EXTENDED ESSAY

Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies

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ABSTRACT

We describe a number of conscientious objection cases in a liberal Western democracy. These cases strongly suggest that the typical conscientious objector does not object to unreasonable, controversial professional services—involving torture, for instance—but to the provision of professional services that are both uncontroversially legal and that patients are entitled to receive. We analyse the conflict between these patients' access rights and the conscientious objection accommodation demanded by monopoly providers of such healthcare services. It is implausible that professionals who voluntarily join a profession should be endowed with a legal claim not to provide services that are within the scope of the profession's practice and that society expects them to provide. We discuss common counterarguments to this view and reject all of them.

INTRODUCTION

It is not unusual for students in any given bioethics class to offer something like following defence of conscientious objection rights: 'Remember the Nazi experiments and the abuse of prisoners there and then? It is good that conscientious objection rights exist to protect good doctors refusing to participate in such crimes'. There are more sensible versions of this argument, such as one published by an admittedly not 'very courageous' doctor who wrote in the *British Medical Journal* that he would have hoped to object on conscience grounds to the abuse of prisoners in Stalinist Russia, and claims that knowing that he was 'part of an independent medical profession with allegiance to something higher and more enduring than the regime of the day' would have increased the odds of him doing the right thing.[1] We know, of course, in bioethics, that whenever a Nazi analogy is brought up to defend a particular normative stance, the odds are that that stance is weakly supported, if not outright indefensible. Unlike contemporary liberal democracies, the Nazis and Stalin's Soviet Union did not respect conscientious objectors, and neither did Pol Pot's henchmen and henchwomen. Well-known pacifists such as Hermann Stöhr, the leader of the German branch of an international pacifist organisation, perished in German concentration camps.[2] Conscientious objection typically does not flourish in dictatorships. Toleration of conscientious objectors in liberal democracies does little to support conscientious objectors in North Korea. The concept has evidently little currency there: its utility and legitimacy cannot be defended by pointing to Nazi Germany or Stalinist Russia. The same cannot be said for liberal democracies where respect for both individual as well as professional autonomy ranks highly. The medical historian John J Michalczyk got it probably right, when he noted that 'those who invoke the Nazi analogy in a broad or general fashion are pressing the limits of valid analogy simply because the broader the scope of their reference, the harder it becomes to understand exactly what they think the Holocaust was, and thus why it is of moral relevance to the current issue'.[3] We aim to take the ethical debate about conscientious objection in medicine back to where it currently properly belongs, namely liberal Western democracies where some medical doctors wish to see their private moral or religious objections to the provision of certain professional medical procedures accommodated by regulatory regimes. This is invariably at a cost to patients hoping to access medical services that they are legally entitled to access.

Liberal democracies rightly do not take a stance on the substance of their citizens' moral or religious or other convictions, what is protected in liberal democracies' constitutions is the citizen's' right to hold such beliefs and live by them—within reason. Typically, no distinction is and should be drawn between religious and other moral convictions, but that is not always the case.[4 5] In the kinds of societies that we are concerned about in this paper, the vast majority of litigated cases are triggered by religious conscientious objectors as opposed to secularists or atheists.[6] That in its own right is not a reason to disregard such complaints, because the protection of an individual's rights to adopt significant beliefs and live by them is at the heart of what living one's own life in a liberal polity is all about. For all practical intent and purposes, we are discussing predominantly religiously motivated conscientious objectors in the medical profession who ask that their objections to the delivery of particular professional services are protected by the secular state. There might be instances of conscientious objection in other kinds of societies. There might also be conscientious objection in other contexts, for instance, in case of military conscripts. This article will not address those contexts. We are concerned only with conscientious objectors who decided to join a particular profession (in this case medicine) voluntarily and who then wish to be exempt from providing services that are typically expected of that profession.

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CONSCIENTIOUS OBJECTION IN LIBERAL DEMOCRACIES: WHY SHOULD WE RESPECT IT?

