscience within the professional sphere. Physicians who cannot do their jobs should seek other employment.

Ordinary Morality and Role Morality and the Need for Moral Judgment

It might be argued, however, that the special requirements of the medical profession are inconsistent with the hard line on conscientious objection extracted from Kant's remarks on freedom of conscience. Perhaps his conception of critical conscience can ground the practice of exemptions for conscience in medical practice. But how?

Tim Dare argues on Kantian lines that "role occupants are not entitled to appeal to ordinary morality from within their roles. Rather they are limited to moral principles and resources 'internal' to the role."[29] He says of lawyers that good lawyers are bound by the rules governing professional practice even in cases in which they conscientiously disagree. Their recourse is to advocate for reform of the rules—changes in the institutional framework—so as not to *unilaterally disadvantage clients* who rely on these lawyers to act in their legal interests.

The key notions relied on by Dare are (1) the primacy of the relevant interests of the client/patient, (2) the standards governing the professional role, and (3) excluded reasons. Considerations of conventional morality or religion are, for Dare, as irrelevant to the professional encounter and the exercise of professional judgment as are the aesthetic tastes or sporting allegiances of the physician. Such considerations

are excluded from consideration within the professional encounter. The conscientious objector on this account appears to be restricted to claims about the misapplication of the rules or violation of the relevant professional standards.

It has, however, been argued against Dare by Justin Oakley and Dean Cocking that professional role morality ought not to be entirely insulated from ordinary and widely shared moral views and debates.[30] Widely shared views about the evils of racism, for example, have quite correctly been incorporated into the professional standards expected of physicians. Oakley and Cocking argue strongly that the development and exercise of the virtues characteristic of the "good doctor" requires sensitivity to such broad-based moral considerations.

In line with this idea, Daniel Weinstock suggests that as "the work of doctors and nurses involves them in daily interactions with patients and with other health care professionals in which moral judgment and agency is required … the practice of interrogating and critically reflecting on" the demands of their work requires some space to express itself. He says a right to conscientious exemption "is one of the elements through which they are enabled to develop the moral agency required for professional practice."[31] In these ways it might seem, contrary to what I have been arguing, that accommodation for conscientious objection is *more* consistent with Kant's concerns for critical conscience than a denial of this right would be.

However, the problem of conscientious objection in medicine is often that accommodation is sought for views that are not the result of such critical exercises of conscience about one's professional responsibilities, are not related to the requirements of professional practice, and do not rest on or involve the exercises of whatever virtues we would regard as characteristic of the good doctor. Even if it is agreed that professional standards cannot and should not be insulated from moral debates and should be responsive to shifts in moral understanding, it is plausible that professional role morality should take precedence over the private moral views of health professionals in determining their professional duty to their patients.

Where physicians and patients disagree on the moral rather than the medical status of some type of treatment, the conscientious objector effectively imposes his or her conscience on the patient, and this is worrying, given the imbalance of power in the doctor patient relationship and the physician's professional duty of care to the patient. In this context, professional role morality requires the physician to prioritize

1) Beneficence and nonmaleficence: a focus on the medical interests of the patient.
2) Respect for patient autonomy.

Conscientious refusal by physicians can jeopardize both these requirements, as is seen in prominent cases of abortion refusal. Such physicians may try to argue that it is not in the medical interests of women to have access to contraception or safe abortions, but the many available examples of women injured or killed by denial of treatment suggest that these claims are not credible and serve only to obscure these physicians' real motivations. Likewise, refusal to treat addicts or to provide them with the same standard of healthcare that is extended to other patients, which stems from private moral disapproval of drug-taking rather than professional concern for the medical interests of the addict, cannot be justified in terms of professional role morality.[32] A physician's moral disapproval of meat-eating or

obesity would not justify a refusal to treat colon cancer or diabetes or a heart attack in his or her patients. Further, the requirement of respect for patient autonomy suggests that in cases of moral disagreement it is the patient's conscience that should ordinarily prevail. To deny the patient a legal and recognized treatment in the service not of *the patient's* health but of *the physician's* moral views is to fail to respect the patient's rational agency, moral views, and decisionmaking capacity. It is evident that such refusals are often experienced as hurtful and demeaning by patients, and may deter them from seeking needed medical treatment.

