bioethics

Bioethics ISSN 0269-9702 (print); 1467-8519 (online)
Volume 30 Number 5 2016 pp 358–364

doi:10.1111/bioe.12233

A DEFENCE OF CONSCIENTIOUS OBJECTION IN MEDICINE: A REPLY TO SCHUKLENK AND SAVULESCU

CHRISTOPHER COWLEY

Keywords
conscientious objection,
abortion,
euthanasia,
physician-assisted suicide

ABSTRACT

In a recent (2015) Bioethics editorial, Udo Schuklenk argues against allowing Canadian doctors to conscientiously object to any new euthanasia procedures approved by Parliament. In this he follows Julian Savulescu's 2006 BMJ paper which argued for the removal of the conscientious objection clause in the 1967 UK Abortion Act. Both authors advance powerful arguments based on the need for uniformity of service and on analogies with reprehensible kinds of personal exemption. In this article I want to defend the practice of conscientious objection in publicly-funded healthcare systems (such as those of Canada and the UK), at least in the area of abortion and end-of-life care, without entering either of the substantive moral debates about the permissibility of either. My main claim is that Schuklenk and Savulescu have misunderstood the special nature of medicine, and have misunderstood the motivations of the conscientious objectors. However, I acknowledge Schuklenk's point about differential access to lawful services in remote rural areas, and I argue that the health service should expend more to protect conscientious objection while ensuring universal access.

In a recent *Bioethics* editorial,[1] Udo Schuklenk argues against any provisions for conscientious objection in medicine, notably in the areas of abortion and end-of-life care. In this he follows Julian Savulescu's 2006 *BMJ* article,[2] which became notorious for the sheer number of angry comments it provoked (i.e. in the comment section of the *BMJ* website). Schuklenk's basic argument is simple and powerful: first, it is for legislators to make uniform and universal law, and for doctors to follow it – *all* doctors. Once the legislators (in consultation with the medical profession) have decided that a particular medical procedure such as abortion is lawful, that marks the temporary end of the political debate in that jurisdiction, at least until the launch of a new political initiative. If a doctor does not like the law, she can move to another jurisdiction, or to another profession, or she can campaign for the law to be changed. But unless and until it is changed, then the law binds all citizens in that jurisdiction. Second, the law should not be seen merely as *permitting* a willing doctor (with the relevant training and skill) to provide the lawful service, but as *requiring* all suitable doctors to provide the service wherever and whenever the patient fulfils the conditions for it. This second consideration is also boosted by considerations of fairness within the medical profession: even if the patient's access to the service is unimpeded, once a doctor has chosen her speciality she should not be allowed to pick and choose which lawful services within that speciality she is or is not willing to provide.

In the context of abortion in the UK, Savulescu argued that the 1967 Abortion Act was flawed because of its conscientious objection clause. The main purpose of the law was to make abortion accessible, and that purpose was being regularly undermined by, to borrow

[1] U. Schuklenk. Conscientious Objection in Medicine: Private Ideological Convictions must not Supercede Public Service Obligations. *Bioethics* 2015; 29(5): ii–iii.
[2] J. Savulescu. Conscientious Objection in Medicine. *BMJ* 2006; 332(7536): 294–297.

Address for correspondence: Christopher Cowley, School of Philosophy, University College Dublin, Dublin 4, Ireland. Tel: 00-353-1-716-8228
Email: christopher.cowley@ucd.ie

Schuklenk's words, the 'private ideological convictions' of doctors.

Schuklenk and Savulescu adopt what Mark Wicclair calls the 'incompatibility thesis', namely, that conscientious objection is incompatible with a fair system of healthcare delivery.[3] In his book-length treatment, Wicclair provides a number of arguments against the incompatibility thesis, and it is noteworthy that Schuklenk does not even mention this piece of wide-ranging, thorough scholarship on the topic, or any of the detailed examples which Wicclair discusses. (I understand that Schuklenk was writing an editorial with a limited word-count, however.) I will not try to summarize Wicclair's arguments here. Instead, I want to offer some new arguments (or perhaps they are variations on Wicclair's) by way of response to both Schuklenk and Savulescu, in order to defend the option of conscientious objection in medicine. Like Wicclair, I will argue for a specific compromise, one that makes an important concession to Schuklenk's argument.