Let us begin by trying to understand what *conscience* actually is. Daniel Sulmasy describes it as something that seems to operate both retrospectively as well as prospectively; it impacts on particular past actions and it impacts on how we evaluate normatively possible future actions.[7] He conceptualises conscience both as our conviction that we should act in accordance with our individual understanding of what morality demands of us, and on wilfully and voluntarily acting in accordance with what we consider to be morally good and right.[8] It is uncontroversial that asking someone to violate their conscience-based convictions in matters that are of great importance to them is also asking such individuals to accept a potentially fairly high psychological cost. Typically, when we act contrary to our conscience we will be plagued by guilt and possibly worse. Hermann Stöhr died rather than recant his pacifist convictions. There are others like him.

Why then should we, prima facie at least, *tolerate* conscientious objectors in liberal societies? There are various reasons that have been suggested for this. One is obvious from the above. Prima facie no society should force conscientious objectors to suffer the psychological cost that they would incur if they were forced to act against their conscience. Peter West-Oram and Alena Buyx have offered a number of other reasons. They write, 'the right to exempt oneself from the fulfilment of a generally held duty is typically justified on the grounds that such a right is vital for the preservation of freedom of conscience. The latter is itself argued to be a core value of pluralist, liberal-democratic states, and 'a moral right'. Further, the rights to freedom of conscience and conscientious objection are argued to be constitutive of liberty and autonomy, and to be necessary for the preservation of individual moral integrity. In promoting these goods, the rights are argued to be vital for the adequate toleration of different moral and philosophical perspectives in a pluralistic society.'[9] These are powerful reasons. On this reading respect for an individual's conscience is something of a corollary of the principle of respect for persons. Mark Wicclair has suggested in an influential paper that a blanket refusal to tolerate conscientious objection would constitute a significant threat to some doctors' moral integrity.[10] Similar views are expressed by Pellegrino.[11] It is not surprising then that there appears to be a broad consensus between religious voices in bioethics[12] and liberals[13] according to whom the failure to tolerate, protect and respect some conscientious objectors is incompatible with what it means to live together in a liberal multicultural society. It is also fair to say that some bioethicists have voiced more or less strong opposition to the view that we should accommodate medical doctors' conscientious objections.[14–16]

As mentioned in the 'Introduction' section, based on the review of hundreds of legal cases reported in Brian Leiter's book *Why Tolerate Religion?*, respect for conscience in the 21st century translates into a fairly one-sided affair: it is fought for and demanded by religious healthcare professionals without much regard for actual patient care and health outcomes, or indeed respect for these patients' moral choices. Considering the significant power differential between patients and doctors, this is remarkable in its own right. Whenever there is a conflict, on this account, a doctor's private ideological convictions generally take precedence in the professional practice of medicine. Various bioethicists have tried to suggest limiting criteria to avoid the possibility that arbitrary stances taken by doctors could pass successfully the conscience muster.[17] Typically, conscientious objections occur in the context of reproductive health (eg, abortion, in vitro fertilisation, contraceptives), end-of-life care (eg, assisted dying) and also affect negatively gays, lesbians and patients with gender dysphoria.

WHY CONSCIENTIOUS OBJECTION HAS NO PLACE IN THE PRACTICE OF MEDICINE

It is worth noting that scepticism about the importance of an individual's conscience claims within a community has been expressed by influential thinkers for many years. Thomas Hobbes had this to say in his *Leviathan*:

> another doctrine repugnant to civil society is that whatsoever a man does against his conscience is sin; and it dependeth on the presumption of making himself judge of good and evil. For a man's conscience and his judgement is the same thing; and as the judgement, so also the conscience may be erroneous. Therefore, though he that is subject to no civil law sinneth in all he does against his conscience, because he has no other rule to follow but his own reason, yet it is not so with him that lives in a Commonwealth, because the law is the public conscience by which he hath already undertaken to be guided. Otherwise in such diversity as there is of private consciences, which are but private opinions, the Commonwealth must needs be distracted, and no man dare to obey the sovereign power farther than it shall seem good in his own eyes.[18]

Poignantly, Hobbes makes this point in a chapter on 'those things that weaken or tend to the dissolution of a commonwealth'. Of course, Hobbes is not quite our archetypical defender of liberal democracies, but the point he is making here is valid, it applies to the case of conscientious objectors in liberal democracies, too.

