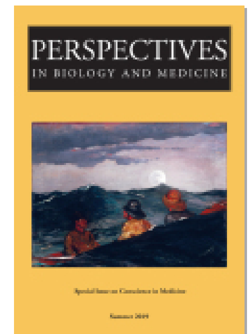
PROJECT MUSE®

Conscience and the Way of Medicine

Farr A. Curlin, Christopher O. Tollefsen



Perspectives in Biology and Medicine, Volume 62, Number 3, Summer 2019, pp. 560-575 (Article)

Published by Johns Hopkins University Press
DOI: https://doi.org/10.1353/pbm.2019.0033

For additional information about this article
https://muse.jhu.edu/article/732240

For content related to this article
https://muse.jhu.edu/related_content?type=article&id=732240

[Tue Sep 26 08:17:06 2023] Access provided at 26 Sep 2023 13:17 GMT from University of Notre Dame

Conscience and the Way of Medicine

Farr A. Curlin* and Christopher O. Tollefsen†

ABSTRACT Disputes about conscientious refusals reflect, at root, two rival accounts of what medicine is for and what physicians reasonably profess. On what we call the "provider of services model," a practitioner of medicine is professionally obligated to provide interventions that patients request so long as the interventions are legal, feasible, and are consistent with well-being as the patient perceives it. On what we call the "Way of Medicine," by contrast, a practitioner of medicine is professionally obligated to seek the patient's health, objectively construed, and to refuse requests for interventions that contradict that profession. These two accounts coexist amicably so long as what patients want is for their practitioners to use their best judgment to pursue the patient's health. But conscientious refusals expose the fact that the two accounts are ultimately irreconcilable. As such, the medical profession faces a choice: either suppress conscientious refusals, and so reify the provider of services model and demoralize medicine, or recover the Way of Medicine, and so allow physicians to refuse requests for any intervention that is not unequivocally required by the physician's profession to preserve and restore the patient's health.

*Trent Center for Bioethics, Humanities, and History of Medicine; and Theology, Medicine and Culture Initiative, Duke University, Durham, NC.

†Department of Philosophy, University of South Carolina, Columbia, SC.

Correspondence: Farr A. Curlin, Box 3040, DUMC, Durham, NC 27710.

Email: farr.curlin@duke.edu.

Perspectives in Biology and Medicine, volume 62, number 3 (summer 2019): 560–575.

© 2019 by Johns Hopkins University Press

Doctors often refuse patients' requests, even when patients request interventions that are legal and permitted by the medical profession. This is a fact about the practice of medicine so familiar that it is easy to overlook.

Doctors' refusals are neither new nor infrequent, and only a small minority occasion any controversy. Surgeons refuse to operate when they believe a surgery is unlikely to succeed. Physicians refuse medications when they believe the medications are unlikely to be helpful. Clinicians refuse requested interventions because of concerns about safety or efficacy, and they refuse because of less tangible concerns that are no less real. Some pediatricians refuse to supplement the growth hormone of boys who are short because of concern about crossing a line between treatment and enhancement. Some primary care physicians refuse costly workups for what they believe are psychosomatic syndromes out of concern for their colleagues' time and other medical resources. Obstetrician-gynecologists who will abort fetuses with lethal congenital anomalies may refuse to abort those with Down syndrome or cleft palate out of concern about societal attitudes toward those with disability, or those who are female out of concern about sexism. Physicians refuse patient requests even when such requests are informed, even when patients meet some published criteria for the intervention in question, and even when physicians are aware that some or even most of their colleagues would disagree with their refusal.

In recent years, however, controversy has erupted over the issue of physicians refusing to provide or facilitate patient access to certain morally contested interventions, such as abortion, physician-assisted suicide, or surgical modification of secondary sex characteristics (gender transition services). When physicians refuse such interventions, many now argue, they are letting their personal values interfere with their professional obligations. A recent essay in the *New England Journal of Medicine* by Ronit Stahl and Ezekiel Emanuel (2017) illustrates the point: Stahl and Emanuel assert that patients have a right to choose the health-care services they need for their own *well-being*, and physicians have a corollary obligation to accommodate the patient's choices, either by providing the requested interventions directly or by referring the patient to someone who will.