In what follows I'm going to begin by focusing first on doctors and abortion, just to keep things simpler, and will move on to the end-of-life context later. Schuklenk wrote his editorial in the context of the Canadian Medical Association demanding that doctors have the right to conscientiously object to any impending legislated requirements to assist patient suicide.[4] I will not discuss pharmacists, or other controversial services such as IVF. I will also assume a context of a publicly-funded healthcare system, as in the UK and the Canadian provinces. I will ignore Schuklenk's claim that conscience clauses are 'nothing other than protections for Christian doctors,' and that no secular healthcare professional has 'reasonable conscience-based cause' for refusing treatment. Instead, I will assume that both sides of the abortion debate can be rendered entirely in secular terms.

Schuklenk's arguments appear very reasonable, and his concern for patients is genuine. What he and Savulescu lack is an explanation of why their arguments have failed to move legislators or professional bodies. In the UK context, there has been no serious Parliamentary debate about eliminating the conscience clause of the Abortion Act. In the US, as Wicclair's book shows, there is an enormous number of conscience clauses in state legislation. And it seems more than likely that a conscientious objection clause will be inserted in the legislation governing euthanasia in Canada. I want to suggest that Schuklenk and Savulescu err in seeing conscientious objection as no more than a self-serving non-moral aversion.

THREE WEAK ARGUMENTS

It is worth starting by spelling out some weak, pragmatic arguments in favour of allowing conscientious objection in medicine. Consider the general practitioner. For the GP, the authorization of abortions is a very small part of the job description. The vast majority of the job involves dealing with ordinary illness and injury to all parts of the body, among all members of the patient group. And there is no reason to think that an objecting GP would be any less good at the rest of her job. So if the proportion of GPs who want to object is relatively small in a densely populated area, and if the objection concerns only a small proportion of their job, and if the GP's objection is strong enough that she would leave the profession if it was not accommodated, then we might as well make a *small* accommodation in order to keep her on, as Savulescu indeed allows. Accommodating conscientious objection in this way would be akin to accommodating a GP with back pain by providing a special office chair at relatively low cost. However, I call this a weak pragmatic argument because of two obvious flaws.

First, it will not justify conscientious objection in remote rural areas, and as Schuklenk emphasizes, 'rural' in the Canadian context could easily mean a flight away. Even if the objecting GP can be required to inform the patient of available treatment options (i.e. including abortion), and required to refer or transfer the patient to another, non-objecting doctor, that only works if the second doctor is nearby. In obstetrics, if the number of objectors is too great, then the pragmatic accommodation argument might not even work in the major urban centres.

Second, even if we could accommodate a small proportion of objectors, Schuklenk would say that the patient and the service should be the centre of the medical encounter, rather than the doctor. What does this patient need? What treatments are both lawful and clinically indicated? Does this nearby doctor have the skill and knowledge to provide the treatment? Importantly, this is the focus in the event of an *emergency*, when conscientiously objecting doctors are legally required to abort the foetus if it is the only way to save the life of the woman. So one way of describing what Schuklenk proposes is the mere extension of the attitudes that govern emergency treatment to non-emergency treatment. In contrast, Schuklenk would probably accommodate (to a degree) a doctor with a bad back, because the bad back is (typically) a random event and not at all the doctor's fault or choice – whereas a doctor *chooses* to object and

[3] M.R. Wicclair. *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge: Cambridge University Press; 2011.

[4] Schuklenk cites the following article by S. Kirkey: Unacceptable to force doctors to participate in assisted dying against their conscience: CMA. *National Post* 2015 March 5. http://news.nationalpost.com/2015/03/05/unacceptable-to-force-doctors-to-participate-in-assisted-dying-against-their-conscience-cma-head/ [accessed 23 June 2015].

therefore could, he believes, choose not to object if objections were forbidden.

