Conscientious objection in healthcare: How much discretionary space best supports good medicine?

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Abstract

Daniel Sulmasy has recently argued that good medicine depends on physicians having a wide discretionary space in which they can act on their consciences. The only constraints Sulmasy believes we should place on physicians' discretionary space are those defined by a form of tolerance he derives from Locke whereby people can publicly act in accordance with their personal religious and moral beliefs as long as their actions are not destructive to society. Sulmasy also claims that those who would reject physicians' right to conscientious objection eliminate discretionary space thus undermining good medicine and unnecessarily limiting religious freedom.

I argue that, although Sulmasy is correct that some discretionary space is necessary for good medicine, he is wrong in thinking that proscribing conscientious objection entails eliminating discretionary space. I illustrate this using Julian Savulescu and Udo Schuklenk's system for restricting conscientious objections as a counter-example. I then argue that a narrow discretionary space constrained by professional ideals will promote good medicine better than Sulmasy's wider discretionary space constrained by his conception of tolerance. Sulmasy's version of discretionary space would have us tolerate actions that are at odds with aspects of good medicine, including aspects that Sulmasy himself explicitly values, such as fiduciary duty. Therefore, if we want the degree of religious freedom in the public sphere that Sulmasy favours then we must decide whether it is worth the cost to the healthcare system.

INTRODUCTION

The extent to which we should accommodate conscientious objections in healthcare, if at all, continues to be vigorously debated. One way to advance the debate is to establish which system for dealing with conscientious objections would result in the best healthcare. Many believe that conscientious refusals of service undermine the quality of healthcare and, therefore, healthcare professionals should not have any right to conscientious objection.[1] Those in favour of accommodating (at least some) conscientious objections make the opposite claim – being free to act on conscience is a necessary condition for providing good healthcare, therefore, (excessively) limiting conscientious objections will undermine good healthcare.[2]

Daniel Sulmasy has recently developed one of the more thorough lines of argument for the latter claim using the concept of professional discretionary space, i.e. the range of situations in which a professional is free to act on her own judgment without deferring to rules or authorities.

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[1] J. Savulescu. Conscientious objection in medicine. *Br Med J* 2006; 332: 294 –7; J. Savulescu, & U. Schuklenk. Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception. *Bioethics* 2016; 31: 162–70; U. Schuklenk, & R. Smalling. Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *J Med Ethics* 2017; 43: 234-240; P. West-Oram, & A. Buyx. Conscientious objection in health care provision: a new dimension. *Bioethics* 2016; 30: 336–43; R.A. Charo. The Celestial Fire of Conscience – Refusing to Deliver Medical Care. *N Engl J Med* 2005; 352: 2471–73; A. Giubilini. Objection to conscience. An argument against conscience exemptions in healthcare. *Bioethics* 2017; 31: 400-8; J. Cantor, & K. Baum. The limits of conscientious objection—may pharmacists refuse to fill prescriptions for emergency contraception?. *N Engl J Med* 2004; 351: 2008–12; M.S. Swarz. 'Conscience Clauses' or 'Unconscionable Clauses': Personal Beliefs Versus Professional Responsibilities. *Yale J Health Policy Law Ethics* 2006; 1: 269–350.

[2] D. Weinstock. Conscientious refusal and healthcare professionals: does religion make a difference?. *Bioethics* 2014; 28: 8–15; M.R. Wicclair. *Conscientious objection in healthcare*. Cambridge: Cambridge University Press; H. Lynch. *Conflicts of Conscience in Health Care*. Cambridge, MA: MIT Press.

[3] He argues that ruling out conscientious objection eliminates physicians' discretionary space resulting in suboptimal medicine, and that physicians with a wide discretionary space in which to exercise their consciences will practice better medicine.[4] The only constraints Sulmasy believes we should place on physicians' discretionary space are those defined by his interpretation of Lockean tolerance whereby people can publicly act in accordance with their personal religious and moral beliefs as long as their actions are not 'destructive to society'.[5] Thus, on Sulmasy's view, physicians' wide discretionary space, the freedom to publicly act on non-destructive religious beliefs, and the practice of good medicine happily support one another; those who would eliminate discretionary space undermine good medicine and unnecessarily limit religious freedom.

I argue that, although Sulmasy is correct that some discretionary space is necessary for good medicine, he is wrong in thinking that proscribing conscientious objection entails eliminating discretionary space. I use Julian Savulescu and Udo Schuklenk's account to illustrate how physicians' conscientious objection can be ruled out while maintaining the discretionary space to act within the bounds of relevant laws, professional policies, and professional ideals.[6] This, however, is a narrower discretionary space than Sulmasy favours and he could adjust his objection accordingly. The adjusted objection is that ruling out conscientious objection undermines good medicine, not by eliminating discretionary space, but by narrowing it. I then

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[3] D.P. Sulmasy. Tolerance, Professional Judgment, and the Discretionary Space of the Physician. *Cambridge Q Healthc Ethics* 2017; 26: 18–31.

