

Conscientious Objection, Professional Ethics and Public Spheres

A paper presented at Symposium on 'Dying Well: Enacting Medical Ethics' at St Bartholomew's Hospital Pathology Museum, London, on 26 September 2015

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The Symposium reflected on responses to a production of Arthur Schnitzler's play *Professor Bernhardt* by [Foreign Affairs], an international theatre company based in East London. The translation was by Judith Benniston with Nicole Robertson. The director was Trine Garrett.

For further details, see www.foreignaffairs.org.uk and for podcasts from the Symposium, including the oral presentation of this paper, see <http://backdoorbroadcasting.net/2015/09/dying-well-enacting-medical-ethics/>

Abstract: Conscience matters deeply, but professional roles are not merely personal. They involve shared identities, values and responsibilities. We all have multiple roles and identities. Professor Bernhardt is at once a doctor and a Jew, a hospital director and a father. These identities are both personal and archetypal. They are also vocational, as is the role of priest. The 'calling' is to something pre-defined, to serve in a particular role. Professional conscience can never be a truly private matter. The four acts illuminate the interplay between roles and expectations; changing by location, time and space, including the degree to which they can accommodate personal adaption. The clinic has its own hierarchy of authority. Professor Bernhardt, as doctor, is in charge. There is no place for conscientious objection. The focus is on matters of the body. The patient becomes a person only when the priest challenges the jurisdiction of the doctor, and in response Professor Bernhardt becomes her protector. Professor Bernhardt the Director has different responsibilities. The reputation of his hospital matters. He can contemplate an apology now that time is not critical. It is about the 'big picture' and the conflict is portrayed within grand battles; faith against science, darkness against light. We should encourage full, unconstrained, conscientious engagement in such debates. In the Hospital Board Room, the play makes comedy of the rivalries and factions of hospital life, but it also models a process of negotiation over the resolution of competing claims. We should respect conscience in service organization, but balance it with patient's rights. Finally, in the privacy of Professor Bernhardt's home, the doctor and priest might unburden themselves of their roles in favour of an underlying common humanity. In fact, the attempt to do so collapses and they cannot avoid their public identities.

My contention in this paper is that conscience matters deeply, but that the ways in which it matter vary across roles, across time and across spaces. If we cannot act conscientiously, then it is unclear why our lives have value. If we cannot be true to our consciences, our sense of self will implode. Yet, professional roles involve shared identities, values and responsibilities. I am in favour

of the recognition of professional conscience, including the rights of doctors to withhold clinically inappropriate treatments that patients may demand. However, I am opposed to rights of conscientious objection, such as are included in current proposals for legislation on assisted dying. This is because they automatically privilege the private personal morality of professionals over the legitimate expectations of patients. What we need is a framework to facilitate the negotiation of conflicting values, complex identities and ambiguous roles that is sensitive to the fact that health care sits in the public sphere and must balance personal and professional conscience with service requirements.

The play reminds us that we all have multiple roles and identities. Professor Bernhardt is at once a doctor and a Jew, a hospital director and a father. These identities are both personal and archetypal - the role of Bernhardt can be shared amongst the cast because it is a 'role' not a purely personal identity. The public nature of the role is characterised by the badges of office, marking the common recognition of the bearer as medical. The cast puts on white coats to mark the commencement of the performance as a medical drama. The passing of the stethoscope to identify who is playing Bernhardt reminds us that the doctor's role is given to individuals rather than created by them from nothing. This is a point that we can characterise through the idea of vocation - something that both the doctor and the priest share. The calling is to be something that is pre-defined, a call to serve in a particular role.

We should not lose this idea of vocation. It captures some of the reasons why the dilemmas explored in the play are questions of conscience not personal preference. First, a sense that the reason for serving is partly external and makes demands that cannot comfortably be ignored.

Second, that those demands have a non-negotiable element – if I respond to the call, then I must accept that the role is constrained. I can develop my vocation but it must be a development of the role, a response to the call, not the substitution of purely personal vision. The degradation of the vocational sense of the health professions by the law and by government should be a cause for concern. I see this degradation being exacerbated by the Supreme Court's recent assertion of amoral consumerist rights in relation to both end of life care and also informed consent (*R (Nicklinson) v Ministry of Justice* [2014] UKSC 38, *Montgomery v Lanarkshire Health Board* [2015] UKSC 11). It is apparent too in the aggressive approach of the current government to the medical profession, threatening to impose rather than negotiate contracts of employment. Requiring health professionals to work to rules also encourages them to 'work to rule'. It undermines their conscientious exercise of professional judgment by undermining their agency. However, this sense of professional conscience is rooted in the collegiate values of the profession not personal morality. It is not the freedom to do as you wish, but the freedom to be a doctor.

One of the ways that the play illuminates the complexities of the interplay between roles and expectations is through the different locations in which the drama is set. The four acts of the play remind us of the way in which time and space characterises the expectations of our role, including the degree to which expectations are fixed and to which they can accommodate personal adaption.