So the pragmatic argument does not get one very far, but it will become indirectly relevant later on. The second weak argument is the 'moral integrity' argument, advanced (with some reservation) by Wicclair (p. 25 *ff.*), and it has two prongs. According to the first prong of the argument, being forced to act against one's conscience can result in a loss of integrity, and this in turn leads to 'strong feelings of guilt, remorse, and shame as well as a loss of self-respect' (26), to people dropping out of the profession or, if they know their integrity will not be protected, to their not entering the profession in the first place. By itself, however, the threat of guilt or any other merely psychological harm is not enough reason to grant an exemption. After all, people could feel guilty about lots of things, just as integrity can involve loyalty to bad things as well as good. Schuklenk would rightly respond: if your so-called integrity can't handle medicine, then you should get out of medicine. The second prong of the moral integrity argument says that the fact that a GP has shown herself willing to incur the anger of some of her patients and colleagues, for the sake of avoiding what she considers wrong, means that she would be even more effective at the rest of her job. But such a link is hardly guaranteed, and would need much more evidence to back it up. Wicclair concludes that, in the same way that courage and loyalty can be admirable even though they can be put to selfish or harmful ends, so too there is at least a *prima facie* argument for taking integrity into consideration when formulating policy and its exceptions. Although I am not impressed by the argument from moral integrity, I do feel that it gestures at another, more powerful argument, which I will discuss below.

As for the third weak argument, too often the debate over conscientious objection stands proxy for the debates over the legalisation of abortion or euthanasia. And the 'argument' then runs: we know that abortion is wrong and therefore conscientious objection to abortion is right. I want to stress that I am not taking a position on either abortion or euthanasia. With minor adjustments my defence of conscientious objection would probably pertain just as much to Vera Drake, who performed covert abortions in 1950s Britain when abortion was illegal.

ANALOGIES

Both authors based some of their arguments on analogies with clear cases. Schuklenk compares the conscientious objector to the racist or the homophobe. In the same way that a doctor's private racist convictions should not be allowed to affect the standard of her care or the selection of her patients, so too should a doctor be required to perform a lawful medical procedure in a situation where the patient fulfils all the conditions, clinical and legal, for its performance. Anything else would be to subject the patient to a 'conscientious objection lottery,' making for inconvenience, cost and perhaps embarrassment for the patient, and of course particularly difficult in a remote rural region.

Medicine, as guided and restricted and monitored by the law, should be taken as an all-or-nothing package, Schuklenk would say. As long as entrance to the profession is entirely voluntary, and as long as applicants understand the full nature of the lawful services that they can be asked to perform in a given specialization, then their progression through medical school and into that specialization can be taken as tacit moral consent to all the services that make up that specialization. A medical student has the option to drop out before becoming a doctor, or to switch interests before becoming an obstetrician – perhaps there are far fewer objectionable procedures in pathology, dermatology, pure research or teaching. The fact that, in Canada and the UK, it is the state that pays most of the cost of medical school, and most of the costs of medical practice, means that the state is entitled to make such a demand on the doctors.

Any alternative arrangement such as a conscience clause, says Schuklenk, is like a person with moral objections to automobile pollution who nevertheless voluntarily joins a taxi company running cars with internal combustion engines. Importantly, this point about voluntariness distinguishes conscientious objection in medicine from conscientious objection to military conscription. It would be perfectly consistent for both Schuklenk and Savulescu to allow an 18-year-old conscript to object to bearing arms. (I do not know their views on this.)

However, I argue that the analogy with racism and homophobia won't stand. One feature of the modern age is that racism has been entirely discredited in public in both discursive 'directions'; that is, nothing can publicly ground racism, and racism cannot publicly justify any policy or action. I stress the word 'publicly' – obviously there is still plenty of racism around, but racists cannot express their racism in mainstream public discourse if, for example, they have serious political ambitions. Typically racists and homophobes will talk about more or less relevant parallel issues such as 'immigrants stealing our jobs' or about 'gay marriage threatening children's welfare'. In the same way, a racist doctor would never attempt to refer to the patient's skin colour as a sufficient reason (or as any reason at all) for not treating them, even if the doctor does decide not to treat them out of racism. In contrast, a doctor *can* refer to the wrongness of abortion as an intelligible reason for refusing a patient, without thereby losing moral and intellectual credibility. There is a real debate to be had about abortion, whereas there is no debate about racism. Abortion is one of several legitimate 'fault lines' in the public

moral consensus, where each side has a *prima facie* respectable point of view, and there are no grounds for thinking that one side is necessarily ignorant or prejudiced in some way.