[4] Sulmasy focuses on physicians rather than healthcare professionals more generally. I follow his lead; however, analogous versions of our arguments could be applied to the discretionary space of any professional.

[5] D.P. Sulmasy. What is conscience and why is respect for it so important?. *Theor Med Bioeth* 2008; 29: 135–49; Sulmasy, *op. cit.* note 3.

[6] Savulescu, & Schuklenk, *op. cit.* note 1.

argue that a narrow discretionary space constrained by professional ideals will promote good medicine better than Sulmasy's wider discretionary space constrained by his conception of tolerance. Sulmasy's version of discretionary space would have us tolerate actions that are at odds with aspects of good medicine, including aspects that Sulmasy himself explicitly values, such as fiduciary duty.[7] Therefore, Sulmasy's wide discretionary space entails a degree of tolerance for religiously grounded public acts that is actually in conflict with good medicine. If we want the degree of religious freedom in the public sphere that Sulmasy favours, then we must decide whether it is worth the cost to good healthcare.

SULMASY'S ARGUMENT AGAINST RULING OUT CONSCIENTIOUS OBJECTION

Savulescu and Schuklenk's account[8] is typical of those that Sulmasy objects to. They believe that when physicians refuse a legal, requested service, they interfere with the patient's right to

[7] Throughout the article I assume, as Sulmasy does, that there is such a thing as objectively good medicine. This assumption is essential for the entire project of selecting a system for dealing with conscientious objections based on whether conscientious objections support good medicine. My dispute with Sulmasy doesn't depend on either of us holding any particular conception of good medicine, therefore, I don't look to attack or defend a conception of good medicine. For purposes of exposition, I take a relatively inclusive view of the goods that are commonly thought to be essential to good medicine, e.g. prevention and healing of disease, relief from suffering, responsiveness to empirical evidence, respect for patient autonomy, and concern for just distribution of scare medical resources. For an account of why the normative demands of good medicine do not simply reduce to the demands of morality more generally see J.D. Arras. A Method in Search of a Purpose : The Internal Morality of Medicine. *J Med* 2001; 26: 643–62; F.G. Miller, & H. Brody. The internal morality of medicine: an evolutionary perspective. *J Med Philos* 2001; 26: 581–99.

[8] Savulescu, & Schuklenk, *op. cit.* note 1.

the service and immorally prioritise their personal values over their professional duty to the patient. On their view, those who conscientiously refuse to provide healthcare services should face sanctions and, if they cannot reconcile themselves with providing the necessary services, seek other employment. Sulmasy claims that such anti-conscientious objection views require the physician to unreflectively do as the patient requests, thereby wrongly reducing professional medicine to a service-providing occupation, such as that provided by taxi drivers and salespersons [9]. Unlike those in service occupations, physicians need to make professional judgments to do their job well. That is, they need to 'make particular judgments about particular individuals in particular situations, applying the specialized knowledge of the profession, in conformity with its moral norms, for the service of those individuals' [10]. Non-professional service providers sell their services to any client who will pay for them[11] unlike professionals who 'are not oriented primarily toward the satisfaction of the preferences of clients or customers, but toward the realization of goods internal to the profession's practice'[12]. To illustrate how physicians' discretionary space supports good medicine, Sulmasy compares two clinical cases, one where a patient's ear needs to be removed to treat a cancerous tumour and the other where the patient wants an ear removed to look like Vincent van Gogh. According to Sulmasy, the treatment of cancer is part of the role of medicine but such cosmetic surgery is not. If the physician lacked the discretionary space to selectively deny the patient services (services that he would provide in other circumstance), medicine would be detrimentally co-

[9] Sulmasy *op. cit.* note 3, pp.22-26.

[10] Ibid: 23.

[11] However, they do need to judge whether providing the service is within the bounds of the law. A shopkeeper needs to judge whether to ask someone for identification before selling them alcohol. A taxi driver can refuse a client who asks them to drive the wrong way down a one-way street.

[12] Sulmasy, *op. cit.* note 3, p.23.

opted for non-medical purposes. [13] Other features typically thought to be essential to good medicine also depend on physicians' discretionary space for their promotion. For example, to respect the patient's autonomy, the physician needs the discretionary space to judge when the patient has a sufficient understanding of the idiosyncratic moral and medical details of the clinical situation to make an informed choice. If physicians unquestioningly provide services requested by patients, they risk going against the patient's best interests (as judged by the patient) because the patient may be ignorant of the risks involved or overly optimistic about the prospects of treatment. Similarly, physicians can better promote distributive justice if they have the discretionary space to refuse services that they judge will run contrary to distributive justice. At the very least, they should be able to refuse legal, requested services that they judge to be futile or unnecessary, such as when a patient with a muscle tension headache requests a CT scan [14].

