"Dissecting Bioethics," edited by Tuija Takala and Matti Häyry, welcomes contributions on the conceptual and theoretical dimensions of bioethics.

The section is dedicated to the idea that words defined by bioethicists and others should not be allowed to imprison people's actual concerns, emotions, and thoughts. Papers that expose the many meanings of a concept, describe the different readings of a moral doctrine, or provide an alternative angle to seemingly self-evident issues are therefore particularly appreciated.

The themes covered in the section so far include dignity, naturalness, public interest, community, disability, autonomy, parity of reasoning, symbolic appeals, and toleration.

All submitted papers are peer reviewed. To submit a paper or to discuss a suitable topic, contact Tuija Takala at tuija.takala@helsinki.fi.

Toleration and Healthcare Ethics

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Toleration is a touchstone of contemporary liberal democracy, a "moral duty" according to the 1995 UNESCO Declaration on Tolerance,[1] and a widely accepted norm of liberal everyday life. In the United Kingdom and many other countries medical and nursing ethics require doctors and nurses to be tolerant of a wide range of behaviors, attitudes, and beliefs among their patients of which they nonetheless disapprove. Even if a doctor is a sincere Roman Catholic he or she should tolerate patients who seek abortion or contraception: Although not required to provide either intervention, he or she should, however, explain that other doctors are available who can accede to these requests. Medical and nursing ethics require that patients who are racist, sexist, homophobic, and or religiously intolerant themselves ought nonetheless to be tolerated and treated by their doctors and nurses, at least insofar as they are not being grossly abusive or violent.

If a doctor or nurse discovers that a patient is cheating the income tax authorities, deceiving his or her spouse, engaging in burglary, or growing cannabis in the garden, the doctor or nurse is expected to tolerate, maintain confidentiality, and treat as necessary. If a competent patient makes what to the doctor appears to be a grossly mistaken decision to reject a proffered life-saving treatment, that decision must nonetheless be tolerated, no matter how wrong the doctor believes the decision to be, no matter how tragic, unnecessary, and harmful to others are the consequences. Conversely, doctors and nurses who are themselves intolerant—who are, for example, religious zealots who try to convert their patients to what they see as religious truth or who are zealously racist, sexist, or homophobic—such healthcare

Cambridge Quarterly of Healthcare Ethics (2005), **14**, 100–106. Printed in the USA.
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https://doi.org/10.1017/S0963180105050115 Published online by Cambridge University Press

workers are not to be tolerated by their peers: They require either reeducation toward properly tolerant attitudes and behavior—at least in the context of their work—or expulsion from their profession. In contemporary Western healthcare ethics, toleration is widely regarded as a vital virtue for all healthcare workers to possess. Those that do not possess this virtue and cannot or will not acquire it are not to be tolerated as healthcare practitioners.

Paradoxes

To require toleration of what many would regard as intolerable behavior by patients and simultaneously to be intolerant of similar behavior when manifested by doctors and nurses is an example in the healthcare setting of the so-called paradoxes of toleration. In politics these paradoxes show themselves in the theory that tolerant societies should be tolerant and the fact that tolerant societies incarcerate and sometimes kill those who threaten to undermine their existence. In religion these paradoxes manifest themselves in theories of tolerance and practices that are intolerant of other religions or of branches of their own that themselves reject such tolerance. In liberal legal systems such paradoxes appear in the form of laws defending tolerance that include rigorously restrictive sanctions against those who seek to undermine the existence of liberal legal systems.

But do these examples demonstrate insoluble paradoxes? Are they, and the paradoxes of toleration generally, summarized and resolved in the eye-catching T-shirt slogan “bombing for peace is like fucking for virginity,” seen while I was writing this piece? Or does that slogan merely demonstrate (even when tidied up) that toleration is an important but limited value in itself, that its preservation where it is of value may require intolerance, and that the paradoxes of toleration are only logically insoluble if based on the mistaken assumption that toleration is an absolute value? Although I suspect that the answer to each of these questions is “yes” in all contexts in which the paradoxes of toleration arise, I shall in this brief article confine myself to toleration in healthcare, and address only tangentially or not at all toleration in its more familiar contexts of religion, law, and social and political philosophy.

