

CONSCIENTIOUS REFUSALS WITHOUT CONSCIENCE: WHY NOT?

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Abstract: In this paper I uncover and critically analyze a methodological assumption in the literature on conscientious refusals in health care. The assumption is what I call the “Priority of Conscience Principle,” which says the following: to determine the moral status of any act of conscientious refusal, it is first necessary to determine the nature and value of conscience. I argue that it is not always necessary to discuss conscience in the debate on conscientious refusals, and that discussing conscience is even problematic, since it can lead authors to beg the question.

1. INTRODUCTION

After decades of widespread neglect by philosophers, conscience is making a comeback in the literature. The occasion of this return of conscience is the recent attention given to conscientious refusals by health-care professionals. The problem of conscientious refusals in medicine arises whenever a physician, nurse, pharmacist, midwife, etc., is confronted with a request for a legal medical service which that health-care professional is not comfortable providing. The cases of refusals by physicians or nurses to participate in abortion and refusals by pharmacists to fill prescriptions for contraception have received the lion’s share of attention, but the issue extends far beyond these particular cases.¹ In light of the rapid advances in medical technology and the increasing cultural diversity in America, the issue will only become broader and more pressing.

Commentators on this debate have approached it from a number of angles, but there has been a common tendency to begin the discussion with reflection on the nature and value of conscience. Moreover, there have even

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been recent calls for more detailed reflection on conscience in order to advance the debate, which for certain authors is really just about the place of conscience in medicine.² Thus, some authors have concluded that “[i]n the absence of consensus on what the conscience is, it may be impossible to agree on what the role of the conscience should be [in the practice of medicine].”³ These authors have cleared centre-stage for conscience by maintaining that this debate is aided by, and even necessarily requires, prior reflection on conscience: call this the “priority of conscience principle,” or PCP for short. Thus PCP is a methodological prescription that says the following: to determine the moral value of an act of conscientious refusal, you must first determine the nature and value of conscience. It is, I believe, the implicit adherence to PCP in the literature on conscientious refusals that explains the recent renewal of interest in theoretical questions about conscience.

PCP is a seemingly uncontroversial methodological suggestion. It may even seem unconscionable to an analytically-minded person to approach the debate on conscientious refusals in any other way than by first analyzing and seeking agreement on the nature of conscience, which after all, is the very root of the term “conscientious.” Many of us would agree with Daniel Sulmasy that it is “very odd” whenever the debate on conscientious refusals takes place without prior attention paid to “what conscience is and what its importance might be.”⁴ Many would therefore say that conscience has rightfully made its comeback in the context of this important ethical debate.

But not so fast: like all fundamental intuitions that creep into social debates, PCP deserves to be scrutinized by philosophers. Such scrutiny is especially needed in this debate in which there has been relatively little methodological discussion. The authors cited above (Lawrence, Curlin, Sulmasy) who urge PCP do so without argument; instead, they rely on their and our intuitions. But we must remember that the terms within which a debate is initially framed colour the entire debate and sometimes favour one side over another in largely imperceptible ways. We should not, therefore, frame the debate on conscientious refusals in terms of questions about the nature and value of conscience without at least first surveying whether this approach is necessary, and without noting the effects, both positive and negative, which have thus far arisen from such a framing.

In this paper I investigate PCP to determine whether its methodological recommendation is sound by inquiring whether prior reflection on the nature and value of conscience is helpful or a hindrance for determining the moral status of conscientious refusals in medicine, and whether such prior reflection on conscience is ever necessary. (By focusing on the “moral status of an act of conscientious refusal in medicine” I am narrowing the debate to the questions of whether health-care workers are morally justified in refusing to deliver legal medical services, and whether the professional medical associations and the states that license professionals have moral, rather than legal and political, grounds for permitting such refusals. There are, of course, other dimensions to the problem of conscientious refusals.) My suggestion in this paper is that PCP is a problematic methodological principle

when applied uncritically and that we should be careful when basing moral judgments about conscientious refusals on any individual theory of conscience. While it is not always necessary explicitly to discuss conscience in the context of this debate, I will nevertheless conclude that conscience-talk can indeed be useful, and I will outline several practical guidelines to make reflection on conscience a fruitful starting point in this important debate.

The structure of this paper is as follows. In Section 2 I explore the consequences of the claim in PCP that it is *necessary* to discuss conscience in the debate on conscientious refusals. Conscience, I argue, must either be (a) an irreducible mental act or (b) a strongly-unified complex of mental acts, or else it is not necessary to discuss it. After briefly surveying historical attempts to give a theory of conscience that answers to one of these descriptions, I finish the section by asking how likely it is that ethicists can today come to agreement on such a theory of conscience. In Section 3 I move from the requirements and possibility of agreement on a theory of conscience to whether we *should* adopt a single theory for this debate. I argue that the “dominant view of conscience” that has arisen today as a compromise between competing theories of conscience is inappropriate as a basis on which to judge the moral status of conscientious refusals. The use of this theory of conscience in this debate begs the question at hand and tips the balance in favour of patients over their refusing health-care providers. This particular instance illustrates more general reasons we have to believe that *any* single theory of conscience would beg the question against either patients or health-care workers, and so I conclude that we should be wary of adopting any single theory of conscience in this debate. In Section 4 I argue that, in any case, we do not always need to discuss conscience at all because there are conscientious refusals in which conscience, however it is conceived, plays no part. In Section 5 I draw conclusions from the above sections and end by offering methodological recommendations for those who continue to make reference to conscience in the debate on conscientious refusals.

