**“Conscientious Objection or an Internal Morality of Medicine?”**

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**I. Introduction**

A right of conscientious objection in medicine has been much criticized in recent years (Savulescu, Emanuel, Schuklenk, Stahl, Minerva, Smalling, etc.). These critics insist that doctors should not be injecting their personal ethical views into the practice of medicine, refusing to deliver care that is legal, common, accepted and expected. Wicclair labels the charge “the incompatibility thesis” for “conscience-based refusals to provide legal and professionally permitted goods and services within the scope of a practitioner’s competence are incompatible with the practitioner’s professional obligations.” Such appeals to conscience will open an “a Pandora’s box of idiosyncratic bigoted discriminatory medicine” (Savulescu). Alleged compromises like publicizing doctors’ refusals will have the “absurd logical conclusion…(of) websites where patients can find out whether their doctor objects on grounds of conscience to treating sexually active gay patients…or…patients of a particular objectionable minority” (Schuklenk). A major worry is that there will be no arbitrary and principled way to distinguish legitimate from illegitimate exceptions of conscience. Patients will be at the mercy of the whims of their doctor’s conscience while hospital administrators and other doctors will be burdened unfairly by their peers’ random recusals. Conscientious objection might have a role in military conscription (Emmanuel and Stahl) but not when one voluntarily enters a field. Such refusals are made worse by medical professionals having a monopoly on the provision of medical services and often their medical research, education and salaries being publicly financed. Opponents of conscientious objection suggest that doctors should not enter a field if they are not going to deliver the legal practices accepted by peers and expected by patients (Savulescu, Emanuel). In Schuklenk’s vivid analogy: one doesn’t take a job as a cab driver and then refuse to drive on the basis of one’s environmental objection to combustible engines.

I offer two responses. The first is that doctors who refuse to offer patients abortifacients, suicide assistance, contraception, sterilizations, sex changes etc. are not engaging in conscientious objection. They are not “placing professionals’ personal beliefs above professional standards” (\_\_). They do not meet Rawls’s description that “A conscientious objector does not invoke the convictions of the community.” My contention is that the above physician refusals are not beliefs that are at odds with the profession’s moral nature and ends and thus can “invoke the convictions of the (medical) community.” I will argue, pace Boorse, that the essence of medicine is pathocentric, despite doctors from the start of western medicine providing services that didn’t prevent, cure, or mitigate pathologies. So when doctors don’t provide abortifacients, emergency contraception, and physician-assisted suicide (PAS), or refuse to euthanatize patient, execute prisoners, facilitate torture for interrogations, remove organs for donation after cardiac death (DCD), and withdraw medically provided nutrition and hydration (MPNH) etc. they are not imposing their own morality. They have not hijacked medicine, but, to put it somewhat melodramatically, medicine has been kidnapped by the culture of death and its practitioners are suffering from the Stockholm Syndrome.

Once medicine’s pathocentric nature has been recognized, given that medicine in an inherently moral profession and its practitioners profess allegiance to its goals due to its nature, it is a small step to a minimally pathocentric internal morality of medicine. Conscience need not be appealed to since the very nature of medicine doesn’t include the contested practices to which orthodox Christian doctors will object. So to apply the conference title question to just the domain of *medical refusals*, the answer, to be qualified a bit later, is that Christianity doesn’t make a difference. Or more cautiously, it need not make much of a difference in the domain of refusals, assuming the nature of medicine is properly understood. Against a pathocentric background, orthodox Christian doctors can’t justly be accused of allowing “personal moral judgment to masquerade as medical practice” (Stahl and Emmanuel).

I will next consider that I have mischaracterized conscientious objection. There may still be a need for conscientious objection, even if the nature of medicine is pathocentric, due to the services that medical law allows, doctors standardly provide, and patients regularly expect. So while the *proper* practice of medicine may not include abortion, euthanasia, sterilization, contraception etc., *current* practice of doctors does. So understanding conscientious objection as the refusal to provide established, legally protected services in the patient’s interest will indicate the need for conscientious exemptions. I will then suggest that when the exclusions are pathocentric there is still no hijacking of medicine for individual moral integrity. That will be true not just of refusal to deliver certain services but refusals to inform patients about or provide referrals for them. None of the standard objections will apply. Doctors refusing to induce pathologies are not, pace Schuklenk, refusing qua Christian, but qua doctor.[[1]](#footnote-1) There is no slippery slope to not caring for homosexuals, trans-patients, and other maligned minorities. There won’t be surprises other than to patients who expect doctors to provide more than what is essential to medicine. It isn’t unfair to ask doctors to restrict themselves to medicine. The patients are not being *medically* harmed and neither they nor the other doctors who want the refusers to provide services not essential to medicine are being unfairly burdened. Doctors should not look for other jobs because they refuse to use their training to do things that aren’t essential to medicine. This is true even if they know that such expectations are there when they freely enter their profession as opposed to being conscripted into the armed services as doctors or soldiers. At least this will follow if I am right about the pathocentric nature of medicine and the internal morality of medicine. So establishing that will be my main concern in sections II and III below.

