Conscientious objection, conflicts of interests, and choosing the right analogies. A reply to Pruski

In our article *Beyond Money. Conscientious objection in healthcare as a conflict of interests*, recently published in this journal, we argued that *certain* non-financial conflicts of interests (NFCOI) in healthcare should be managed in the same way as financial conflicts of interests (FCOI). More specifically, if there are reasons to prevent FCOIs from interfering with the fulfilment of one's professional obligations – which is widely accepted - these reasons equally apply to certain NFCOIs. Importantly, we did not argue that this equivalence should be applied to *all* cases of non-financial conflicts of interests. However, we argued that it should be applied to non-financial conflicts of interests deriving from healthcare professionals' own moral or religious views and that typically translate into 'conscientious objection' to certain medical procedures. The most widely discussed case is conscientious objection to abortion, but there are others. Thus, in our paper we offered one possible argument against conscientious objection based on a comparison between FCOIs and NFCOIs management. To support our argument, we deployed various analogies with other cases in which conflicts of interests arise, both within and outside the healthcare context.

In his response paper, Pruski picks out our analogy between a doctor's and a solicitor's professional obligations. As we wrote, in both cases the professionals have a professional obligation to act in their client's or patient's best interest, quite regardless of what other personal interest (either financial or non-financial) they might have. According to Pruski, this analogy does not support our argument against conscientious objection, for the following reason:

" The purpose [of the 'solicitor' analogy'], presumably, is to highlight that in cases involving abortion requests, doctors should be concerned only with the best interests of the pregnant woman, who is analogous to the solicitor's client. If this is indeed the analogy's purpose, its reasoning is flawed: while it is true that solicitors should work in the interests of their clients, they are not allowed to perform all and any acts that would be in their clients' interests, and may even be obliged to discourage their clients from performing some such acts"

We agree with Pruski on the point he makes about solicitors' obligations. Actually, we would welcome including this observation in~~to~~ our analogy and accept that, to paraphrase Pruski, while it is true that doctors should work in the interests of their patients, they are not allowed to perform *all and any* acts that would be in their patients' interests. In other words, we do not think that

'doctors should be concerned *only* with the best interests of pregnant women', as Pruski says. Attributing this claim to us is a straw man strategy.

The relevant question is about what constraints there may legitimately be on pursuing one's client or one's patient best interests. Our claim was that – in the doctor's case as well as in the solicitor's case - such constraints cannot be dictated by the professional's personal interests, whether financial or non-financial in nature. The only legitimate constraints can be other conflicting professional or legal requirements. In the medical context, one such constraint might be for example fairness in allocation of scarce resources, which can easily conflict with a patient's request to receive a certain treatment that is in their best interest. That patients' best interest ought to be weighed against certain other principles does not mean that *any* principle or value, including those dictated by a professional's own religious or moral views, has a legitimate claim to enter the moral weighing process. This applies to the doctor's case and to the solicitor's case alike.

Thus, we fully agree with Pruski that "there is a limit to how far doctors may go in supporting their patients' interests". But this is not the issue at stake in our article. The issue is about the nature of such limits. We argued that letting doctors' (or, for that matter, solicitors') personal moral views limit patients' best interests or indeed any other professional requirement– e.g. just distribution of scarce resources – would be ethically equivalent to letting some other of their own personal interests, such as financial ones, limit patients' interests. Pruski does not really tackle this claim, which is the main point of our article.

His counterexamples with regard to the solicitor's case include blackmailing or physically threatening the other parties in order to achieve better results for their client. Pruski rightly takes these practices to be impermissible, even if they benefit one's client. But these examples are irrelevant to the point of our paper. They are really not *counter*examples. They illustrate well the aforementioned general point with which we obviously agree, i.e. that there are limits to what a professional may do to pursue their client/patient's best interest. However, the more specific point we made was about the nature of of such limits. Our target was one's own moral or religious beliefs standing in the way of pursuing a patient's best interest, not *anything* that could stand in the way of pursuing a patient's best interest. Obviously enough, blackmailing and physically threatening people contradict professional requirements of solicitors, and indeed of any professional. Among the other reasons, professionals are expected to operate within the limits of the law, and blackmailing and physical threats are illegal. They are limits because they are illegal, not because a solicitor has a religious or moral objection to them.

Indeed, if a tax lawyer failed to identify a legal tax minimisation strategy to their client because they personally did not believe in tax minimisation, they would be failing in their professional obligation (no matter how worthy that view of tax minimisation might be).