2. AGREEING ON A THEORY OF CONSCIENCE: PRELIMINARIES AND PROSPECTS

As we have seen, some authors believe that it is necessary in the debate on conscientious refusals first to discuss the nature and value of conscience. Obviously, then, these authors believe that there is such a thing as conscience, and presumably they believe that it is a mental phenomenon of some sort of which most, if not all, of us are aware. But they must believe something further and less obvious about conscience if they think that it *must* be discussed in this debate; they must believe that conscience is more than just a tag-word for a string of mental acts like believing, judging, deciding, fearing, feeling ashamed and so on. For if “conscience” were nothing more than a label for sequences of acts such as these, then we could focus all our attention in this debate on the role of beliefs, judgments, fears and so on in medicine. In other words, if conscience is treated neither as a simple mental act nor as a strongly-unified complex of mental acts, then we can

always get by in the debate on conscientious refusals without explicitly discussing conscience, as long as we discuss the more primitive mental acts which comprise it or are simply denoted by it. Adherents of PCP, therefore, need to treat conscience as simple or as a strongly-unified complex in order to uphold the necessity of discussing conscience in this debate. Both views about conscience—that it is irreducible and a strongly-unified complex—have arisen in the history of conscience, so it is initially plausible that adherents of PCP can find a theory of conscience of the sort they need. A brief and admittedly cursory look at several moments in the history of conscience will be useful to provide a context for the contemporary discussion.

Conscience was initially put forward in the West as an irreducible part of the soul when St. Jerome was led by a Scriptural passage to posit a fourth soul-part beyond Plato's three (emotion, appetite, reason). That fourth part was called by him, "*synteresis*: that spark of conscience which was not even extinguished in the breast of Cain. . . ."⁵ It was important for Jerome's Biblical exegesis that conscience not be "mixed up with" emotion, appetite, or reason: that it be its own part, in other words. Therefore, for Jerome, conscience was not to be equated with a combination of emotion, such as guilt; desire, such as the desire to be in good repute; and rational judgment, such as "this act that I am considering is morally bad." Conscience watched over all these other three parts separately, like the eagle represented in Scripture.

The philosophical literature on conscience expanded when later Medieval thinkers wrote commentaries on Jerome's biblical exegesis. Jerome was ambiguous about whether a person could lose his conscience, which led all later Medieval authors to distinguish two things where Jerome had focused on just one: *synderesis*,⁶ which could not be lost, and which was thought to be a disposition of reason by which general moral truths are known; and *conscientia*, which could be lost in degrees, and the nature of which was usually taken to be a disposition or action of the rational soul involving the application of the basic moral truths grasped by *synderesis* to particular moral acts under consideration. Therefore, from at least the time of Bonaventure and Aquinas, conscience was not taken to be its own power of the soul, but was analyzed into acts or dispositions mainly of reason.

Although conscience was analyzed by later Medievals in terms of other dispositions, acts, and ends of other parts of the soul, the notion of conscience was not thereby a superfluous label for these. Conscience was strongly unified in all human beings through their end and through the tools God gave human beings to achieve that end. God's eternal law was the expression of His will for the universe and was communicated in part to human beings as the natural law, the general tenets of which were known through *synderesis*. Conscience was the moral directedness of human beings: it was the instinctive rallying together of the emotional, appetitive, and rational parts of the human soul to ensure that a person acted in an objectively morally good way, that is, in conformity with the natural and eternal laws. Conscience in all people was unified in a twofold way: first through the objective moral principles known by *synderesis*, and second

through the disposition to apply and act according to *synderesis* in the here-and-now. *Synderesis* was therefore the most important unifying “glue” of the various parts of conscience.

Whereas the later Medievals removed the irreducible character of conscience given to it by Jerome, most contemporary authors have removed the source of strong unity of conscience given to it by the Medievals. The foundation of the unity of the Medieval conscience, as we have just seen, was *synderesis*, which is no longer a concept enjoying widespread acceptance, with the result that the Medieval conscience has lost its unity.

In the wake of this widespread rejection of *synderesis*, intuitively discoverable objective moral truths, the eternal and natural laws, the division of the soul, and other Medieval concepts, recent authors have effectively been given *carte blanche* to reinvent the notion of conscience. The common problem facing all these authors is to find a new unifying principle for the phenomenon of conscience: what is it that makes a sequence of mental phenomena, like belief, reflection, judgment and guilt, into a new whole *still* worthy of our attention, *still* worthy of its own name—“conscience”? Agreement on issues related to conscience is not easy to come by today, as several authors have demonstrated;⁷ but despite this challenge, a “dominant view” of conscience has emerged in the literature attempting to supply a common bridge to span opposing views.⁸ The new unifying principle of conscience supplied by the dominant view is illustrated in the following passage from a groundbreaking article by James Childress: “In appealing to conscience I indicate that I am trying to preserve a sense of myself, my wholeness and integrity, my good conscience, and that I cannot preserve these qualities if I submit to certain requirements of the state or society.”⁹

Adherents of the dominant view unify the notion of conscience through the goal of preserving one’s “wholeness and integrity.” Reason, imagination, judgment, feeling and desire are rallied together into single acts of conscience by the concern in each person for “inner psychological unity.”¹⁰ Conscience still watches over individual human acts like Jerome’s eagle, but now it is in order to ensure that one is acting on one’s principles whatever they may be; and when the need arises, it swoops down and pesters the mind into an effort to defragment its personality. This pestering, defragmentation and consequent inner harmony are what unify the complex underlying structure of conscience on the dominant view today.