The Clinic

We begin in a clinical space, not quite the ward but within shouting distance of it. It has its own hierarchy of authority and is the jurisdiction of Professor Bernhardt the doctor. The space is porous; outside life is present in the anticipated pleasures of a ball, the rivalries of professional ambition, and the sinful origins of the dying woman's sepsis. Whether the sin is hers - the cost of pleasure with the lover she dreams of - or that of the back street abortionist, is unclear. But it seems that the wages of sin is death as St Paul taught. In this space, the focus is on matters of the body; dead, alive and dying. In the clinic, the medical truths are paramount and we are even told that it is a divine injustice to die before you can discover all the things that are medically wrong with you. The patients are primarily vehicles for their medical conditions. The woman becomes a person only when the priest challenges the jurisdiction of the doctor, and in response Professor Bernhardt becomes her protector.

This is not an act of conscience but an assertion of professional role and jurisdiction. Authority in the clinic belongs to medicine not the Church. However, the play also calls into question the claims of medicine to be scientific rather than moral. The cause of death that was previously described as an inevitable biological certainty suddenly becomes the psychological shock of being confronted with her mortality through her awareness of the presence of the priest.

Clinical spaces are characterised by purpose and time as well as jurisdiction. The purpose of the clinic is patient care. In the clinic, the needs of the individual patient are privileged over the wider public good and even of other patients. In the clinic, to permit health professionals to limit the options of the patient for reasons of personal conscience violates the purpose of the space. It introduces extraneous issues that replace the patient as the centre of attention with the interests of others around her.

The clinic also has a limited time frame. Decisions must be taken urgently and the play focuses on the final hour of a life. The clinical tussle between science and faith must be resolved in a single and brief clash rather than the protracted dissection of possibilities that unfolds through the play. This is another reason why conscientious objection has no place in the clinic. There, the patient is wholly reliant on their doctor to be the incarnation of medicine to them not some dim and partial reflection – glimpsed only through a glass darkly, to bring in St Paul once again. Health professionals should not be permitted to opt out of their calling by picking and choosing those elements that they find conducive.

This is partly recognised in the specific legal recognition of conscientious objection in the Abortion Act 1967, which does not permit professionals to opt out of providing emergency care 'which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman' (s 4(2)). This recognition is not, however, contained in Baroness O'Loan's Conscientious Objection (Medical Activities) Bill, currently before the House of Lords. My contention is that rights to opt out of direct patient care are incompatible with the vocation of medicine. The clinic is a place for professional conscience - conformity with the shared values of medicine - not personal preference.

Conscience and policy debate

The second act is in a different space; the director's office. Here different questions are raised as to exactly which the roles are that are being played out. The Minister is a former doctor, but now a politician. A past medical misdemeanour is discussed; causing a death by an omission (a vexed question for the law and ethics of professional responsibility). In this case an omission to speak up. Today, in England, we would see it as a matter of whistleblowing and the newly created duties of candour. We have created a legal duty to speak out. The play suggests that failing to speak with conviction was already a sin against the vocation of medicine. However, it also seems to suggest that it is entirely consistent with the role of politician to subordinate openness and integrity to the desire for power and influence.

There is also once against the variant of time. Decisions in the clinic are a matter of the moment. Decisions in the director's office are a matter of longer-term context. Consistency with the past matters. So does shaping the future. The big picture prevails over the immediate problem, and the conflict is portrayed as caught up in grand battles; faith against science, darkness against light. The Minister claims that 'the thing is to follow the main idea of your life with faithfulness', and suggests that small immoralities are justified in the pursuit of the greater good. The Minister points out the breach of etiquette in challenging the pride of superiors and the risk to careers in doing so.

Professor Bernhardt the Director has different responsibilities now that he is out of the clinic. The reputation of his hospital matters. He can contemplate an apology now that time is not critical. It is far from clear what the medical role requires of him. In these circumstances, when the workings of the hospital and profession are open to reshaping, we should champion the exercise of

conscience, including those elements which are brought in from outside the corporate values of medicine. Health professionals have distinctive experience and expertise to bring to a debate such as that about good care at the end of life. They should be able and encouraged to contribute freely and to draw on the full richness of the range of their identities and roles. This is conscientious engagement, not objection (even if it takes the form of opposition to the professional status quo). It is entirely proper to engage as a doctor and person of faith in such debates. In the contemporary politics of bioethics at the end of life the Christian and Jewish voices are as likely to be aligned as in competition. In this public sphere of policy formation, conscientious voices should be encouraged because debate that is not infused with conscience will be much poorer for it.

Conscience and service management

The third space occupied in the play is the Hospital Board Room. This is an environment with which I am familiar, although it would not these days solely comprise medics (any more than it would comprise only men as in the play). The play makes comedy of the rivalries, extraneous motives, and competing factions of hospital life, but it also models a process of negotiation over the resolution of competing claims. It is the model of negotiation to explore the potential for accommodating personal conscience that I believe should characterise the response of health services to professionals who do not wish to participate in care about which they have moral concerns. Although I believe there is no place for conscientious objection in the clinic, we should seek ways to respect conscience in the organisation of the hospital, or wider health service. This is a matter of balancing the rights of professionals and patients. Neither should automatically prevail as they do both in the cases of rights of conscientious objection and also where there is complete disregard for matters of professional conscience.