Defining *Toleration*

Let me start by admitting immediately that it is difficult even to give an uncontentious account of the meaning of the term *toleration*. It clearly involves self-restraint from acting against something that one dislikes or of which one disapproves—one does not “tolerate” what one likes or approves of, nor does one “tolerate” that about which one is indifferent. But what is meant by *acting against* here? In particular, if one asks a person to do something—to turn down loud music, say—but accepts the person’s refusal (even though one could simply go and turn down the radio or television oneself), is the request to turn down the volume an example of intolerance? I am inclined to think not, even though such requests are surely forms of acting against, trying to negate, or trying to avoid enduring something one dislikes. Thus although it is undoubtedly true that the person who, despite disliking the loud music, says nothing at all is *more* tolerant (of the loud music) than the person who asks for it to be turned down, both tolerate it. By contrast, the person who—having requested and sweet reason having failed—simply goes and turns it down is clearly intolerant, at least of the

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loud music on that occasion. (He or she may or may not be, in general, an intolerant sort of person.)

In this paper I use the terms *tolerance* and *toleration* as synonyms that, when applied to actions, mean self-restraint from *trying to enforce* the prevention of that which is disliked or disapproved of, despite the tolerator having the power to *try to enforce* its prevention. When applied to persons, they mean the disposition or tendency or character trait of manifesting attitudes and acts of tolerance or toleration. They contrast with *intolerant*, which, when applied to actions, means actions that *try to enforce* the prevention of what is disliked or disapproved of and when applied to persons, means persons who tend to *try to enforce* the prevention of what they dislike or disapprove of. There can, of course, be various ways of trying to enforce one's will upon others, but I simply assume that reasoning (if unaccompanied by bullying of any sort) is not one of them.

Not Necessarily a Moral Term

Toleration is not necessarily a moral term, as Mary Warnock has so clearly argued,[2] for one can disapprove of, yet tolerate, things about which one is morally neutral (like loud music). I recall that one acute dilemma in my clinical practice was whether or not to continue to tolerate—in breath-holding self-restraint—the visits of a particular patient who was totally unaware that the smell of his feet would have made a combination of durian fruit, ripe camembert, well-hung pheasant, and blocked lavatories a sweet-smelling nosegay by comparison. (On his third visit I discussed the matter with him—he was most surprised that there was anything offensive about his feet but agreed to try washing his socks rather than waiting until vacation for his mother to do them.) My admittedly ancient pocket Oxford dictionary gives as examples of what one might tolerate—"or find or treat as endurable"—"Jews, polygamy, sweating [which is what reminded me of my patient], infringement of copyright, slang, crude colours, bores." Of these, only tolerance of polygamy and copyright infringement would be candidates for tolerance in a moral but nontheological sense, assuming (charitably) that tolerance of Jews was intended as an example of religious toleration, the main focus of writings on toleration from the 13th (yes, Aquinas discusses a principle of toleration) to the 20th centuries; the remaining examples concern toleration of things that may simply be disliked.

I started by pointing out that tolerance is regarded as a virtue in healthcare ethics, but of course it is no more regarded as an *absolute* value—to be manifested in all possible circumstances—in healthcare than in any other context. I've already indicated that racism, sexism, homophobia, and religious intolerance exhibited by patients need not be tolerated if accompanied by violence or by gross abuse (doctors and nurses are expected to tolerate a *certain* amount of abuse!). Not everything that a doctor or nurse discovers about a patient has to be tolerated; thus the important presumption of confidentiality in healthcare ethics can and should be overturned and the patient reported to the appropriate authorities if he or she is found to be threatening the lives of others, for example as a terrorist or murderer or rapist, or even by continuing to drive a car after a diagnosis of epilepsy. Although the doctor must tolerate patients' refusal of lifesaving treatment for themselves, such toleration does not extend to refusal of (beneficial) lifesaving treatment for their children. Although the doctor is expected to tolerate the pa-

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tient's cannabis growing in the garden, he or she would not be expected to tolerate and maintain confidentiality about the patient's role as a major supplier of heroin or crack cocaine.

Why Value Toleration?

But why should toleration be valued at all? Various reasons are offered by the great advocates of religious toleration, among them Milton, Locke, Spinoza, Voltaire, Kant, and Mill. These justifications include pursuit of self-interest, social harmony, the common or greater good or the lesser evil, and also the need for humility about the extent of our knowledge of God's will. But perhaps the most important justification offered by these and by contemporary writers is what today we would call respect for people's autonomy—their thought-out choices for themselves, including their privacy choices and their freedom of conscience. When one thinks about the intolerance that leads patients to resent their doctors or nurses in dysfunctional clinical interactions, it is often the ignoring or the overriding of their autonomy that patients find most objectionable.