At first sight it may appear as though this account goes some way toward reconciling a wide range of views on the nature and value of conscience, and might therefore be a suitable common theory of conscience for the debate on conscientious refusals. Take, for example, two very contrary positions on conscience: on the one hand, the later Medieval view described above (call it the “Medieval view”); and on the other hand, what we might call the “Relativist view,” which holds that conscience is just the guilt that arises whenever we act, have acted, or consider acting contrary to whatever moral values we happen to have internalized. The Medievalist will hold that one is truly whole and a person of integrity only when one’s life is lived in

accordance with the natural law, which can be known through conscience, which is therefore that which brings about wholeness in a person's life. The Relativist will hold that wholeness is living according to one's internalized norms, gained through the influence of family and culture; conscience is triggered whenever one is about to step out of line with these norms.

Medievalists and Relativists will disagree on much, but they can agree in a formal way that conscience is that thing in a person which promotes wholeness and integrity, however these latter terms are understood. However, this similarity is merely superficial and does nothing to cover the gaping chasm between these two views; for the Medieval view is built on the belief in an eternal, objective moral law, while the Relativist view is linked to the rejection of objective morality. Consequently, the violation of conscience on the Medieval view entails (for the Medievalist) the violation of a law of the universe, a disruption of something greater than the individual; while the violation of the Relativist's conscience amounts to little more than the breaking of a single individual's inner psychological unity. There is thus very little in common between these two views beyond the possible common use of the words "wholeness" and "integrity." And unless several of the most difficult perennial problems in ethics are solved to the satisfaction of everyone (e.g. are there objective moral truths?; can human beings immediately intuit basic moral truths?), it is unlikely that any theory of the nature and value of conscience could ever bridge the gap between the competing views of conscience that exist today.

We have expanded on what would be required to identify and agree upon the nature of conscience. It would either entail collectively treating conscience as an irreducible mental act or treating it as a strongly-unified complex, in addition to identifying the source of that strong unity (the "glue"). We have also briefly considered the prospects of using the dominant view as a compromise between competing theories of conscience. What is more important, however, is to ask whether the dominant view, or any view for that matter, *should* be agreed upon at the outset of the debate on conscientious refusals. Carolyn McLeod has argued that we should not all get on board with the dominant view, based on the claim that it overvalues inner psychological unity, especially in the case of oppressed women, for whom such unity can actually be a barrier to living autonomous lives.¹¹ I will argue the more abstract methodological point that the dominant view of conscience *begs the moral question of conscientious refusals and unduly tips the balance of this debate against the refusing health-care professional*. These hazards will be associated with adopting any particular theory of conscience at the outset of the debate.

3. BEGGING THE QUESTION AND TIPPING THE BALANCE IN THE DEBATE ON CONSCIENTIOUS REFUSALS

Commentators on conscientious refusals have not appreciated the fact that questions about the nature and value of conscience are often the very heart

of conflicts between health-care workers and patients. For writers on this topic to seek to adopt a single theory of conscience for this debate is therefore dangerous. This is particularly so in light of the break with the traditional literature on conscience and the resultant freedom that this has given to contemporary writers to reinvent conscience, which are the sources of numerous potential problems. For given the break with the tradition and the current lack of consensus on conscience, authors can decide the question of the morality of conscientious refusals first and then subsequently offer a novel theory of conscience that grounds their position on such refusals, all the while presenting their results as following the method of PCP. While the order of their presentation may be in accord with PCP, we might worry that the order of discovery or motivation was just the opposite. Theories of conscience may serve as Trojan horses in the debate on conscientious refusals, quietly allowing authors to slip into this debate more than what most readers suspect or realize. I do not suspect, nor am I accusing any authors of such deception; the mere possibility of it is troubling enough and consequently worth mentioning. The focus of the rest of this section will rather concern the logic of certain arguments in the literature. In particular, the following examples will show how adherence to the dominant view of conscience at the outset of this debate has unwittingly led several authors to beg the moral question of conscientious refusals and to disadvantage refusing health-care workers.

In Martin Benjamin's article on conscience in the *Encyclopedia of Bioethics*, a theory of conscience is developed and then quickly put to work in sketching an approach to judging the morality of, and to setting policies for, conscientious refusals in medicine. Benjamin's presentation, in other words, exemplifies the method called for by PCP. After surveying two faulty theories of conscience (the intuitionist "moral sense" model and the internalized social norms model), Benjamin settles on a theory which states that "appeals to conscience are closely connected to reflective concern with one's integrity. The focus is not so much on the objective or universal rightness or wrongness of a particular act as on the consequences for the self of one's performing it."¹² The experience of conscience arises upon reflection on a past, current, or future action—one's *own* action—and consists in a "signal that something is wrong—that one's integrity has been, is currently, or would be compromised," followed by "an actual or anticipatory feeling of guilt, shame, or remorse."¹³ Benjamin's view of conscience draws heavily upon that of Childress, cited above, and is another excellent example of the dominant view.