Such claims are starting to gain the force of policy in some jurisdictions. Historically, the medical profession has given wide latitude to physician discretion in areas of disagreement. Professional codes have consistently stated that physicians are not obligated to satisfy patients' requests for interventions that the physician believes are not in the interest of the patient's health (Kaldjian 2019). In 2015, however, Ontario's College of Physicians and Surgeons (CPSO) issued a rule requiring physicians to make "effective referrals" for all legal interventions that a patient might request, including euthanasia (CPSO 2018). The college's working group concluded that there is "no qualitative difference" between euthanasia and other "health care services." In 2016, the Illinois General Assembly revised a decades-old law that had prevented employers from discriminating against health-

care workers who refused to engage in practices to which they had principled moral objections. The new version requires employees to at least make referrals. In 2017, Sweden's Labor Court ruled that clinics can lawfully refuse work to nurse midwives who refuse to perform abortions (BBC 2017). If physicians have personal objections to some interventions, the reasoning goes, they must avoid areas of medicine in which those interventions are likely to be requested.

Something is right about all of this. After all, as Stahl and Emanuel (2017) put it, physicians are not conscripts. No one is compelled to become a physician, and in becoming a physician, one willingly takes on responsibilities that go with the role. Surely the profession and the public can hold physicians to fulfill their professional responsibilities, or as Stahl and Emanuel put it, their "role morality" (1382). We would not countenance teachers who refuse to grade their students' work or attorneys who refuse to represent their clients before the justice system. Why would we allow physicians to refuse what patients request?

Yet the boundaries of what we accept and what we reject where professional refusals are concerned clearly center on answers to the following questions: what is the profession for? and what are those obligations that come with one's profession? Teachers are allowed and even expected to refuse requests of students if those requests are irrelevant or run contrary to the purposes of teaching. The same is true for lawyers and their clients.

The same is true for medicine, yet medicine is in the grip of a conflict between two radically different ways of answering these questions, and debates about conscientious refusals indicate the profession of medicine cannot continue indefinitely with these two contradictory construals of its purpose. Physicians face a choice, and the stakes are high. Insofar as the profession embraces the ascendant *provider of services model* (PSM), the physician's conscience threatens the patient's well-being and must be suppressed. Unfortunately, by suppressing conscientious practice, the PSM reduces medicine to a demoralized job and augurs the end of medicine as a profession. As such, we encourage physicians to reject the PSM and recover the profession's orientation to the patient's health as a genuine good. This commitment to the patient's health gives physicians a reasonable standard for discerning which requests should be accommodated and which refused.

The Provider of Services Model and Physician Refusal

On the PSM, informed consent gives way to informed choice: patients choose, physicians provide. Physicians may refuse interventions that are technically infeasible, illegal, or unavailable, and they may refuse interventions that are futile with respect to the goal for which the patient seeks the intervention. But if these threshold conditions are met, then the patient's choices are to be accommodated. Principles can be brought to bear, of course, and utilities can be measured

in an effort to maximize. The physician can also advert to "accepted clinical and professional norms." Only the patient, however, is in a position to balance and specify the relevant principles or to weigh the relevant utilities in order to determine what the patient's well-being requires. Moreover, according to the PSM, the central clinical and professional norm is putting patient well-being first; personal scruples cannot get in the way of a patient receiving what she genuinely believes she needs.

This idea of patient well-being plays a central role in the provider of services model. When proponents of the PSM criticize conscientious refusals, they consistently refer to the patient's well-being rather than to the patient's health. "Health care *providers,*" write Stahl and Emanuel (2017), "have a primary interest: to promote the well-being of patients" (1382, emphasis added). And again: according to the American Congress of Obstetrics and Gynecology (ACOG), "*Providers*" have a "fundamental duty to enable patients to make decisions for themselves" (ACOG 2007, 1205, emphasis added). Under the PSM, medical professionals are providers whose goal is to do what is conducive to patient well-being. This defines what Stahl and Emanuel call the physician's "role morality." Adhering to that morality "means offering and providing accepted medical interventions in accordance with patients' reasoned decisions" (1383).

Given all of this, we might expect proponents of the PSM to condemn all of the refusals in the cases described in the Editors' Introduction to this issue of *Perspectives in Biology and Medicine*, but that is not what happens. True, in each case, the interventions requested are feasible, legal, and available, and none of the interventions is futile with respect to the goals of the ones making the request. Moreover, in each case, it is likely that the patient or surrogate believes that the patient's well-being requires the requested intervention. J.P., who requested antibiotics for an upper respiratory infection, may understand that the physician does not recommend antibiotics because the physician believes J.P. almost certainly has a viral infection, but J.P. may want the prescription in order to reduce the (albeit small) risk of him missing more days of work. H.W.'s family, who insist on starting hemodialysis despite the fact that H.W. is dying from lung cancer, may acknowledge that H.W. is dying and that the physicians have gone through a fair process of seeking second opinions and trying to negotiate a mutually acceptable way forward, but after that process the family may still insist that for them initiating hemodialysis is part of promoting H.W.'s well-being to the end. E.K. is a 14-year-old of male sex who for the past several years has identified as female gender. E.K.'s parents can recognize the physician's reluctance to change otherwise healthy secondary sex characteristics and yet still want gender transition procedures in order to preserve E.K.'s overall well-being as a transgender girl. M.G., a 30-year-old Californian with advanced brain cancer, knows that doctors typically do not cause the death of their patients, but she seeks a lethal prescription as a means of avoiding suffering that she considers unbearable. Despite these

parallels between the cases, only the physician's refusal of E.K.'s and (to an increasing extent) M.G.'s requests raises the ire of those who criticize conscientious refusals.

