

CONSCIENCE AND AGENT-INTEGRITY: A DEFENCE OF CONSCIENCE-BASED EXEMPTIONS IN THE HEALTH CARE CONTEXT

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ABSTRACT

The issue of conscientious refusal by health care practitioners continues to attract attention from academics, and was the subject of a recent UK Supreme Court decision. Activism aimed at changing abortion law and the decision to devolve governance of abortion law to the Scottish Parliament both raise the prospect of altered provision for conscience in domestic law. In this article, building on earlier work, we argue that conscience is fundamentally connected to moral integrity and essential to the proper functioning of moral agency. We examine recent attempts to undermine the view of conscience as a matter of integrity and argue that these have been unsuccessful. With our view of conscience as a prerequisite for moral integrity and agency established and defended, we then take issue with the ‘incompatibility thesis’ (the claim that protection for conscience is incompatible with the professional obligations of healthcare practitioners). We reject each of the alternative premises on which the incompatibility thesis might rest, and challenge the assumption of a public/private divide which is entailed by all versions of the thesis. Finally, we raise concerns about the apparent blindness of the thesis to issues of power and privilege, and conclude that conscience merits robust protection.

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I. INTRODUCTION

The question of whether and to what extent conscientious refusals by health care professionals (HCPs) should be permitted is the focus of ongoing academic interest.¹ Conscience is also very much a live issue beyond the academy: the conscience provision in section 4(1) of the Abortion Act 1967 was recently interpreted narrowly by the Supreme Court in the case of *Greater Glasgow Health Board v Doogan*;² a current campaign to decriminalise abortion completely³ raises questions about whether (and how) conscience would continue to be protected were the existing legislative apparatus to be swept away;⁴ and the decision to devolve governance of abortion law to the Scottish Parliament raises the prospect of new domestic law on abortion north of the border, including new (or even *no*) protection for conscience.⁵

Against this background, we set out here to defend the place of conscience-based exemptions (CBEs) in health care. In Section II we consider what ‘conscience’ means and why it is important, and endorse a version of the ‘mainstream’ or ‘dominant’ view that

¹ See, for e.g., the recent special issues of the *Medical Law Review* (volume 23(2) in 2015) and *Bioethics* (volume 28(1) in 2014) devoted to the issue.

² [2014] UKSC 68.

³ See, for e.g., C Murphy, ‘Why it is time to decriminalise abortion’, 12 February 2016, Progress website, www.progressonline.org.uk/2016/02/12/why-it-is-time-to-decriminalise-abortion/ accessed 23 April 2016; British Pregnancy Advisory Service (bpas), ‘10 reasons to decriminalise abortion’, bpas website, www.bpas.org/get-involved/advocacy/briefings/10-reasons-to-decriminalise-abortion/ accessed 23 April 2016.

⁴ In the view of Sally Sheldon, a prominent academic proponent of decriminalisation, “it would be appropriate to maintain a right of conscientious objection for healthcare professionals who choose to opt out of participating in abortion procedures”: S Sheldon, ‘The Decriminalisation of Abortion: An Argument for Modernisation’, (2015) *Oxford Journal of Legal Studies* published online 29 September 2015. It is unclear where such a right would be enshrined, since the 1967 Act (s4(1) of which currently provides the right of conscientious refusal in relation to abortion) would presumably be repealed as part of the decriminalisation process.

⁵ Scotland Act 2016, s53.

conscience is a matter of personal integrity. Specifically, we associate conscience with the possibility of moral agency, arguing that what is safeguarded when we protect conscience is ‘agent-integrity’; the integrity of the individual *qua* moral agent. In Section III we defend the integrity view of conscience against recent attempts to problematise it. In Section IV, having set out and defended our understanding of conscience, we address the ‘incompatibility thesis’,⁶ i.e. the claim that allowing HCPs to refuse to participate in certain practices on grounds of conscience is incompatible with their professional obligations. We argue that the incompatibility thesis is grounded either in claims of value-neutrality or of an ‘internal morality of medicine’, and we reject each of these claims in turn. Throughout, our argument is animated by the understanding that failure to protect conscience poses an unacceptable threat to the moral agency of affected HCPs, so that we see a strong positive case for protecting conscience over and above the negative argument that the incompatibility thesis is not made out.

Our focus throughout is on CBEs—the facility to *opt out* of performing certain actions on grounds of conscience. We appreciate that conscience can also be discussed in terms of perceived moral obligations *to act* (‘conscientious commitment’), but we regard this as raising different issues, and therefore as being beyond the scope of our discussion here.

II. CONSCIENCE AS A MATTER OF AGENT-INTEGRITY

Daniel Sulmasy has expressed surprise that ‘in all the recent debates about conscience ... so little attention has been paid to understanding what conscience is and what its importance might be’.⁷ Those who do address the meaning of conscience tend to treat it as a matter of

⁶ MR Wicclair, ‘Is conscientious objection incompatible with a physician’s professional obligations?’ (2008) 29 *Theoretical Medicine and Bioethics* 171, 172.

⁷ D Sulmasy, ‘What is conscience and why is respect for it so important?’ (2008) 29 *Theoretical Medicine and Bioethics* 135, 135.

integrity, either by making a direct link between the concepts of conscience and integrity (often referred to either as ‘moral integrity’ or ‘personal integrity’), or by making the link more obliquely, via a discussion of moral agency. In the former category, Mark Wicclair canvasses various alternative explanations for why conscience deserves protection (including ethical relativism, toleration of diversity, respect for autonomy and respect for moral integrity) and concludes that ‘the most promising [explanation] is respect for moral integrity’,⁸ so that ‘appeals to conscience can be understood as efforts to preserve or maintain moral integrity’.⁹ Likewise, Armand Antommara agrees that ‘[c]laims of conscience should fundamentally be understood as claims to maintain personal integrity’ and that the importance of CBEs derives from the significance of the value of integrity which underpins them.¹⁰

While some simply assert the connection between conscience and integrity, others reflect on the nature of the link. Dan Brock, for example, explains that:

Deeply held and important moral judgments of conscience constitute the central bases of individuals’ moral integrity; they define who, at least morally speaking, the individual is, what she stands for, what is the central moral core of her character. Maintaining her moral integrity then requires that she not violate her moral commitments and gives others reason to respect her doing so, not because those commitments must be true or justified, but because *the maintenance of moral integrity is an important value, central to one’s status as a moral person.*¹¹

⁸ MR Wicclair, ‘Conscientious objection in medicine’ (2000) 14 *Bioethics* 205, 205.

⁹ *Ibid.*, 213.

¹⁰ AHM Antommara, ‘Conscientious objection in clinical practice: Notice, informed consent, referral, and emergency treatment’ (2010) 9 *Ave Maria Law Review* 81, 82. Also, 91.

¹¹ DW Brock, ‘Conscientious refusal by physicians and pharmacists: Who is obligated to do what, and why?’ (2008) 29 *Theoretical Medicine and Bioethics* 187, 189, emphasis added.

In Sulmasy's view, conscience 'arises from a fundamental commitment or intention to be moral. It unifies the cognitive, conative, and emotional aspects of the moral life by a commitment to integrity or moral wholeness'.¹² Similarly, Kent Greenawalt observes that someone who conscientiously refuses to participate in a particular practice 'would disregard a deep aspect of her identity if she went along'.¹³ Brock's, Sulmasy's and Greenawalt's accounts all clearly connect conscience, integrity and *identity*, and suggest that protection for conscience promotes personal integrity precisely by enabling individuals *to develop and maintain their identities as moral agents*.

The connection between conscience and moral agency is made even more explicit by Daniel Weinstock who notes that a person's 'sense of who she is as a person is partly constituted by the ongoing activity of thinking for herself about moral issues', so that 'when we recognize a healthcare professional's right to [conscientiously] refuse, we ... respect the moral agency of those who hold reasonable dissenting views'.¹⁴ Conversely, 'a state that did not protect conscience, and that did not allow the individual to act according to the conclusions of her moral reasoning would fail to display appropriate respect for her *as a moral agent*'.¹⁵ Farr Curlin and colleagues also reflect that 'acting conscientiously is the heart of the ethical life, and to the extent that physicians give it up, they are no longer acting as moral agents'.¹⁶

However, some of those who emphasise agency when discussing conscience seem to be conflating rather than connecting those concepts. For example, John Hardt defines

¹² Sulmasy, n 7 above, 138.

¹³ K Greenawalt, 'Refusals of conscience: What are they and when should they be accommodated' (2010) 9 *Ave Maria Law Review* 47, 49.

¹⁴ D Weinstock, 'Conscientious refusal and health professionals: Does religion make a difference?' (2014) 28 *Bioethics* 8, 11-12.

¹⁵ *Ibid*, 9, emphasis added.

¹⁶ FA Curlin, RE Lawrence and JD Lantos, 'The authors reply' (2007) 356 *New England Journal of Medicine* 1889, 1891.

conscience as ‘making moral judgments about a practical course of action’,¹⁷ or, citing Aquinas, as ‘the making of reasonable decisions in light of moral norms, practical considerations, and contextual facts’.¹⁸ Yet the concepts are not coterminous, as a brief consideration of the philosophical literature on conscience clarifies.

Allen Wood suggests that ‘philosophical theories of conscience might be categorized under three headings: *moral knowledge* theories, *motivation* theories, and *reflection* theories’.¹⁹ Moral knowledge theory treats conscience as a source of moral knowledge, as something we consult for information about what is right and wrong.²⁰ Examples include the image of conscience as ‘a law written by God [in men’s hearts]’,²¹ or John Henry Newman’s understanding of conscience as ‘divine law ... apprehended in the minds of individual men’, where conscience is understood as something innate, bestowed upon the human individual before she becomes rational, enabling her to hear the ‘voice of God’ as distinct from her own wills and desires.²² A moral knowledge understanding might lead someone to say that ‘my conscience tells me *x*’, or to speak of ‘consulting’ her conscience. By contrast, motivation theories treat conscience as a *stimulus* for behaviour. This is the kind of view signalled by references to the ‘urging’, ‘prompting’ or ‘prodding’ of conscience and is reflected in Christopher Hitchens’ memorable (and sceptical) description of conscience as ‘whatever it is that makes us behave well when nobody is looking’.²³ Finally, in reflection theories the exercise of conscience is taken to involve reflecting upon, and making judgements about, moral matters.