Respect for Autonomy

Thus, analyzed in terms of the four principles of medical ethics, toleration is prima facie morally desirable because and insofar as it tends to respect people's autonomy, and intolerance is prima facie morally undesirable because and insofar as it tends to ignore or override people's autonomy. But of course in any reputable account of respect for autonomy, such respect is morally required insofar as it is compatible with respect for the autonomy of all whom it potentially affects. Thus if toleration of one person's autonomous choices for himself or herself will result in infringement of other people's autonomous choices for themselves, the principle of respect for autonomy does not require such toleration, and it will become a question of judgment in the context of competing claims whether to be tolerant in the circumstances.

Nonmaleficence

Can one ever *do* harm by being tolerant? My own analysis would reject this possibility, while fully accepting that toleration may permit harm to be done. Thus by not joining up with *Medecins sans Frontieres* I do not *do* harm, even though I do not help to prevent the medical harm that I could help to prevent if I did join up. By not telling the police about my dangerous pedophile patient I do not *do* the harm that he subsequently does when he rapes a child, even though it is undoubtedly true that I fail to prevent that harm and that I probably could have prevented it. However, whether or not I am right to make this distinction—one astonishingly sometimes encounters those who deny that there is any moral distinction possible between my doing a harm and my failing to prevent the same harm—it will surely be the case that if *sufficient* harm will be caused by tolerating bad behavior in others and the amount of harm could be *sufficiently* reduced by not tolerating it, then it is morally desirable not to tolerate it. Conversely, if sufficient harm will be caused by not tolerating the bad behavior whereas tolerating it would prevent that harm, then toleration will be morally desirable—as the lesser evil. Once again it will be a matter of judgment what will count as sufficient. Part of such judgment is societal and manifested in social and professional norms, values, and pressures, formal and informal—and part of such judgment is personal.

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Societal (including legal) and professional judgment does not require me to join up with *Medecins sans Frontieres* (this would be admirable but supererogatory and the harms of my not joining up are tolerated). But societal and professional judgments *do* require me to report my dangerous pedophile patient—the harms risked by my tolerating my patient and not reporting him are not to be tolerated. (My personal judgment concurs in both cases.)

Beneficence

Can toleration ever fail to benefit? Obviously it can. In any situation where it would be possible for people to benefit others and they do not try to do so, they are tolerating failure to benefit. One implication of this incontrovertible fact might be that toleration is always prima facie wrong in such cases. An alternative—and I believe correct—inference is that the obligation of beneficence is limited or "imperfect" and that, even prima facie, it is morally permissible to tolerate failure to benefit, except in those cases where there is a prima facie moral obligation to benefit. Joining *Medecins sans Frontieres* provides an example where I do not have a moral obligation to benefit (admirable though it would be to do so). But when I was a practicing doctor I did have obligations to benefit my patients. These obligations were part of the general professional obligation of nurses and doctors to provide healthcare benefits to patients, and it is this commitment that justifies, in the examples I have given, both tolerance of what would be widely regarded as intolerable behavior, when manifested by patients, and intolerance of the same sort of behavior when manifested by our colleagues.

Differences in the scope of my obligation of medical beneficence lead me to a more controversial moral distinction. I am (albeit reluctantly) ready to tolerate (in the sense of *not trying to enforce* change of behavior—I would certainly try to persuade) my HIV patient's marital deceit by maintaining confidentiality when the deceived spouse is not my patient. On the other hand I am (also reluctantly) ready if necessary to override my duty of confidentiality—and thus not tolerate my HIV patient's deceit—when the deceived partner is also my patient, to whom I have a duty of medical care or medical beneficence, if my patient is not prepared himself to tell his wife about his HIV.

Justice

Considerations of justice, too, may prima facie require toleration in some circumstances, intolerance in others. Distributive justice in the context of healthcare requires, prima facie, that we distribute scarce healthcare resources in proportion to people's healthcare needs. On the other hand, distribution in proportion to need may conflict with other relevant moral obligations—for example, with the obligation to respect a patient's autonomous rejection of such resources. Such rejection should, of course, be tolerated. On the other hand, demands to jump the queue that are not based on need should not be tolerated.

Rights-based justice requires, prima facie, that we respect people's rights and are therefore intolerant of abuse of those rights. (Some would see *both* of my last two cases as examples where rights-based justice requires me not to tolerate my patient's deceit of his wife, whether or not the wife is my patient.) Rights-based justice provides one of the justifications for *not* tolerating violence and gross abuse in the context of healthcare. On the other hand, as also already mentioned, people's rights to have their autonomy, liberty, and pri-

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vacy respected prima facie *require* toleration even when such toleration may not be in their best interests and even where it may cause some degree of harm to others.