How can this be? On the Way of Medicine, each refusal may be justified insofar as it is grounded in a judgment that what is requested does not serve, or indeed is contrary to, the end of patient health. How, though, can the PSM distinguish between the cases? It does so by introducing and leaning heavily on a new distinction: between refusals based on professional reasons, and refusals based on personal reasons (Brody and Night 2007; Card 2014; LaFollette and LaFollette 2007; Savulescu 2006; Savulescu and Schuklenk 2017; Schuklenk and Smalling 2017). According to the PSM, the physician who refuses J.P.'s request for antibiotics or H.W.'s family's request for hemodialysis is justified because the physician refuses for *medical* or *professional* reasons and thereby upholds the physician's "role morality." In contrast, the physician who refuses E.K.'s request or M.G.'s request is condemned for allowing *personal* and *private* concerns to intrude upon what should be a strictly professional consideration.

It is difficult to overstate the importance of the distinction between the personal and the professional for critics of conscientious refusals, whether that distinction is posed as personal moral values versus professional ethical obligations, personal conscience versus professional conscience, personal integrity versus professional integrity, or simply personal reasons versus medical reasons (Brody and Night 2007; LaFollette and LaFollette 2007). Physicians may believe what they will "in their private lives," write Stahl and Emanuel (2017), "but in their role as health care professionals, they must provide the appropriate interventions as specified by the medical profession" (1383).

It perhaps goes without saying that judgments of conscience are, for the PSM, the apotheosis of the personal. To refuse on the basis of conscience is to allow personal biases to interfere with professional obligations, and particularly with the obligation to respect patient *autonomy*. It may be difficult, the reasoning goes, but sometimes clinicians have professional obligations to do what their personal consciences object to doing.

Yet even these authors concede that clinicians may refuse patient requests when they have strong medical reasons to do so, as presumably J.P.'s physician did, judging that antibiotics are not medically indicated for a viral infection. How does one know whether one's reasons are sufficiently medical? The PSM fails to provide any nonarbitrary standard to guide such judgments (a problem to which we return below), but proponents of the PSM are clear that medical reasons simply cannot include traditional norms such as the injunction to never intentionally damage or destroy the patient's health. They are equally clear that physicians who allow personal concerns to influence their professional practices thereby abuse their power and threaten harm to the patient—not harm to the patient's health, per se, but harm to "well-being as the patient perceives it" (ACOG 2007, 1205).

Here we see a conceptual novelty of the PSM: its standard for harm emerges from its standard for benefit—patient well-being. In the end, if the patient desires something in accordance with her conception of her own well-being, the PSM calls on physicians to provide what the patient requests, or at least refer the patient to someone who will. To do otherwise is to fail to obey the principle of nonmaleficence.

This position comes with deep political and professional implications. From the standpoint of social authorities, including the state and professional licensing organizations, the PSM implies that physicians are obligated via an implicit social contract to provide health-care services according to the patient's informed choices. Dan Brock (2008), in arguing that physicians are at least obligated to refer patients for any legal intervention, takes for granted that the medical profession is obligated by social contract to make available all legal interventions. As such, authorities must scrutinize physician refusals carefully; the burden of proof is on physicians to justify their refusals and to show that they are not based on personal values.

ACOG (2007) proposes further scrutiny to make sure that physician refusals are not based on prejudice, and that they are based on sound science. Physicians may not, for example, refuse to prescribe contraceptives based on concern about preventing implantation of an embryo, because studies suggest the incidence of such effects is low (no need to consider whether the incidence is low enough to make the moral difference, so long as there is "scientific support" for treating the incidence as trivial). Some proponents of the PSM ask policymakers to mandate such scrutiny, to demand alternative service from those who refuse patient requests, and to threaten sanctions that would make conscientious refusals costly (Stahl and Emanuel 2017).

But such demands appear to be merely stop-gap measures in anticipation of the desired end state: the elimination of conscientious refusals from the professional life of the physician. As Julian Savulescu (2006) put it more than a decade ago in an essay that seems increasingly prophetic, "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors" (294).