To determine the role morality of health care providers, the method will be one that even critics of conscientious objection like Stahl and Emanuel accept, Rawlsian reflective equilibrium.

should health care professionals provide or refuse specific interventions? …

debates focus on medical value and suitability, not political or cultural acceptance… Professional societies can make mistakes. …But the profession also uses reflective equilibrium to self-correct (Emanuel and Stahl).

What I propose to do, in line with the method of reflective equilibrium, will be to get clear about which practices are essential to medicine and which are not. Paradigm duties of doctors will be put forth and principles abstracted from them. The initial principles will are then be judged against less obvious or nonstandard practices to determine whether they are appropriately considered medicine. The result will be that our conception of the essence of medicine requires pathology-fighting practices but not pathology-inducing undertakings. Hence objections to the latter can claim do so on the basis of being loyal to the nature of medicine.

**II. A Pathocentric Internal Morality of Medicine**

The idea of an internal morality of medicine is that some acts that aren’t immoral in themselves are still wrong for medical practitioners to undertake. They are wrong because they are contrary to the nature of medicine which is usually understood in terms of certain goals being definitive of the practice. One traditional conception is that medicine’s essence is to combat disease or pathology (Pellegrino). Christopher Boorse understands a pathocentric emphasis of fighting disease “as an abbreviation for any of three things: (1) preventing pathological conditions, (2) reducing their severity, and (3) mitigating their bad effects.” Paradigm examples of actions that violate the pathocentric principles guiding an internal morality of medicine would involve physicians participating in torture or execution even if the external morality of society (the general non-role based morality) permits torture and executions. Other examples of actions that might be prohibited by a pathocentric internal morality of medicine include abortion, euthanasia, physician-assisted suicide, terminal sedation, sterilization, some forms of contraception, and perhaps sex changes.[[2]](#footnote-2)

Boorse challenges the idea that medicine has historically been pathocentric. He draws upon a rich historical record of doctors devoting their skills to practices other than curing or preventing diseases. He concludes that such practices prevent a historically sensitive internal morality of medicine from proscribing practices like hastening the deaths of some patients or helping others avoid becoming pregnant by pills or sterilization. Boorse suggests that the rejection of such practices must have its source in moral ideas that originate from outside of medicine, as the latter is not essentially pathocentric.

 I will take issue with Boorse, arguing that he doesn’t appreciate that these historical activities of doctors need not at odds with the medical craft being essentially pathocentric. I contend that we can construe medicine’s pathocentric essence in a way that doesn’t exclude doctors from applying their technical skills and knowledge of the body to ends other than thwarting pathologies. Acknowledging a pathocentric essence can instead serve merely to protect medical practitioners, enabling them to refrain with impunity from procedures that cause pathologies in their patients.

My account differs from the more conservative pathocentric accounts in that it doesn’t limit doctors to fighting pathologies.I highlight the distinction between acts “contrary to” medicine’s essence and those merely “not entailed by” its essence. Ending a life is contrary to the essence of medicine. Fighting pathologies is entailed by the essence of medicine. Cosmetically enhancing a life is neither contrary to the essence of medicine, nor entailed by its essence. Cosmetic surgery doesn’t undermine or advance health. My concern here is in allowing doctors to refuse to induce pathologies without suffering a penalty. I am not advocating that they be limited to fighting pathologies.

Boorse brings attention to the fact that whether one thinks that medicine has its origins in the ancient Greek Hippocratic School or the 19th century with the discovery of germ theory and antiseptic surgery, medical practitioners at those times didn’t restrict themselves to preventing and combating pathology. Boorse points to ancient contraception and modern obstetrical anesthesia. Fertility is not a disease that contraception prevents, and obstetric anesthesia is treatment for normal pain, not pain that is a symptom of disease.