¹⁷ JJ Hardt, ‘The conscience debate: resources for rapprochement from the problem’s perceived source’ (2008) 29 *Theoretical Medicine and Bioethics* 151, 154.

¹⁸ *Ibid.*

¹⁹ A Wood, *Kantian Ethics* (Cambridge: Cambridge University Press, 2007) 182, emphasis in original.

²⁰ One way of translating the Latin root ‘conscientia’ is ‘with knowledge’.

²¹ Pastoral Constitution on the Church in the Modern World, *Gaudium et Spes*, Promulgated by His Holiness, Pope Paul VI on December 7 1965, para 16.

²² JH Cardinal Newman, ‘Letter to the Duke of Norfolk (1875)’ in *Certain Difficulties felt by Anglicans in Catholic Teaching Vol. II* (London: Longmans Green, 1900), 247.

²³ C Hitchens, *God Is Not Great: How Religion Poisons Everything* (London: Atlantic Books, 2007) 256.

The various categories are not mutually exclusive, so a particular account might acknowledge, for example, *both* the importance of moral reflection *and* the capacity of conscience to function as a spur to action. St Thomas Aquinas, for example, understood conscience as practical reason; the capacity to use reason to derive moral principles and apply them in particular situations²⁴ Likewise, although Joseph Butler emphasised the motivational element when he described conscience as a ‘natural guide’ that we have a duty to follow,²⁵ for Butler this process was reflective and not intuitive - necessarily involving the ability to use reason in moral decision-making. In Immanuel Kant’s ethical theory, having a conscience amounts to having the fundamental capacity for carrying out moral reflection, and our duty is to engage in this reflection and then to ‘attend to the verdict of our conscience’ (thus it could be said that Kant’s approach combines elements of reflection and motivation).²⁶

The word ‘verdict’ in Kant’s account hints at the legalism that characterises his approach to conscience. As Wood observes, Kant understood conscience as ‘an inner court of moral judgment’,²⁷ so that when we exercise conscience we ‘place ourselves before the inner judge and heed the verdict’.²⁸ As Wood also points out, Kant’s choice of the legal metaphor serves to emphasise the rational and objective nature of conscience as he (Kant) understands it.²⁹ The exercise of conscience is envisaged here as a complex internal role-play involving various personae, all performed by the same human protagonist. Although the forum is internal, ‘the moral law that all the inner parties recognize [is] one that has been legislated by the idea of the will of every rational being, and in that sense, the rational standards used in the inner court are the same as would apply in a public forum’.³⁰ Thus, the arguments and

²⁴ *The Summa Theologiae of Saint Thomas Aquinas*, Latin-English edition, Volume II, *Prima Pars*, Q. 65-119 (NovAntiqua, Michigan, 2009) I, q. 79, a. 13, co. (emphasis added).

²⁵ J Butler (1726), WR Matthews (intro), *Butler’s Fifteen Sermons & A Dissertation on the Nature of Vice* (London: Bell and Sons, 1964) 6.

²⁶ Wood, n 19 above, 187.

²⁷ *Ibid*, 185.

²⁸ *Ibid*, 187.

²⁹ *Ibid*, 185.

³⁰ *Ibid*, 186.

reasons used in arriving at judgements of conscience must be reasoned, must appeal to objective or universal standards and cannot be ‘merely a response to inchoate, prerational ... feelings’.³¹

‘Moral agency’ can refer both to an activity (acting in relation to right and wrong) and to a property. An individual is a moral agent if she has the capacity to act morally (whether or not she is presently exercising that capacity); in other words, if she can be held morally responsible for her actions.³² Here, we suggest that moral agency entails the capacity to do all of the following:

- (i) identify the sources of moral authority (values, standards, principles and so on) which the moral agent recognises as valid and to which she ought, therefore, to have regard;³³
- (ii) reflect on what these moral standards require of the agent, either in terms of a general, ongoing commitment, or in terms of what is right and wrong in relation to a particular set of circumstances;
- (iii) recognise that the demands of morality provide the agent with a motivation to act; and
- (iv) act in accordance with the demands of morality.

Each of the philosophical theories of conscience identified by Wood identifies ‘conscience’ with one of these elements of moral agency. For moral knowledge theorists,

³¹ *Ibid.* Cf Hedley J in *Re Wyatt* [2005] EWHC 2293 (Fam) at [35]: ‘Conscience (whether one believes it to be God-given or culturally conditioned) is not a wholly rational sense. It is more in the nature of intuition or hunch as to whether something is right or wrong’.

³² In adopting this definition of moral agency, we do not make the quite distinct and more controversial claim that only moral agents are entitled to full or equal moral respect and consideration. The question of whether human beings who are not ‘agents’ in this sense (for example, infants and permanently unconscious patients) are full members of the moral community is a separate issue and not one which we are required to address here.

³³ Here, ‘have regard to’ might mean anything from ‘owe absolute obedience’ to ‘be guided by’, depending on the nature of the standard and the nature of the agent’s commitment to it.

conscience involves apprehending, recognising and perhaps also ranking the various sources of authoritative information regarding what is right, wrong, required and prohibited, morally speaking. Thus, it corresponds to (i) above. Reflection theories seem to identify conscience with deliberation about moral matters and the application of moral standards to real life situations and contexts: i.e. with activity under (ii). Motivation theories map on to (iii), at least insofar as they emphasise motivation *by reasons*. Motivation theories of conscience which identify conscience with instinctive or emotional responses are possible, but unless they acknowledge some scope for the individual being motivated by moral *reasons*, it is difficult to see how they could have the kind of connection with moral agency we are discussing here. As already noted in relation to the examples of Aquinas, Butler, and Kant, many influential theories of conscience identify conscience with *more* than one element of moral agency. In our view, the link between conscience and moral agency is not only well-established in mainstream discussion of conscience, but is clearly entailed by our understanding of what moral agency involves.

It follows from all of this that we can characterise as ‘integrity-based accounts’ of conscience not only those which make explicit the link between the concepts of conscience and integrity, but also those which refer to the close relationship between conscience and ‘moral agency’ or ‘moral identity’. Hardt, for example, has noted that ‘conscience is a necessary component of the moral life in general and a necessary resource for maintaining a coherent sense of moral agency’.³⁴ Identifying conscience as an essential element in the development and maintenance of the individual’s identity as a moral agent in the face of external pressure, entails acknowledgment of the relationship between conscience and integrity.

³⁴ Hardt, n 17 above, 151.

Here, we have unpacked the familiar claim that conscience is a matter of integrity, arguing that the faculty of conscience is an essential element in the activity of moral agency and so is a prerequisite for the status or identity of being a moral agent. We use the term ‘agent-integrity’ to emphasise that what conscience enables/supports/promotes/protects is the integrity of moral agents *qua* moral agents - the *integrity of the capacity for agency itself*, as opposed to ‘integrity’ loosely conceived as moral consistency, inner harmony, loyalty to one’s moral commitments, an absence of guilty feelings, or such like.³⁵ We see protection for conscience as having at least two important functions in preserving agent-integrity. First, in a positive sense, conscience rights foster the development and maintenance of agent-integrity by delineating a protected zone wherein the individual is able to develop and practice her skills as a moral agent, and develop and maintain her identity as such. Second, in a negative sense, CBEs are a shield against violations such as forced complicity in perceived wrongdoing that would undermine the coherence of an individual’s agency, disrupting the link between the stages of agency by severing the link between conscientious reflection and conscientious action.

III. NO PERSUASIVE REFUTATION OF ‘INTEGRITY’ VIEWS

There has been surprisingly little attempt to critique integrity based views of conscience, although two recent interventions are noteworthy - Alberto Giubilini’s attempt to refute the

³⁵ It has recently been argued that when ‘integrity’ is understood in these ‘weak’ ways, it fails to provide sufficient justification for protecting and respecting rights of conscience: C Cowley, ‘A defence of conscientious objection in medicine: A reply to Schuklenk and Savulescu’ (2015) *Bioethics* DOI: 10.1111/bioe.12233. What we propose here is a stronger ‘integrity’ view, which sees conscience as a *sine qua non* of moral agency.

integrity view,³⁶ and Carolyn McLeod's proposal for a 'relational feminist view' of conscience,³⁷ which has subsequently been adopted and developed by Chloë Fitzgerald.³⁸

A. Giubilini: a sceptical view of integrity/conscience

Giubilini aims to show that 'arguments in defense of conscientious objection based on respect for...moral integrity are extremely weak' and that 'the role of moral integrity and conscientious objection in health care should be significantly downplayed and left out of the range of ethically relevant considerations'.³⁹ His argument consists of two main stages. First:

it is not possible to defend conscientious objection in healthcare by simply appealing to the value of respect for moral integrity, because it is not possible to constrain such respect to prevent undesirable (and unacceptable) consequences.⁴⁰

This is where we might expect to encounter the argument denying that conscience is a matter of integrity; however Giubilini makes no such case. Instead, for Giubilini, *both* conscience *and* 'moral integrity' ought to be avoided in decision-making 'in the healthcare context'⁴¹ because they are 'anemic moral concepts' which '[do] not allow us to make any progress in moral reasoning'.⁴² Throughout, Giubilini bundles the concepts of conscience and moral integrity together, which has the effect of reinforcing, rather than destabilising, the notion that they are fundamentally connected. His thesis is that respect for conscience/integrity cannot be

³⁶ A Giubilini, 'The paradox of conscientious objection and the anemic concept of "conscience": Downplaying the role of moral integrity in healthcare' (2014) 24 *Kennedy Institute of Ethics Journal* 159.