Let us begin our argument by making the general case for why conscientious objection in medicine should not be accommodated.

We recognise that conscientiously objecting healthcare professionals can have various rationales to support their opposition to the participation of doctors, in particular medical procedures. They include typically a recourse to tradition, the Hippocratic Oath, the Bible, the Quran and any number of other documents that have no legitimate bearing on the practice of 21st century medicine. It is easy to show that even the objecting doctors' standard recourse to the Hippocratic Oath when it comes to abortion and assisted dying is not always credible.[19 20] It is evidently the case that other ideological convictions held by particular doctors motivate their deployment of the argument from tradition, in the guise of the Hippocratic Oath, because only the lines from the Oath that suit a particular objecting doctor's interests are typically cited, while those they disagree with are quietly ignored. But in any case, the Oath is not a defensible ethical guide to modern medical practice.[21] Mercier might be right in this context, when she writes that

> religion is all about believing that one's beliefs are right, but not about having right beliefs. If first-order religious beliefs had content, their content could be checked against the truth. It is precisely because such beliefs lack content that one can go on about believing that one believes them despite any and every evidence. But the price of second-order belief in vacant first-order beliefs is self-deception.[22]

On this background, it is fortunate from the conscientious objector's perspective that secular liberal democracies do not typically test whether the views conscientious objectors profess

to subscribe to are defensible. What matters is that they are deeply held, or, more to the point, that the conscientious objectors *claim* that they hold those convictions deeply.[23] Even on this count we are incoherent. A female Muslim doctor refusing to see a male patient would not be granted a conscientious objection exemption, whereas a pharmacist refusing to sell contraceptives in some countries might. Let us assume that both of these conscience decisions were loudly proclaimed to be genuinely held by the professionals in question. Why should one be respected and the other one not? It could be argued that in liberal democracies, constitutional documents and human rights legislation variously protect against gender-based discrimination but may not guarantee access to contraception. While this may be true it misses the point of the argument—that the substance of conscience-based objections that are protected is arbitrary. Take as an example the unfolding debates around marriage equality. Until quite recently this was a concept alien to liberal constitutions and human rights legislations. Those with conscience-based objections to same sex marriage were free to assert those beliefs against such couples. However, that is increasingly no longer the case. Nothing has changed about the same sex couples or the beliefs of the objectors; society has simply decided that such objections will no longer be tolerated.

Furthermore, just as we cannot test the plausibility of the ideological dicta that lead to conscientious objections (there is no test for the existence of 'God', for instance, or truth of the Bible), it is also impossible to ascertain whether conscientious objectors actually hold the views they profess to hold. The US Supreme Court writes on this issue,

> What principle of law or logic can be brought to bear to contradict a believer''s assertion that a particular act is "central" to his personal faith? Judging the centrality of different religious practices is akin to the unacceptable "business of evaluating the relative merits of differing religious claims..".. it is not within the judicial ken to question the centrality of particular beliefs or practices to a faith, or the validity of particular litigants' interpretation of those creeds…courts must not presume to determine the place of a particular belief in a religion or the plausibility of a religious claim.[24]

If that is the case, it remains unclear why untestable conscience claims from privileged professionals who voluntarily chose to join a particular profession, and who have been endowed by society with a monopoly on the provision of particular procedures, should be accommodated, given that this toleration subverts the very objectives the profession is designed to achieve. This does not deny anyone the right to hold any number of private religious and moral views, as they see fit and as they choose to hold. What we are denying is that professionals are entitled to subvert the objectives of the professions they voluntarily joined by prioritising their private beliefs over the professional delivery of services to the public, especially when they are monopoly purveyors of these services. Legal scholar Alta Charo called it right, when she wrote, 'claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust—all the worse if it is not in fact a personal act of conscience but, rather, an attempt at cultural conquest'.[25]