Boorse claims two points are crucial for his argument. First, contraception on demand was not universally condemned, so we can erase it from the Western medical tradition only by expelling those ancient physicians who prescribed it. Second, even if Hippocratic medicine is canonical, as commonly maintained, it doesn’t seem to have placed restrictions on contraception.

Boorse considers the alternative possibility that scientific medicine originated in 19th century. He draws upon Wootton’s work where it is argued that not until the 19th century did “physicians” do more good than harm, that is, the result for patients became better than placebo effects. So scientific medicine, on Wootton’s approach, has a recent origin. Earlier “medicine” was no more medical than astrology was astronomy. But Boorse points out that even in the 19th century, anesthesia during labor achieved near total acceptance. While women suffer great pains in labor because of the size of the fetus’s cranium and torso, and strong contractions and widening of various areas is needed but painful, the pain is normal for delivery and not pathological. The pain is inherent in human design.

Boorse concludes that these examples (contraception and obstetrical anesthesia) prove one of two things: either i) medicine has no essential connection to disease or ii) physicians may practice qua physician something besides medicine. Either way, physicians are not limited to promoting health. There was no Golden Age of pathocentric physicians. So Boorse concludes that no internal morality of medicine offers good reasons to ban controversial actions by doctors such as euthanasia and enhancements.

**III. Reflective Equilibrium and Pathocentric Medicine**

Boorse imagines three responses to the physician being unbound from a focus on the pathological:

 i) Retreat and reject as unethical all of physicians’ treatments of normal conditions

ii) Endorse these as ethical acts by physicians, but not as medical since they’re not health directed

iii) Accept them all as medicine embracing an internal morality of medicine that allows any use of biomedical knowledge and technology for the patient’s benefit.

Option i rejects medical history. If ii or iii are accepted, then there are no objections from an internal morality of medicine against voluntary active euthanasia and enhancements because these are either genuine medicine or permissible for doctors to undertake. Thus there is no objection on the basis of an internal morality of medicine to such practices. We would be left with only objections from general or external morality.

Boorse overlooks another response. This is that there is a pathocentric essence of medicine and this provides grounds for why doctors should be able to *refuse without penalty* to participate in actions that promote pathology, as is obviously the case with suicide, abortion, removing MPNH, executions, torture, as well as live donor organ removals, DCD, sterilization, and some contraception.

My contention is that Boorse fails to appreciate that there is a conceptual analysis defense of clinical medicine’s pathocentric core. It doesn’t matter that doctors have always prescribed contraception or provided relief for natural pain, or even if they always practiced cosmetic surgery. Such practices might still not be essential or central to medicine, just as it doesn’t matter if the army always helped out with disaster relief, quelling riots, and search and rescues. If the institution known as the “army” didn’t protect against foreign military threats, then we would say it was not an army even if it did search and rescues, put down domestic riots, and provided disaster relief. But if the institution called the “army” only protected against the foreign military threats, we would still say it was an army despite not helping out domestically with riots, disaster relief, or search and rescues. The essence of the army is to protect against foreign military threats. Something structurally similar can be said about medicine. If some people refused to cure the sick or ameliorate the consequences of their pathological conditions, or prevent diseases, but only prescribed contraception, alleviated natural childbirth pains, and removed unattractive wrinkles with creams, we would say they were not physicians. But if such persons only prevented disease, cured the sick, and lessened the effects of the diseased, but refused to prescribe contraception, do cosmetic surgery, or alleviate the pains of childbirth, we would still be inclined to label them physicians.

We may be misled by the fact those who cosmetically enhance, abort, or execute engage also in pathology fighting medical practices or used to engage in anti-pathological practices. To offset their distorting influence, imagine if they have never done anything but abort or poison or torture, though they have the skill set to do more. We would then more readily consider them not to be engaged in medicine. We would be even more inclined to claim that those engaging in euthanasia, executions, enhancements, and abortion weren’t medical practitioners if they not only didn’t want to treat pathologies but couldn’t do so effectively even if they were so inclined. There is an asymmetry in how we classify those without the abilities to produce pathologies or enhancements and those without the abilities to counter pathologies. An individual with a flourishing ob/gyn practice who doesn’t know how to abort fetuses or sterilize women or freeze embryos or thaw and fertilize eggs is still a doctor. But someone who knows only how to abort, sterilize, etc., but is ignorant of how to cure reproductive pathologies would not be a medical doctor. A poison control doctor who specializes in reversing effects of poisons but doesn’t know how to apply toxins to painlessly and effectively execute someone is still a doctor. Someone who only poisons prisoners but doesn’t know how to heal those poisoned is not a doctor. I suspect that readers would be disposed to accept plastic surgeons as physicians if they only had the skill set to engage in pathology-curing operations and didn’t know how to tighten aging skin or create swollen (bee sting) lips and produce other cosmetic enhancements, but they wouldn’t consider as doctors those people who could only enhance or beautify skin but not cure its pathologies.

