Revision Date: 2015-03-17

Medicine, morality and humanity

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Introduction

The College of Physicians and Surgeons of Ontario, the state regulator of the practice of medicine in the province, has approved a policy that requires all physicians who object to a procedure for reasons of conscience to facilitate the procedure by referring patients to a colleague who will provide it.[1] A policy to the same effect has been approved in principle by the College of Physicians and Surgeons in Saskatchewan, though it is now under review.[2]

Remarkably, no evidence was provided to justify the policy in either province. There is no evidence that even a single person in either Ontario or Saskatchewan has ever been unable to access medical services because of conscientious objection by a physician. Materials provided by the working group to the College Council in Ontario were deficient, erroneous and seriously misleading,[3] while the development of the policy in Saskatchewan was marked by what appears to be a pattern of concealment, selective disclosure, and false or misleading statements.[4]

Submissions made by the Protection of Conscience Project to the Colleges in Ontario and Saskatchewan during public consultations included a discussion of morality and medical practice which has been adapted for this presentation.

Medicine is a moral enterprise.

The practice of medicine is an inescapably moral enterprise precisely because physicians are always seeking to do some kind of good and avoid some kind of evil for their patients.[5] However, the moral aspect of practice as it relates to the conduct and moral responsibility of a physician is usually implicit, not explicit. It is normally eclipsed by the needs of the patient and exigencies of practice. But it is never absent; every decision concerning treatment is a moral decision, whether or not the physician specifically adverts to that fact.

This point is frequently overlooked when a physician, for reasons of conscience, declines to participate in or provide a service or procedure that is routinely provided by his colleagues. They may be disturbed because they assume that, in making a moral decision about treatment, he has done something unusual, even improper. Seeing nothing wrong with the procedure, they see no moral judgement involved in providing it. In their view, the objector has brought morality into a situation where it doesn't belong, and, worse, it is his morality.

In point of fact, the moral issue was there all along, but they didn't notice it because they have been unreflectively doing what they were taught to do in medical school and residency, and what society expects them to do.

Nonetheless, in deciding to provide the procedure they also implicitly concede its goodness; they would not provide it if they did not think it was a good thing to do. What unsettles them is really not that the objector has taken a moral position on the issue, but that he has made an explicit moral judgement that differs from their implicit one.

Hence, the demand that physicians must not be allowed to act upon beliefs is unacceptable because it is impossible; one cannot act morally without reference to beliefs, and cannot practise medicine without reference to beliefs. Relevant here is a comment by Professor Margaret Somerville. "In ethics," she writes,"impossible goals are not neutral; they cause harm."[6]

Once medicine is understood to be a moral enterprise, it becomes easier to understand why it is a mistake to think that moral or ethical views are unwelcome intruders upon the physician-patient relationship. Morality and ethics are actually intrinsic to it. Of course, some moral or ethical views may be erroneous, but that is a different matter that must be addressed by explaining why they are erroneous. It will not do to pretend, for example, that the claim that best medical practice in some circumstances means killing a patient does not involve at least implicit moral or ethical judgements.

Consistent with the practice of medicine understood as a moral enterprise, a physician first considers the well-being of the patient.[7] Patient-centred medical practice is directed to ensuring good medical care, but good medical care is not provided by automatons. Medical schools do not manufacture made-to-order products that perform according to factory default settings, or finely machined cogs that keep health care delivery apparatus running smoothly. Medicine is a moral enterprise, morality is a human enterprise, and physicians, no less than patients, are moral agents.

Morality is a human enterprise.

All public behaviour - how one treats other people, how one treats animals, how one treats the environment - is determined by what one believes. Some of these beliefs are religious, some not, but all are beliefs. This applies no less to "secular" ethics than to religious ethics. That human dignity exists - or that it does not - or that human life is worthy of unconditional reverence - or merely conditional respect - and notions of beneficence, justice and equality are not the product of scientific enquiry, but rest upon faith: upon beliefs about human nature, the meaning and purpose of life, the existence of good and evil.