Benjamin was writing an encyclopaedia article, not an intricate policy on conscientious refusals in medicine, so while the essentials of his approach to the problem are present, the details are predictably and forgivably sparse. What is absolutely clear, however, is that he believes that the correct approach to dealing with conscientious refusals follows closely upon the account of conscience he has just sketched—that is, Benjamin argues about the morality of conscientious refusals in a way that conforms to PCP. The following passage serves as an illustration of Benjamin's method in action:

The values underlying appeals to conscience within the health-care system are not, therefore, radically at odds with the values underlying medical and nursing care. In each case, the aim is to preserve or restore personal wholeness. Insofar, then, as appeals to conscience and the health-care system share a fundamental commitment to preserving and restoring personal wholeness or integrity, we ought in cases of conflict to seek some sort of balance or accommodation between them.¹⁴

On Benjamin's view, a patient requesting a medical service and a health-care professional who conscientiously objects to that service both desire that their wholeness and integrity be either restored (in the case of a patient) or preserved (in the case of the health-care worker) through their interaction. What conflicts of conscience in medicine boil down to is therefore competing self-interests: usually the patient's self-interest in his physical well-being versus the physician's self-interest in her psychological well-being (of which moral integrity is an important part). The general policy advocated in the short passage above is to "balance" or "accommodate" the self-interest of, and potential harms done to, both parties in the conflict. Without his view of conscience, however, it would not be immediately clear that an appeal to conscience would be the kind of thing that *could be* placed on a common scale with a patient's interest in and request for medical attention. A physician's respect for morality is not *prima facie* commensurable with a patient's need or desire for medical treatment. It is for these reasons that Benjamin's approach to conscientious refusals is in need of close scrutiny, for he derives a non-intuitive plan for handling conscientious refusals from his previously defined account of conscience, and if the account of conscience were criticized or changed, then the policy would need to be radically reconsidered. How this constitutes begging the question will be seen momentarily.

For now it is easy to see how Benjamin's view of conscience—the dominant view—unfairly tips the balance on the side of patients' interests. In fact, Benjamin says as much: "[R]espect for conscience requires going to greater lengths for patients, however, than it does for health-care professionals."¹⁵ The reason we must favour patients is because their position in the conflict of conscience is not voluntary, while that of the health-care professional is. In other words, it is not the patient's fault that his well-being is at risk, whereas it *is* the physician's fault that her well-being is at risk through this conflict of conscience, because she chose to be a doctor in the first place. As Holly Fernandez Lynch has put it, just as there are health risks to which physicians must be prepared to consent (such as catching a patient's flu), so too there are moral risks involved in being a health-care worker that manifest themselves in conflicts of conscience.¹⁶ Benjamin's account of conscience taken in tandem with the assumption that physicians implicitly give their consent to a certain degree of moral risk makes conflicts of conscience analogous to illnesses that are implicitly consented to, perhaps even self-inflicted, by physicians. If a person does not like the kind of moral risk associated with medicine, then she should refrain from becoming a doctor, nurse, or other health professional.

Following Benjamin's reasoning, it would be tempting to say of every physician who conscientiously refused to render some service that this physician put her own interests ahead of her patients'. We might even be tempted to sum up the whole issue of conscientious refusals just as Julian Savulescu has memorably, but controversially, done: "[t]he door to value-driven medicine is a door to a Pandora's box of idiosyncratic, bigoted, discriminatory medicine. *Public servants must act in the public interest, not their own.*"¹⁷ On a theory of conscience other than the dominant view, however, it would not be so easy to paint every conscientious objector as someone who puts her own interests ahead of her patients'; for on other views of conscience (say the Medieval view), conscience is not primarily, if at all, concerned with any kind of self-interest—it is God's interest, or respect for the moral order, or simply doing the right thing that is at the heart of conscience. None of these things can be "balanced" with a patient's self-interest in any obvious way that would render Benjamin's recommendation remotely workable.

We have now seen concretely how adhering to PCP can lead one to beg the moral question of conscientious refusals: physicians were doomed to Savulescu's charge the moment conscience was intimately linked with self-interest, as it is in the dominant view. The moral question of conscientious refusals involves asking, among many other things, whether physicians who conscientiously refuse to provide a medical service should be considered selfish or heroic; but once conscience is equated with a form of self-interest, this question becomes trivial, for heroes don't act for the sake of their own "inner psychological unity," they act for the sake of selfless ideals much higher than themselves. It is not clear how, on the dominant view, a person with a strong conscience could be anything other than selfish, let alone admirable from the perspective of others or heroic, which should be a problem for anyone who has the intuition that having a tenacious conscience is generally a virtue to be applauded.

A refusing physician who happened to adhere to the Medieval account of conscience would have good reason to respond to Benjamin and to Savulescu that it is unfair to judge her case in terms of a theory of conscience with which she disagrees in some fundamental respects. She could point out that on her view of conscience, self-interest is not at all what motivates conscientious action. She might point out that she finds acting morally very difficult, and often unpopular in her workplace, with the result that self-interest seems to be the furthest thing from conscientious action. For such a physician, conscience is respected to the detriment of inner psychological unity, not out of an interest for it. This physician, in light of Benjamin's disposal of her view of conscience from the outset, might even wonder why she bothers explaining her refusal: her case was decided as soon as the dominant view of conscience was introduced into it. In other words, the question of the morality of her refusal was begged because the moral status of the refusal—the thing to be determined—was built into the notion of conscience that was used to judge her case.

It will be valuable to consider a few more examples from the literature of the effects of the dominant view and PCP on the debate on conscientious refusals. In Mark R. Wicclair's paper, "Conscientious Objection in Medicine," the notion of conscience is introduced immediately because Wicclair begins his paper with a consideration of "conscience clauses" that have arisen in the United States over debates concerning controversial medical treatments like abortion and physician-assisted suicide. One such clause that Wicclair quotes is the Hastings Center *Guidelines*, which states that "If a health care professional has serious objections to the decision of the patient or surrogate, so that carrying it out is impossible as a matter of conscience or commitment to principle, the professional is not obligated to do so. . . ." ¹⁸ The explicit mention of "conscience" in this guideline initially justifies Wicclair's decision to focus on this concept in his article. But notice that the Hastings Center gives a choice here for how to frame the debate: "as a matter of conscience or commitment to principle." Wicclair does not discuss this alternative in his paper and instead assumes throughout that every serious objection is conscientious in the sense of stemming from conscience.