Readers may protest that it is unrealistic and also unfair to propose a classification as non-medical of those who only want to do enhancements *and* who lack the skills to practice any pathology-combatting medicine. So let’s assume a moderate case where the skill set enabling those solely engaged in cosmetic enhancements also provides them with the skills to reshape noses and tighten skin that has been damaged due to *pathological* agents. The procedures for the enhancements would be roughly the same as those of medical treatments. It is just that the cosmetic surgeon refuses to ever engage in pathology fighting surgery. To help us here still resist any pull to include those enhancement-only providers as engaged in the practice of medicine, consider an analogy between security guards and *merely* cosmetic surgeons. Imagine that the security guard at the sporting goods store uses the skills he learned on the football field to tackle shoplifters with stolen footballs in their possession. He even knocks the ball out of their hands when he tackles them, just as he used to cause fumbles when tackling opponents on the gridiron. We can even imagine him next punting the ball away from the thief or passing it over his outstretched hand to a fellow employee and then blocking the miscreant from retrieving the ball. Just because there is a narrow description of the security guard’s abilities and movements that is the same as that given of a football player tackling and blocking an opponent or throwing a pass is no reason to claim the security guard is a football player. We can even put security guards in teams of 11 and award points proportional to the value of the property they preserve. Nevertheless, any such guard is engaged in a very different goal than a football player despite his skills arising from his earlier playing football and their still being applicable to success on the football field. The aims of providing security and playing football are very different, as are the aims of enhancement and treatment. We shouldn’t classify the security guards and football players as being in the same field despite their skill sets allowing them to do what the other does. I suggest that we also treat as distinct professions those who engage in treatments of disease from those who just enhance the healthy. Some readers may resist this because they believe that both aim at improvements moving people further away from the boundary of what is considered a disease. But I don’t even need to defend my earlier claim against this categorization as there is an even more compelling contrast and demarcation of professions involving those dedicated to fighting pathologies from those who are all too willing to induce pathologies. Saving lives, restoring healthy function, and preserving organs and other parts are goals about as different as you can get from those of taking lives, producing unhealthy dysfunction, and destroying body parts.

**IV. Refusals to Induce Pathologies**

Let’s turn now to the main upshot of the operations of minimal internal morality of medicine - protected refusals. My conception of a minimal internal morality of medicine is that once the essence is understood, medical providers (doctors, nurses, and even pharmacists) should be allowed to refrain from carrying out certain requests of an external morality’s requests. That is, they can refuse to abort fetuses, castrate or mutilate willing patients, torture terrorists or execute prisoners, provide some forms of contraception, even emergency contraception (I’m not assuming that the latter are always abortifacients) despite the external morality of society being one that has come to want medical providers to start doing those things. The refusal should be protected. So if personal commitments are understood to be commitments to values other than medicine, then I can agree with Stahl and Emanuel that doctors should not allow “*personal* commitments to outweigh the interests of patients.” I can also agree with Savulescu that “doctors should not offer partial *medical* services” because the protected refusals that I have in mind are in order to allow doctors from being coerced into services beyond medicine.

Why should medical providers be allowed to avoid certain practices? Well, it is contrary to the nature of the profession that they entered. They didn’t sign up for such when they became doctors, nurses or pharmacists. They professed allegiance to the principles of a profession that was devoted to healing and making people whole, or as whose as possible. In addition, it could very well be that their vocational self-understanding and professional integrity are tied to these ends. They conceive of themselves as tasked with saving the lives of present generation *and* the preventing the destruction of those of the next. They can’t easily, and shouldn’t have to, think of themselves as both healers and killers. They mastered a healing vocation and not another profession. Even if the external morality maintains that it is moral, all things considered, to facilitate abortion, euthanasia and sterilization etc., physicians have a right to not do so, and may even believe that they have a duty to refrain from these actions lest they compromise their professional integrity as *doctors*.