Schuklenk's analogy with the environmentally-conscious taxi driver is not quite as strong as he thinks it is, since internal-combustion-engine taxis *always* pollute the atmosphere while they are in operation. It is impossible to drive such a taxi and do one's job without polluting. In contrast, as I said above, the authorization of abortions is a very small part of a GP's job: most of the time she is carrying out the ordinary business of healing the sick. And although the obstetrician's performance of abortions takes up more of her working hours, it is surely the case that she chose medicine and she chose her specialization primarily in order to treat the normal range of obstetric problems.

Savulescu draws a more interesting and argumentatively useful analogy with a doctor supporting the 'good innings' argument. Within the context of a public health care system like the NHS, this argument offers a justification for denying scarce, expensive and non-futile medical treatment to those over a certain age (e.g. 80), in favour of younger patients, on the grounds that the over-80s have already had a long life. Although this is a controversial position, it is nevertheless philosophically respectable, and is certainly as worth debating as abortion, in the universities, in the public sphere, and in Parliament. However, the fact is that so far the good innings argument has not guided official policy in most healthcare systems, and certainly not in the NHS. The NHS is guided by the thought of distributing resources on the basis of health need and the likely response to treatment, regardless of the person's age (although the person's age may of course be indirectly relevant in determining the chances of success). Savulescu's point is simple: an NHS doctor with a personal commitment to the good innings argument, no matter how persuasively she can argue the point in the philosophy seminar, cannot allow her decisions to be influenced by that argument so long as it contravenes NHS policy.I would agree with Savulescu in the case of the 'good innings' doctor. But I challenge that case's effectiveness as an analogy with conscientious objection to abortion.

The two cases differ in the *directness* of the contemplated wrong. In the abortion context, the objecting doctor is very clear about the nature of the moral wrong that she is being asked to authorize or perform, and she is very clear about the victim of the wrongful act. On the other hand, it is less clear that such a 'good-innings' doctor, in being forced to override her objection and treat an over-80 patient, thereby commits or even colludes with what she considers wrong; the wrong, for her, is the more abstract one of some other, younger patient whose treatment has perhaps been postponed because of the proposed use of expensive scarce resources on this over-80 patient. And it would be a stretch to say that *this* doctor is responsible for *that* younger patient's suffering or death, when there are so many other causally relevant institutional factors between them.

In addition to the problem of determining causality here, there are two very different perspectives in play: the good-innings argument is *ultimately* focused on changing the resource distribution policy; if there were enough resources, that same doctor might well treat the over-80 patient. On the other hand, the anti-abortion doctor adopts a local policy when she contemplates the destruction of the innocent human being in the woman in front of her, regardless of the impact that such a conscientious objection might have on the rest of policy.

VOLUNTARINESS AND VOCATION

Both Schuklenk and Savulescu make the point that the health professions are open to individuals to join voluntarily, if they meet the required academic and personal criteria. Nobody forced them to study medicine, and such are the attractions of the profession that there will always be plenty of other sufficiently good applicants to take up the objector's place. The series of free and informed decisions that brought them to where they are now means that it is *too late* for them to object since they had implicitly accepted the 'rules of the game' with each step in their career. It is true that some medical students might only discover their moral objections to certain medical procedures once they start work (once they experience the reality of how abortions work in practice, say), but Schuklenk's response would still be uncompromising: shape up or ship out.

I want to return to the moral integrity argument, which I rejected earlier as weak. The mere threat of feeling guilty is not enough of a reason for an exemption, because so much of feeling guilty is a matter of choice. However, the moral integrity argument points toward a stronger argument, which I would like to develop in this section, one that challenges the assumption that both medicine – and conscientious objection – is a matter of choice.