Various authors have warned that an unqualified right to conscientious objection in medicine would result into harmful consequences, for instance, for women wanting to have an abortion, who could be denied timely access to this healthcare procedure not because of legal constraints, but because of healthcare professionals refusing to provide such a healthcare service on conscience grounds. Frequently, a middle-ground is sought, as legal systems are indeed rare where conscientious objection rights cannot be overridden by a competing stronger right (eg, a patient's right to access healthcare in a timely manner). Typically, then the argument is not over whether conscience rights are defensible, but about what kind of compromise is reasonable for everyone affected.[26 27]

Unfettered versus fettered conscientious objection accommodation

It could be objected that the argument advanced in this paper is too simplistic as it appears to target only unfettered conscientious accommodation stances, when the focus in today's policy debates is about fettered conscientious objection accommodation. It may be argued that the question really is: where and how could society draw reasonable lines that take into account societal interests as well as those of individual objectors? The preceding section explains to some extent why we have taken this stance. The courts in various jurisdictions have already, rightly so, conceded that it is a moot point trying to establish the truth or even plausibility of the views purportedly held by conscientious objectors. That is not an insignificant point, because this concession opens the door to any number of more or less arbitrary and random conscientious objection claims. For policy makers aiming to establish a functioning healthcare system with predictable service delivery and guaranteed service levels to the people who finance the system, this constitutes an insurmountable problem. It is nigh impossible to predict which healthcare professional, in which part of the system will demand accommodation for which kinds of purported or real convictions. It is also evidently impossible to verify whether objecting healthcare professionals even hold the views they profess to hold. Such claims may merely be a convenient way out of the provision of inconvenient healthcare services.

In light of this, it seems to us that whatever attempt at a principled fettered accommodation is made, it is by necessity resulting in arbitrary outcomes. Regardless of the accommodations that we make today, these can and likely will be challenged time and again by new generations of conscientious objectors. Today it might be abortion and assisted dying, tomorrow it might be the use of the tools of personalised medicine or something else altogether. Limiting conscientious objection accommodation to defensible claims seems impossible to us, unless we overcome the two problems mentioned: demonstrate the truth of the foundations of the conscientious objection and demonstrate evidence that objectors actually genuinely hold the views they claim to hold. Failing that, as we will show, the inevitably ensuing arbitrary accommodation demands will have harmful real-world consequences as far as healthcare outcomes and patient access to care is concerned.

A few Canadian examples

Lobbyists for doctors usually defend the view that doctors must never be required to provide services that they object to on conscience grounds. Their focus is on ensuring that conscientious objectors do not have to oblige patients asking for such healthcare services, or even have to assist them in finding a healthcare provider who will oblige them. A good example of this is Dr Jeff Blackmer, the Director of the Canadian Medical Association's Ethics Office. Dr Blackmer writes on behalf of the Canadian Medical Association that medical doctors are neither obliged to provide abortion services, nor are they obliged to transfer patients on to doctors they know will provide abortions to women seeking one.[28] Women are legally entitled to access abortions in Canada if they so wish, and typically abortions are

fully funded by provincial public healthcare systems. Canadian doctors are the only professionals legally entitled to provide such procedures. They are monopoly providers. Dr Blackmer's considered view on this subject matter is that pregnant women who wish to have access to a medical procedure that they are legally entitled to, and that is fully funded by the state, should have to depend on the goodwill of volunteering doctors who also happen to be the only licensed providers of this procedure in the country.

A second example: At the time of writing, Canadian legislators grapple with the question of how to implement a Supreme Court of Canada judgement that effectively decriminalises providing assistance in dying to competent patients suffering from an irreversible chronic illness that renders their lives not worth living in their own considered view.[29] Dr Cindy Ford, the current president of the Canadian Medical Association, mirrors Dr Blackmer's stance on the obligations of conscientious objectors. In a statement made to the Canadian parliamentary committee tasked with investigating possible legislative options on assisted dying, Dr Ford reportedly stated that it is unreasonable to require conscientious objectors to even refer such patients to a clinician who they know will be prepared to render assistance in dying.[30] Dr Blackmer agrees with her, while at the same time trying to assure the Canadian parliamentary committee members of reliable professional service delivery; as he says, 'I can sit here…and guarantee that from simply a number perspective, access will not be an issue'.[31] Dr Blackmer's argues that given that 30% of Canadian doctors are willing to provide assistance in dying, there should not be a problem for patients wanting to access such services. If it was just a numbers game, Dr Blackmer would certainly be correct. Given the relatively small number of eligible patients likely to ask for assistance in dying, there should be a sufficient number of doctors willing to provide assistance to such patients. However, as so often, the devil is in the detail. The problem is—we suspect this is the reason why Dr Blackmer does not actually offer unconditionally guaranteed access on behalf of his association—that this likely will not help seriously sick and vulnerable patients who happen to live in remote areas of Canada where only few doctors happen to practice, and where all of them might be opposed to assisted dying on conscience grounds. It is irrelevant then that elsewhere in the country plenty of doctors would be willing to provide assistance in dying on request, if a particular patient is unable to travel to them. To these patients, Dr Blackmer's 'guarantee' is worth very little.