Wicclair's assumption leads him to search for a theory of what grounds the moral value of appeals to conscience. The theory he settles on is again the dominant view: "When a physician claims that there is an action that he or she cannot in good conscience perform, the physician is not merely stating that the action is unethical. Rather, the physician is stating the stronger claim that his or her moral integrity is at stake, and appeals to conscience can be understood as efforts to preserve or maintain moral integrity." ¹⁹ On the basis of the dominant view of conscience, Wicclair derives the following guideline for evaluating the morality of appeals to conscience in medicine.

Conscience based objections have more moral weight when they are based on beliefs that are more central to the physician's core ethical values; and they have less moral weight when they are based on beliefs that are more peripheral to those values. Moral beliefs that are more central to a physician's core ethical values are also more central to a physician's self-image or self-understanding, and, hence, moral integrity. ²⁰

This passage is another excellent example of PCP at work: Wicclair's prior reflection on conscience and the source of its value clearly becomes the foundation for a principle for dealing with the moral issues surrounding conscientious refusals. At first glance, the guideline is a good one: we do not want our health-care workers refusing to provide services for reasons that mean little to them, and this guideline ensures that refusals arise only when much is at stake for the one doing the refusing. But whether intentionally or not, Wicclair has led us down the same path as Benjamin toward a policy whereby the morality of conscientious refusals is determined by weighing competing interests, or equivalently, the relative harms done to the health-care worker (if she is not permitted to refuse) and to the patient (if the refusal is permitted). This move is subtly made by Wicclair when he makes the value of conscience lie in the relation of conscience to "self-image" and "self-understanding"—the destruction of which leads to psy-

chological harm. Again, the refusing physician or nurse could object that what is at stake for her is not her self-image or self-understanding, but Right and Wrong, or something else beyond her personal interests. Once we accept this “weighing-harms approach,” which is the inevitable result of the conjunction of the dominant view and PCP, refusing physicians will ultimately seem selfish, as we have already seen.

Fernandez Lynch provides a list of authors who urge this “weighing-harms approach” to the moral value of conscientious refusals.²¹ She rightfully calls the approach “question begging,” but she does not give the strongest reason for this otherwise correct analysis. On Fernandez Lynch’s view, the approach of Benjamin and Wicclair (among others) begs the question “since it offers little guidance as to how harms to various parties should be weighed.”²² The deeper problem with the approach is that it assumes that moral refusals and patient demands are the kinds of things that *could be* weighed in common units in the first place, which is a non-intuitive, even slightly bizarre, notion: for what do pain, distress, and desire for treatment on the one hand, and respect for morality on the other, have in common that could serve as currency between them? How much pain in my leg is worth the violation of a moral law by you?

In fact, Fernandez Lynch herself implicitly adheres to the dominant view, which is clear when she speaks of the physician’s respect for morality in terms of self-interest, and argues that these interests can be more or less weighty.²³ The result is that she, too, leads us toward the weighing-harms approach to conscientious refusals that she herself called question-begging. Fernandez Lynch’s constant analogy—introduced toward the beginning of her book²⁴ and faithfully employed thereafter²⁵—between physical risk and moral risk, encourages this question-begging element to sneak into her analysis. Consider her treatment of the “hard cases” of conscientious refusals, that is, the cases of the “last doctor in town.” Fernandez Lynch’s position in this section of her book is coloured by the dominant view in ways reminiscent of Benjamin’s and Wicclair’s earlier articles, especially in invoking the notion of integrity: “the physician’s moral autonomy is trumped by her own autonomous choice to enter a profession that bears social benefits and social responsibilities. Personal integrity is worthy of protection, but it can be outweighed by the need for professional integrity.”²⁶ Her moral judgment on refusals in the hard cases is most reminiscent of Benjamin:

Doctors have the flexibility to control their exposure to situations they find morally problematic by virtue of their selection of employment and geographic location, and they may avoid having to consent to moral risk if they take action to ensure that they will never stand as the sole gatekeeper for any patient. However, if they have failed to do so, their voluntary choice renders *their interests* less compelling than those of patients depending on them for care.²⁷

Fernandez Lynch recognizes that weighing harms begs the question in this debate, but she has failed to realize that weighing “interests” in this debate begs the question just as much. Moreover, why does Lynch assume

that it is only the interest of the last doctor in town that is in competition with the interest of the patient? Is it not arguable that, on some sense of “interest,” it is in *everybody’s* interest that the morally right course of action be taken in this small town; and if the refusal is a morally justifiable one, then is it not in everybody’s interest that it be respected and that the patient therefore be denied his treatment, regardless of whether the physician voluntarily became the last doctor in town? The dominant view of conscience has coloured Fernandez Lynch’s analysis and caused her to portray the “hard cases” debate as a conflict between two isolated interests: the physician’s and the patient’s.

Admittedly, I have only given reasons to worry about agreeing on the dominant view of conscience. However, it should be clear that *any* theory of conscience will meet with difficulties similar to those met by the dominant view. For instance, the adoption of the Medieval view would obviously tip the balance of the debate as well, but this time in favour of refusing health-care workers over their patients, since to ask a physician, for example, to act contrary to her conscience would be tantamount to asking her to disobey one of God’s laws. In general, as long as there is disagreement over the nature of conscience, and as long as this disagreement figures into conflicts, then there will always be patients and health-care workers who should object to any particular theory of conscience being used as the measure of the morality of their acts of conscientious refusal, especially if that theory differs radically from their own and tips the scales against them.