Good medicine will tend not to be promoted if the physician must do what the patient requests because, unlike the physician, the patient is not professionally committed to good medicine and, typically, lacks the training to promote it anyway. 'Society has an interest in promoting good medicine, and, therefore, society has an interest in granting physicians the wide discretionary space that is required to make medical practice excellent' [15]. Of course, one might also doubt *physicians'* interest in and capacity to promote good medicine. To prevent physicians from undermining good medicine one could set strict, comprehensive professional

[13] Of course, Sulmasy's vision of medical indications is disputable. Perhaps good medicine *should* entail providing cosmetic ear surgeries to those who autonomously request them. However such disputes are resolved, if we assume we need to place *some* limits on what counts as a medical indication, then those limits will benefit from being enforced by physicians.

[14] Sulmasy, *op.cit.* note 3, p.24.

[15] Ibid: 24.

rules aimed at good medicine. One problem here is that rule-makers cannot anticipate the variety of clinical situations that will arise. When unanticipated situations arise, there is a risk that existing rules will guide actions that the physician can see are at odds with good medicine. Therefore, to promote good medicine, one should not attempt to excessively regulate medical practice. 'The quest for uniformity [in decision-making] would be both unwise and unrealistic' [16].

I agree with Sulmasy that we should reject positions that provide the physician *zero* discretionary space because such positions will undermine good medicine. However, as I show in the next section, one can rule out conscientious objections without eliminating the physician's discretionary space, therefore, Sulmasy has been attacking a strawman.

COUNTEREXAMPLE: SAVULESCU AND SCHUKLENK'S NARROW DISCRETIONARY SPACE

Savulescu and Schuklenk don't discuss discretionary space explicitly but we can infer their view of discretionary space from the limits they place on conscientious objection.[17] The strongest limit Savulescu and Schuklenk place on discretionary space is defined by the law – physicians should not conscientiously provide or refrain from providing a service if it would be illegal to do so. For example, one mustn't provide euthanasia where it is illegal and one must destroy excess embryos created by IVF when it would be illegal to preserve them.[18] In those cases, if one's conscience recommended providing euthanasia or refusing to destroy the

[16] Ibid: 25.

[17] When necessary I complement this joint account with detail from Savulescu's sole-authored paper (*op. cit.* note 1). As far as I can tell the positions advanced in both papers are consistent.

[18] Savulescu, & Schuklenk, *op. cit.* note 1, p. 166.

embryos, then one should not be allowed to act on one's conscience without sanction. However, legal limits on medical practice are open to a degree of interpretation. In the United Kingdom, for example, the Human Fertilisation and Embryology Act (1990) sets no upper gestational limit on termination when the foetus has a 'substantial risk of serious handicap'. However, a termination after 24 weeks would be illegal if the foetus did not have a substantial risk of serious handicap. This leaves it to the physician to judge what counts as a 'substantial risk' and what counts as a 'serious handicap':

> In the absence of [legal] clarification, practitioners have a legitimate right to refuse to provide a service which they believe to be illegal. However, they should make this reason clear to patients and also the fact that the law is unclear. They should also inform patients of the availability of other practitioners who take a different view of the law.[19]

On Savulescu's view, then, physicians have the discretionary space to judge which treatments count as illegal in areas of legal uncertainty. Importantly, however, this discretionary space does not allow refusals of service on personal conscientious grounds. Although the physician's personal conscience might guide her legal interpretation, the ultimate justification for her actions must be grounded in a justifiable interpretation of the law, not her personal morality.[20]

Savulescu and Schuklenk also place more specific limitations on discretionary space by claiming that physicians are obliged to follow professional policies. This is illustrated in their objection to an example of secular conscientious action where physicians (allegedly)

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[19] Savulescu, *op. cit.* note 1.