The Way of Medicine and Physician Refusal

The Way of Medicine casts physician refusals in a very different light, asking first whether a refusal is consistent with, or contradicts, the physician's commitment to the patient's health. Rather than a prima facie obligation to provide whatever the patient seeks, the physician instead has an obligation to pursue that which the patient's health requires (understanding that there may be several possible avenues of pursuit) and to refuse to act in ways that are contrary to the patient's health. Such refusals, rather than abusing power, properly exercise the physician's authority.

Note how differently the Way of Medicine treats the categories of *personal* and *professional*. Because the PSM eschews any objective end for medicine, the professional obligations of the physician must come from outside the practice of medicine. Those obligations cannot be generated and justified by commitments to an objective good that provides the purpose of the profession. Hence the importance of what is legal, what is technically possible, and what is desired by the patient, none of which are intrinsically related to an essential purpose of medicine. Thus also, professional obligations are potentially at odds with the physician's personal commitments, which must be left behind or overcome when they conflict with the "professional."

By contrast, the Way of Medicine calls on the physician, as a member of the profession, to personally deepen and specify a commitment the physician already has made: attending to those who are sick so as to preserve and restore their health—to raise that commitment to the level appropriate to a vocation-defining profession. For practitioners of medicine, then, the central obligation in each of the four cases above is clear: act reasonably to preserve and restore the patient's health, and refuse to act otherwise.

As we see from a slightly more philosophical perspective in the next section, physicians can succeed in this task only if they practice according to conscience. A physician's conscience is clinical judgment in action: it is the capacity used when judging whether an inclination to refuse J.P.'s or M.G.'s request is based on good reason, unreasonable desire, or unjustified prejudice. Practicing conscientiously may be difficult, but it can never be reasonable for a clinician to do otherwise.

The Way of Medicine also has implications for those with professional and political authority. It teaches them that if physicians are to attend to those who are sick using reasonable means to preserve and restore their health, then they need professional space to exercise judgment and to practice conscientiously. Although the state has grounds to hold physicians accountable to general norms of justice, and the licensing and accrediting authorities have grounds to hold physicians accountable to meet their professional obligations, neither the state nor any other authority has grounds to compel physicians to contradict their professional commitment to the patient's health.

Thus, neither the state nor the profession should be in the business of coercing physicians into meeting patient demands, any more than they should coerce patients to accept this rather than that physician proposal. Patients must be protected from the unscrupulous and the incompetent, which a profession's best efforts will never entirely succeed in weeding out, and a profession must ensure that all its professionals carry out the constitutive commitments of the profession to seek healing for those who are sick. But professional responsibility encompasses the obligation, and hence the right, to make conscientious judgments about what is required in light of one's guiding professional commitments. This is no less true for physicians than for other professionals.

Virtues of the Way of Medicine

So far we have seen that critics of conscientious refusals tend to take for granted that, at least in areas of controversy, medicine should be understood under the PSM. The Way of Medicine, however, has several virtues that the PSM lacks.

A Better Understanding of Conscience

What makes a refusal *conscientious*? A judgment of conscience is, in the paradigm case, a person's final determination of what is permitted, not permitted, or obligatory in a particular circumstance. Or, in Kaldjian's (2019) terms, "the final and best assessment of what a person believes is right" with respect to that person's own action (392). What faculty is responsible for these judgments? The traditional view is Aquinas's from the *Summa Theologiae* (1485): it is *practical reason*, which knows the first principles of the moral law; and *practical reason* that applies those principles to situations and circumstances so as to lead to particular moral judgments about how one ought to act. Thus, the faculty that is responsible for judgments of conscience, as well as the more general normative judgments presupposed by conscience, is human reason (1–1, q.79, aa12, 13).

Three points are worth noting here. First, conscience judges a person's *own* actions or motives, not those of others. Second, conscience is not a set of considerations that a person might weigh in making a moral judgment; rather, conscience is exercised in the *judgment* about how one should act in light of all such considerations. Third, as an act of human reason, conscience is necessarily limited and fallible; no person sees with absolute clarity, and no person judges their own actions with perfect accuracy.

In light of these three points, we can see that although conscientiousness—following one's judgments of conscience—is necessary for ethical action, it is not sufficient. A malformed or misinformed conscience will err. For example, a conscientious physician may fail in his duties to relieve a patient's debilitating pain because he has not been trained to pay close attention to or seek to relieve pain. Alternatively, he may fail because he mistakenly interprets the patients' behavior as drug-seeking and malingering. So every physician is obligated to seek to inform his or her conscience with the best available information, including true moral principles. Every physician must consider arguments made by patients or colleagues that call the physician's initial judgment into question, and physicians must be willing to change their judgment when they can see that it was mistaken.