4. CONSCIENTIOUS REFUSALS WITHOUT CONSCIENCE

As we have seen, Sulmasy has remarked that it is strange whenever discussions of conscientious refusals in medicine begin without a discussion of conscience (which he considers to be too often). But surely it is even stranger whenever a discussion of conscientious refusals begins without discussing what is required for a refusal to be considered conscientious rather than something else; and I think that *this* happens all too often, including in Sulmasy’s paper, which includes no such discussion at all. If we had such a discussion of what makes a refusal conscientious, then it might occur to us to ask whether an explicit appeal to conscience is necessary. If we agreed (as I think we would have to) that no *explicit* appeal to the concept of conscience by a health-care worker was required for her refusal to be considered conscientious, then we might still cling to the idea that all conscientious refusals must involve at least an *implicit* appeal to conscience; that is, all such refusals must ultimately, if only unconsciously, be grounded in the activity of conscience. The purpose of this section is to ask whether this latter idea is actually the case: must conscience always be at the root of every conscientious refusal, even if only implicitly?

Fernandez Lynch is an author who would respond affirmatively to that question. On the one hand, she defines “conscientious refusal” in very general terms, excluding any mention of conscience as such: “the phrase ‘con-

scientious refusal' ought to be defined broadly to include nearly every *normative* ground for objection to a medical service. . . ."28 Fernandez Lynch's definition is meant to distinguish conscientious refusals from refusals based on non-normative grounds, such as those of regret, self-loathing, boredom, convenience, and laziness. A conscientious refusal is therefore, on her view, any refusal grounded in moral reasons, whether or not the description of these reasons includes any mention of conscience. However, she finishes the above definition as follows: ". . . even if philosophical definitions of conscience have traditionally been more restricted." This passage indicates that she still understands her definition of conscientious refusals to include, implicitly, the notion of conscience.²⁹

Fernandez Lynch appears to believe that conscience is obviously at the root of every judgment that something or other is *wrong* and *should not* be done. Others believe that conscience is restricted to only a subset of such normative claims, and so they restrict conscientious refusals to a narrower class of actions than Lynch does. Kent Greenawalt, for example, writes: "'Moral grounds' is a broader category than 'conscientious objection'; the notion of not committing an act against conscience probably lies closer to 'conscientious objection' on this spectrum of possibilities."³⁰ For Greenawalt, conscientious refusals are those refusals that indicate that a person not only has principled moral objections to some requested service, but also that they "cannot comfortably participate" in that service.³¹ But Greenawalt does not attempt to give a detailed theory of conscience to further ground this distinction between conscientious and normative reasons.

I do not believe, however, that there is any reason to distinguish conscientious and normative reasons for the purposes of the conscientious refusals debate. Fernandez Lynch is correct that we ought to consider any refusal on the basis of normative reasons to be a conscientious objection. However, she makes an unnecessary move when she assumes that we should then consider every normative reason to be grounded in conscience. To make this equation is really to strip "conscience" of all concrete meaning; it simply becomes a synonym for "morality." Here, then, are some examples of conscientious objections without conscience.

Suppose a nurse objects to participating in plastic surgery. When asked why, he responds that the aim of medicine is not to make people more beautiful, but to restore their health. He adds that medical personnel and resources are too expensive and scarce to waste on such frivolity as making someone's nose narrower. There is no explicit appeal to conscience by this nurse, yet his refusal, I believe, should be considered conscientious. If a plastic surgeon were in need of a nurse to aid him with a patient, and if no other nurse were available but this objecting one, then we would have as genuine an instance of a conflict of conscience in medicine as could be imagined. Now suppose that, even in the absence of any explicit appeal to conscience by the nurse, we decided to evaluate and resolve this conflict by appealing to the dominant view of conscience. We would say that the nurse is attempting to protect his inner psychological unity by refusing to aid the

plastic surgeon. But the nurse would likely object to this understanding of his behaviour, and he might exclaim: “Forget about my inner unity! I simply refuse to see the medical profession reduced to a vending machine for whatever whimsical desires people have.” Someone might respond that this nurse’s inner unity would be harmed if the medical profession became a vending machine, and this harm is really the nurse’s motivation in refusing. But I have already dealt with the fallacious and gratuitous nature of this approach to the problem in the above sections. It would be equally fallacious to insist on any other theory of conscience as a means of explaining this nurse’s objection, which is therefore an example of what I have in mind by a “conscientious refusal without conscience.” Here is another example.

Suppose a physician refuses to perform abortions. When asked why, she responds that when a pregnant woman walks into her office there are, in her mind, two patients present: the woman and an unborn child. The physician continues by saying that the aim of medicine is to do whatever is in one’s power to help patients, and since there are two patients, the physician must do whatever is in her power to help them both. Consequently, the pregnant woman’s request to end the life of the other patient in the room is incompatible with the aim of medicine. There may be a thousand objections to what the physician has said, but none of them is to the point that I want to make here, which is that this physician has made no explicit appeal to conscience in her refusal, yet her case is the epitome of a conscientious refusal. It would be arbitrary and would beg the question to insist that she is refusing out of an interest for her conscience or inner unity when the physician insists that her motivation is rather the interest of each and every patient who walks into her office, that is, the fulfillment of the goal of medicine.