It is true that medical school and the medical profession is voluntary in the sense that there is nothing like the compulsion behind military conscription. And it's true that many young adults with good grades look around at all the different subjects in university and freely choose medicine, perhaps for entirely external reasons such as the promise of prestige and money or family tradition. However, it is worth remembering that many medical students and doctors do not see their decision to enter medicine as a choice of merely one option among others, but rather as a vocation or calling. And typically

the calling of a *doctor* finds expression in some notion of caring and healing, of saving lives, of fighting death. Such a person, I suggest, could intelligibly find the notion of killing a healthy foetus[5] wrong not only because she already considers the foetus a full moral being, but also because it goes so strikingly against the essence of her calling. In other words, it is not a contingent aversion to abortion that she happens to hold, it is not a psychological quirk that can and should be overcome, it is not some debating-society posture that should be abandoned in the 'real world', and it need not even be theologically motivated. Rather, it has to do directly with the nature of medicine as she understands and identifies with it, an understanding grounded in the role of doctor as healer. For her, pregnancy is not simply a disease or injury that needs medical treatment. The important thing to stress here is that this understanding of medicine is not at all bizarre or idiosyncratic.[6]

One can of course reject the idea of a calling as irrelevant, and just focus on the job description, as defined by the profession and limited by the law. But this is risky because medicine is not a normal job, and demands so much more from practitioners than merely fulfilling a contract. The best doctors are those who identify with the role and who are motivated to go beyond their contractual duties on occasion without carrots and sticks, and who have an understanding of a job well done that is separate from remuneration and promotion. Once we take seriously the idea of a calling, then we come closer to understanding the motivation of the conscientious objector; they deserve accommodation not out of respect for their integrity, but rather out of respect for their conception of medicine; (even if, of course, there are plenty of *non*-objecting doctors who would also describe their work as a calling.)

So far I have been mainly speaking of the GP as the doctor who authorizes the abortion and refers the patient on to a clinic for the procedure itself. However, I do concede Schuklenk's point that a given public health system might not have enough non-objecting GPs in remote rural parts, let alone enough non-objecting obstetricians to meet the demand for lawful abortions. Unlike Schuklenk, I would say that the onus is not on the objectors to shape up or ship out, but on the public health system to arrange and fund (and financially encourage) extra GP and obstetrics posts to meet demand. At this point a lot will depend on the empirical details: I accept that if such a cost were significant enough to directly threaten patient care elsewhere in a public health system, then it might only function as a guiding ideal in competition with others. But unlike Schuklenk, I would allow conscientious objection as worthy of consideration among other considerations when budgeting and staffing.

Let me conclude our discussion of abortion with one more point. In addition to the possible failure of the 'obligation to refer' in rural areas, Schuklenk makes a good point about the very nature of the obligation to refer. From the objector's perspective, it would seem strange to accept such a compromise when it means effectively saying to the pregnant woman: 'I'm not going to arrange for the foetus to be killed, but here's the name of someone who will.' Whereas the more honest thing to do, implies Schuklenk, would be for the doctor to abandon her objection or abandon her profession, without searching for a non-existent compromise that preserves patient access to lawful services.

There is certainly a problem with complicity here, but I suggest that in many cases it does not work like this. Sometimes a GP's objection is known in advance, and the pregnant woman avoids that GP and proceeds directly to an appropriate clinic, staffed by (presumably non-objecting) volunteers. But even if an unknowing patient requested authorization for an abortion from an objecting GP, the GP can still refer to one of her colleagues in the knowledge that she (the GP) is not responsible for her colleague's free actions, she is merely describing a fact – a widely available fact, and hardly a secret – of what her colleague is willing and able to do. Refusing to inform a patient in such a context would not only be illegal, it could also be akin to sulking and preciousness. This is one place to draw the line, and where the conscientious objector has to accept the reality of a genuine moral pluralism, as well as her status as a minority in a reasonably democratic society.

END OF LIFE

Schuklenk's article mainly concerns end-of-life care.[7] As with many discussion of legalized euthanasia, the obvious first place to look is the Netherlands. According to the Termination of Life on Request and Assisted

[5] To keep things simple, I am taking cases of 'social' abortion and avoiding cases of severe foetal defect as well as cases of pregnancy resulting from rape and incest. One can imagine an objecting doctor reluctantly consenting to an abortion in the latter cases.