Nevertheless, in the end physicians must act, and however fallible, physicians can only act ethically if they act according to conscience. Errors with respect to conscience obscure this fact. According to ACOG (2007), "An appeal to conscience would express a sentiment such as 'If I were to do "x," I could not live with myself/I would hate myself/I wouldn't be able to sleep at night'" (1204). In fact, rarely are conscientious practices so emotionally momentous. Rather, to

practice conscientiously is simply to act according to one's best judgment about how one ought to act from situation to situation, patient to patient.

Others allege that appeals to conscience are disingenuous and hide unspoken prejudices. For example, in response to pharmacists who refused to fill prescriptions for emergency contraception before the FDA made the drug available over the counter, Brody and Night (2007) wrote that they "suspect that what the 'conscientious' pharmacist actually objects to, but does not have the nerve to say outright, is the possibility that a woman can engage in sexual activity without having to face the 'moral' consequences of her potentially illicit act" (17).

It goes without saying that physicians who act disingenuously are not acting conscientiously. To act conscientiously is to act according to what one understands to be the demands of reason. Even where agreement exists about the purposes of medicine, physicians still must consider innumerable different factors in order to discern how best to seek the health of a particular patient in a particular context. This task is almost always attended by ambiguity and uncertainty, requiring what Aristotle in *The Nichomachean Ethics* called *phronesis* or practical wisdom, the manifestation of which in the practice of medicine has been called good clinical judgment (Thomasma 1983). If physicians are to exercise clinical judgment in seeking their patients' health, they will necessarily refuse some patient requests.

These points illustrate another virtue of the Way of Medicine: its understanding of conscience is much more adequate than that of the PSM. The PSM asks us to treat conscience not as a faculty of reason but as a set of arbitrary and idiosyncratic personal values. Stahl and Emanuel (2017) equate conscience with appeal to "personal religious or moral beliefs" (1380). So construed, the physician who acts conscientiously is focused on himself and his own needs, rather than on the good and what is required of him. ACOG (2007) similarly associates conscientiousness with a need to be able to sleep at night and a defense against moral disintegration. These personal needs, however important, are in tension with one's professional commitments: "By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice. Thus, with professional privileges come *professional responsibilities* to patients, which must precede a provider's *personal interests*" (1205, emphasis added). Stahl and Emanuel (2017) similarly aver that "physicians' personal commitments cannot outweigh the interests of patients," and they contend that to follow conscience in refusing a patient request "violates the central tenet of professional role morality in the field of medicine: the patient comes first" (1384).

These misconstruals of what the conscience is lead critics to make unsupportable and contradictory claims. Critics claim that a clinician who refuses a patient's request thereby allows the clinician's conscience to trump the patient's conscience, when in fact no conscience can trump another conscience, since conscience only judges one's own actions. Critics claim that physicians should

distinguish "personal conscience" from "professional conscience," or that physicians should balance one or both against other considerations in deciding what to do in a given case. ACOG (2007), for example, holds that, "Although respect for conscience is a value, it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance" (1207). Some critics also suggest that a physician occasionally has an obligation to act against conscience.

Such claims can only make sense if the conscience is a set of values. Then one could have a professional conscience and a personal conscience, and perhaps others as well. One could weigh up the conscience against other considerations, or one conscience against another. One might even have reason to act against conscience. But none of these construals make sense in light of what the conscience is: the faculty of reason that renders the final judgment as regards what one ought to do, all things considered. So understood, an individual has but one conscience, and integrity requires that her conscience cannot be split into components. She cannot take up her judgment of conscience as one consideration among others. While a physician might well have reason to reconsider an initial judgment in light of new information, it can never be right to act against conscience, for in doing so one is acting contrary to one's final judgment about how one ought to act. That is a paradigm case of acting unreasonably.

A Better Understanding of "Professional Responsibility"

The Way of Medicine not only has a more adequate construal of conscience and its place in the practice of medicine, it also possesses a nonarbitrary standard for distinguishing refusals that align with the physician's professional obligations from those that contradict those obligations. Unless we are to say that physicians may never refuse anything patients request, physicians must have some criterion by which to distinguish between justified and unjustified refusals.

The PSM turns for such criterion to the putative distinction between the personal and the professional. As we show here, the problem with this putative distinction is that the term *personal* has no meaning in these debates except "not professional," and *not professional* has no meaning unless one can specify the content of the physician's profession. As the cases above demonstrate, without an objective standard for the medical profession, saying that a concern is merely personal is not possible. Anything that relates to patient well-being can be considered a professional concern.