In the same way, doctors may not legitimately blackmail someone or threaten one of their colleagues' patients in order to free up space in an intensive care unit for their own patient. Even thinking about such a scenario would be absurd, regardless of the religious or personal moral justifications for it. And yet, this scenario is analogous to the one in Pruski's examples, once transported in to the healthcare context. Of course, neither us nor anyone arguing for the priority of patients' interests over healthcare professionals' conscience would ever argue for the permissibility of blackmailing or physically threaten people in the healthcare context. The ethical, professional, and legal prohibition to blackmail or to physically threaten a person is a legitimate constraint on pursuing a client's best interest. To produce a real counterexample, Pruski would need a scenario where a client's best interest is threatened not by a solicitor's unwillingness to blackmail or physically threaten someone, but by some financial or non-financial interest, e.g. interests of conscience of the solicitor, such as her view about tax minimisation.

Another line of argument against our position that Pruski advances is the one according to which, on some metaphysical accounts, practices like abortion or sterilization are not medical acts but "socioclinical acts". It is not very clear what kinds of metaphysical accounts Pruski refers to and what he means by 'socioclinical act'. However, it seems the relevant point here is that on such accounts "ethical conflicts of interest are in fact the backbone of medicine" (p.5).

If by this Pruski means that the conflict between healthcare professionals' own moral or religious views and professional requirements is common in medical practice, then we agree with the factual statement. However, from an ethical point of view, we should revise what is common in medical practice if good enough ethical reasons exist. In our paper we have provided some such reasons, which would need to be counteracted by other ethical reasons, not simply by statements about matters of fact.

If instead Pruski means to make a normative statement about how medicine should be, this would indeed address our ethical argument. But in that case we would need to know why we should accept his metaphysical account of medicine, what it means to say that abortion is a 'socioclinical act', and why this understanding is relevant to the issue of conscientious objection.

It is true that there is deep moral disagreement about the moral status of the fetus, or the rightness of euthanasia for psychiatric conditions. These are legitimate topics for moral dialogue and disagreement. But the place for this is not the bedside, but rather the courts, parliament or public fora. Once a practice is legalised and doctors own a monopoly over its provision, it becomes their duty to provide it if it is in the patient's best interests, they want it and it is consistent with distributive justice [quote my BMJ article]. Those are constraints on its provision at that point, not the doctor's own morals or religion. When a homosexual man asks for a condom, or pre-exposure prophylaxis (if it is available), the doctor should provide it, regardless of their personal view of homosexuality or risky sex. Of course we can debate whether doctors should be providing condoms or pre-exposure prophylaxis, themselves or at all. But the place for that is not the clinic.

Pruski also raises a standard "eugenics objection" to our argument. As he writes:

"Another challenge for Giubilini and Savulescu is to reconcile their account with the problem of eugenics movements in early twentieth century Western democracies (MacKenzie, 1976; Tanner, 2012) – are they committed to condoning eugenics because it was a well established practice in society?"

We are not committed to condoning 'early twentieth century' eugenics (e.g. the Nazi practices) and we do not think our argument commits us to that. In fact, we think these practices were objectively wrong both because the violated liberty and did not aim a plausible good but rather racist Social Darwinist goals. Part of the problem of conscientious objection is a commitment to ethical relativism [cite Bioethics paper with Udo]. Just because a society condones a practice does not make it right. But just because an individual objects to it, does not make it wrong. The best we can hope for is a rational reflective equilibrium, or practical reflective equilibrium (cite moral machines ppaper with guy and chris in Nat Hum Behav)

But f~~F~~ollowing Pruski, ~~we want to~~let us leave aside the issue of the objectivity of ethics ~~whereby those practices are objectively wrong quite regardless of how they were perceived at that time~~. ~~We just briefly mention that those who, like us, think that there are objective ethical standards would also~~Even subjectivists about ethics have to think that ethics does progress and improve, which is why for example the F~~f~~our P~~p~~rinciples of biomedical ethics we use as reference point in our article would rule out the early t~~T~~wentieth' century eugenics practice. ~~But arguing for the objectivity of ethics is a complex metaethical task that would require a separate discussion.~~

However, we want to point out how Pruski's objection reveals the danger of a relativistic ethics. While this not in itself an argument against relativism, it shows how without some objective ethical standards Pruski's objection backfires. A right to object grounded in a principle of freedom of conscience is a right to object on the basis of personal moral views simply because they are a matter of conscience, and not because they are right or good ones. However, personal moral beliefs can flawed and dangerous. For example, doctors could, for reasons of conscience, object to saving Black patients on the basis of racist beliefs, women or men on the basis of sexist beliefs, young infant with disabilities on the basis of ableist beliefs, and so on. There is no reason why certain ethical or religious beliefs that can harm certain patients (e.g. doctors' pro-life views which stand in the way of women accessing safe abortion) should be treated differently from other ethical or religious beliefs that would also harm patients (e.g. ableist views that stand in the way of disabled children getting life-saving treatments), unless we have an objective ethical standard to differentiate the two. The risk of early 20th cCentury eugenics practices or indeed any other equally unethical practice is at least as large, if not larger, if we allowed doctors to act or not act merely on the basis of their conscience.