[20] Ibid: 296. Savulescu would like to see less discretionary space in this case and argues that, the Human Fertilisation and Embryology Act should be made more specific to provide patients more certainty about what treatment they can expect. However, even if we adopt a highly specified legal code, there will always be borderline cases where the physician will have to exercise her discretion.

deprioritise heart transplants for children with intellectual disabilities on the grounds that a greater good is achieved by saving the lives of those without intellectual disabilities. 'Here we have a secular conflict between some doctors' values (utilitarianism) and a stated healthcare policy (egalitarianism)' [21]. In this case, physicians should not act on utilitarian approaches because they are 'in direct contravention of the stated principle of most international guidance and principles of egalitarianism that underpin public health systems' [22]. For similar reasons they also explicitly rule out 'fair innings' approaches to distribution of medical resources where the elderly are systematically denied resources in favour of the young even when treating the elderly would not be futile [23]. As with interpreting the law, requiring physicians to follow professional policies still leaves the discretionary space to judge which professional policies apply in any given situation and how to resolve conflicts between guidelines. For example, a professional policy might indicate that a potential recipient of a heart transplant should be deprioritised if the recipient lacks the capacity to follow post-operative treatment regimes. Physicians will vary in their assessment of the recipient's capacities and the minimum capacity required to follow the regimes.[24]

Where the physicians' actions are underdetermined by the law and established professional policies, they still cannot act in any way that their conscience recommends. They must act in ways that are consistent with objectively good medicine, i.e. respect for patient autonomy, promotion of the patient's objective interests, and just distribution of finite medical resources

[21] Savulescu, & Schuklenk, *op. cit.* note 1, 169.

[22].Ibid: 169.

[23] Ibid: 165.

[24] Of course, some professional policies take the decision out of the physician's hands. The physician might only have the discretionary space to decide whether she wants to escalate the decision to a committee and the committee will decide, for example, whether treatment is futile or not.

[25]. Therefore, Savulescu and Schuklenk would claim that, even without a professional policy guiding egalitarian distribution of transplants, physicians should distribute transplants in that way anyway because it is most consistent with objectively good medicine. The requirements of good medicine also entail that, 'if a service a doctor is requested to perform is a medical practice, is legal, consistent with distributive justice, requested by the patient or their approved surrogate, and is plausibly in their interests, the doctor must ensure the patient has access to it' [26]. As with laws and professional policies, however, the physician has discretionary space to judge whether any particular service aligns with objectively good medicine. Physicians may differ on their assessment of whether a patient is autonomous and which treatment best promotes the patient's interests. Physicians may refuse to provide treatment if they can justify their decision in terms of objectively good medicine. Here, there is also some discretionary space to judge exactly what counts as objectively good medicine. For example, physicians might disagree over whether certain treatments, such as elective amputation, can *ever* be in a patient's best interest, or over whether objective assessments of patients' objective interests can *ever* be prioritised over the patient's autonomy. Schuklenk and Savulescu appear to favour a relatively narrow conception of good medicine and thus a narrower discretionary space given their claim that just distributive justice must be egalitarian and, at another point, that the patient's autonomous assessment of their own interests should always override the physician's assessment of the patient's objective best interest [27]. My goal here, however, is not to argue for a particular conception of objectively good medicine. The relevant point is that, Savulescu and Schuklenk's account maintains a discretionary space even as it rules out conscientious action contrary to the law, professional policy, and (narrowly defined) ideals of medicine. One is free

[25] Savulescu, *op. cit.* note 1, pp.294-5.

[26] Savulescu & Schuklenk, *op. cit.* note 1, p.167.

[27] Ibid: 170.

to act on one's conscience to the extent that it aligns with the law, professional policies, and professional ideals.[28] Physicians do not have to provide services that the patient requests if, in their professional judgement, it would be illegal to do so, against established professional policies, or at odds with the ideals of medicine. Physicians are, however, obliged to provide services when to refrain would be illegal, against professional policies, or against the ideals of medicine.

Savulescu and Schuklenk's view of discretionary space can, therefore, accommodate many of the examples that Sulmasy assumes they will find problematic. This isn't surprising since Sulmasy had incorrectly assumed that those against conscientious objection require a much narrower definition of discretionary space than they actually do. Regarding the patient with a muscle tension headache who asks for a CT scan, Savulescu and Schuklenk can agree with Sulmasy that the physician should refuse the request because there are no laws or professional policies that say the physician must provide the service, and it would be at odds with distributive justice. Savulescu and Schuklenk's view of discretionary space also enables them to negotiate a similar example from Christopher Cowley. Cowley argues that if one insists that physicians provide euthanasia where legal and requested, then one must also insist that physicians provide a legal treatment that the patient requests after reading about it on the

[28] Savulescu and Schuklenk's view would benefit from further development of how they understand the relationship between the demands of the law, professional policies, and the ideals of good medicine. Presumably, the law has the most authority, followed by professional policies, and then the ideals of good medicine, given that they say: 'The place to debate issues of contraception, abortion and euthanasia is at the societal level, not the bedside, once these procedures are legal and a part of medical practices that healthcare professionals may agitate to change laws but not at the patient's bedside' (Ibid: 164). One downside of this approach is that, physicians cannot conscientiously refuse to follow immoral laws and/or professional policies should they develop.

internet.[29] However, as will now be clear, Savulescu and Schuklenk are not committed to the view that the physician must provide a treatment just because it is legal and the patient asks for it. On their view, the physician is only obliged to provide legal, autonomously requested euthanasia (or internet-marketed treatment) when they judge it to accord with professional policies and good medicine. If, in the circumstances, euthanasia or the internet treatment were either clearly against professional policies, not in the patient's objective best interests, or at odds with distributive justice, then the physician should refuse to provide those treatments.