[6] In this section I am drawing from the extensive work of Edmund Pellegrino and David Thomasma. See, for example, their (1981) *A Philosophical Basis of Medical Practise: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press). Wicclair, *op. cit*. note 1, discusses the 'essentialist conception of the internal morality of medicine' in on pp. 49 *ff*.

[7] Since Schuklenk focused mainly on physician-assisted suicide and euthanasia, I do too in this section. For completeness, it is worth mentioning two other forms of conscientious objection in the end-of-life context: when a medical team decides to accede to a competent patient's request for the withdrawal of life-saving treatment, then a member of that team can recuse herself, citing a conscientious objection to the withdrawal. (If the patient is incompetent, then the request for withdrawal will come from the patient's family.) In either case, the patient's care must not be affected by the objection.

Suicide (Review Procedures) Act of 2002, Dutch citizens can request assistance with suicide from a doctor, provided that the citizen fulfills six explicit conditions, most importantly the patient's repeated competent request, and the 'unbearable and untreatable' nature of her suffering. (They can also request active euthanasia if they are not physically able to commit suicide by drinking poison, but for the sake of simplicity I will speak only of physician-assisted suicide for now, henceforward PAS.)[8] However, such a patient cannot make such a request to *any* doctor – but only to doctors who volunteer their names to a centralized registry. In effect, therefore, any doctor can refuse to volunteer her name, and thereby to conscientiously object, although such an omission is not called that. In practice, there are enough doctors to fulfil all the legitimate requests, although it's true that the Netherlands is so small that patients can easily find a volunteering doctor nearby.

In this respect, the end-of-life context is different from abortion: the vast majority of pregnant women are mobile enough to make their way to an appropriate clinic for the procedure to be carried out, whereas most Dutch citizens fulfilling the criteria for assisted suicide have severely impaired mobility, and so the volunteering doctors understand the need to travel when they volunteer. The details of the new Canadian regime for assisted dying are not yet clear, but presumably they will also have measures to pay the expenses of a volunteering doctor to travel – by plane if necessary – to remoter regions to assist the suicide of a patient with severe mobility impairments. It remains to be seen whether there will be enough doctors volunteering to cover demand.

Schuklenk would presumably object to this Dutch system of seeking volunteers, on the grounds of non-uniformity. However, it is important to see how this misdescribes what is going on. Do patients (who meet the six conditions) have a *right* to euthanasia or PAS in the Netherlands? No. The patient requests PAS, and the (volunteer) doctor offers it. What's more, assisting suicide is still illegal, but doctors are granted immunity from prosecution if the six conditions (and other procedural requirements) are met. In contrast, a sick patient does have a right to medical treatment under the Dutch public health system, and of course there is nothing illegal about a qualified doctor providing medically justified treatment within the limits of her expertise.

Schuklenk does not seem to be interested in these subtleties, but I'm not sure he has thought through the implications of his patient-centred proposal. If PAS is legally permitted, and if this equates to a patient (fulfilling the six criteria) having a right to PAS, then that patient can effectively approach any on-duty doctor employed by the public health system and say: 'you must kill me'. Even if we soften the demand to 'you must help me die' or 'you must help me to end my suffering by offering me poison,' the idea is that the patient is reminding the doctor what her job is. Would a doctor be wildly mistaken in interpreting such a demand as almost akin to an act of violence? True, some doctors will see their job as the alleviation of suffering, where such a task can include the provision of ordinary medical treatment or the provision of PAS when no ordinary medical treatment will work. But some doctors will see their job as the *restoration* of health, as far as possible. They may reluctantly admit that the autonomous patient has a moral right to commit suicide; they may even claim to understand why the patient wants to commit suicide; and they might even feel inclined to assist the patient in that suicide *as private individuals*. But as *doctors*, they will say that assisting such a suicide contravenes the ideal of medicine – an otherwise eminently plausible ideal – with which they identify, and therefore they conscientiously 'object' to volunteering.