We should note here that the Canadian Medical Associations stance is not unusually radical among its peers. The British Medical Association, too, produced a guideline stipulating that 'whenever possible physicians who are conscientiously opposed to forgoing treatment should be permitted to hand over care of the patient to a colleague', but they are not obliged to do so.[32] The entitlement mentality that drives these associations' stances is unsurprisingly supported by the doctors they represent.[33]

A further example of the potential impact of conscientious objection on patients' access to care in Canada can be seen in the recent application filed by various religious physicians and associations representing them in the Ontario Superior Court. The application challenges the College of Physicians and Surgeons of Ontario (CPSO) *Policy Statement #2-15: Professional Obligations and Human Rights*, which among other things requires that physicians 'provide a referral to another appropriate health-care provider for the elements of care the physician is unable to manage directly'.[34] The applicants, including the Christian Medical and Dental Society of Canada and the Canadian Federation of Catholic Physicians' Societies, described the referral provisions of the CPSO policy statement as 'unconscionable' and a violation of their freedom of conscience and/or freedom of religion.[35] This example is hardly unique.[36] These kinds of hardline positions disregard the needs of patients.

Statements and actions of this kind strongly suggest that Professor Charo was not attacking strawmen in her article.

Respect for private conscience choices is already limited

Regardless of the views espoused by representatives of the Canadian Medical Association and the religious doctors' groups mentioned, there are already limits placed on the conscience choices of Canadians in various settings. The Supreme Court of Canada stated that 'freedom of conscience and religion protects the right to entertain beliefs, to declare them openly and to manifest them, while at the same time guaranteeing that no person can be compelled to adhere directly or indirectly to a particular religion or to act in a manner contrary to his or her beliefs'.[37] In that same case, the Court went on to say that the 'state's duty to protect every person's freedom of conscience and religion means that it may not use its powers in such a way as to promote the participation of certain believers or non-believers in public life to the detriment of others'.[38] These principles are seen as cornerstones of maintaining a free and democratic society.[39]

This is not to say that physicians and other medical professionals should be denied the right to hold religious or conscience beliefs. In liberal democracies, a diversity of beliefs and opinions is welcomed and individuals are free to advocate for societal acceptance of their particular worldview. It is also trite to say that the law in liberal democratic societies may protect a particular social or moral position espoused by a particular religion; however, it should not do so on the basis that it is a religious position, but on the basis that 'in reason its merits commend themselves'.[40] Therefore, in order to maintain a defensible balance between competing beliefs in a liberal and democratic society, such societies have generally considered 'the practice of religion and the choices it implies to relate more to individuals' private lives or to voluntary associations'.[41] To this end, it has been recognised that within the public realm an individual's freedom of religion and conscience may be legitimately burdened. In another case, the Supreme Court of Canada explicitly acknowledged that legislative or administrative actions may increase the cost of practising or otherwise manifesting one's religious beliefs.[42] Further, such legislative or administrative burdens may be justified where they prevent conduct that would potentially cause harm to or cause interference with the rights of others.[43] The reasoning of the Court supports the view that the conscientious belief of a physician may be legitimately halted at the point that it interferes with the rights of patients to access services they are entitled to receive. That interference, however, is precisely what happens each time a conscientious objector is accommodated and the patients are unable to access the required service elsewhere.