At this point Sulmasy might modify his objection. Savulescu and Schuklenk may not have eliminated discretionary space but they have narrowed it, and this will result in worse healthcare than a wider discretionary space. In order to assess which form of discretionary space would better promote good medicine we need to look at Sulmasy's wider discretionary space in more detail.

SULMASY'S WIDER DISCRETIONARY SPACE

Sulmasy is against restricting discretionary space with obligatory professional policies because he believes that clinical decisions are too complex for such rules. Given this complexity, '*all* algorithms are ultimately only guidelines. Medicine may be scientifically informed, but medical practice is ultimately an art and not a science.' [30]. Compulsory professional policies would force physicians to overlook important nuance, resulting in worse outcomes.[31] This view

[29] C. Cowley. A Defence of Conscientious Objection in Medicine: A Reply to Schuklenk and Savulescu. *Bioethics* 2016; 30: 358–64.

[30] Sulmasy, op. cit. note 3, p. 24, my italics.

[31] I think he exaggerates the complexity of clinical decisions; they are not so complex that *all* professional principles should be considered optional. I return to this issue below.

of medicine motivates Sulmasy's view that society should cultivate 'practitioners of conscience' [32], i.e. practitioners whose consciences are somehow 'tuned-in' to good medicine. Sulmasy thus gives physicians the discretionary space to act on personal, perhaps religiously informed, conceptions of good medicine. He does, however, recognise the danger of allowing physicians to apply just *any* conception of good medicine.[33] To restrict physicians' discretionary space, he draws on Locke's idea that the practical principles and opinions by which people regulate their actions with one another ought to be tolerated unless destructive of society, the common good, or the well-ordered functioning of the state. [34] When applied to medical practice, this principle entails that we should tolerate physician's conscientious acts unless they are destructive in these ways [35].

Sulmasy specifies three conditions for assessing whether a conscientious public practice is destructive of society and, therefore, whether it should be tolerated [36]. First, if the practice undermines or contradicts the principle of tolerance itself, then it cannot be tolerated. 'A moral system that tolerated intolerance would seem internally inconsistent.' [37] This condition rules

[32] Sulmasy, *op. cit.* note 3, p. 25.

[33] Sulmasy, *op.cit.* note 5, p.145. If we accommodate objections whatever their grounds, we will accommodate objections with discriminatory, self-interested, and incoherent grounds that would clearly undermine the quality of healthcare. See J. Harries, et al. Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa. BMC Public Health 2009; 9: 296; C. Meyers, & R.D. Woods. Conscientious objection? Yes, but make sure it is genuine. Am J Bioeth 2007; 7: 19–20.

[34] J. Locke. 2010. An essay concerning toleration. In \M. Goldie, ed. A Letter Concerning Toleration and Other Writings. Indianapolis: Liberty Fund: 111, note 11.

[35] Sulmasy, *op. cit.* note 3, p.26.

[36] Sulmasy, *op. cit.* notes 3 and 5.

[37] Sulmasy, *op. cit.* note 5, p.146.

out discriminatory conscientious actions because it is inconsistent to ask others to tolerate one's intolerance toward, for example, people of a particular race, gender, or sexual orientation. Second, if conscientiously refusing a service entails a substantial risk of serious illness, injury, or death to others, the conscientious refusal cannot be tolerated because it would be destructive of society [38]. Conscientious refusals of service that merely cause others inconvenience, psychological distress, or mild symptoms are not destructive of society and so should be tolerated:

> For example, the fact that a patient might need to be transferred to another institution; might be upset that the doctor or nurse disagrees; or might continue to experience some amount of dizziness while attempting to find someone who agreed with his or her request would not seem to be sufficient grounds to compel the consciences of physicians and nurses. Symptoms should be treated symptomatically while awaiting the resolution of any conflict of conscience, provided that the symptomatic treatment is not itself a problem for conscience. But deep mutual respect for conscience demands that we ought to be willing to be inconvenienced, if necessary, for each other's sake. [39]

Sulmasy introduces a third condition because he hopes to justifiably prohibit physicians from conscientious actions such as proselytising patients 'no matter how zealous the clinician might

[38] Sulmasy, *op. cit.* note 3, p.28.