There is another way to put this. I referred above to the patient's right to medical treatment under a public health system. But this does not include a right to a *particular* treatment, e.g. one whose miraculous properties the patient has just read about on the Internet. The patient has a right to medical attention to her symptoms and problems, but it will be for the doctor, using her expertise, skills and judgement, to decide on the most appropriate course(s) of treatment. And it will be up to the hospital or health service management to decide whether such a treatment represents good value for public money. This is a well-established principles of clinical judgement and discretion. The same principle can be applied to the case of PAS in a jurisdiction such as the Netherlands where it is legally permissible. The patient presents herself to the doctor and demonstrates her fulfilment of the six conditions, and informs her of her wish to commit suicide. Under the principle of medical discretion, it is for the doctor to decide whether PAS is or is not the most appropriate 'treatment'. I have put 'treatment' in scare quotes, of course, since the provision of poison does not constitute treatment of the patient's disease – there *is* no further treatment available for the disease, that's why the patient is requesting PAS in the first place! Under the principle of medical discretion, therefore, the doctor can refuse to provide the PAS, and instead offer different treatments – either further disease-oriented

[8] H. Buiting, J. van Delden, B. Onwuteaka-Philpsen et al. Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands: descriptive study. *BMC Med Ethics* 2009; 10: 18. The other famous example of legalized euthanasia is that governed by the 1994 Death with Dignity Act in the American state of Oregon, but I prefer the Dutch one because of the context of a public health service.

treatments (e.g. chemotherapy), or further suffering-oriented treatments (palliative pain control).[9]

The whole edifice of rights and duties does not have such a clear application in the therapeutic encounter between patient and doctor within a publicly-funded health service, as it does in the world of business contracts. Instead, the notion of trust plays a much more significant role: not only the patient's trust in the doctor, but above all society's trust in the medical profession. And it is because we already trust doctors with so much that Schuklenk's dismay that conscientious objections are not 'tested' misses the point.

With military conscription (whether or not we think it justified), there are clear reasons why a healthy 18-year-old would not want to serve in the army and risk injury and death, and the goal of a tribunal is to distinguish the genuine conscientious objectors from the cowards and the ambitious civilians. In contrast, it is not clear what ulterior motives a doctor might have for faking a conscientious objection. And even if there was the possibility of an ulterior motive, surely the difference between doctors and 18-year-old conscripts is that we as a society already trust the doctor so much that it seems disproportionate to ask the objector to somehow prove her sincerity.

CONCLUSION

As I say, it remains to be seen what kind of regime the Canadians set up. Schuklenk has argued that Canadian doctors should not be allowed to conscientiously object to providing PAS (or euthanasia). I have tried to argue against him by showing that the situation is more complicated than he understands it. I have, however, granted his point about remote rural regions, and this will be a real problem in Canada. It is already difficult and expensive to get ordinary GPs to work in the far north, for example. If my defence of conscientious objection (in both the abortion and the end-of-life contexts) is accepted, then it will become even more difficult and expensive for the Canadian healthcare system. But given the link between conscientious objection and the ideals of medicine, I have argued that it is that much more deserving of respect.

One last thought. There is an interesting contrast between abortion and PAS. In abortion, the foetus is not directly visible and has no autonomous voice; in PAS, the (competent) victim is very much visible, has a clear voice, and can be talked to. I suggest that this is relevant to the moral permissibility of conscientious objection in the two contexts. However, it is not clear how exactly it is relevant, since in both contexts the visibility or invisibility of the victim can pull the doctor in opposite ways. In the context of PAS where the patient has fulfilled the six Dutch conditions, we could say that the patient's autonomous wishes generate strong reasons in favour of accepting them; on the other hand, the possibility of assisting the suicide of a living, breathing competent adult human being (with a face) might strike some as much more impossible in an *ethical* sense, and not just a psychological sense. In the context of abortion, the invisibility of the foetus makes it easier to see the bump as some sort of problem that can be solved, if the woman whose bump it is (whose *body* it is) so requests it. On the other hand, it is the foetus's voiceless vulnerability and innocence that would lead some to consider it worthy of much greater protection.

Christopher Cowley works at the School of Philosophy, University College Dublin, Ireland.

[9] This point is made in much greater detail in Jonathan Montgomery. Conscientious Objection: Personal and Professional Ethics in the Public Square. *Med Law Rev* 2015; 23: 200–220.