³⁷ C McLeod, 'Taking a Feminist Relational Perspective on Conscience' in J Downie and JJ Llewellyn (eds.), *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver: UBC Press, 2012).

³⁸ C Fitzgerald 'A neglected aspect of conscience: awareness of implicit attitudes' (2014) 28 *Bioethics* 24.

³⁹ Giubilini, n 36 above, 159.

⁴⁰ *Ibid*, 160.

⁴¹ *Ibid*, 162 and 182.

⁴² *Ibid*, 162.

limited in a satisfactory way, or, more accurately, cannot be limited to *his* satisfaction. Giubilini acknowledges that others have proposed limits to the scope and exercise of CBEs, often converging around the same or similar criteria, but complains that:

any criteria proposed for limiting freedom of conscience fall short of providing a satisfactory account of why certain forms of conscientious objection - for instance to abortion - should be accepted and certain others - for instance to inspecting patients of the opposite sex - should not.⁴³

Even if Giubilini is correct that none of the criteria proposed so far succeed in this regard, this does not mean that no satisfactory way of distinguishing between ‘acceptable’ and ‘unacceptable’ conscience claims is possible. The literature is ever-expanding and new suggestions about how to delimit the scope of CBEs continue to emerge. For example, we have argued that it is possible to identify a number of logical and defensible restrictions on the scope of CBEs.⁴⁴ Our first restricting factor is that the logical territorial extent of CBEs is the periphery of ‘proper medical treatment’, where the status of a practice as ‘proper’ is liminal:

A treatment may occupy liminal status because, despite being lawful, it is ‘morally controversial and contentious’. Practices which involve the ending of human life, such as abortion, IVF, and withholding or withdrawing treatment from unconscious patients or severely disabled newborns are liminally ‘proper’ for this reason; assisted dying will be too, if it becomes lawful to provide it within the healthcare context ...

[a] treatment may also have liminal status if it is extremely risky or experimental, or if

⁴³ *Ibid*, 164

⁴⁴ S Fovargue and M Neal, ‘In good conscience: Conscience-based exemptions and proper medical treatment’ (2015) 23 *Medical Law Review* 221

it is more concerned with the satisfaction of preferences than with healing or treating disease (as is arguably true of certain cosmetic procedures, and assisted reproduction for same sex couples and single people).⁴⁵

This is, of course, only one suggestion, but it illustrates that it *is* possible to make reasonable attempts to capture the difference between seeking CBEs from abortion, on the one hand, and examining patients of the opposite sex, on the other. Our suggestion is that the cases can be distinguished on the basis that whereas abortion is liminally proper medical treatment because it involves the ending of human life, treating patients of the opposite sex is not liminal under any of the categories of liminality we propose.

Even if our suggestion is rejected, this does not mean that no satisfactory criterion is *possible*, as Giubilini claims. He does not suggest that no criteria can be identified at all, only that none can be identified which do not ‘prevent undesirable (and unacceptable) consequences’.⁴⁶ One obvious riposte to this is that consequences are undesirable and/or unacceptable, not objectively, but from a particular point of view. Many may welcome, for example, a consequence such as the extension of CBEs to new areas of health care or to new categories of HCP, or the increased rarity of practices like abortion. If a set of criteria is *prima facie* defensible, the conclusion that its consequences are ‘undesirable and unacceptable’ is a subjective judgement that presupposes precisely the sort of moral consensus that is missing and whose absence the CBE serves.

⁴⁵ *Ibid*, 229.

⁴⁶ Giubilini, n 36 above, 160.

In the second stage of his argument, Giubilini proposes an ‘alternative and more promising approach’ to the problem he thinks he has identified - the lack of acceptable constraints on conscience.⁴⁷ The question we ought to ask, he says, is:

whether impartiality towards conflicting parties should refer to (1) the individuals involved in the conflict, in which case we should grant them equal rights and protections in the name of respect for moral integrity ... or to (2) the different moral positions at stake, in which case we should base the acceptability of these positions on an unbiased and rational assessment of their plausibility.⁴⁸

Giubilini maintains that the majority of the literature on conscience in health care to date approaches the issue in the first way. Instead, he proposes adopting the second approach and claims that when we do so, it becomes apparent that ‘only by defending (some form of) moral relativism or subjectivism is it possible to make a case for respecting health care practitioners’ moral integrity and granting them a right to conscientious objection’.⁴⁹ In Giubilini’s view, however, relativist and subjectivist positions are untenable for proponents of CBEs, because insofar as the latter make objectivist claims about the wrongness of particular practices (like abortion), they are committed to saying that their view is *superior* to opposing views, not that it is equally valid and deserving of equal respect.⁵⁰ The essence of this second stage of his argument is that to defend CBEs is to concede relativism and promote moral compromise, and that this is clearly incompatible with holding that there is an objective ‘truth of the matter’.

⁴⁷ *Ibid*, 161.

⁴⁸ *Ibid*, 161.

⁴⁹ *Ibid*.

⁵⁰ *Ibid*, 179

This analysis can be challenged on a number of grounds. First, much of Giubilini's argument depends on the idea that CBEs represent a compromise. He introduces them as such at the outset and continues to refer to them in this way throughout.⁵¹ But even if we are confident that, historically, a particular conscience provision *is* the result of *political* compromise, this does not mean that each individual who avails herself of the provision's protection is thereby engaging in *moral* compromise. We *may* wish to describe section 4(1) of the Abortion Act 1967, for example, as a historical (and perhaps ongoing) political compromise, but this is irrelevant at the level of individual ethics. A doctor who declares herself bound by conscience to refrain from participating in abortion is not thereby signalling her approval for the political compromise that may or may not be reflected in the statutory provision she relies on. Nor is she expressing respect for the views with which she disagrees. She is simply ensuring that she does not incur personal moral responsibility for action she believes to be gravely wrong. Giubilini acknowledges that CBEs are 'often claimed by those who believe that abortion is wrong ... [and] that this is an objective truth, and not out of the belief that the pro-abortion and anti-abortion arguments are on equal footing'.⁵² However, Giubilini's position is that CBEs, as 'compromises', are *incompatible* with objectivist views. He claims that someone who regards abortion as objectively wrong is obliged to commit 'not [to] the compromise represented by conscientious objection, but [to] civil disobedience aimed at changing an unjust and wrong law'.⁵³

This is mistaken, and not only because the exercise of a CBE is *not* (or not necessarily) a moral compromise at the individual level. Even if it is accepted that those committed to the view that abortion is objectively immoral are obliged not only to protect *themselves* from complicity in moral wrongdoing, but also to seek to eradicate the immoral practice as a whole (and Giubilini does not establish such an obligation), it is consistent for

⁵¹ *Ibid.*, at (eg) 160, 164, 175, 177, 179, 181.

⁵² *Ibid.*, 179.

⁵³ *Ibid.*

them to exercise CBEs in order to ensure their own non-complicity in moral wrongdoing *while also* engaging in efforts to change the law - efforts which need not amount to civil disobedience. Being committed to ‘changing an unjust law’ but might involve lobbying one’s MP when Parliament is due to vote on relevant issues, considering parties’ policies (and individual MPs’ voting records) on ‘pro-life’ issues when deciding how to vote in elections, donating to organisations that work to change the law, and making the ‘pro-life’ case when the opportunity arises in debate and discussion with friends and colleagues. Many lawful, democratic means for effecting change exist, and individual CBEs can surely be used in conjunction with these wider strategies. But it is problematic to suggest, as Giubilini does, that the doctor with ‘pro-life’ views should *only* seek to change the law and should be willing to participate in abortions in the meantime. The leap to ‘civil disobedience’ seems unnecessary *precisely because* no-one is obliged by law to participate in abortion.

Thus, the supposed incompatibility between compromise and objectivism never arises for those actually *exercising* CBEs, since they are not engaging in compromise at all. As far as those *defending* CBEs are concerned (academics and policymakers, for example): taking abortion once again as the example, it is open to these people to argue that, whatever their personal views about the morality of abortion, they regard it as immoral to require another person to participate in a practice that she considers to be seriously wrong, and that it is this latter moral intuition that animates their defence of CBEs, rather than any objective position on the morality of abortion. Thus, the defence of CBEs need not embody compromise either (instead, it may express the positive moral position just described), and it certainly need not coexist with any objective view about the (im)morality of abortion.

Another problem with Giubilini’s analysis is that he seems to suppose that the central question is one of ‘impartiality’.⁵⁴ The mainstream position, as we discussed in Section II,

⁵⁴ *Ibid*, 161, 175.

however, is that protecting conscience is *not* about impartiality, but is, rather, the non-neutral enterprise of positively respecting the agent-integrity of others. Giubilini does not succeed in problematising this mainstream idea, so his assertion that CBEs are somehow about impartiality (either toward individuals or ideas) is not made out. Furthermore, his assumption that conscience belongs in the ‘private sphere that requires each individual to provide justifications only to herself, not to anyone else’⁵⁵ is questionable, because although legitimate concerns about subjectivity do arise in relation to conscience rights, conscience clearly has both private *and* public dimensions. Recall Kant’s view of conscience in which, although much deliberation *does* take place internally, the standards applied are collectively determined and publicly accessible. Some have described conscience as a ‘relational’ phenomenon insofar as ‘we may require the help of others to become aware of our implicit attitudes and thus to be able to regulate them’.⁵⁶ Additionally, the *exercise* of conscience is usually public and many commentators propose requiring those exercising CBEs to make good faith attempts to articulate their positions (and the reasoning that has gone into arriving at them) in a forum that is, to some extent, public.⁵⁷ Elsewhere, we have described a willingness to do this not only as one of the *duties* of a HCP seeking to exercise a CBE but as one of the *criteria* for genuine conscientiousness.⁵⁸ Thus, conscience naturally straddles both the public and private spheres, and the public dimension can be enhanced by making the exercise of CBEs conditional on the fulfilment of publicity or articulation requirements.