The internal morality of medicine could be construed as rendering certain actions non-mandatory. On my minimal internal morality of medicine physicians can legitimately opt out of certain acts by appealing to the nature of their profession. Prison- or army-employed physicians cannot be morally commanded to increase pathologies through, respectively, executions, or torturous interrogations. Hospital and clinic workers should be able, without penalty, to refuse to provide abortions or even contraception that makes organs malfunction. The right to refuse should also be extended to pharmacists unwilling to prescribe abortifacients, emergency contraception, and to Catholic hospitals when governments or insurers insist that they must provide such contraception. And medical schools training the next generation should allow students to refuse to learn how to perform an abortion, contra Allison Jaggar, who insists that ob/gyn training and certification should require abortion training and practice as a matter of respect for women’s equal rights (2009).[[3]](#footnote-3)

Of course, nearly every surgical medical procedure will kill some cells but that is in the service of making them healthy. I would still maintain that a pathocentric essence is compatible with creating a minor pathology to prevent a greater pathology. The pathocentric account just demands that overall, the aim is that the patient’s health be improved. I am understanding a patient to be unhealthy only if a condition including a part malfunction increases the probability of death or reproductive failure.

A right to refuse applies even if there is an expectation that one will engage in the objectionable practice. I’ll say more about this later. It is, admittedly, easier to defend refusals to engage in those activities that weren’t expected of doctors when they entered the profession. It is likewise fairly easy to defend refusal against duties that were imposed by the government as with Obama care. Somewhere in between in difficulty is defending refusals where the health care worker changed her view after observing or taking part in a practice such as abortion that they didn’t think earlier was objectionable.

**V. Traditional Christian Doctors have no Need for Conscientious Objection**

Rawls famously contrasts conscientious objection with civil disobedience.

There are several contrasts between conscientious refusal (and evasion) and civil disobedience. First of all, conscientious refusal is not a form of address appealing to the sense of justice of the majority… One simply refuses on conscientious grounds to obey a command or to comply with a legal injunction. One does not invoke the convictions of the community, and in this sense conscientious refusal is not an act in the public forum. Those ready to withhold obedience recognize that there may be no basis for mutual understanding; they do not seek out occasions for disobedience as a way to state their cause…They are less optimistic than those undertaking civil disobedience … there may not be any chance that the majority will be receptive to their claims. Conscientious refusal is not necessarily based on political principles; it may be founded on religious or other principles at variance with the constitutional order. Civil disobedience is an appeal to a commonly shared conception of justice, whereas conscientious refusal may have other grounds.

 I want to highlight that conscientious objectors are, according to Rawls, not appealing to shared conceptions of justice or morality. They are not accusing the majority of failing to live up to their own beliefs. They aren’t urging the society to change the laws so they conform to the society’s own fundamental commitments to justice. Instead, conscientious objectors are appealing to dictates of conscience that don’t appear to be shared. My contention is that given the pathocentric nature of medicine, the appeal of those who refuse to provide services actually share the core values of medicine. They can “invoke the core convictions of the (medical) community” and demand that others live up to their ideals. So what is called conscientious objection in medicine (construed pathocentrically) actually has more in common with civil disobedience than conscientious objection. “In justifying civil disobedience one does not appeal to principles of personal morality or to religious doctrines, though these may coincide and support one’s claims.”[[4]](#footnote-4)

I have argued that doctors can refuse to act contrary to the pathocentric essence of medicine.[[5]](#footnote-5) This is not to say that physicians ought to refuse to do things that aren’t essentially medicine. They have skill sets that enable them to say, do cosmetic surgery, that others can’t and it wouldn’t be efficient to train others to do so. My contention is only that they should remain protected when governments or employers want them to do things *contrary* to the essence of medicine – induce pathologies rather than prevent or cure or mitigate pathologies. So abortion, executions, euthanasia, sterilizations torture, and the like are directly at odds with the ends of medicine. It is a distinct question if doctors should be allowed to refuse to do things that aren’t part of the pathocentric essence of medicine. Philosophers sometimes move too quickly from the view that the core goals of medicine exclude certain actions contrary to its essence to excluding actions not entailed by its essence. It might be fine to alleviate ‘healthy’ birth pain, prescribe contraception, perform cosmetic surgery, etc.[[6]](#footnote-6)

Other doctors may want to be excused from practices that are not inducing pathologies and my account doesn’t extend protection to them. So a Muslim female doctor who doesn’t want to see naked male patients can’t appeal to the pathocentric nature of medicine and a moderate internal morality of medicine. Nor can UK Muslim medical students who reportedly refused to learn about alcohol-related and sexually transmitted diseases because it offended their religious sensibilities (Foggo and Taher). The same is true of a Jewish physician who doesn’t want to offer medications made with non-kosher gelatins. Likewise for a Jehovah witness surgeon that won’t make use of blood transfusions. I am not concerned with protecting those practices. They do seem to me to be more susceptible to the standard critiques of the conscientious objector as hijacking medicine, appealing to idiosyncratic values that have nothing to do with the principles of medicine. Such a compromise between physician conscience and the interests of patients may “only compromise patients” (Schuklenk and Savulescu). The expectations of patients will be dashed, their health worsened, and colleagues unfairly asked to provide care that their colleagues won’t.