How then should we as a society proceed? How do we balance the competing requirements to foster the development and exercise of critical moral agency in medical settings while guarding against the proliferation of conscientious exemptions that would threaten the fair, respectful, nondiscriminatory, and timely provision of healthcare, and place an undue burden on other professionals?

Answerability for Conscientious Objection: An Analogy with Civil Disobedience

I suggest that conscientious objection in medicine should be conceptualized and treated analogously to civil disobedience. According to John Rawls's (1971) account of civil disobedience it is "a public, non-violent and conscientious breach of law undertaken with the aim of bringing about a change in laws or government policies. On this account, the persons who practice civil disobedience are willing to accept the legal consequences of their actions, as this shows their fidelity to the rule of law."[33] The liberal democratic state in turn often extends a degree of forbearance to the conscientious disobedient.

As Kimberley Brownlee[34] describes Rawls's position, civil disobedience is never conducted covertly or secretively. It requires advance notice to legal authorities. Rawls's account may be too restrictive, as an account of the conditions under which civil disobedience may be warranted particularly in non-liberal states (see Brownlee for discussion); however, I suggest that it is an excellent model for conscientious refusal of service in healthcare settings. Indeed some aspects of this account such as advance warning to authorities are already captured by medical codes covering conscientious objection.

The decision to engage in civil disobedience is not trivial. The protestor is typically willing to risk something of importance, including liberty, to advance or defend deeply held moral views. Likewise, refusal of service on the grounds of conscience should be seen by individual health practitioners and by their professions and governing bodies as a serious and weighty matter that is never to be undertaken lightly. If the service refusal is indeed a matter of conscience, then the practitioner must be prepared to stand behind this refusal and answer for it.

Sometimes a good doctor might act in a professionally disobedient way by refusing to participate in certain procedures or to provide certain types of treatment for what he or she regards as weighty moral reasons. A good doctor must then show fidelity to the regulatory ideals and moral goals of their profession by being prepared to submit to the judgment of the relevant professional association, and to accept restrictions on practice or compensatory duties to relieve the burdens that this service refusal places on other practitioners.

A Kantian requirement to defend and justify one's position to one's professional peers and ideally to representatives of the relevant patient group at a formal

tribunal would promote the development and exercise of critical conscience by providing a forum for careful and respectful examination of the practitioner's position. The prospect of facing relevant restrictions on practice may also, I suspect, reduce levels of conscientious objection to practices such as abortion in the hospital system, where some physicians may elevate their dislike of performing the procedure to the level of conscientious objection, although they would, for example, find no insuperable moral objection to it being provided to their family members if needed.[35] If practitioners object on nonmedical religious or moral grounds to providing the full range of reproductive services to women, then perhaps they ought not to be permitted to practice in rural areas where alternative health services are not readily available for women denied their care, or ought not to be permitted to work as a general practitioner in a solo practice, or ought not to be permitted to practice unless the restrictions on their practice are prominently advertised both in the waiting room and externally, or ought not to be permitted to specialize in obstetrics and gynecology. If practitioners object to providing healthcare to addicts, perhaps they should not be allowed to work in hospital emergency rooms or as general practitioners.[36] Conscientious objectors in healthcare settings should not, as is presently the case, be able to offload all the costs of their objection onto colleagues and worse, onto patients. The requirement of respect for integrity and freedom of conscience does not entail that conscientious objection should be made cost free. We trivialize rather than respect conscience if we are not answerable for it.

Conclusion

On the Kantian view I have outlined here, respect for conscience and protection of freedom of conscience are consistent with fairly stringent limitations and regulations governing refusal of service in healthcare settings. This is how it should be. Respect must be earned. Those Australian physicians who risk jail by speaking out against the abuses being perpetrated against the asylum-seeker children and adults in their care earn our respect and draw our attention to a grave moral wrong. In publicly standing by their consciences in a civilly disobedient way, they may even succeed in effecting a change of policy. If practitioners think that aspects of ordinary medical practice involve them in the commission of serious moral wrongs that are not outweighed by considerations of the autonomy of patients or the smooth running of the system, then conscience would surely require that they do more than seek a special exemption or simply refuse to treat the patient. My suggestion that conscientious refusal of service be treated in the same way as Rawlsian civil disobedience would require practitioners to elevate their concerns to a level at which they can receive serious and critical examination while affirming their epistemic humility and their allegiance to the guiding principles of their professions.