The two refusals above do have something in common, though it is not an appeal to conscience; it is rather an appeal to the aims of medicine. Both the nurse and physician believe they are faced with a demand that runs contrary to the spirit of their profession. Rather than evaluating the morality of their refusal in terms of prior reflection on the nature and value of conscience, which are beside the point, we should evaluate their refusals by reflecting on whether or not there is room within the medical profession for disagreement over how to interpret the aims of medicine. Is it beneficial or is it harmful to the medical profession, to individual hospitals, to patients, to allow health practitioners to disagree with one another in an open way about the goals of their practice? Concerning what particular aims and what concrete procedures can and should we allow disagreement? These questions are more concrete and more relevant to the above two cases than questions about the degree to which conscience, personal integrity and inner psychological unity ought to be valued and protected in health professionals, none of which questions were suggested by the reasons given by the nurse or physician themselves.

If there are conscientious refusals without conscience, as I have argued there are, then the problem of conscientious refusals is more difficult to deal with than proponents of PCP would lead us to believe. We can no longer

group all conscientious refusals together through a supposed common appeal to conscience. Instead, we must investigate each refusal on its own terms, and be willing to apply different principles to each case and reflect variously on them as the issues they raise vary. If conscience is invoked by an objector, then we must reflect on the nature and value of conscience and its role in medicine. But if conscience is not invoked, as it was not in the above two cases, then we must be ready to analyze other problems that *are* raised. If the refusal is grounded in religious belief, then we must reflect on the place of religion in medicine; if the doctor-patient relationship is the problematic element, then this issue must be studied; if the goals of medicine are at stake, then that is the terrain of the dispute; and so on.

5. METHODOLOGICAL RECOMMENDATIONS

I have argued above that there are potential problems with beginning the discussion of conscientious refusals with an analysis of the concept of conscience, and I have furthermore argued that this method is not always necessary. The goal of the paper has not been entirely to discourage the discussion of conscience, but rather to highlight the subtle ways in which such discussion can colour the debate on conscientious refusals. In fact, in the context of some conscientious refusals, I believe it *is* necessary to begin the moral evaluation of the case with a discussion of conscience, as I have already suggested regarding the cases where conscience is explicitly invoked. There is another case where discussion of conscience is most useful, and perhaps even necessary, and this case may be the most important instance of conscientious objection of all. Childress focuses our attention on this important instance:

The agent typically views his appeal to conscience as a last resort to be employed only when he thinks that he has exhausted other arguments justifying or excusing his conduct. For the appeal to conscience is unnecessary if other reasons are acceptable, and it appears to constitute a cloture of debate. Usually the agent has given up the attempt to convince others of the objective rightness of his act and is content to assert its subjective rightness, perhaps to secure some positive treatment such as an exemption from ordinary duties.³²

The case in question is where the agent's refusal is not attended with any attempt to explain in objective terms, or to convince others of, his reason for the refusal. It is the case where the motivation for the refusal is ultimately "personal." We should be careful not to confuse personal reasons with self-interested reasons, however. By saying that the refusal is personal, we mean that the agent does not believe his reasons are valid for everybody, or that his reasons are understandable by everybody. The agent despairs of being able to make his case clearly or convincingly, and so settles by saying: "I cannot do what you are asking, because it would be wrong *for me*. Please respect that." The agent may believe that the act in question is wrong for others too, but he does not engage that reason in his refusal; he wishes only

that his concern for his own moral character be respected. Such a debate-ending appeal to personal morality, whether or not conscience is explicitly invoked, seems amenable to an analysis in terms of conscience and its value for individuals and society. This is because whatever conscience is, we can surely agree that it is the deeply personal sense of morality that we all possess and that we wish to obey. So we would do well to discuss conscience to engage conscientious objections of this “last resort” type.

What follows are practical guidelines based on the results of this paper for proceeding to evaluate the moral status of these and any conscientious refusals on the basis of prior reflection on conscience.

(a) *Ask whether the refusal is conscientious or not.* Every analysis of conscientious refusals, either in general or in particular, must begin with a discussion of what makes a refusal conscientious. I have argued that not every conscientious refusal is related to conscience, either explicitly or even implicitly. While I have not argued for any specific definition of “conscientious refusal,” I have suggested that a broader understanding of this term, more in line with Fernandez Lynch than with Greenawalt, is preferable.

(b) *Justify any appeal to the notion of conscience.* Since it is not trivially the case that conscience is at the heart of every conscientious refusal, then the appeal to conscience by commentators in this debate must be justified. If conscience is explicitly invoked by a refusing health-care worker, then the justification is simple, but if it is not, then the commentator in the debate must do what has not yet been done in this literature, which is to justify her commitment to PCP.

(c) *Explain the source of unity of the notion of conscience.* As we saw in earlier sections, it is not obvious, in light of the break with Medieval philosophy that long ago occurred, that we should continue to speak of “conscience.”³³ If a commentator insists on the necessity of invoking conscience in this debate, then she must explain what it is that makes conscience a unified notion still worthy of our attention. She must identify the “glue” that binds more primitive mental acts into complex, but unified, acts of conscience.

(d) *Be the first to explore the potential consequences for this debate of one’s conception of conscience.* I have argued above that the dominant view of conscience begs the question and tips the balance in the debate on conscientious refusals. It is possible that some other conception of conscience does not do so, and can therefore be used in the debate to good effect. However, it is also possible—I would even say likely—that *every particular theory of conscience* will meet with disagreement by parties interested in the conscientious refusals debate, and therefore, it is not clear that *any* particular theory of conscience can be used as a standard by which to judge the moral status of acts of conscientious refusals without begging the question and tipping the balance. In any case, commentators who offer a theory of conscience should be the first to explore how their conception of conscience might colour the debate, and the first to neutralize this effect.