In the end, the category of "personal" distracts from and cloaks the fact that the PSM cannot say what the physician's profession requires beyond accommodating patients' considered, informed requests for legal and technically feasible interventions. Without any objective standard to look to, proponents of the PSM draw idiosyncratic and arbitrary lines between the personal and the professional. For example, ACOG (2007) contends that physicians must refuse policies that

require them to report undocumented patients to immigration authorities, because such policies conflict with other professional norms, including the "primary principle of nonmaleficence" (1204). In the same piece, however, ACOG takes it for granted that physicians must refer for abortion, ignoring altogether arguments that abortion violates the same principle of nonmaleficence. Stahl and Emanuel (2017) claim that physicians might justifiably refuse assisted suicide—a practice Emanuel has publicly opposed for decades—because the practice is "currently controversial and subject to debate about whether [it is] medically appropriate" (1382). They cannot bring themselves, however, to imagine that abortion and gender transition surgery are similarly controversial and subject to similar debate. "Professional" responsibilities thus emerge as sufficiently malleable as to rule out what a writer dislikes and to require what the writer affirms.

In seeking to say more about the "professional," proponents of the PSM often look to public and professional opinion in arbitrary and self-contradictory ways, or appeal to straw men to critique moral judgments within medicine. On the one hand, they will refer to "standard of care" and "consensus" as establishing the scope of what physicians must do. But in the next breath they refer to the absence of consensus as the reason physicians cannot justifiably refuse some intervention (because many people disagree with the physician's "personal" opinion). In a particularly curious turn, Stahl and Emanuel (2017) claim that "health care professionals voluntarily choose their roles and thus become obligated to provide, perform, and refer patients for interventions according to the standards of the profession." Yet they then lament that the organizations that most authoritatively establish the standards of the profession "all tend to accept rather than question conscientious objection in health care" (1380–81). ACOG as well as Stahl and Emanuel acknowledge deep societal disagreement about whether abortion is permissible, yet both claim that abortion is standard medical practice. "Although abortion is politically and culturally contested," Stahl and Emanuel write, "it is not medically controversial" (1383). So again, in the absence of clarity about the professional commitments of medicine, proponents sometimes rely upon and sometimes disavow claims of consensus and controversy, adopting a whatever-works strategy in the attempt to force their desired shape of conformity onto the profession.

The Way of Medicine, by contrast, distinguishes not between the professional and the personal but between that which fulfills the physician's profession and that which departs from or contradicts that profession. In an important sense, this merely distinguishes the reasonable from the unreasonable, with attention to the particular vocation of practitioners of medicine.

Critics worry that physician refusals hide invidious discrimination under the guise of conscience. Stahl and Emanuel say that to refuse to participate in "gender reassignment surgery, or the use of contraception . . . is to allow personal moral judgment to masquerade as medical practice" (1383). ACOG (2007) contends,

"Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination" (1206). But the Way of Medicine can coherently condemn refusals that involve invidious discrimination without abandoning either the notion of conscience or the physicians' commitment to the patient's health.

The physician who refuses to care for patients with HIV because of antipathy toward homosexuals, or for patients of another race because of racial prejudice, or for criminals because of revulsion at their crimes violates the constitutive professional obligation to seek the health of patients precisely because they are sick, without regard to their other characteristics. After all, the good of health is good for all persons. This professional obligation to seek the patient's health is not to be contrasted with conscience or with personal obligations, but instead with failures of reason. The solution to such failures is, in fact, sound exercise of conscience.

A Better Respect for Pluralism

In contrast with the provider of services model, the Way of Medicine presents a workable, peaceable approach to living with disagreement—with the pluralism that defines our current age. Stahl and Emanuel (2017), speaking for the PSM, write:

> Health care professionals who are unwilling to accept these limits [to conscientious refusals] have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession (1383).

Following this logic to its conclusions, the profession would have to drum out those who have the audacity to refuse interventions on the basis that the interventions are not required by or conducive to the patient's health. This is a recipe for a homogenous and authoritarian health-care profession, one held together by the forcible imposition of external norms: the norms of the legally permitted, the technologically feasible, and what patients desire. Physicians unwilling to work within these constraints must go.

Perhaps paradoxically, the Way of Medicine has much more flexibility. Let us grant the "fact of reasonable pluralism" (Rawls 1993, 36). There is, we concede, no way to recover (or forge anew) full agreement on the part of all physicians regarding the moral obligations of medical practitioners. Nevertheless, if we imagine a profession structured even minimally upon a commitment to the patient's health, then the profession should allow conscientious refusals where reasoned dispute exists about whether an intervention is consistent with that goal.