Notes

1. See, for example, the Australian Medical Association statement on conscientious objection, which requires that patient access to care not be impeded by the objector nor undue burdens placed on colleagues; available at https://ama.com.au/position-statement/conscientious-objection-2013 (last accessed 25 July 2016).
2. Cannold L. The questionable ethics of unregulated conscientious refusal. *ABC Religion and Ethics* March 25, 2011; available at http://www.abc.net.au/religion/articles/2011/03/25/3174200.htm (last accessed 20 Feb 2016).

3. Cook H. Soul Pattinson pharmacy chain dumps devout Catholic chemist in furore over pill. *The Sydney Morning Herald*, February 15 2014; available at http://www.smh.com.au/national/soul-pattinson-pharmacy-chain-dumps-devout-catholic-chemist-in-furore-over-pill-20140214-32rj3.html#ixzz49XkKPGhp (last accessed 25 July 2016).
4. Hasham N. Hospital refuses to discharge asylum seeker toddler to prevent return to Nauru. *The Sydney Morning Herald*, February 13, 2016; available at http://www.smh.com.au/national/nauru-baby-being-kept-by-brisbane-hospital-20160212-gmt3dg.html (last accessed 25 July 2016).
5. Australian Medical Association. Doctors 'obliged' to speak out on asylum seeker health. *Australian Medicine* 2015; available at https://ama.com.au/ausmed/doctors-'obliged'-speak-out-asylum-seeker-health (last accessed 23 May 2016).
6. Wood AW. Kant on Conscience. Forthcoming in Russian: Kalinniko L, trans. in *Kantovski Sbornik;* available at: http://web.stanford.edu/~allenw/webpapers/KantOnConscience.pdf (last accessed 15 Feb 2016).
7. Aksan N, Kochanska G. Conscience in childhood: Old questions, new answers. *Developmental Psychology* 2005;41(3):506.
8. Garnett AC. Conscience and conscientiousness. In: Feinberg J, Feinberg J, eds. *Moral Concepts*. Oxford: Oxford University Press; 1969.
9. Kant I. The doctrine of virtue (DV). In: Gregor M, trans. *The Metaphysics of Morals*. Cambridge: Cambridge University Press; 1991, at DV 399. (Marginal numbers are standardly used to refer to Kant's texts across different editions and translations, rather than page numbers).
10. See note 9, Kant 1991, at DV 401.
11. See note 9, Kant 1991, at DV 400.
12. See note 9, Kant 1991, at DV 438.
13. See note 6. Wood forthcoming.
14. See note 9, Kant 1991, at DV 401.
15. See note 9, Kant 1991, at DV 401.
16. See note 9, Kant 1991, at DV 442.
17. See for example, Kochanska G, Aksan N. Conscience in childhood: Past, present, and future. *Merrill-Palmer Quarterly* 2004;50:299–310; Kochanska G, Coy KC, Murray KT. The development of self-regulation in the first four years of life. *Child Development* 2001:72:1091–111; Mischel W. Metacognition and the rules of delay. In: Flavell JH, Ross L, eds. *Social Cognitive Development*. Cambridge: Cambridge University Press; 1981:240–71.
18. Kant I. An answer to the question: What is Enlightenment? 1784; available at https://web.cn.edu/kwheeler/documents/What_is_Enlightenment.pdf (last accessed 25 July 2016).
19. See note 18, Kant 1784.
20. See note 18, Kant 1784.
21. See note 18, Kant 1784.
22. See note 18, Kant 1784.
23. In the second kind of case, the profession agrees that the practices are wrong and contrary to medical principles. Conscientious exemptions are only sought when the practice objected to is not thought to be contrary to those principles, but it is recognized that some people sincerely disagree with the practice or are under a religious obligation to refrain from participation. And even then, sincere and religiously based disagreement is not a sufficient basis for exemption, as the racist physicians examples demonstrate. It appears that religion can still provide respectability for sexism, however.
24. See note 18, Kant 1784.
25. I am not suggesting that this is true of all cases of religiously based objections; however, I am suggesting that the reasons offered in justification need to be accessible to those who do not share the religious worldview of the practitioner.
26. See note 18, Kant 1784.
27. See note 18, Kant 1784.
28. See note 18, Kant 1784.
29. Dare T. *The Counsel of Rogues?: A Defence of the Standard Conception of the Lawyers' Role*. London: Ashgate; 2013;44.
30. Oakley J, Cocking D. *Virtue Ethics and Professional Roles*. Cambridge: Cambridge University Press; 2001. See, especially, chapter 5. See also Kennett J. Roles, rules and Rawls: Commentary on: *The Counsel of Rogues*. *The Australian Journal of Legal Philosophy* 2011;36:156–65.
31. Weinstock D. Conscientious refusal and health professionals: Does religion make a difference? *Bioethics* 2014;28(1);8–15, at 11.