Respect for private conscience choices will result in avoidable suboptimal access to healthcare

Any society that grants medical professionals a conscientious objection-based opt-out will have to accept suboptimal health outcomes with regard to procedures that are considered at that point in time part and parcel of good professional healthcare practice in those societies. Why would toleration of conscientious objection lead invariably to suboptimal health outcomes?

Take the Canadian assisted dying example. It is apparent that the representatives of Canadian doctors are unconcerned about the distress they would inflict on—often—dying patients in rural areas who cannot access easily a doctor willing to provide assistance in dying. In many cases, doctors' objection could be more than an inconvenience, it could be an insurmountable barrier to access. A case in point is the small Canadian province of Prince Edward Island (also known as PEI). Women in that province, at the time of writing, are required to leave the province if they wish to have an abortion because healthcare providers are not offering this service in the province. Empirical evidence elsewhere suggests strongly that 'travel is a barrier to accessing legal abortion'.[44] The situation in PEI is not unique in the world, far from it. Minerva reported recently that some 70% of Italian gynaecologists conscientiously object to performing abortions, which is arguably one of the reasons for staggeringly high backstreet abortion rates in that country.[45] Patient interests come clearly last here. As we have seen, the representatives of the monopoly providers of these healthcare services in Canada are quite content with that outcome, as long as the association's members' consciences—or, more precisely, their untestable claims about the content of their consciences—are not burdened or otherwise inconvenienced. This attitude is quite the opposite of what it means to be a professional, where a promise is made to serve the public good and to serve patient interests first and foremost. Apparently such central features of what it means to be a professional can readily be sacrificed when arbitrary, untestable individual conscience claims are mounted by professionals.

Respect for private conscience choices will result in avoidable inequitable workloads for doctors

It seems also uncontroversially true to us that toleration of conscientious objectors will have a detrimental impact on healthcare practice in other respects. Because patients can expect to be shepherded around among different healthcare professionals choosing 'conscientiously' to provide different levels of healthcare, there will be an increasing level of upheaval visited upon healthcare systems. Worse, if the Canadian Medical Association had its way, patients would not even be shepherded through the system, it would be up to them to find doctors obliging them for particular ailments that might be of concern to doctors with any number of idiosyncratic private views of the universe and on what may or may not be ethically acceptable. An important consequence of such a situation would be that doctors who are willing to provide services conscientiously refused by some or many of their colleagues, would have to carry an inequitable load of such work. We cannot think of a good reason for why they ought to accept such an inequitable burden, and indeed, why a just society should design a health delivery system that burdens such doctors unfairly.

Respect for private conscience choices will result in unpredictable and unfair service delivery

Because of the unpredictable nature of what it is that conscientious objectors will object to, patients can never be quite certain about the kinds of services that they will be able to receive from a particular doctor, even their long-time family doctor. That is the opposite of what can reasonably be expected of a profession and professionals. Uniform service standards are arguably one of the hallmarks of what constitutes a profession. Another aspect of this has to do with the unfairness of this situation vis-à-vis the patient. Patients, as Ruth Purtilo rightly notes, 'can expect to be treated fairly. Persons seeking treatment should not be given advantage on the basis of arbitrary favouritism or be left out on the basis of arbitrary dislike'.[46] Given the intractability of conscience claims, it is not unwarranted to characterise them as essentially arbitrary dislikes. They might not be arbitrary in the eyes of the objector, but we cannot even be certain of that, given our inability to test the objector's conscience claims. They are arbitrary with regard to what kinds of services particular patients can or cannot expect from particular professionals belonging to the same profession in the same jurisdiction.

The nature of professions is that they provide privileged services to the public. They are quite unlike political parties, churches, animal welfare or environmental organisations. While the latter cater to particular sectarian audiences, professionals must cater uniformly to everyone within the scope of professional practice. The services professionals provide to the public must not be subject to their private normative judgements about individual needs of members of the public, as long as what these members of the public require falls within the scope of professional practice. After all, patients do not seek out doctors for their individual convictions, but to receive professional services that they are trained to provide.