⁵⁵ *Ibid*, 182.

⁵⁶ See, eg, Fitzgerald, n 38 above, 27; McLeod, n 37 above. Both are discussed more fully in Part II B below.

⁵⁷ See, for eg, C Meyers and RD Woods, ‘An obligation to provide abortion services: What happens when physicians refuse?’ (1996) 22 *Journal of Medical Ethics* 115; TA Cavanaugh, ‘Professional conscientious objection in medicine with attention to referral’ (2010) 9 *Ave Maria Law Review* 189; E LaFollette and H LaFollette, ‘Private conscience, public acts’ (2007) 33 *Journal of Medical Ethics* 249; RF Card, ‘Reasonability and conscientious objection in medicine: A reply to Marsh and an elaboration of the reason-giving requirement’ (2014) 28 *Bioethics* 320; M Magelssen, ‘When should conscientious objection be accepted?’ (2012) 38 *Journal of Medical Ethics* 18; L Kantymir and C McLeod, ‘Justification for conscience exemptions in health care’ (2014) 28 *Bioethics* 16.

⁵⁸ Fovargue and Neal, n 44 above, 230-231.

Also problematic is Giubilini's proposal that we should concentrate on the rationality of the ethical positions at stake, rather than on the integrity of the agents who hold them. The emphasis should not be on respecting, tolerating, or protecting human beings, he says, but on 'an unbiased and rational assessment' of the plausibility of the various competing positions.⁵⁹ An obvious response to this is to point out that 'plausibility' is, quite simply, far too subjective to be allowed to be the test for the permissibility of CBEs. Whether I regard a proposition as 'plausible' or not will depend not only on its objective merits, but also on my background, my prejudices, and my inclinations. Moreover, to focus on positions in the abstract, rather than on people, is to ignore ethically relevant factors like emotion, vulnerability and harm. A supporter of the mainstream position might well point out that the harm of failing to respect integrity is harm to *people* and not to positions.

Giubilini is mistaken, therefore, in his claim that no credible basis for distinguishing between valid and invalid exercises of conscience is possible, and also in failing to recognise that the judgement that consequences are 'undesirable or unacceptable' is a subjective one. His claim that the exercise of a CBE reflects a compromise is problematic too, as is his insistence that respect for conscience is (or ought to be) motivated by impartiality. For present purposes, however, the most important thing to note about Giubilini's account is its failure to dissociate conscience from integrity. Insofar as he believes he has problematized the role of integrity, Giubilini believes he has *also* problematised conscience. As such, his critique is really another iteration of the 'incompatibility thesis' (the view that CBEs are incompatible with HCPs' professional obligations, discussed more fully in Section IV) already familiar from the work of Julian Savulescu,⁶⁰ Ian Kennedy,⁶¹ Julie Cantor⁶² and

⁵⁹ Giubilini, n 36 above at 161.

⁶⁰ J Savulescu, 'Conscientious objection in medicine' (2006) 332 *British Medical Journal* 294.

⁶¹ I Kennedy, 'What is a medical decision' in *Treat Me Right: Essays in Medical Law* (Clarendon Press: Oxford, 1988) 28.

⁶² J Cantor, 'Conscientious objection gone awry – Restoring selfless professionalism in medicine' (2009) 360 *New England Journal of Medicine* 1484.

others.⁶³ Critically, Giubilini's rejection of integrity *and* conscience seems to reinforce, rather than undermine, the idea of an association between them. Indeed, in a later piece, he describes the view 'that our conscience is essential to our moral integrity' as 'uncontroversial'.⁶⁴

B. McLeod and Fitzgerald: A 'feminist relational view' of conscience

McLeod is concerned to challenge what she calls the 'dominant view of conscience', according to which conscience promotes 'integrity' conceived as 'inner or psychological unity'.⁶⁵ The dominant view sees the function of conscience as being 'to keep us in a certain relation to ourselves, one in which we have proper regard for, and actively promote, our moral integrity',⁶⁶ and it fulfils this function by providing internal warnings and reminders about the 'impact on the self of violating our deep moral commitments' - shame, guilt, feelings of self-betrayal, and the like.⁶⁷ According to McLeod, on the dominant view conscience has a personal but not a social value because it functions to keep us 'in "the proper relation" to *ourselves* but not [necessarily] to others'.⁶⁸ McLeod regards the dominant view as 'deficient', partly because its focus on preserving internal unity causes it to overlook at least two kinds of important problematic cases. First, there are cases where individuals internalise oppressive (for example, sexist or racist) values as a result of exposure and normalisation, so that any internal unity they achieve is grounded in immoral premises. Such

⁶³ See, for eg, J Morrison and N Allekotte, 'Duty first: Towards patient-centered care and limitations on the right to refuse for moral, religious or ethical reasons' (2010) 9 *Ave Maria Law Review* 141; A Kolers, 'Am I my profession's keeper?' (2014) 28 *Bioethics* 1; LF Ross and EW Clayton, 'To the Editor' (2007) 356 *New England Journal of Medicine* 1890.

⁶⁴ A Giubilini, 'Conscientious objection and medical tribunals' (2016) 42 *Journal of Medical Ethics* 78.

⁶⁵ McLeod, n 37 above, 161.

⁶⁶ *Ibid.*, 163.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*, emphasis added.

individuals may be internally unified but still have a ‘bad character’.⁶⁹ Second, there are cases where acting in accordance with conscience leads not to internal unity and harmony but to ‘brokenness’ and despair because of negative societal reaction to that conscientious action.⁷⁰ McLeod offers the example of a woman who speaks out against sexual harassment in the workplace only to find herself shunned, unemployed and dejected because an unsupportive society determines the meaning of her action to be troublemaking rather than courage.⁷¹

McLeod proposes an ‘alternate view’ of conscience, which she describes as a ‘feminist relational perspective’.⁷² It is *relational* because it acknowledges the importance of social relationships in shaping individuals’ moral agency and *feminist* because it highlights the fact that these relationships can be characterised by oppression and privilege, so that agency develops distortedly. The alternate view can be distinguished from the dominant view in at least three important ways. First, in the alternate view, the primary function of conscience is ‘not to preserve inner unity, but rather to encourage people simply to act in accordance with their moral values’.⁷³ McLeod’s is still an integrity based view of conscience because ‘a conscience of this sort promotes our moral integrity, although integrity here is understood not as inner unity, but, rather, as abiding by one’s best judgment (in this case, moral judgment)’.⁷⁴ On this analysis moral integrity requires ‘[t]aking responsibility for our moral selves’ and not internal unification *per se*.⁷⁵ The second important difference between the dominant and alternate views is that whereas the former is an individualistic view in which conscience has only *personal* value, the latter emphasises the *relational* nature of conscience and its social value:

⁶⁹ *Ibid*, 167.

⁷⁰ *Ibid*, 170.

⁷¹ *Ibid*.

⁷² *Ibid*, 161.

⁷³ *Ibid*, 171.

⁷⁴ *Ibid*, 174.

⁷⁵ *Ibid*, 175.

Moral integrity - adhering to our best moral judgment - requires social support, but it is also good for society. Its value is social rather than merely personal ... there is social value in people taking their own best moral judgment seriously. Society needs this commitment from people so that genuine debates about moral right and wrong occur, which have value because they help to improve our moral understanding ... and integrity has social value - it involves being in the 'proper relation' to others - because it contributes to this process.⁷⁶

Thus, unlike the dominant view which (according to McLeod) sees conscience only in terms of preserving internal unity regardless of the values being internalised, on the alternate view '[c]onscience is valuable ... not only when it urges us to take our moral values seriously but also when it forces us to rethink those values, after perhaps clarifying for us what those values are'.⁷⁷ Thus, '[w]hile the alternate view of conscience emphasizes the importance of people reflecting on the judgments that inform their conscience, the dominant view says relatively little in this regard'.⁷⁸ Fitzgerald has developed this aspect of McLeod's alternate view and agrees with her that the dominant view 'neglects an important aspect of a well-functioning conscience', namely, the need to have awareness of, and control over, implicit attitudes.⁷⁹ Fitzgerald claims that an advantage of the alternate account is that it encourages agents to be 'emotionally self-aware', to engage in 'reflective self-monitoring', and to be attentive to social feedback.⁸⁰ The moral community has an important role as a corrective influence, therefore, but it also has an equally important role in providing a supportive environment in which judgements of conscience can be exercised and vindicated. In the health context, for example:

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*, 171.

⁷⁸ *Ibid.*, 173.

⁷⁹ Fitzgerald, n 38 above, 30.

⁸⁰ *Ibid.*

genuine protection for conscience ... require[s] that the culture of health care institutions not be hostile toward individual conscience, especially the conscience of health care professionals who have minority views, who are members of marginalized social groups, or who are powerless relative to doctors or administrators.⁸¹

McLeod and Fitzgerald share Giubilini's concern that conscience debates in health care have focused, so far, on form at the expense of content (McLeod's 'bad characters' and Fitzgerald's 'implicit biases'),⁸² and they suggest that mainstream accounts of conscience appear to lionize 'integrity', in the sense of inner unity or wholeness of the self, with no substantive questions asked. As we have noted in relation to Giubilini's argument, however, legitimate concerns about content and subjectivity *have* long been a feature of debates about conscience in health care. An 'internal values of medicine' approach, which Giubilini acknowledges but (rightly) dismisses as a solution,⁸³ is one way in which some have tried to limit the permissible content of CBEs. As an alternative, we have proposed using the legal concept of 'proper medical treatment' to confine CBEs to cases where the status of a practice is genuinely liminal and seriously contested.⁸⁴ Whether or not either of these approaches appeals, they demonstrate that the current debate is cognisant of questions of content, so that any suggestion that it neglects such matters is incorrect. Moreover, others whom McLeod might regard as part of the 'dominant' tradition have recommended that an 'articulation requirement' should attach to the exercise of CBEs.⁸⁵ We support such a requirement, with

⁸¹ McLeod, n 37 above, 166-167.