(e) *As much as possible, work within the terms of individual conflicts.* Instead of imposing one's own theory of conscience as a template on others, commentators should seek as much as possible to work within the framework that is provided by the refusing health-care worker. If an objector invokes the Medieval conception of conscience to justify her refusal, then we must work to some degree within that model. We might, for instance, ask to what degree appeals to natural and eternal law, or to one's religion, should have any weight in the medical profession. This is more fruitful than denying the natural and eternal laws from the outset of the debate and then translating all such appeals into concerns for inner psychological unity. Before despairing and claiming that there are infinitely many possible terms within which a conflict can be framed, we should rather study empirically how refusing health-care workers express the motivation for their refusals. We may find that very few invoke conscience; or we may find that a certain conception of conscience is dominant "on the street" that differs from the dominant view in the literature; or we may find that two or three conceptions exist; etc. The point is that academics should not decide for health-care workers what motivates every one of their refusals, which has the result of *oversimplifying* an inherently complicated issue.

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NOTES

1. See Holly Fernandez Lynch, *Conflicts of Conscience in Health Care* (Cambridge, Mass.: MIT Press, 2008), Introduction, for a general overview of the problem and for a variety of cases of conscientious refusals.

2. See Ryan E. Lawrence and Farr A. Curlin, "Clash of Definitions: Controversies about Conscience in Medicine," *American Journal of Bioethics* 7.12 (2007): 10–14; and Daniel P. Sulmasy, "What is Conscience and Why is Respect for it so Important?" *Theoretical Medical Bioethics* 29 (2008): 135–149.

3. Lawrence and Curlin, "Clash of Definitions," p. 10.

4. Sulmasy, "What is Conscience," p. 135.

5. See Timothy C. Potts, *Conscience in Medieval Philosophy* (Cambridge, UK: Cambridge University Press, 1980), esp. chap. 1 and pp. 79–80.

6. For the fascinating etymologies of and linguistic connections between *synderesis*, *synteresis*, and *conscientia*, see Potts, *Conscience in Medieval Philosophy*, pp. 10–11; and C.S. Lewis, *Studies in Words* (Cambridge, UK: Cambridge University Press, 1967), chap. 8, "Conscience and Conscious."

7. See Lawrence and Curlin, but see also Thomas E. Hill, Jr., "Four Conceptions of Conscience," in *Integrity and Conscience*, *Nomos* vol. 40 (New York: New York University Press, 1998), pp. 13–52.

8. Carolyn McLeod has identified the dominant view (and coined that term for it) in her paper, "A Feminist Relational Perspective on Conscience," in *Being*

Relational: Reflections on Relational Theory and Health Law and Policy, ed. J. Downie and J. Lewellyn (Vancouver: University of British Columbia Press, forthcoming). The dominant view is espoused and developed in at least the following works: Martin Benjamin, "Conscience," in *Encyclopedia of Bioethics*, 2nd edn, ed. Warren T. Reich (New York: Macmillan: 1995), pp. 469–472; Dan W. Brock, "Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?" *Theoretical Medical Bioethics* 29 (2008): 187–200; James Childress, "Appeals to Conscience," *Ethics* 89 (1979): 315–335; Mark R. Wicclair, "Conscientious Objection in Medicine," *Bioethics* 14:3 (2000): 205–227.

9. Childress, "Appeals to Conscience," 327.

10. See McLeod, "A Feminist Relational Perspective" (forthcoming), for discussion of the different senses of this term in the literature.

11. See McLeod, "A Feminist Relational Perspective" (forthcoming).

12. Benjamin, "Conscience," p. 470.

13. *Ibid.*

14. *Ibid.*, p. 472.

15. *Ibid.*

16. Fernandez Lynch, *Conflicts of Conscience*, p. 51.

17. Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 322 (2006): 294–297, at 297 (my italics).

18. The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*, pp. 32–33; quoted from Wicclair, "Conscientious Objection in Medicine," p. 209.

19. Wicclair, "Conscientious Objections in Medicine," p. 213.

20. *Ibid.*, p. 221.

21. Fernandez Lynch, *Conflicts of Conscience*, p. 147.

22. *Ibid.*, p. 148.

23. *Ibid.*, p. 198.

24. *Ibid.*, p. 51.

25. But especially on pp. 196–203.

26. *Ibid.*, pp. 196–97.

27. *Ibid.*, p. 197, emphasis mine.

28. *Ibid.*, p. 36.

29. This was made clearer in Lynch's book when she wrote, "For obvious reasons, conscience plays a major role in ethical endeavours, and those within the realm of bioethics are certainly no exception," p. 21. Why is it *obvious* that conscience is involved in ethical endeavours, especially considering that there is little consensus on what conscience is? The answer must be that Lynch, like so many others, assumes that all of ethical reflection just is, by definition, the consultation of one's conscience.

30. Kent Greenawalt, "Objections in Conscience to Medical Procedures: Does Religion Make a Difference?" *University of Illinois Law Review* (2006): 821.

31. *Ibid.*, p. 818.

32. Childress, "Appeals to Conscience," p. 329.

33. Another reason, which I have not had time to explore in this paper, why we should be wary of the language of "conscience" in this debate is that conscience is a distinctively Western concept and does not capture, and is even opposed to, the experience of morality of large segments of the world's population. In an increasingly culturally diverse medical community, this is a strong reason to explore conscientious refusals in terms independent of "conscience." See George D. Chrystides, "Buddhism and Conscience," in *Conscience in World Religions*, ed. Jayne Hoose (Notre Dame, Ind.: University of Notre Dame Press, 1999), pp. 176–199.