A benefit of avoiding appeals to conscientious objection for an internal morality of medicine is that the former cuts in both directions. The latter does not leave itself open to *positive* conscientious objections. For example, during the Bush administration, doctors could then have appealed to their conscience and moral integrity to break the law and engage in new embryo destruction to acquire embryonic stem cells. Likewise, doctors of international agencies funded by US taxpayers might appeal to their conscience to violate gag laws that prevent them from providing advice about procuring abortions. Wicclair defends positive conscientious objections that an internal morality of medicine would not.

If one considers the ethical basis of protecting health care professionals’ conscience-based objections, selectively protecting negative appeals to conscience does not appear to be justified. The primary reason for recognizing and safeguarding appeals to conscience is to protect moral integrity. This rationale applies equally to negative and positive appeals to conscience (Wicclair)

**VI. Is there still a Need for Christian Conscientious Objection?**

Perhaps I am wrong about the internal morality of medicine renders orthodox Christian conscientious objection superfluous.[[7]](#footnote-7) It may be that conscientious refusals are needed even if the nature and proper practices of medicine is pathocentric since the current legal understanding and professional conduct involves doctors in pathology-inducing actions. Wicclair describes conscientious objection in medicine occurring when health care workers “1) refuse to provide *legal* and *professionally* accepted goods or services that fall with the scope of their professional competence and 2) justify their refusal by claiming that it is an act of conscience or it is conscience based.” So I may be right about medicine’s nature but doctors are expected to do more than what is medicine, if the latter is construed pathocentrically. An internal morality of medicine, after all, recognizes that there are moral norms beyond those of the professions. For example, it may be that capital punishment is justified; perhaps even torture can be permissible beyond a deontological threshold when the stakes are high enough (ticking A-bomb hidden by terrorist). Abortion to save the mother’s life may be justified or thought justified, even if it induces pathologies in one human being for the sake of another. (I actually think that the fetus is a part of the pregnant woman so all abortions are also inducing pathologies in the pregnant women as well as the fetus.) So there may still be a need for conscientious objection as doctors want to refrain from doing what society has judged they should do.

Thus even if “conscientious objection” is needed by Christian doctors, I still want to insist that it doesn’t lead to the opening of a Pandora’s Box of problems that critics insist upon trotting out time and time again. The pathocentric essence of medicine serves to show there are principled distinctions that distinguish refusals to abort, sterilize, contracept from other conscientious refusals. The Jewish doctor who doesn’t want to provide a medication made from unkosher gelatin is not appealing to the pathocentric nature of medicine. Nor is the Muslim female doctor who refuses to see male patients in the nude. They are not objecting qua doctor but qua Jew or qua Muslim.

Even if these doctors were to be protected in their conscientious refusals, a view to which I am not that sympathetic to, there is no reason why the Jewish or Muslim doctors shouldn’t refer patients to doctors of the same sex or without kosher taboos. But the Christian doctor who doesn’t want to abort or sterilize can appeal to the pathocentric nature of medicine for why they are not only refusing to impose pathologies but refraining from recommending to patient other doctors who will produce pathologies or informing patients of pathology inducing options. The Christian doctor is not refusing to refer qua Christian but is doing so qua doctor. Or even if she is doing so *qua* Christian, she can do so qua doctor. The Jewish and Muslim doctors obviously can’t in the above scenarios. When their conscience demands that they refrain from activities that aren’t pathology inducing, they have no analogue to Karen Brauer, President of *Pharmacists for Life,* protesting mandated referrals:

I don’t kill people myself but let me tell you about the guy down the street who does. What’s that saying? I will not off your husband but I know a buddy who will. It’s the same thing (Stein).