⁸² *Ibid*, 167; Fitzgerald, n 38 above, *passim*.

⁸³ Giubilini, n 36 above, 169-174. We consider the idea of an 'internal morality of medicine' in Part III B, below.

⁸⁴ Fovargue and Neal, n 44 above.

⁸⁵ For eg, Meyers and Woods, n 57 above; Cavanaugh, n 57 above.

the proviso that the articulation process should not take the form of a ‘tribunal’ or ‘draft-board’,⁸⁶ because:

[w]e regard conscience ... as a matter of reflection, deliberation and judgement. As such, a good faith exercise of conscience ought to include a willingness to *try* to externalise these processes in order to alleviate any legitimate concerns about the subjective elements of conscience.⁸⁷

McLeod herself, with Lori Kantymir, has made an important contribution to this area of the debate.⁸⁸ The fact that versions of this suggestion feature regularly in academic debates about conscience demonstrates a willingness to address fears about subjectivity and legitimate concerns regarding content.

What is most striking about McLeod’s critique, for present purposes, is that it explicitly acknowledges the connection between conscience and integrity. For McLeod, as for the mainstream writers she critiques, conscience *is* a matter of integrity. Although McLeod claims to understand ‘integrity’ differently, she does not reject the idea of a connection. Moreover, it is possible to dispute that mainstream authors really conceive of integrity in the way McLeod alleges that they do, as synonymous with ‘inner unity’.⁸⁹ Sulmasy’s observation that few have defined what they mean by conscience could also apply to integrity.⁹⁰ In any case, the agent-integrity view we defend here sees the sort of integrity which CBEs exist to protect not as reducible to ‘inner unity’, but as the proper functioning of moral agency.

⁸⁶ Fovargue and Neal, n 44 above, 237.

⁸⁷ *Ibid*, 231, emphasis in original.

⁸⁸ Kantymir and McLeod, n 57 above.

⁸⁹ McLeod, n 37 above, 161.

⁹⁰ Sulmasy, n 7 above.

Ultimately, McLeod offers an explicitly integrity-based (albeit alternate) account of conscience. Her complaint that existing accounts of conscience pay too little attention to its social or relational aspects is important, but it is by no means clear why the idea of a fundamental connection between conscience and integrity is incompatible with, or is likely to inhibit the development of, accounts of conscience which place greater emphasis on seeking and heeding feedback from the moral community. The very notion of integrity (including agent-integrity) seems, to us, to *presuppose* engagement with a moral community.

In our view, both Giubilini's and McLeod's critiques leave the view of conscience as a matter of integrity, '[t]he prevailing view of conscience in bioethics',⁹¹ undisturbed. Giubilini's account never seriously challenges the link between conscience and integrity, and the powerful case for a more relational approach can be accommodated *within* an integrity based account, as McLeod herself proposes.

IV. REJECTING THE INCOMPATIBILITY THESIS

Having argued that conscience is a matter of agent-integrity and rejected some recent criticisms of 'integrity' views in general, we now seek to defend the idea of protection for conscience in health care against the 'incompatibility thesis'—the claim that CBEs are incompatible with HCPs' professional obligations. Among those who can broadly be described as proponents of this thesis, differences exist regarding both the source of the perceived incompatibility and what ought to be done about it. Regarding the latter, while proponents all agree that HCPs 'must choose careers in which their fundamental values do not interfere with the autonomy and well-being of patients',⁹² this yields three possible alternative conclusions. The first is that that individuals whose consciences forbid them from

⁹¹ Fitzgerald, n 38 above, 25.

⁹² Ross and Clayton, n 63 above, 1890.

being involved in certain lawful practices should not be HCPs at all, since ‘[i]f people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors’.⁹³ The second is that HCPs who would seek to exercise CBEs should avoid those specialities in which they might encounter the practices that they find offensive.⁹⁴ The third possible conclusion is that HCPs may practise in any area of medicine provided that whenever they perceive a conflict between their professional obligations and their personal views, they give priority to the former.⁹⁵ All of those who argue that CBEs ought to be disallowed, severely restricted or merely tolerated in the health care context can be regarded as proponents of the incompatibility thesis, since these views reflect the belief that personal ethical commitments are, in some sense, incompatible with professional roles.

Regarding the source of the incompatibility, some claim it arises because HCPs have a professional obligation to practice their profession in a *value neutral* way.⁹⁶ Others claim that health care has its own *internal values* and that it is these, rather than private or personal values, which HCPs are obliged to apply when performing their professional roles.⁹⁷ We now consider the difficulties with each of these claims.⁹⁸

A. ‘Value neutrality’

⁹³ Savulescu, n 60 above, 294.

⁹⁴ See, for eg, Cantor, n 62 above, 1485 (‘physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them’). Also, JM Thorp and WA Bowes, ‘Prolife perinatologist – Paradox or possibility?’ (1992) 326 *New England Journal of Medicine* 1217; J Blustein and AR Fleischman, ‘The pro-life maternal-fetal medicine physician: A problem of integrity’ (1995) 25 *Hastings Center Report* 22. For judicial endorsement of this position see *R v Bourne* [1938] 1 KB 687, 693 *per Macnaughten J*.

⁹⁵ See, for eg, MS Swartz, “‘Conscience clauses’ or “‘unconscionable clauses’”: Personal beliefs versus professional responsibilities’ (2006) *Yale Journal of Health Policy, Law and Ethics* 269; J Morrison and M Allekotte, ‘Duty first: Towards patient-centred care and limitations on the right to refuse for moral, religious or ethical reasons’ (2010) 9 *Ave Maria Law Review* 141.

⁹⁶ Discussed in Section A below.

⁹⁷ Discussed in Section B below.

⁹⁸ See Part III C and D below.

Some commentators insist that HCPs ought to aspire to the ‘ideal’ of value neutrality. Robert Baker, for example, endorses a ‘conception of medical professionalism as morally neutral, equitable, and non-judgmental’,⁹⁹ and Cantor claims that ‘patients ... should be able to expect ...professionals to be neutral arbiters of medical care’.¹⁰⁰ On this view, the individual consciences of HCPs have no *proper* role in influencing their practice. ‘Private’ or personal moral views must be eschewed in favour of the neutral performance of professional obligations. Although Baker is willing to concede that, under certain conditions, ‘professionals who fail to maintain moral neutrality’ may be ‘excused’ from certain duties provided that they apologise to patients, he emphasises that where permission to be excused is granted this is a *concession* rather than the exercise of any ‘right to conscience-based denials of healthcare’.¹⁰¹ On the neutrality model, conscientious unwillingness to engage in particular practices is to be understood as a moral failure - the failure to live up to the moral ideal of neutrality. As such, while it may be tolerated, it cannot be admired or protected.

This approach has been criticised by those who deny that neutrality is an ideal in health care at all, and by others who observe that the neutrality model is *not itself neutral* since it embodies its own ethical values. In the first category, Adrienne Asch notes that health care is ‘a field that often finds itself in the thick of ethical quandaries’,¹⁰² and Weinstock calls it a ‘moral minefield’¹⁰³ that is ‘rife with moral controversy’.¹⁰⁴ These critics note that ‘[h]ealth care professionals ... often operate at the frontier between life and death’,¹⁰⁵ so will often find themselves ‘making moral, and not merely medical, assessments of pain, suffering, and the benefits and burdens of continued life’.¹⁰⁶ But it is not only in life and death cases

⁹⁹ R Baker, ‘Conscience and the unconscionable’ (2009) 23 *Bioethics* ii, iii.

¹⁰⁰ Cantor, n 62 above, 1485.

¹⁰¹ Baker, n 99 above, iii.

¹⁰² A Asch, ‘Two cheers for conscience exceptions’ (2006) 36 *Hastings Centers Report* 11, 11.

¹⁰³ Weinstock, n 14 above, 8.

¹⁰⁴ *Ibid*, 11.

¹⁰⁵ *Ibid*, 8.

¹⁰⁶ Asch, n 102 above, 11.

that health care is an inescapably moral enterprise, since ‘the work of doctors and nurses involves them in daily interaction with patients and with other health care professionals in which moral judgment and agency is required’.¹⁰⁷ In day-to-day practice, then, the role of the HCP ‘demands ethical integrity and not merely technical proficiency’.¹⁰⁸ As such, ‘[t]he inescapable fact is that value choices enter into most clinical decisions’ so that ‘[t]here is no way to make clinical decisions value-free’.¹⁰⁹

The second type of criticism is that value neutrality ‘is simply a label for the preferential imposition of one set of values—those of secular bioethics—as the only acceptable “values” in a pluralistic society’.¹¹⁰ Requiring HCPs to be ‘neutral’ amounts, in practice, to requiring them to be *willing* to participate in abortion, dispense emergency contraception and, in effect, go along with whatever is legal without raising any ethical objection. Far from requiring *true* neutrality, then, value neutrality really amounts to insisting that HCPs take one particular side across a range of ethical dilemmas. Willingness to participate in these contested practices either demonstrates agreement with one ethical standpoint rather than another (as Pellegrino puts it, ‘the pro-choice stance is as value-laden as the pro-life stance’¹¹¹), or reflects the HCP’s belief that her own moral view on the matter ought to be subordinated to the demands of her professional role. Either way, participation embodies a moral choice, not neutrality. Insisting upon value neutrality involves insisting either that individual HCPs must sign up with sincerity to the view of the majority within their profession or that they must behave *as if* they do, leaving their personal values at the door when they come to work.