In such circumstances, patients like J.P. and M.G. may face clinicians who make clear, in so many words, that they do not believe what the patient seeks is what the clinician should be doing. Patients in some areas, particularly rural areas, may struggle to find clinicians who will provide interventions that are available

elsewhere. The profession will sustain in its ranks an ongoing contention about what good medicine requires. The presence of differences will push people to consider why they are making the choices they make, rather than taking practices for granted. Physicians will represent the diversity of moral communities found in a society, and the range of choices among philosophies of care will reflect the ongoing moral disagreements among those communities. When people like Stahl and Emanuel insist that physicians put their professional obligations first, we will insist that they make an argument to show how the physician's commitment to the patient's health, objectively construed, requires them to participate in the intervention in question.

We are optimistic that such a profession would come to recognize again that certain practices are simply incompatible with commitment to patient health. Abortion, euthanasia, and sex reassignment surgeries, for example, would be seen as simply not the business of physicians. Yet there would still be considerable room for disagreement, given the complexity of health and the vagueness and indeterminacy around its boundaries—and that is to say nothing of the scope for disagreement over how best to address the health of a particular patient, given the inevitable limitations of medical knowledge and technology.

The Way of Medicine recognizes that a profession must have something that its practitioners *profess* in common; that something, for medicine, is the patient's health. The PSM gives, by contrast, a merely formal shared end: satisfaction of patient desires within what the law and medical science allow, a goal that will frequently lead the physician to pursue contradictory ends—the life of this fetus, the death of that one, for example. But within the pursuit of health, the Way of Medicine sees room for professional comity and amity: comity when the conscientious judgments of other physicians are respected, and amity when the profession is willing to tolerate diverse moral and religious views when those are not essentially unjust. That is a far cry from the PSM's increasingly aggressive intolerance of disagreement.

The Future of Medicine

We close by noting three logical if unintended consequences of elevating the PSM over the Way of Medicine.

First, any policy that constrains the scope of conscientious refusals thereby erodes the possibility of conscientious practice. It seems obvious that patients want their physicians to be conscientious insofar as possible. Who wants a physician who is in the habit of doing what he knows he should not do? Fortunately, individuals from virtually all moral traditions and communities can conscientiously commit themselves to caring for the sick. That is one reason the profession of medicine has been able to maintain prestige and a measure of unity in a society comprising many different moral communities. Yet efforts to reduce the scope of

conscientious refusals will gradually squeeze out or block from entry all but those who are willing to make available to patients the full range of legal technological interventions, and to set aside their judgment about which interventions are congruent with the patient's health.

Consider obstetrics and gynecology. If the PSM prevails, the obstetrics and gynecology practice of the future will be hospitable only to those willing to engage in elective abortion, sterilization, contraception, IVF, prenatal genetic diagnosis, surrogate pregnancy, artificial insemination, cosmetic genital surgery, gender transition surgery, and whatever comes next. Only a minority of Americans can cooperate conscientiously in all of these legal, feasible, and yet morally controversial practices. Paradoxically, patient choices will be reduced insofar as patients will not be able to seek out trained clinicians who share their judgment that such practices contradict the purposes of medicine. So the process goes. Every time the scope of conscientious refusal is narrowed, the pool of people who can be conscientious physicians is reduced.

The second consequence is that by requiring physicians to do what patients request, policies that constrain the scope of physician refusals put physicians and patients at odds with one another. The PSM already treats the physician's judgment as a threat to the patient. If physicians cannot refuse patient requests, they will wonder when their patients might, with the backing of legal sanction, ask them to act against their own understanding and do that which they believe is unethical. By making physicians obey patients, we make patients a moral threat to their physicians.

The third consequence of reducing the scope of conscientious refusals is that patients will lose the basis for trusting that their physicians are committed to their good. Under the old model of paternalism, patients could trust that physicians had committed themselves to their patients' best interests, albeit in a limited way—only insofar as those interests included restoring and preserving health. The patients' rights movement and the doctrine of informed consent rightly qualified and delimited physicians' commitment to pursue health. Out of respect for persons, physicians are to act only with the permission of their patients. Because health is neither the only nor the highest good, patients are authorized to situate that good in relation to other concerns such as not being overburdened by medical technology.

The PSM differs fundamentally: in it, patients not only qualify how their health will be pursued, but they also decide what outcomes and states of affairs physicians will seek. Patients gain technicians committed to cooperation and lose healers committed to their good. They gain control over physicians but thereby divest physicians of responsibility. As a result, patients will "often navigate treacherous medical terrain without adequate medical guidance" (Quill and Brody 1996, 765). Physicians can wash their hands of patients' decisions, so long as the physician gives accurate information and provides technically proficient "health-care services."