There are other sounds reasons for refusing to tolerate conscientious objectors in medicine. They have to do with the voluntary choices made by those who decided to join the profession.

Choosing to join a profession is a voluntary activity undertaken by an autonomous adult

It seems to us that the argument from voluntariness is important in this context. *Nobody* is forced to join a particular profession, medicine included. Pace Christopher Cowley's argument that the practice of medicine for some is a 'calling'—one can still choose not to answer the 'call'.[47] The decision to join the medical profession is quite distinct to, say, joining the military as a conscript. Medical schools the world all over reject most applicants, not because the applicants are unsuitable to become doctors, but because the number of places they have available is always much smaller than the number of people who apply. Anyone joining a profession knows, or should know, that it is ultimately up to society to determine the scope of professional practice. Society can do this through professional bodies, but it can also choose to do so by other regulatory means. Having a monopoly on the provision of services within that scope of practice is not something that comes cost-neutral to those who choose voluntarily to join a particular profession. Indeed, given the high-stakes competition to join the medical profession in the first place, it is reasonable to suggest that doctors refusing to provide professional services that are within the scope of practice should be replaced by someone who is willing to undertake the work. If at any given time a doctor is unable to continue practicing due to their—ultimately arbitrary—conscience views, nothing would stop them from leaving the profession and taking up a different vocation. This happens across industries and professions very frequently. Professionals can be expected to take responsibility for the voluntary choices they make.

Does the nature of a particular procedure matter?

It has been suggested that not all conscientious objections fall into the same category. The reason why it would not be acceptable for the female Muslim doctor in our example to refuse to see a male patient had to do with that being in violation of the core values in medicine. Assisted dying or abortion, on the other hand, would then be seen if not in violation of traditional

medical values, but at least being sufficiently controversial to justify the accommodation of conscientious objectors. Wicclair argues for one possible threshold that a conscientious objection must meet in order to be prima facie worthy of accommodation. He proposes that a conscientious objection 'has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine'.[48] Wicclair is, therefore, supportive of conscientious objection to abortion or assisted dying because to his mind neither of these medical procedures corresponds uncontroversially to these core values. We think that he is mistaken about what he considers to be the core values of medicine, which would be applicable in these two instances, but we do not wish to debate the merits of this claim here. Rather, his argument also fails, because despite his protestations to the contrary it is essentially an argument from tradition. What he calls core values could be more aptly described as traditional values. However, it is in the nature of such values that they are changing. Medicine is currently arguably undergoing a paradigm shift from maintenance of human life at nearly all cost to a quality-of-life focused approach.[49] The traditional core values of medical practice are in flux, and that is one reason for why abortion is available in most liberal Western democracies, and that is the reason why the number of jurisdictions that are decriminalising assisted dying is steadily increasing.

To highlight just one example of this, again from Canada, the past president of the Canadian Medical Association, Dr Chris Simpson, on behalf of the association, referred to assisted dying as a 'therapeutic service', a mere 15 years after Wicclair suggested that core professional values would make such a description impossible.[50] It is unlikely that the association would refer to assisted dying as a 'therapeutic service', if it thought that the provision of this service would violate Wicclair's claimed core values of the profession. If it is a therapeutic service, as we agree it is, Canadian doctors wanting to go the conscientious objector route to avoid providing this service to eligible patients could no longer avail themselves of Wicclair's analysis, because the 'moral integrity of the medical profession' would not be served by accommodating individual doctors who refuse to provide therapeutic services. It is important to recognise that medical practice is also a cultural practice that changes over time. No democratic society, and no medical profession should leave the scope of the provision of professional medical services to the vagaries of its members' personal ideological convictions.

What about our societal ability to recruit people to join the medical profession?