Similarly, the conflicting demands of legal justice have already been alluded to. It requires us, again prima facie, to tolerate and obey laws that have come about through a morally acceptable process even when we disapprove of them—though we are at liberty to try to influence the democratic process to try to change them. On the other hand, the laws themselves may require all of us, including health professionals, to be intolerant of certain sorts of law breaking and to try to impose adherence to those laws by others whom we know to be violating them. Hence, for example, the obligation on all of us, including health professionals, to report crimes that seriously endanger others.

An Independent Virtue?

An interesting strategy that would give toleration a near absolute value is proposed by David Heyd. Under his approach a distinction is made between judgments about tolerating actions, attitudes, beliefs, events, states of affairs, and so forth and tolerating *people*.[3] Toleration is then the process of switching one's perception away from the action, attitude, belief, state of affairs, and so on of which one disapproves, (the duck) and toward the person (the rabbit) whom one tolerates. Toleration is thus to be seen as a subclass of respect for persons—a moral attitude to others that typically disregards most actions and opinions of the object of respect. Three worries incline me to reject this otherwise appealing idea. First, respect for people's autonomy—always qualified by the need for such respect to be compatible with respect for the autonomy of all potentially affected—is in my view the clear and appropriate moral obligation and virtue: "respect for persons" is too nebulous a term, and facilitates, for example, imposed social separation of women from men, subjecting women's autonomy to the will of their menfolk, imposing their cloistering away from men and their hiding of their bodies and faces when they are allowed to be in the presence of men—often all in the name of "respect" for their persons. Second, since Heyd accepts that sometimes the appropriate attitude *is* to judge the action, belief, behavior, and so forth, it is not clear how the duck/rabbit gestalt switch from action to person, or vice versa, is different from, or superior to, the more usual models of balancing, harmonizing, judging, prioritizing, or simply choosing between moral values when they conflict. Third, it is not clear to me *why* we should tolerate, let alone respect, persons whose actions, behaviors, or speech are clearly persistently immoral. There is a hint of the Christian doctrine of hate the sin, love the sinner in Heyd's proposal(!). It is not clear to me in either case why we *should*.

Even under Heyd's very tolerant account of tolerance it is clear that toleration is not and should not be regarded as a moral absolute, required in all possible circumstances, but rather that it is sometimes morally desirable and sometimes morally undesirable. The examples I have outlined above certainly do not support any notion of toleration as a moral absolute. Rather, the character disposition of tolerance is like many other character dispositions that are claimed to be "virtuous": It and they are to be assessed as virtues when and insofar as they lead or tend to lead to morally desirable states of affairs. Where instead they lead or tend to lead to morally undesirable states of affairs they are vicious, not virtuous. Although I believe that a tolerant disposition tends to make for

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a good doctor or nurse (though an empirical study of this assumption would be valuable, if difficult), even tolerant clinicians are morally required to assess particular circumstances and/or particular people which or whom they dislike or disapprove of, and make decisions as to whether or not they should tolerate them. Often toleration is morally admirable, but sometimes it is indeed morally undesirable, even morally despicable![4]

Toleration as a "Default Position"

However, given that toleration is likely to be a morally desirable mindset in clinicians—the default position as it were—and given that toleration presumptively involves respect for other people's autonomy, we as clinicians should surely reflect carefully before we decide, in a given set of circumstances, that toleration is morally unacceptable and that we should instead intolerantly try to *impose* our views (a defining feature of intolerance). We should reflect about how much our proposed intolerance would enhance respect for the autonomy of all affected by our decision, how much harm it would cause, especially, of course, harm to health, how much benefit—especially health benefit—it would produce (including prevention of harm, especially prevention of harm to health), and how fair or just it would be, whether in terms of use of scarce resources, of respect for people's rights, or of respect for laws that have come about in morally acceptable ways. If we do so reflect we may often find that toleration, despite our firm disapproval, is the best approach. Sometimes we may even find ourselves less certain of our original firm disapproval!

Notes

1. The Declaration is reprinted in Ricoeur P, ed. Tolerance: Between intolerance and the intolerable (Diogenes). Providence, RI: Berghahn Book; 1996:207–13.
2. Warnock M. The limits of toleration. In: Mendus S, Edwards D, eds. *On Toleration*. Oxford: Oxford University Press; 1987 at p. 125.
3. Heyd D. *Toleration*. Princeton, NJ: Princeton University Press; 1996:10–7.
4. For some plausible examples see Catherwood J. An argument for intolerance. *Journal of Medical Ethics* 2000;26:427–31.

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