¹⁰⁷ Weinstock, n 14 above, 11

¹⁰⁸ Asch, n 102 above, 11.

¹⁰⁹ ED Pellegrino, ‘Commentary: Value neutrality, moral integrity, and the physician’ (2000) 28 *Journal of Law, Medicine & Ethics* 78, 79.

¹¹⁰ *Ibid.*, 78.

¹¹¹ *Ibid.*, 79

B. An ‘internal morality of medicine’?¹¹²

According to other commentators, health care has its own ‘internal morality’ and appeals to conscience deserve to be accommodated *only* if they are based on values that ‘correspond to one or more core values in medicine’.¹¹³ John Arras identifies four approaches to the ‘internal morality of medicine’ (IMM):¹¹⁴ (i) ‘essentialism’, which claims that there is a universal and unchanging ‘essence’ of medicine; (ii) the ‘evolutionary perspective’, which acknowledges that internal standards exist but claims that they are influenced by, and evolve with, external values; (iii) ‘historical professionalism’, which privileges the values established and endorsed by those within the relevant profession(s); and (iv) the ‘practical precondition’ approach, which tries to identify the conditions that must exist if the practice of medicine is to be possible at all.¹¹⁵

The latter two can be dealt with briefly. First, the practical precondition approach tries to describe for medicine, as Fuller did for law,¹¹⁶ the norms which are prerequisites for the efficacious functioning of the practice.¹¹⁷ Arras gives the example of a duty of confidentiality in medicine.¹¹⁸ If confidentiality were not observed, patients would not trust HCPs or disclose the information necessary for effective diagnosis and treatment. The norms identified by this approach render a ‘very thin account of the goals of medicine’, according to Arras, which tells us only what must hold in order for the practical activity of medicine to be able to ‘get

¹¹² For discussion of an internal morality of medicine in the contexts of the proper domain of medicine and assisted dying, respectively, see L Frith, ‘What do we mean by ‘proper’ medical treatment?’ and R Huxtable, ‘Death on demand: ‘Proper medical treatment?’’, both in S Fovargue and A Mullock (eds.) *The Legitimacy of Medical Treatment: What Role for the Medical Exception?* (London, Routledge, 2015).

¹¹³ Wicclair, n 8 above, 217. See also, Magelssen, n 57 above, 21: ‘the doctor *qua* doctor has a special obligation towards medicine’s own morality and values’.

¹¹⁴ We borrow this acronym from FG Miller and H Brody, ‘The internal morality of medicine: An evolutionary perspective’ (2001) 26 *Journal of Medicine and Philosophy* 581, *passim*.

¹¹⁵ JD Arras, ‘A method in search of a purpose: The internal morality of medicine’ (2001) 26 *Journal of Medicine and Philosophy* 643, 645.

¹¹⁶ LL Fuller, *The Morality of Law* (New Haven, Yale University Press, 1964).

¹¹⁷ Arras, n 115 above, 646.

¹¹⁸ *Ibid.*

off the ground'.¹¹⁹ Second, historical professionalism is not an authentically internalist approach at all.¹²⁰ Unlike the other approaches to internalism, it does not endeavour to identify values that are essential or intrinsic to the practice of medicine (even in the thin, formal sense of the 'practical precondition' approach). Rather, the only sense in which it is internal is the quite different sense of being concerned with values defined *from within* - articulated *by* the profession, *for* the profession. Robert Veatch describes this as a 'corrupted usage' of the term 'internal morality', since it does not describe an attempt to articulate any value which is intrinsic to the practice of medicine itself.¹²¹ Nevertheless, he notes that the corruption has been widely adopted, and indeed, defenders of the incompatibility thesis do sometimes assert simply that HCPs ought to adhere to 'professional values' rather than personal ones, without specifying what they mean by 'professional values'. This has serious implications for agent-integrity, as we discuss in Section IV. D.

Essentialist and evolutionary approaches have generated the most academic discussion. Essentialist approaches are inspired by the concept of a 'practice', defined by Alasdair MacIntyre as:

any coherent and complex form of socially established co-operative human activity through which *goods internal to that form of activity* are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity.¹²²

¹¹⁹ *Ibid.*

¹²⁰ ED Pellegrino, 'The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions' (2001) 26 *Journal of Medicine and Philosophy* 559, 564-565.

¹²¹ RM Veatch, 'The impossibility of a morality internal to medicine' (2001) 26 *Journal of Medicine and Philosophy* 621, 623-624.

¹²² A MacIntyre, *After Virtue: A Study in Moral Theory* 3rd ed (London, Duckworth, 2007) 187, emphasis added.

Essentialists advocate understanding medicine/ health care as a practice and claim that it has an essential, unchanging nature which involves the pursuit of certain ends.¹²³ These ends are claimed to be intrinsic to the practice in the sense of being derived from the nature of medicine itself and definitive of its nature.¹²⁴ Having identified the intrinsic ‘ends of medicine’, essentialists claim that we can answer ethical questions about the practice of medicine by reflecting on the values that promote the achievement of these proper ends, without reference to external values.¹²⁵ Perhaps the best-known essentialist account of the IMM is that advanced by Edmund Pellegrino.¹²⁶ He identified the moral heart of the practice of medicine as being the face-to-face clinical encounter between someone in need (the patient) and someone who professes to be able and willing to help (the HCP).¹²⁷ Wherever and whenever medicine is practised, the clinical encounter forms its moral core.¹²⁸ Thus, the universal ends of medicine are ‘helping and healing’.¹²⁹ Pellegrino uses ‘healing’ not in the narrow sense of ‘restoring to full health’, but in a wider sense which includes comforting, caring, and being present, as in palliative care, for example.¹³⁰ For him, the essence of medicine is an encounter aimed at helping and healing in this broad sense, and the IMM consists of the values that align with this essence by advancing those ends.

Evolutionary approaches agree that there are values internal to the practice of medicine. For example, Franklin Miller and Howard Brody,¹³¹ whose evolutionary perspective is regarded by Arras as the ‘most plausible and attractive model of medical

¹²³ Pellegrino, n 120 above, 562.

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*

¹²⁶ See, eg, ED Pellegrino and D Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Profession* (New York: Oxford University Press, 1981); ED Pellegrino, ‘What the philosophy of medicine is’ (1998) 19 *Theoretical Medicine and Bioethics* 315; Pellegrino, n 120 above.

¹²⁷ Pellegrino, n 120 above, 560, 562.

¹²⁸ *Ibid.*, 563.

¹²⁹ *Ibid.*, *passim*.

¹³⁰ *Ibid.*, 568.

¹³¹ Miller and Brody, n 114 above.

internalism advanced so far',¹³² take the framework of the IMM to include the 'goals' of medicine,¹³³ the proper duties of a physician, and 'clinical virtues'.¹³⁴ In contrast to essentialist approaches, evolutionary approaches regard these internal values as 'evolving' in response to external developments, so that new goals might be identified, or existing ones reinterpreted 'as a result of a dialectic or conversation between the medical profession and larger society'.¹³⁵ Thus, 'the morality of medicine is always forged in a dialectical relationship with the surrounding (external) worlds of common morality, law, commerce, technology, and so on'.¹³⁶ Miller and Brody emphasise that, for MacIntyre, practices are *social* phenomena, embedded in communities, and that we cannot fully conceptualise them, or fully specify their 'ends', without reference to their social scaffolding.¹³⁷

In the 1990s, the Hastings Center convened a panel of experts from 14 countries to reassess the goals of medicine 'in light of [medicine's] contemporary possibilities and problems'.¹³⁸ The panel's approach is best characterised as evolutionary; although they agreed that medicine 'does have, and has always had, some universal core values and is in that sense marked by inherent goals',¹³⁹ they acknowledged that 'its knowledge and skills also lend themselves to a significant degree of social construction'.¹⁴⁰ The resulting report identified four goals which were said to represent 'the core values of medicine':

¹³² Arras, n 115 above, 648.

¹³³ Miller and Brody take 'goals' to be part of the *internal* framework of values (the 'IMM') (n 114 above, 582). Note, however, that Pellegrino distinguishes between 'ends' which are intrinsic and arise (following MacIntyre) directly out of the nature of a practice, and 'goals, purposes, or values' which he says are 'defined externally by social, economic or political convention ... [and] are not what make clinical medicine the kind of activity it is or aims at': n 120 above, 564.

¹³⁴ Miller and Brody, n 114 above, 582.

¹³⁵ Arras, n 115 above, 648.

¹³⁶ *Ibid.*, 649.

¹³⁷ Miller and Brody, n 114 above, 589.

¹³⁸ D Callahan, 'An international project of the Hastings Center - The goals of medicine: Setting new priorities' (1996) 26 *Hastings Center Report (Special Supplement)* Preface.

¹³⁹ *Ibid.*, S8

¹⁴⁰ *Ibid.*

- (i) The prevention of disease and injury and promotion and maintenance of health;
- (ii) The relief of pain and suffering caused by maladies;
- (iii) The care and cure of those with a malady, and the care of those who cannot be cured;
- (iv) The avoidance of premature death and the pursuit of a peaceful death.¹⁴¹

The idea of an IMM can be criticised on a number of grounds. One important criticism is that truly internalist accounts are unable to provide specific guidance for HCPs about what to do when faced with a real life moral dilemma. Once we believe we have identified a valid end/goal, how do we check its validity? Some approaches allow for the identification of multiple, even conflicting ends/goals, yet provide no clear indication of how conflicts between them are to be resolved.¹⁴² Moreover, the ends/goals themselves are invariably expressed in terms so vague that even where there is general agreement that something ('healing', say) is a core value of medicine, it is sufficiently ambiguous to be compatible with competing (indeed, *opposite*) conclusions about what it requires in practice. For example, is euthanasia compatible or incompatible with goal (iv) above?¹⁴³

Perhaps most damaging of all for internalism is that in deciding what is 'good' or 'right' in the health care context it is impossible to avoid reference to *external* values. First, the terms in which the proposed 'ends' are expressed ('health', 'wellbeing', or even 'death') cannot themselves be defined without appealing to external factors.¹⁴⁴ Additionally, knowing what is good and right in the context of a particular patient requires knowledge of external factors, such as the patient's personal wishes, religious and other beliefs, and lifestyle.¹⁴⁵

¹⁴¹ *Ibid*, Executive Summary.