An argument could be mounted that if we prevented doctors from excusing themselves from providing professional services that they happen to feel strongly about, we might find it difficult to find a sufficient number of people willing to become doctors. This seems far-fetched to us, but it is conceivable that some people might reconsider joining the medical profession if the accommodation of their feelings with regard to particular professional services is not guaranteed. We indicated already that the profession and society would likely be better off if such people chose not to join the profession, seeing that they think that their idiosyncratic views of the universe should be of greater significance than the patients whose interests they promised to further first and foremost, as professionals. The concern about recruitment problems does not appear to be based on real-world evidence to begin with. A recent survey reports that countries such as Sweden, Finland and Iceland, which do not permit their doctors to opt out of the provision of abortion service on grounds of conscience, have not experienced harmful consequences, as far as these countries' healthcare systems' ability to train a sufficient number of doctors is concerned.[51]

A somewhat related argument suggests that by preventing doctors from refusing service based on religious or conscience grounds, we would run the risk of losing the participation of those kinds of individuals in the profession. However, that argument does not hold. Those who object to particular procedures could choose specialities that would not require that they violate their conscience, for example, they could opt for dermatology instead of gynaecology if they are opposed to abortion. A self-imposed limit on one's *choice* of speciality is not inherently unfair. Individuals with certain physical limitations can also be excluded from certain specialities in the medical profession. That does not preclude them from joining the medical profession.

Does it matter when professionals joined a profession?

It could be argued that it matters when conscientious objectors joined the profession. The idea here is that they agreed to join a profession that at that time had a particular scope of practice that these professionals agreed to work in. In a way, this scope of practice constitutes a kind of contract between society and its professionals. If a society wishes to change a profession's scope of practice it should accommodate conscientious objectors among those who joined the profession prior to a given controversial change, for example, by grandmothering them in. Some of the reasons we mentioned above mitigate against granting objectors a blanket right to such an accommodation. There is another reason that suggests that this argument is not particularly strong. It is surprising that doctors seem to think in large numbers that society provided them with a monopoly on the provision of medical services but that society at no time would add or subtract from the range of services it considers scope of practice of that profession. This is puzzling given the nature of medicine as an ever-evolving scientific and cultural pursuit. Most of us who do not work as medical professionals have encountered employers who wish to change our scope of practice. Many academics the world all over are suffering under their employers' desire and pressure to introduce online learning programmes, despite our objections on pedagogical and other grounds. However, nobody would think that our employers are not well within their rights to ask us to contribute to such programmes. Unlike doctors, we are not even entrusted with typically well remunerated service delivery monopolies.

Having said this, we do think that we should try at least to accommodate conscientious objectors who have practiced for a long term under a different kind of contract than doctors who join the profession after particular significant changes to the scope of practice have been made. However, that is a far cry from suggesting that doctors have a right to such accommodation.

COULD NOT THE STATE BE THE GUARANTOR OF ACCESS?

Proponents of a fettered accommodation system might argue that we should try to accommodate conscientiously objecting healthcare professionals regardless of the arguments presented by us so far. They could argue that, for instance, institutions other than the medical profession ought to guarantee reliable access in a healthcare system that is proactively being subverted by accommodation-demanding conscientious objectors. Why should not the health ministries in Canada's provinces organise reliable access systems based on doctors who are not conscientiously objecting? We know from the mentioned experiences of pregnant

women seeking an abortion in the province of PEI that this might not be feasible in parts of the country. The odds are fairly high that the more rural an assistance seeking patient is located, the more difficult it could become to guarantee access. We have yet to see a persuasive reason, given the arguments presented so far, why any healthcare system should burden itself, and ultimately patients, with these sorts of logistical problems when there is an obvious, more efficient alternative: saying *no* to the conscience-based accommodation requests of healthcare professionals. A profession that is unable to guarantee reliable access to its services for no other reasons than its desire to accommodate the private ideological convictions of some or many of its monopoly provider members is failing in its mission.

CONCLUSION

Medical professionals have no moral claim in liberal democratic societies to the accommodation of their individual conscientious objections. To accommodate such objections would subvert some of the very reasons for why the medical profession was created in the first place. To accommodate them would also permit such medical professionals to abuse the monopoly privileges that society endowed their profession with. Medical professionals practicing medicine in the 21st century would be well advised to accept professional service delivery, as defined by the scope of professional practice, as one inevitable corollary of their voluntary decision to join the profession. Forcing patients to live by the conscientious objectors' values constitutes an unacceptable infringement on the rights of patients.

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