Appeals to pathocentric nature of medicine also provide a line that rule out doctors not treating groups they despise – sexual or racial minorities. There is no worry here about arbitrariness or a slippery slope. This is not to deny that distinctions can be made between classes of patients and classes of objections (Sulmasy, Eberl) to prevent certain abuses of doctors refusing to provide care to groups subject to invidious discrimination. The liberal distinction may be evaded by appeals to practices that contingently turn out to be limited mostly to the class of persons. Of course, there are other liberal ideas that can be brought to bear to make distinctions between refusals. But I don’t think they are required given the pathocentric nature of medicine. We need not justify conscientious refusals by appeals to the Procrustean bed of public reason (Rawls), the crowded and uncomfortable bed of tolerating diversity (Muldoon), or the dreamless bed of intellectual humility (Sulmasy). Nor need we defend refusals because of what, given the Scandinavian experience (Savulescu and Schuklenk), may turn out to be dubious worries about not attracting and retaining good doctors (Wicclair), or doctors being left ethically desensitized (Wicclair) by being unable to exercise conscientious objection.

I don’t want to be understood as claiming that that pathocentric appeals will never make it necessary for Christian doctors to appeal to a conscientious right of refusal. There may be Christian doctors who don’t want to prescribe Viagra to the bachelor, advice to an unmarried woman on how to get pregnant (without IVF), or remove a lesbian’s ovarian cyst so she can be artificially inseminated. But I’m more inclined to say that these shouldn’t be protected because they consist of refusals to fight pathologies and can’t be distinguished from conscientious appeals that will make medicine a more arbitrary and unpredictable mess as doctors refuse to provide legal and standard services that are in the patient’s medical therapeutic interests but at odds with their personal morality. It might be that in such cases doctors should not be compelled to provide such services but pressured to refer or to practice in another fields. I am not very concerned with such issues. My goal has been to provide a principled defense of refusals to induce pathologies like abortion, contraception, terminal sedation, DCD, euthanasia and PAS, as well as refusals, already recognized by medicine, to facilitate torture and capital punishment.

**VII. Can Medicine Cease to be Pathocentric?**

Yes and no. If the essence of medicine is essentially pathocentric, then it can’t cease to be so without ceasing to be medicine. So it is correct that medicine can cease to be pathocentric; but the institution of medicine going out of existence is probably not what those who typically answer in the affirmative have in mind. They understand “yes” to mean that the very same institution of medicine they have in mind involves medicine continuing to be medicine without being pathocentric which can be accomplished if medicine is a cluster concept and pathocentric practices are just sufficient (or components of a sufficient condition) but not necessary for the institution to be medicine. So for me to answer “no” to our question requires me to deny that medicine is a cluster concept. Given what I earlier claimed and supported with analogies with armies and security guards, readers shouldn't be surprised that I hold that the profession’s increase focus on non-pathocentric ends doesn’t undermine the claim that medicine is essentially pathocentric. So I can accept Schuklenk’s claim when he responds to those who focus on traditional values that there has been a “shift from maintenance of human life to the quality of life focuses approach.” The shift is still compatible with doctors having to fight pathologies to be doctors. The non-pathological concerns with increasing quality of life aren’t necessary, the anti-pathocentric attempts to improve the quality of life are essential. Medicine has an essence, and fighting pathologies is a necessary condition for being a doctor. So medicine is not a cluster concept without any essential traits, merely composed of a number of sufficient traits

Medicine can be pathocentric and doctors may be asked to do things that aren’t medicine. Doctors have skills, often fostered by publicly financed educations that enable them to engage in practices that aren’t essential to medicine. Society may want to compel doctors, especially those that they pay with tax dollars through national health organizations, to do such things. If we protect doctors from executions and torture, why not protect them from abortion and sterilization and euthanasia? Well, the former are clearly not in the interests or serve the well-being of the tortured or killed.[[8]](#footnote-8) Moreover, abortion is not in the interest of the aborted even if it is in the interest of the pregnant woman. Some theorists may want to deny that the fetus has interests, well-being, or is a patient, but I think those views are wrong; nevertheless, everyone should recognize them as contentious and unsettled. Thus those like Emmanuel and Stahl who allow conscientious refusal with unsettled medicine like PAS, should not be so quick to consider abortion settled, not even legally settled. In the absence of Roe, whose legal and moral reasoning is considered quite flawed by quite many, the number of states that would be banning abortion would approach those that outlaw euthanasia and PAS.