[39] Sulmasy, *op. cit.* note 5, p.146. Of course, one might dispute the degree of destruction to society that we should tolerate. Arguably the injustice of having to travel a long distance to receive healthcare because of a conscientious objector, for example, *is* destructive to society. Sulmasy is clear, however, that only a substantial risk of serious illness, injury or death is sufficient to compel someone to go against their conscience. He specifies that the inconvenience of having to work harder to find a treating physician is not sufficient to count as harm (Sulmasy, *op. cit.* note 3, p.23).

be to save the patient's soul.' [40] Proselytising patients is unlikely to cause them serious illness, injury or death, therefore, if Sulmasy is to justifiably limit conscientious actions, he needs other grounds for doing so. He appeals to the idea that it causes people less harm to refrain from acting conscientiously than it does to act contrary to their consciences, so physicians can be more readily compelled to refrain from acting on their conscience than compelled to act contrary to their consciences.[41] Therefore, one can compel a physician to refrain from actions that only '*might* threaten the common good.' [42]

MY RESPONSE TO SULMASY

Sulmasy's wider discretionary space does not promote good medicine as he claims, in fact, it leaves several features of good medicine completely unprotected. The core of the problem is that Sulmasy would tolerate all medical practices that are not destructive to society, however, some practices that are not destructive to society are, nevertheless, contrary to features of good medicine.

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[40] Sulmasy, *op. cit.* note 3, p.29.

[41] Ibid: 28.

[42] Ibid: 29, my italics. Sulmasy doesn't clearly define the risk of harm to the common good that would be sufficient to compel physicians to refrain from acting conscientiously. Furthermore, by linking the degree of harm that a conscientious action may allowably cause to the degree of harm the physician would suffer if he refrained from acting, Sulmsay loses the power to rule out proselytising patients 'no matter how zealous the clinician might be'. An extremely zealous physician might be severely hurt by refraining from proselytising so he shouldn't have to refrain given the relatively small risk of harm to the common good. Even if these issues can be solved, the more fundamental problem for this criterion is that it weighs harm without consideration of the requirements of good medicine (discussed below).

First, the three tolerance conditions place little, if any, limit on what counts as a medical indication. Sulmasy himself recognises the importance of placing limits on medical indications claiming that wanting to look like Vincent van Gogh is not a medical indication and so physicians should not remove ears to meet such requests [43]. However, his conditions for tolerance don't enforce that limit. If a physician judges that patients' desires for such cosmetic enhancements count as medical indications, there is nothing to stop him providing such procedures when asked. If some physicians have liberal interpretations of what counts as a medical indication, e.g. where medicine includes whatever the patient wants, then it seems that the only indications ruled out as non-medical will be those it would cause destruction to society to treat.[44] Therefore, Sulmasy's tolerance conditions cannot prevent medicine being reduced to mere service provision where individual physicians are happy to be service providers like taxi drivers or retailers (the very thing he incorrectly accused the anti-conscientious objection lobby of doing).

Sulmasy's tolerance conditions would also tolerate physicians who denied that commonly accepted ailments, such as, rashes, headaches, mild depression and anxiety, were medical indications because, if untreated, those conditions won't cause the patient substantial risk of serious illness, injury, or death. Similarly, we would have to tolerate physicians engaged in all kinds of practices that would not be destructive of society but that would be contrary to good medicine, for example, a physician who conscientiously refuses to provide antibiotics because

[43] Ibid: 23.

[44] However, perhaps society would be better off if those who autonomously want, say, to have limbs amputated or to be euthanised, receive those treatments. If so, then on Sulmasy's view, *anything* can count as a medical indication if the patient autonomously asks for treatment and the physician agrees to treat.

he believes bacteria have a high moral status. [45] On Sulmasy's conditions this medical practice would have to be tolerated up to the point that the patient faced a substantial risk of serious illness or injury. By tolerating conceptions of medicine that deviate from objectively good medicine, we expose patients to harm they would not be exposed to if all physicians were obliged to act in accordance with good medicine.

A closely related problem arises when Sulmasy attempts to justify compelling physicians to refrain from certain conscientious actions, such as proselytising patients. He appeals to a threshold of harm that is somewhat vague but lower than that required to compel someone to go against their conscience. [46] If an action would risk that lesser degree of harm then the physician must refrain from it. This threshold is under-specified but that isn't its main problem. The fundamental problem is that we cannot distinguish good medical practice from bad based on an assessment of harm alone. The practices we should want to rule out as incompatible with good medicine are not necessarily harmful and those we should want to maintain as part of medicine sometimes cause harm. On Sulmasy's criteria, we would have to accept physicians' conscientious non-medical practices in circumstances where they didn't happen to cause harm. For example, we would have to tolerate proselytising in a society whose citizens were comfortable with lively public religious debate. Similarly, various superstitious and occult practices, such as animal sacrifices to bring good fortune to patients, would be tolerable if they didn't involve social harm. Sulmasy's criteria would also prohibit good medical practices that may cause harm not outweighed by subsequent benefits. For example, physicians would be obliged to refrain from providing distressing diagnoses when they judged that the distress

[45] A. Giubilini. Objection to conscience. An argument against conscience exemptions in healthcare. *Bioethics* 2017; 31: 400-8.