That everyone is a believer reflects the fact that the practice of morality is a human enterprise,[8] but it is not a scientific enterprise. The classic ethical question, "How ought I to live?" is not a scientific question and cannot be answered by any of the disciplines of natural science, though natural science can provide raw material needed for adequate answers.

Answers to the question, "How ought I to live?" reflect two fundamental moral norms; do good, avoid evil. These basics have traditionally been undisputed; the disputes begin with identifying or defining good and evil and what constitutes "doing" and "avoiding." Such explorations are the province of philosophy, ethics, theology and religion.

Internationally, religion continues to be the principal means by which concepts of good and evil and right and wrong conduct are sustained and transmitted. Nonetheless, since the practice of morality is a human enterprise, reflections about morality and the development and transmission of ideas about

right and wrong also occurs within culture and society outside the framework of identifiable academic disciplines and religions.

In consequence, the secular public square is populated by people with any number of moral viewpoints, some religious, some not: some tied to particular philosophical or ethical systems, some not: but all of them believers. There is no reason to deny the freedom to act upon religious belief because it is religious: no reason, that is, apart from anti-religious bigotry.

Further, since morality is a human enterprise, moral judgement is an essential activity of every human person, moral judgement necessarily involves some kind of individual or personal conviction, and maintaining one's personal moral integrity is the aspiration of anyone who wishes to live rightly. Thus, beliefs are "personal," in the sense that one personally accepts them and is committed to them.

However, this does not mean that such "personal" beliefs are parochial, insignificant or erroneous. Christian, Jewish and Muslim beliefs, for example, are shared by hundreds of millions of people. They "personally" adhere to their beliefs, just as non-religious believers "personally" adhere to their non-religious beliefs. In neither case does the fact of this "personal" commitment provide grounds to set beliefs aside. Thus, it is important to recognize that pejorative or suspicious references to "personal" beliefs or "personal" values frequently reflect underlying and perhaps unexamined prejudice against them.

Notes

1. College of Physicians and Surgeons of Ontario, Policy #2-15: Professional Obligations and Human Rights (Updated March, 2015) (http://www.cpso.on.ca/Policies-Publications/Policy/Professional-Obligations-and-Human-Rights) Accessed 2018-03-07.

2. College of Physicians and Surgeons of Saskatchewan, Policy: *Conscientious Refusal* (http://www.consciencelaws.org/archive/documents/cpss/2015-01-20-cpss-policy.pdf).

3. Protection of Conscience Project, *Submission to the College of Physicians and Surgeons of Ontario Re: Professional Obligations and Human Rights, Appendix "B": Unreliability of Jurisdictional Review by College Working Group* (http://consciencelaws.org/publications/submissions/submissions-013-003-cpso.aspx)

4. Protection of Conscience Project, *Submission to the College of Physicians and Surgeons of Saskatchewan Re: Conscientious Refusal, Appendix "A"* (http://consciencelaws.org/publications/submissions/submissions-014-002-cpss.aspx) and *"B"*(http://consciencelaws.org/publications/submissions/submissions-014-003-cpss.aspx).

5. Maddock J.W. "Humanizing health care services. The practice of medicine as a moral enterprise." J Natl Med Assoc. 1973 November; 65(6): 501–passim. PMCID: PMC2609038 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2609038/?page=1) Accessed 2018-03-07.

6. Somerville M. "Why are they throwing brickbats at God?" MercatorNet, 1 June, 2007 (https://www.mercatornet.com/articles/view/why_are_they_throwing_brickbats_at_god)

Accessed 2018-03-07.

7. Canadian Medical Association, *Code of Ethics (2004)*: Fundamental Responsibilities No. 1. (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf) Accessed 2018-03-07.

8. This presumption obviously underlies standard bioethics texts. See, for example, Beauchamp TL, Childress JF, *Principles of Biomedical Ethics* (7th ed) New York: Oxford University Press, 2013.