It might be maintained that we could choose to practice schmedicine rather than medicine. I will end by very briefly considering whether we can change or replace medicine by stipulating new duties. The short answer is institutions can’t be changed by such an agreement as they evolve over time and their very practices embody a pathocentric understanding. We cannot just choose to reinterpret our practices and say they are not pathocentric but serve the patient’s interests or well-being, when most practices seem to aim at restoring medical well-being, not raising general well-being. So there are limits on the alteration and introduction of institutions. That is not to say that people can’t form new institutions. But merely deciding to interpret old one as new ones is not something we can stipulate.

It isn’t even the case that we can change the medical institution by legislating new entry rules and expectations. We certainly can pass laws or hospitals and medical schools can contract with their employees and students that admissions and employment will only go to those willing to induce pathologies on certain occasions. That stipulation can’t change the nature of medicine as any change or replacement will take some time and involve changing practices, not just stipulating and legally enforcing entrance conditions. Perhaps an analogy will help. Imagine that public educational institutions come to believe that a small minority of persons are best “educated” for boring or back breaking menial labor. As a result they gear their “education” to learning “skills” and developing attitudes that make them amenable to such work. The schools, at the urging of the larger society, decide not to teach critical thinking skills or encourage imagination in this small minority of students as that will make them less malleable employees. This has become established and legally supported practice and is understood by those entering the field that they are expected to provide such ‘educations’ on rare occasions. If you then enter education and refuse to tailor your pedagogical lessons to make a minority of your students into automatons, should not your refusal be protected? Has not the nature of the educational profession been hijacked? Are teachers not failing to live up to their ideals of their craft? It would seem so despite the practice becoming legally entrenched and expected and even understood as implied by the wording of the contract or school’s admission policy.

Advocates of conscientious refusal can turn the tables and ask their opponents how principled is their advocacy of compelling doctors to do what is legal and considered at the time to be good medical practice and in the interest of the patient. We can imagine clictorectomies becoming legal and in the interests of some patient (Sulmasy). Should doctors leave the field if they refuse. Likewise, it may have been in the interests of some incapacitated “imbeciles” to be sterilized and it was legal and accepted. Eberl asks do we think those doctors who refused to sterilize should have left the field? Surely not.

**VIII. Conclusion**

Therefore, if my conceptual analysis has captured readers’ intuitions, then they should accept my account that medicine has a pathocentric essence. So even if doctors have come to use their skill sets for more and more non-pathocentric practices, those aren’t essential to medicine. If medicine is a moral profession and doctors profess a loyalty to its goals derived from its nature, then it is wrong to make them act in opposition to the nature of their profession in order to induce pathologies that the larger society has come to favor.

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1. Schuklenk claims “I suspect it isn’t unfair to note that those protections in the real world are nothing other than protections for Christian doctors who are unwilling to deliver services they would be obliged to deliver to patients who are legally entitled to receive these services.” [↑](#footnote-ref-1)
2. Sex changes might eventually need to be stricken from the list if it correctly considered to be the cure for a pathology, not the imposition of an additional pathology. [↑](#footnote-ref-2)
3. However, I believe that medical students should know how to treat abortion complications [↑](#footnote-ref-3)
4. It is worth mentioning that Rawls notes “that there is, of course, in actual situations no sharp distinction between civil and conscientious refusal…the same action (or sequence of actions) may have strong elements of both.” In the spirit of this quote, keep in mind that conscientious objectors against abortion and euthanasia don’t just want personal exemptions but want the laws changed. [↑](#footnote-ref-4)
5. I am not claiming that doctors ought to refuse any pathology inducing procedure like removing kidneys for transplant, blood for donation, or adult circumcisions for religious conversions. [↑](#footnote-ref-5)
6. It is also permissible to legally demand that doctors obtain informed consent. The recent novelty of this demand doesn’t show that medicine is a cluster concept or lacks am essence and is just an evolving set of practices. Paternalistic doctors are still doctors. They may not be doctors that patients want and they may not retain their license to practice medicine but they are still doctors. Since demanding doctors obtain informed consent doesn’t require them to induce pathologies, such demands are not at odds with medicine’s ends and so not a practice that doctor should be protected in their refusal to undertake. [↑](#footnote-ref-6)
7. I am not considering Christian Scientists and Jehovah Witnesses to be orthodox Christians. [↑](#footnote-ref-7)
8. However, it is actually not that obvious that this can be done without making paternalistic appeals to true interests not recognized by those who allegedly have such interests. There could be prisoners who think it is their interest to die than be in jail for life or they have become so guilt stricken that they want to die or just accept a theory of punishment where they have a fatal debt. [↑](#footnote-ref-8)