[46] Sulmasy, *op. cit.* note 3, p.29.

caused would not be outweighed by subsequent treatment. Obviously, we want physicians to provide diagnoses despite harm and not to provide non-medical practices like proselytization even when it wouldn't cause harm. To overcome this problem, we need to distinguish between harms that are part of good medicine and harms that have nothing to do with medical practice. Sulmasy's concern with undifferentiated harm cannot do that.

Second, despite Sulmasy's claim that fiduciary duty is essential to good medicine,[47] his tolerance conditions don't require physicians enter fiduciary relationships with patients. The tolerance conditions assume that we give each other's interests *equal* weight and say nothing about how to proceed in fiduciary relationships where one party gives extra weight to the other party's interests. Giving each other's interests equal weight makes sense *outside* fiduciary relationships. If reasonable private citizens' interests are in unavoidable conflict, the person who will suffer the lesser harm should accept that harm trusting that, had positions been reversed, the other would have done the same for him. For example, it would be unfair to ask someone to go against his conscience when one stood to lose less than him if he acted on his conscience. However, *within* fiduciary relationships, the party with the fiduciary duty should place greater weight on the others' interests and, so be prepared to go against his conscience in a subset of cases where he needn't in non-fiduciary relationships. Sulmasy's tolerance conditions don't articulate any fiduciary concessions that a physician should make to a patient. A physician who gave his own interests equal weight with the patient's interests could meet all three tolerance conditions. The first condition is met because there is nothing internally inconsistent about giving everyone's interests equal weight. While the second and third conditions don't require the physician to do any more for a patient than one private citizen would be expected to do for another. The lack of fiduciary duty is unsurprising given that, when

[47] Ibid: 23.

deciding whether to conscientiously refuse a service, the physician only needs to consider society's interests. The only reason that the physician has to avoid causing serious illness, injury, or death to the patient is because it would be destructive to society. The patient's interests are beside the point.

Third, Sulmasy's tolerance conditions don't require physicians to be sensitive to patients who lack autonomy. According to his conditions, physicians can provide patients any treatment they ask for as long as those treatments don't risk serious illness, injury, or death. Less than fully autonomous and outright incompetent patients might ask for a variety of things that are not plausibly in their best interests yet that would not risk serious injury, illness or death. For example, hypochondriacs might request treatments for imaginary diseases that would unnecessarily expose them to side effects. On Sulmasy's view, the physician only has to make sure those side effects don't risk serious injury, illness or death; he is under no further obligation to work out what is in the patient's best interests (e.g. cognitive behavioural therapy) or if the patient is a competent judge of his own best interests.

In summary, Sulmasy's position does not distinguish medical practices from non-medical practices and so cannot pressure physicians to provide the former and refrain from the latter. Neither does his position require the physician to fulfil a fiduciary duty towards the patient or concern himself with the patient's autonomy. Therefore, his argument that we should adopt his wide discretionary space because it supports good medicine is flawed.

DISCRETIONARY SPACE LIMITED BY PROFESSIONAL RULES

A more obvious path for ensuring good medicine is to derive rules governing physicians' discretionary space from our conception of good medicine. If, for example, respect for patient autonomy, fiduciary duty, promotion of the patient's objective health, and just distribution of

finite medical resources are part of good medicine, then we should adopt professional rules that ensure physicians pursue those goods or, at least, don't act contrary to them. If we think that proselytising, animal sacrifice, or Van Gogh-style cosmetic surgeries are inconsistent with good medicine then we can prohibit those practices.

Obviously, there will be disagreement between people's conceptions of good medicine and epistemic humility should lead us to accept that a range of conceptions of good medicine are reasonable. The public healthcare system should adopt a conception of good medicine that is sufficiently broad to be acceptable to the public given their range of reasonable individual conceptions of good medicine. [48] We can then develop a set of professional rules that promote that broad public conception of good medicine. The specificity of those rules will depend on the breadth of that conception. For example, if the reasonable public agrees that distributive justice in medicine should be egalitarian rather than utilitarian, we can set the rules accordingly. Similarly, the more confident we are that a particular practice is essential (or contrary) to good medicine, the more coercive we can make the rule promoting (or prohibiting) that practice by increasing the sanction for violating the rule. In a private healthcare setting, the situation is fundamentally the same as long as the private institution is committed to some reasonable conception of objectively good medicine. The institution should establish professional rules to promote their conception of good medicine which will limit physicians' discretionary space accordingly. [49]

[48] Setting limits on the range of reasonable conceptions of good medicine and specifying how a broad conception of good public medicine can be justified to the public are significant undertakings which I cannot address here.