Of course, Pruski would reply that he is not arguing for unregulated conscientious objection. But the burden of providing a regulatory criterion is on him. Absent a non-arbitrary criterion for why we should tolerate certain form of conscientious objection but not others, which Pruski does not provide, we should conclude that it is very fortunate that we now have good ethical standards, such as the Four Principles, that prevent professionals from following their own moral morality and adopt unethical and dangerous practices.

However, as we argue in our article, more needs to be done to prevent them from sticking to their personal moral or religious views in those cases where conscientious objection is permitted, but where it conflicts with professional obligations. These include first and foremost the obligation to act in their patients' best interest within professional and legal boundaries. However, there can be other professional obligations that conscientious objection would infringe, such as fairness towards one's colleagues or the healthcare system.

Pruski also points out that it is not true that healthcare professionals who oppose abortion gain from it at the personal level, and that conscientious objection actually creates problems to them. Pruski takes this observation to contradict our conceptualization of conscientious objection as an expression of conflict of interest, as it would seem professionals have no personal interest

in objecting to certain practices. We have to replies. First, someone can have an interest even if they do not benefit in terms of career advances or material goods. For example, preserving one's own perceived 'moral purity' can be an interest of conscience. Second, often there are indeed professional gains in objecting to procedures like abortion, for example in hospitals or even countries (e.g. Italy), where conscientious objection is very widespread, including in medical hierarchies in hospitals, and the "outliers" are the non-objecting doctors. That 70 to 80% of gynaecologists in Italy have a conscientious objection to abortion (Minerva 2015) is quite telling of the cultural climate in those healthcare settings.

The last point is related to another objection that Pruski raises, namely that as a matter of fact many 'governing bodies' and 'most ethicists' (p.5) acknowledge a right to conscientious objection in healthcare. If we take the agreed professional standard as the reference point for what a professional may legitimately do or refuse to do, then this fact would commit us to support conscientious objection. However, we need to distinguish between standards about medical *procedures* and standards about professionals' *conduct*. The American Medical Association considers abortion consistent with good medical practice. This is a judgement about the procedure itself. But how individual doctors ought to behave with regard to good medical practice depends on a number of other considerations about the nature and the ethics of being a professional. Such considerations transcend the professional governing bodies' authority. They involve other factors and other actors.

For example, one consideration is that healthcare professionals are monopoly providers of a certain fundamental service to which individuals have a legal (and in some views a human) right, namely healthcare. The professional obligations with regard to the provision of any service that falls within good medical practice cannot be determined solely by those within the profession. They depend, among other things, on legitimate social expectations. Which expectations are legitimate is an ethical issue that requires ethical argumentation, like the one we have provided in our paper. Of course, our arguments are debatable, but they need to be debated at the normative level, and not by counting how many ethicists support a certain position.

Finally, Pruski draws the analogy with the case of doctors who can freely choose different subspecialties not requiring them to perform certain medical procedures. For example, he mentions the case of an orthopeadic surgeon who chooses to subspecialise only on lower limbs. In the same way, he suggests, doctors should be allowed to choose which procedures to perform on the basis of their personal moral considerations, such as in the case of an obstetrician who chooses not to perform abortions. He implies that the two

cases are analogous, but again, we think his analogy misses the point. There is an important ethical difference between choosing one's speciality or subspecialty and choosing which procedures to carry out once one has chosen their specialisation or subspecialisation on the basis of one's own moral or religious view. Specialising or subspecialising in a certain area is of course a free choice, and of course one is free to choose their subspecialty also on the basis of their own moral or religious reasons. But the relevant point is that once a doctor has chosen their specialisation or subspecialisation, there is a legitimate societal expectation on them to carry out all the procedures that they are legitimately expected to perform as a matter of professional obligation, since they operate in regime of monopoly providers, especially within the public system. The problem with conscientious objection is that one's own personal moral interests stand in the way of fulfilling such responsibilities within one's area of specialisation or subspecialisation. Thus, the relevant analogy with the case of doctors subspecialising would have to be with an orthopaedic surgeon who subspecialises in lower limbs, but refuses to perform a surgery on a patient's lower limb for personal moral reason, for example because they morally disapprove of the behaviour that led the patient to injure their limb.

This would be a case of non-financial conflict of interests. As we argued in our paper, it is as ethically problematic as analogous cases of financial conflicts of interests, such as a doctor who refuses to perform surgery on a patient's lower limb because, say, they receive money from a pharmaceutical company that produces drugs for treating the limbs before surgery. The two types of cases should be managed in the same way.