I interpret the UK Supreme Court's decision in *Greater Glasgow Health Board v Doogan* [2014] UKSC 68 as adopting this approach. It limited the scope of the legal right to opt out of providing care, but recognised that health services would have to work to accommodate the consciences of their staff where it was possible to do so without compromising the services available to patients. The Supreme Court rejected the claim that professionals could refuse to participate in hospital management because they disapproved of the abortion services that were being offered. If Baroness O'Loan's Bill were passed, this position would be reversed and health professionals with a conscientious objection would be entitled to opt out of 'supervision, delegation, planning or supporting of staff. This right would be extended to 'the 'withholding of life-sustaining treatment' and activities under the Human Fertilisation and Embryology and Abortion Acts.

This would be a mistake. Hospitals should seek to reduce the extent to which staff are made uncomfortable by the convictions but they should not subordinate the delivery of high quality care to the demands of staff.

Conscience as a private matter

The final scene of the play takes place Professor Bernhardt's home and explores the possibility that the doctor and priest might unburden themselves of their roles in favour of an underlying common humanity. In fact, the attempt to do so collapses and they retreat into their respective institutions. The priest's attempt to bridge the abyss between them fails and they leave with their identities as priest and doctor intact. Despite the attempt to meet privately, they cannot avoid their public identities. It may be that conscience can never be a truly private matter, rather problems of conscience come from overlapping identities - connections with conflicting value traditions - rather than personal preference.

The mainstream view is that conscientious objection is a matter of personal integrity. I have come to reject that view in so far as we are concerned with the clinic and legal rights. Not because I do not think it important that we have integrity, but that in the clinic it is professional integrity that matters.

In the privacy of his home, with the Priest his only witness, Bernhardt still expresses no doubt in the appropriateness of his actions. From a modern perspective this seems troubling. He preferred his patient to die happy but deceived. He showed no interest in whether she was Catholic. He imposed a reductionist medical view of her well-being. He may have legitimately asserted the jurisdiction of medicine in the clinic, and we should feel constrained to respect its authority in real time, but we should feel free to debate what is expected when reflecting on care options. Arguably, Bernhardt's lack of self-reflection suggests that he is not a man of conscience but of compliance - wedded uncritically to the role of doctor, although insightful into the dilemmas of hospital directors and politicians.

In the Play, the crisis of conscience is not Bernhardt's but the Priest's. He comes to see that his acceptance of the clinic as the jurisdiction of medicine, and of Bernhardt's actions as its necessary expression, would be perceived by others as the abandonment of his Faith's claims to authority. His commitment to truth and the future of his vocation conflict. The need to follow his vocation is the higher claim. This realisation of the risks might have been sound, as in the Play's unperformed fifth Act we discover that he has been transferred to a remote parish on the Polish border. There may, in fact, be no wholly private space, free from the burdens of role-identity. Our many identities may be integrated in our personhood, not separable from them.

Conclusion

My claim, therefore, is that we need to recognise the fact that we have multiple roles, and that these are not merely functions but embody values. Those roles make claims on us, and we must respect those who try to live up to their vocations. However, this does not mean either that those with vocations should not challenge the demands that are made on them by their professions. Nor does it mean that we must accept uncritically all that professions claim, not least because of the obvious connections between such claims and power. However, the proper response depends very much on context including, I have suggested, time and place.

I have tried to build from the structure of the play distinctions that I have found help make sense of some questions that I have engaged with in a more linear way in my academic work (J. Montgomery, 'Conscientious Objection: personal and professional ethics in the public square' (2015) 23(2) Med Law Rev 200-20). It has confirmed my view that we should refuse to accept conscientious objection, but we should aim to accommodate conscience.

The idea of professional identity is, of course, a process of simplification and abstraction, based on the explication of roles as archetypes. I began by pointing out that we all have multiple roles and nothing is simple. Professor Bernhardt had many hats. He could have perhaps have chosen to wear a different one in the scenes. I am not sure he could have been hatless, even in the personal sphere, because identity depends on it.

Sometimes the role you adopt makes the same activities mean different things. When I was promoted from being an NHS non-executive director to being an NHS Chair, I discovered I could no longer tell jokes. They were over-interpreted because people thought they were intended to signal something. Some years later, in a board development process, I got feedback that we needed more jokes because the board meetings were not enough fun.

Being unconstrained by that role here, I want to end with a story that was told to me by a friend whose husband was a priest. I was reminded of it during the performance. She was once in hospital and was visited by her husband and her friends, many of whom (like her husband) were in clerical dress. Once after visiting hours were over a fellow patient consoled her, saying she must

be very ill if so many priests were coming to minister to her. We should perhaps see her response as the mischievous woman in her triumphing over her public role of vicar's wife. I am sure that it was an accurate expression of the truth, but the point was not its accuracy but the confounding of expectations, and it answered a rather different question. Her answer was to reassure the woman that it was fine. She slept with only one of the priests. The others were just good friends.