[49] Private, especially religious, healthcare institutions may often restrict the discretionary space of the physicians working there *more* than the public sector. This is because private institutions can promote relatively narrow conceptions of good medicine that needn't be justified to the broader public. For example, a physician

It is important to note that one could accept that good medicine will be best promoted by using professional rules to limit discretionary space but still reject Savulescu and Schuklenk's account. Their view is just one of a variety of possible views that limit discretionary space by appeal to good medicine. One might, for example, reject their account for conceiving of good medicine too narrowly or, more radically, one might allow physicians the discretionary space to act on reasonable conceptions of good medicine even if it would contravene established professional rules or laws. The downside of this more radical move is that, depending on the range of acceptable conceptions of good medicine, physicians could easily excuse themselves from laws and established professional rules making for a much less predictable healthcare system. A compromise approach is to accept the authority of established professional rules and laws but give physicians the right to conscientious objection if they can show that their position is consistent with a reasonable conception of good medicine.[50]

These approaches to limiting discretionary space entail less religious freedom than Sulmasy's view, but how much less depends on how inclusively we set the range of acceptable conceptions of good medicine. If we are committed to objectively good medicine, we cannot accept conceptions of medicine grounded solely in scripture or religious authorities that appear arbitrary to everyone outside the religion. If we did, then anyone could justify any idiosyncratic conception of good healthcare. To avoid that relativism, we must restrict the acceptable conceptions of good medicine to those that appeal to shared values so that they can meet some

accustomed to the greater discretionary space of the public system might be frustrated by having to waste of resources on futile end-of-life care (even if privately funded) or the inability to offer abortions to those seeking them.

[50] A. Liberman. Wrongness, Responsibility, and Conscientious Refusals in Health Care. *Bioethics* 2017; 31: 495-504; D. McConnell. Conscientious objection in healthcare: Pinning down the Reasonability View. *J Med Philos* forthcoming.

standard of public justification. In multi-cultural, multi-faith societies, shared values are necessarily secular values, however, a commitment to shared values does not discriminate against religious conceptions of healthcare; idiosyncratic secular values that clashed with shared values would also be ruled out, e.g. giving bacteria a high moral status. Despite limiting ourselves to secular conceptions of good medicine, some religiously informed medical practices may yet be compatible with those conceptions. A refusal to provide abortions for religious reasons, for example, might be acceptable because it happens to be compatible with an acceptable secular conception of good medicine. See Weinstock [51] for a more detailed discussion of these issues.

Sulmasy refuses to limit discretionary space with professional rules because he believes that the complexity of clinical decisions renders professional rules detrimental to medical practice. Certainly, clinical decisions are sufficiently complex that obliging physicians to follow overly specific rules would prevent them responding to important idiosyncratic details of each case. We can avoid this problem, however, by making the rules sufficiently general as described above. To insist, as Sulmasy does, that *all* professional rules should be optional entails the belief that good medicine could change completely from one clinical scenario to the next, i.e. that there are unusual cases where the physician should ignore fiduciary duty, patient autonomy, distributive justice, et cetera.[52] This is tantamount to denying that there is such a thing as objectively good medicine. Sulmasy is in a dilemma. If he abandons his commitment to objectively good medicine, he cannot claim that we should adopt his wider discretionary

[51] D. Weinstock. Conscientious refusal and healthcare professionals: does religion make a difference?. Bioethics 2014; 28: 8–15.

[52] Of course, there will be cases where considerations of good medicine should be overridden, e.g. the physician's fiduciary duty doesn't require her to risk her own life for the patient's interests, but that is not the same as saying that sometimes fiduciary considerations are irrelevant.

space because it promotes good medicine. His argument has become self-defeating and he would have to provide some other argument for why we should adopt his wider discretionary space. However, if he remains committed to the existence of certain features of good medicine, such as fiduciary duty, limits on medical indications, et cetera, his wider discretionary space provides no support for those features. A wider discretionary space might be justified because it promotes *other* values, such as greater religious tolerance, however he should be clear that the degree of religious tolerance entailed by his wide discretionary space involves a trade-off with good medicine. Good medicine will be much better promoted by a narrower discretionary space limited by professional rules tailored to those goods.

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