By asking physicians to set aside conscience and detach from their historical commitment to the patient's health, the PSM contributes to a crisis of medical morale, because the PSM quite literally de-moralizes medicine. If medicine merely provides desired services to maximize the patient's vision of well-being, then medicine's pretense to moral seriousness is a charade, and its attempts at professionalism a façade. Is it surprising that today's physicians, conditioned to think of themselves largely as mere functionaries, suffer high rates of burnout? (Shanafelt et al. 2015; Sternberg 2016)

There is a better way. That way involves conscientiousness on the part of physicians. Where ambiguity or dispute arises about whether a particular practice belongs in medicine, physicians and patients do their best to negotiate an accommodation that does not require either to do what they believe is unethical. Rather than feign moral neutrality, physicians tell their patients frankly what the options are, which ones the physician is willing to offer, and why the physician recommends one over another. The scope of permissible accommodations will have to be set through the political process, but we echo the conclusion reached by the President's Commission way back in 1982: "considerable flexibility should be accorded to patients and professionals to define the terms of their own relationships" (38).

In conclusion, unless and until consensus is forged regarding the ends of medicine, refusals of controversial practices cannot be shown to violate physicians' professional obligations. In the meantime, the practice of medicine should be open to anyone willing to commit themselves unreservedly to caring for those who are sick so as to preserve and restore their health.

References

American College of Obstetricians and Gynecologists (ACOG). 2007. "ACOG Committee Opinion No. 385 November 2007: The Limits of Conscientious Refusal in Reproductive Medicine." *Obstet Gynecol* 110 (5): 1203–8.

Aquinas T. 1485. *Summa Theologiae*.

Aristotle. *Nicomachean Ethics*. Trans. D. Ross. New York: Oxford University Press, 2009.

British Broadcasting Corporation (BBC). 2017. "Swedish Anti-Abortion Midwife Loses Court Case." https://www.bbc.com/news/world-europe-39587154.

Brock, D. W. 2008. "Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?" *Theor Med Bioeth* 29 (3): 187–200.

Brody, H., and S. S. Night. 2007. "The Pharmacist's Personal and Professional Integrity," *Am J Bioeth* 7 (6): 16–17.

Card, R. F. 2014. "Reasonability and Conscientious Objection in Medicine: A Reply to Marsh and an Elaboration of the Reason-Giving Requirement." *Bioethics* 28 (6): 320–26.

College of Physicians and Surgeons of Ontario (CPSO). 2015. "Professional Obligations and Human Rights Policy." https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Obligations-and-Human-Rights.

Illinois General Assembly. 2016. Public Act 099-0690. SB 1564. http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0690.

Kaldjian, L. C. 2019. "Understanding Conscience as Integrity: Why Some Physicians Will Not Refer Patients for Ethically Controversial Practices." *Perspect Biol Med* 62 (3): 383–400.

LaFollette, E., and H. LaFollette. 2007. "Private Conscience, Public Acts." *J Med Ethics* 33 (5): 249–54.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. 1982. "Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship." repository.library.georgetown.edu/bitstream/handle/10822/559354/making_health_care_decisions.pdf.

Quill, T. E., and H. Brody. 1996. "Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice." *Ann Inter Med* 125 (9): 765.

Rawls, J. 1993. *Political Liberalism.* New York: Columbia University Press.

Savulescu, J. 2006. "Conscientious Objection in Medicine." *BMJ* 332 (7536): 294–97.

Savulescu, J., and U. Schuklenk. 2017. "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception." *Bioethics* 31 (3): 162–70.

Schuklenk, U., and R. Smalling. 2017. "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies." *J Med Ethics* 43 (4): 234–40.

Shanafelt, T. D., et al. 2015. "Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population between 2011 and 2014." *Mayo Clin Proc* 90 (12): 1600–1613.

Stahl, R. Y., and E. J. Emanuel. 2017. "Physicians, Not Conscripts: Conscientious Objection in Health Care." *N Engl J Med* 376 (14): 1380–85.

Sternberg, S. 2016. "Diagnosis: Burnout." *US News & World Report,* Sept. 8. https://www.usnews.com/news/articles/2016-09-08/doctors-battle-burnout-to-save-themselves-and-their-patients.

Thomasma, D. C. 1983. "Beyond Medical Paternalism and Patient Autonomy: A Model of Physician Conscience for the Physician-Patient Relationship." *Ann Intern Med* 98 (2): 243–48.