32. People with a history of addiction are often denied pain relief in circumstances where it would be offered to others, and are disbelieved when they present with symptoms that in other patients would be carefully explored. See Lianping TI, Voon P, Dobrer S, Montaner J, Wood E, Kerr T. Denial of pain medication by health care providers predicts in-hospital illicit drug use among individuals who use illicit drugs. *Pain Research Management* 2015;20(2):84–8; available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4391443/ (accessed 25 July 2016). Although these are not cases of conscientious objection as such, the denial of care to stigmatized groups is often moralized. Transgender individuals also regularly report denial of care on moral grounds. "An Australian-first study of the experiences of older trans people reveals many have faced a lifetime of discrimination and abuse …Refusal of care from GPs, psychiatrists, dentists and other medical specialists was a common experience for the study's participants, with some saying doctors had denied them treatment on moral or religious grounds." In Stark J, 'We don't look after people like you.' Transgender people refused medical care. *Sydney Morning Herald,* October 18, 2015; available at http://www.smh.com.au/national/we-dont-look-after-people-like-you-transgender-people-refused-medical-care-20151015-gk9ss1.html#ixzz40GsQDkpJ (last accessed 25 July 2016).
33. Brownlee K. Civil disobedience. In: Zalta EN, ed. *The Stanford Encyclopedia of Philosophy*, Spring 2016 ed.; available at http://plato.stanford.edu/archives/spr2016/entries/civil-disobedience/ (last accessed 25 July 2016).
34. Brownlee K. Conscientious objection and civil disobediences. In: Marmor A, ed. *The Routledge Companion to the Philosophy of Law*. New York: Routledge; 2012:527–39.
35. The gaming of exemptions for conscientious objection in order to avoid performing abortions has been suggested to me in conversation by several practitioners who argue that this places an undue burden on those practitioners who believe this is a necessary service for women and who feel stigmatized within the profession for offering it. No one likes performing abortions, but to dislike is not conscientious objection.
36. Where service refusal is based on a perceived and irreducibly religious requirement, Weinstock suggests that the practitioner's reasons are not shareable (See note 31, Weinstock 2014). He argues that freedom of conscience and freedom of religion are rights grounded in distinct sets of moral considerations. I agree that it is useful to distinguish the two. Here is one difference. Practitioners citing a religious requirement as grounds for consideration may have no interest in bringing about a broad change in professional practice. Muslim physicians may have no moral issue with non-Muslim physicians examining (non-Muslim) opposite sex patients for example. Orthodox Jewish physicians may have no problem with others working on the Sabbath. But this is not always the case. Catholic physicians opposed to abortion presumably believe that no one should have or perform abortions or use oral contraceptives, and some physicians may object on religious grounds to any offering of reproductive assistance to homosexual people. Weinstock suggests that accommodations should be granted to the religious physician in the interests of promoting diversity within the profession and making care accessible and acceptable to religious minorities. I cannot address the question of religious accommodation here; however, examples provided by Cannold of the disastrous consequences of treatment refusals by religious hospitals suggest that this should be strictly regulated, and that such physicians and hospitals should be made accountable for harms suffered by patients as a result.