¹⁴² Veatch, n 121 above, 630-631. Also Wicclair, n 6 above, 179.

¹⁴³ *Ibid*, 629-631. Also Wicclair, n 6 above, 174, 179.

¹⁴⁴ Veatch, n 121 above, 631.

¹⁴⁵ *Ibid*, 632.

Moreover, when we want to claim that HCPs should not be involved in certain activities (such as euthanasia, judicial execution or torture), this is invariably because we disapprove of the activities for external moral reasons (such as respect for dignity, the sanctity of life or consideration of the social risk involved). Arguments in *favour* of doctors being involved in controversial practices also cite external factors (such as lawfulness, public good or freedom of choice).¹⁴⁶

To these familiar criticisms we would add another: doubt about just how internal the supposedly ‘internal values’ are. Take the ends identified by Pellegrino, for example: ‘helping’ and ‘healing’ defined broadly so as to include caring, comforting and simply ‘being there’. Although Pellegrino sources them in the HCP-patient encounter, these are arguably *general* moral obligations insofar as it seems possible to regard them as arising in many (if not all) human encounters. Once we move beyond narrow technical skills, it becomes possible to argue that the ‘softer’ goods and skills associated with medicine are specific exercises of more general moral duties, rather than moral duties ‘internal’ to the practice of health care itself. We discuss this further under heading C below. For all of the reasons canvassed here, we regard ‘internal morality’ as no more successful than value neutrality as a basis for the incompatibility thesis.

C. Personal commitments and professional obligations

Regardless of whether the rationale for the incompatibility thesis is given as value neutrality or internal morality, the thesis always depends on the notion that HCPs *can and should* compartmentalise their public and private ethics, sealing their private values safely away from their professional practice. Insofar as this idea presupposes a distinction between the

¹⁴⁶ *Ibid*, 634-635.

‘public/professional’ and ‘private/personal’ aspects of individuals’ lives, however, it is problematic.

1. The distinction between ‘public’ and ‘private’ moral obligations is questionable

As we have just noted, it is possible to regard the ethical values and duties that attach to HCPs in their professional roles as being continuous with general ethical values and obligations. Professional duties of veracity, fidelity and confidentiality, for example, map fairly straightforwardly on to general ethical duties of truthfulness, good faith and confidence-keeping (albeit that with regard to the latter, whereas a duty of confidentiality is automatically implied into the HCP-patient relationship, an expectation of confidentiality may need to be made explicit in some (but not all) other cases before an ethical duty can be said to exist). Likewise, duties of beneficence and non-maleficence are widely recognised outside of the healthcare context. The Golden Rule, for example, entails duties to help and not harm others; the rule ‘has been expressed, in some form, in most or all of the world’s religions’¹⁴⁷ and is also embraced by secular moral systems including humanism.¹⁴⁸ As one of us has noted in another context:

All [mainstream ethical theories] seem to proceed upon some version of the idea that moral agents are required, ethically, to respond to the vulnerability of their fellow human beings ... by positively protecting/assisting them, and/or by refraining from exploiting them or otherwise causing them harm.¹⁴⁹

¹⁴⁷ J Wattle, *The Golden Rule* (OUP, 1996), 9.

¹⁴⁸ Think Humanism, ‘The Golden Rule’, www.thinkhumanism.com/the-golden-rule.html, accessed on 23rd April 2016.

¹⁴⁹ M Neal, ‘“Not Gods But Animals”: Human Dignity and Vulnerable Subjecthood’ (2012) *Liverpool Law Review* 33(3): 177-200

At first glance, it may be tempting to think that (say) a doctor's ethical duty to keep her knowledge and skills up to date is specific to her role as a doctor and has nothing to do with her private commitments, and that, vice versa, her duty to be faithful to her domestic partner is a purely private obligation. On closer inspection, however, the former duty can be seen as a particular instance of the wider duties of non-maleficence and beneficence (which, we have argued, are not exclusive to the healthcare setting) and the latter duty can be seen as an instance of the wider moral duties to be truthful and act in good faith (which translate as veracity and fidelity in the clinical encounter).

General moral obligations do take on more specific forms depending on the circumstances and the role being performed, so that the precise content of my duty to be truthful is different when with a patient than with friends or a partner. A HCP's moral obligations may also be *heightened* by certain features of the clinical encounter, such as the patient's increased vulnerability, the HCP's enhanced ability to help, any oaths the HCP has taken, and the HCP's implied commitment to her profession's codes of ethics. But the same moral obligations may be just as heightened in other contexts by other factors (for example, in the context of the parent-child relationship).

In our view, the health care encounter can be regarded as involving an *intensification* of general moral obligations, rather than as giving rise to obligations that are specifically 'professional'. As such, we doubt whether the contours of a professional's public and private obligations can be mapped with sufficient clarity to make confident assertions about appropriate compartmentalisation.

2. Criticism of 'public/private divides'

One major project of feminist legal theory has been to problematise notions of the 'public/private divide', not least the idea that 'home' is a 'private sphere' and 'work' belongs

to the ‘public sphere’. The important role of the ‘public/private’ divide in entrenching women’s subjugation has been exposed and the validity of the divide challenged, as encapsulated in the famous slogan insisting that ‘the personal is political’.¹⁵⁰ Thus, an important legacy of twentieth century legal feminism is that any assertion of a public/private divide can no longer be accepted uncritically. Instead, we ought to regard such claims with suspicion and interrogate what their acceptance would mean for the power relations involved. As Frances Olsen has asked, ‘[w]hat does the person who wields power gain’ by making the distinction?’¹⁵¹ Of concern to feminist scholars was the tendency to designate home and family as ‘private’ in order to exclude state power from these areas, leaving men free to oppress women ‘in private’ without the threat of state intervention. Traditionally, therefore, it has been assertions of ‘private-ness’ that have been regarded as troubling. But once the public/private divide has been destabilised, we can also object to problematic assertions of ‘public-ness’, such as the claim that HCPs should leave their personal ethical commitments in the ‘private realm’ and apply different (even *contradictory*) standards in their ‘public roles’.

3. *Compartmentalisation is the antithesis of integrity*

To insist that HCPs operate *only* as HCPs and give weight *only* to the responsibilities and values that are supposedly associated with their professional roles, while ignoring or suppressing any values they have absorbed from other sources, such as ‘life experiences, religious beliefs, and family values’,¹⁵² is to deny integrity in the clearest possible way. Moreover, research suggests that it risks serious negative consequences, not only for HCPs themselves, but also for their patients. The risk for HCPs is that ‘[c]ompartmentalization

¹⁵⁰ F Olsen, ‘Constitutional law: Feminist critiques of the public/private distinction’ (1993) 10 *Constitutional Commentary* 319, 322.

¹⁵¹ *Ibid.*

¹⁵² *Ibid.*

leads to the moral fragmentation of the person’,¹⁵³ since ‘[a]cting against your conviction in choice situations of great importance will injure your moral identity, sometimes with psychological and emotional repercussions’.¹⁵⁴ These repercussions might include feelings of ‘self-betrayal’ or ‘loss of self-respect’,¹⁵⁵ ‘burnout, fatigue and emotional exhaustion’,¹⁵⁶ ‘anger, anxiety, guilt, sorrow, frustration, and/or helplessness’,¹⁵⁷ ‘outrage’,¹⁵⁸ or ‘moral distress’ which results from ‘a perceived violation of one’s core values and duties’.¹⁵⁹ In an effort to avoid these outcomes, some HCPs may ‘deadened’¹⁶⁰ their consciences in order to continue in their professional roles, risking even higher levels of burnout.¹⁶¹ Weinstock suggests that the risk for *patients* is that they ‘will not be well-served by moral automatons who shape their practices, without struggle or reflection, to the desires of patients and the dictates of whatever regime is currently in power’.¹⁶²

These are, ultimately, empirical claims, and our argument here does not depend on their truth. Regardless of any measurable harm to HCPs or patients, compartmentalisation is the antithesis of integrity. An ability to cast off or suspend one’s personal ethical commitments is ethically suspect and should raise serious doubts about integrity and commitment. As Charles Hepler has remarked, ‘[w]e would be naïve to expect [a HCP] to forsake his or her ethics in one area (e.g., abortion) while applying them for the patient’s

¹⁵³ Hardt, n 17 above, 157.

¹⁵⁴ Magelssen, n 57 above, 19. Also, A-L Glasberg, S Eriksson and A Norberg, ‘Burnout and “stress of conscience” among healthcare personnel’ (2007) 57 *Journal of Advanced Nursing* 392; A-L Glasberg, S Eriksson and A Norberg, ‘Factors associated with “stress of conscience” in healthcare’ (2008) 22 *Scandinavian Journal of Caring Sciences* 249.

¹⁵⁵ Magelssen, n 57 above, 18; Antommaria, n 10 above, 83.

¹⁵⁶ Magelssen, n 57 above, 19.

¹⁵⁷ S Davis, V Schrader and MJ Belcheir, ‘Influencers of ethical beliefs and the impact on moral distress and conscientious objection’ (2012) 19 *Nursing Ethics* 738, 739. ‘Guilt’ and ‘shame’ are also cited by Antommaria, n 10 above, 83.

¹⁵⁸ C Laabs, ‘Perceptions of moral integrity: Contradictions in need of explanation’ (2011) 18 *Nursing Ethics* 431, 432.

¹⁵⁹ *Ibid.*

¹⁶⁰ C Juthberg, S Eriksson, A Norberg and K Sundin, ‘Perceptions of conscience in relation to stress of conscience’ (2007) 14 *Nursing Ethics* 329, 329.

¹⁶¹ G Gustafsson, S Eriksson, G Stranberg and A Norberg, ‘Burnout and perceptions of conscience among health care personnel: A pilot study’ (2010) 17 *Nursing Ethics* 23.

¹⁶² Curlin et al, n 16 above, 1892.

welfare in every other area'.¹⁶³ If health care is, as we believe, an inescapably moral enterprise in which integrity and commitment are essential, it is HCPs who *lack* these qualities who ought to be regarded as unfit to perform their roles and not those who allow personal commitments to inform their professional practice.

4. Insistence on compartmentalisation amounts to a denial of moral agency

In Section II, we discussed and endorsed the view of conscience as a matter of integrity and as associated with one (or more) aspect(s) of moral agency (we used 'agent-integrity' as shorthand for all of this). In Section III we demonstrated that this view has not been successfully undermined. If the agent-integrity view is accepted, the demand that individual HCPs suspend their private consciences while at work equates to a demand that, while practising, HCPs suspend elements of their moral agency and cease, to some extent, to be moral selves. Suppressing personal convictions in the performance of a role means that 'the value of being a moral agent is lost and replaced by the instrumental value of being a good role-performer'.¹⁶⁴ This is an alarming prospect. Once the capacity for moral agency has developed, there is arguably not only a right but a *duty* to exercise it - to care about questions of right and wrong, to be committed to right action, to deliberate, and to 'do right'. Insofar as this can be expressed in terms of a moral right to be allowed to function as a moral agent, it seems reasonable to regard such a right as being *at least* as important as any of the moral rights that might be taken to weigh *against* enshrining protection for conscience in law; for example, the rights of patients to specific health interventions (except perhaps life-saving interventions), or the rights of institutions (such as NHS trusts or governing bodies of the health professions) to jurisdiction over their members/employees. When individuals are prevented from closing the agency loop by acting on their consciences, this can be regarded

¹⁶³ CD Hepler, 'Balancing pharmacists' conscientious objections with their duty to serve' (2005) 45 *Journal of the American Pharmacists Association* 434, 434.

¹⁶⁴ Hardt, n 13 above, 158.

as fundamentally undermining the whole enterprise of moral agency¹⁶⁵ and as quintessentially morally harmful. As Hardt concludes:

[t]he presumption that conscience is best kept in the realm of one's private conduct is ultimately morally untenable. A coherent understanding of moral agency requires a unified moral agent who carries with her some fundamental moral commitments that inform the conscience across role-specific boundaries.¹⁶⁶

D. Professional ethics as 'dominant discourse'

In section IV.B, we noted that references to 'professional' values may sometimes denote not the timeless 'ends' of medicine as a *practice*, but the contingent values of the health *professions*, agreed by their members and reflected in, for example, guidance documents or codes of ethics. This approach is exemplified in Avery Kolers' statement that '[t]o be a professional is, among other things, to endorse as one's own the ends of the profession'.¹⁶⁷ Kolers is aware of the implications of this for moral agency, and seems to regard them as unproblematic, observing that:

on a professional model no one is the sole proprietor of her own moral agency. Identification with professional norms means that both one's moral commitments themselves, and one's interpretation of those commitments, are shaped by the institution.¹⁶⁸

¹⁶⁵ Magelssen, n 57 above, 18.

¹⁶⁶ *Ibid*, 157.

¹⁶⁷ Kolers, n 63 above, 4.

¹⁶⁸ *Ibid*, 5

However, any claim that individual HCPs should be willing to cede moral authority to ‘professional ethics’ while at work should prompt us to question how these professional norms are created and the legitimacy that is claimed for them. Critical Discourse Analysis has taught us, when confronted with a powerful discourse or narrative, to ask questions such as: who has access and who lacks access to the discursive process by which norms of professional ethics are created; who controls and who lacks control over the framework within which the discourse takes place (in terms of timing, location, participation, agenda, format and parameters); and what mechanisms, if any, exist for resisting/challenging/subverting its normative conclusions? The purpose of asking these questions is to understand the patterns of power that are present in a given discourse (which includes talk/text itself *and* all the background conditions, rules and categories against which the talk or text occurs),¹⁶⁹ and to question the legitimacy of the narrative(s) that emerge(s) from the production process.

It is appropriate to pose these questions whenever we encounter a powerful discourse, especially one that claims normative authority over the behaviour of particular individuals or groups. In the healthcare context, it is pertinent to ask whether ‘professional ethics’ can be regarded a dominant discourse - a way of conceptualising and discussing ethical issues in health care which reflects the values and assumptions of the most powerful members of the professions. Until now, the ethical guidance issued by professional bodies has scarcely been scrutinised in these terms.¹⁷⁰

¹⁶⁹ RJC Young, *Untying the Text: A Post-Structuralist Reader* (Boston, Routledge and Kegan Paul, 1987), 48.

¹⁷⁰ A couple of exceptions can be found in B Farrand, ‘Conceptualising conscientious objection as resistance’ (2014) 2 *Journal of Medical Law and Ethics* 69, and in Helen Coale’s passing observation, in the context of psychotherapy, that ‘[t]he language of professional ethics has *dominant discourses* that empower certain standards of ethical functioning, while disempowering and making suspect others’: HW Coale, *The Vulnerable Therapist: Practicing Psychotherapy in an Age of Anxiety* (New York, Haworth Press, 1998) 89, emphasis added. Some have identified a dominant discourse within *academic* literature on health care ethics and have variously characterised the dominant voice as being that of ‘secular bioethics’ (Pellegrino, n 109 above, 78), or as the voice of ‘liberal legalism’ (GJ Annas, ‘Medical Ethics and Human Rights: Reflections on the Fiftieth

Until there has been such scrutiny, we have reason to question demands that individual HCPs (and particularly relatively powerless members of the professions) be willing to abide by the normative conclusions rendered by such discourses, even in defiance of their own consciences. On the agent-integrity view of conscience we propose in Part I, the jurisdiction of individual conscience can be justified quite straightforwardly on the basis that the exercise of conscience is essential to the development and maintenance of moral agency. As Albert Bandura has noted, '[a] complete theory of moral agency must link moral knowledge and reasoning to moral conduct'.¹⁷¹ By contrast, neither the justification for the jurisdictional claim of 'professional ethics' nor the case for it being sufficiently strong to displace the jurisdiction of individual conscience has been made out.

If our concerns about professional ethics as dominant discourse are well-founded - and we hope to investigate this in future work - CBEs are likely to be one of the main mechanisms by which the master narrative and its normative assumptions are challenged and resisted.¹⁷² Whether we express this in terms of 'dominant discourse' or not, disallowing CBEs will inevitably silence or drive out dissenting voices, and we can reasonably expect this to cause professional values to become more static and conservative.

Anniversary of the Nuremburg Code' in RB Baker, AL Caplan, LL Emanuel and SR Latham (eds), *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society* (Baltimore, John Hopkins University Press, 1999), 299). There is, of course, considerable cross-fertilisation between 'academic' and 'professional' discussion of health care ethics, but our primary focus here is on the guidance on ethical matters produced by professional/regulatory bodies.

¹⁷¹ A Bandura, 'Selective moral disengagement in the exercise of moral agency' (2002) 31 *Journal of Moral Education* 101, 101.

¹⁷² Ben Farrand has recently analysed conscientious refusal as 'resistance': Farrand, n 170 above.

V. CONCLUSION

Here, we have sought to defend the place of CBEs in healthcare in two ways. First, we have argued that conscience is fundamentally and ineluctably connected to integrity and the possibility of moral agency, and that this connection can be defended against its critics. Second, we have sought to demonstrate that the main argument against protection for conscience, the incompatibility thesis, is fatally flawed. We have challenged the incompatibility thesis by rejecting each of the alternative claims that might underpin it, namely that the practice of health care ought to be value-neutral or that it ought to be informed only by values which are internal to the institution of health care itself. We have argued that value-neutrality is impossible for HCPs because value choices are unavoidable in the health care setting, and that it is also disingenuous, since insistence upon value-neutrality is really a demand that HCPs participate in a range of contested practices which are themselves far from value-neutral. In relation to ‘internal’ values (the IMM) we have argued that these cannot be formulated in any way that provides concrete answers to morally controversial practices. Even if they could, it would still be problematic to insist that they be given precedence over moral agents’ own conscientious conclusions, for several, related reasons.

First, because the idea of a clear division between ‘public’ and ‘private’ moral commitments is itself problematic; second, because assertions of public/private divides may serve partisan purposes, and ought not to be accepted uncritically; and, finally, because the kind of self-fragmentation envisaged here is the very antithesis of integrity/commitment and an offence to moral agency (it ‘make[s] a mockery of the whole concept of moral integrity’¹⁷³). There is also, in our view, a need to subject discourses of professional ethics to

¹⁷³ Pellegrino, n 109 above, 79.

critical analysis, enquiring about access to the process of discourse production and the availability of opportunities for resisting dominant narratives.

Elsewhere, we have identified three important types of natural limit on the scope and exercise of CBEs which, if observed, would prevent any erratic or excessive expansion of CBEs.¹⁷⁴ Within these parameters, CBEs are essential to the maintenance of HCPs' agent-integrity and, as such, they require robust protection.

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¹⁷⁴ Fovargue and Neal, n 44 above.