Freedom of Conscience and the Needs of the Patient

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Introduction

The presentation on fetal surgery caused me to reflect upon what might happen, some time in the future, if surgery to correct a congenital abnormality were unsuccessful. How would the surgeons or nurses who assisted respond, if they were asked, three weeks later, to inject potassium chloride into the heart of their former patient, in preparation for a genetic termination?[1] If one or two declined, for reasons of conscience (as opposed to personal discomfort), might they jeopardize their continued employment or opportunities for promotion?[2]

The theme of this conference - *New Developments - New Boundaries* - reminds us that developing technologies have the potential to deliver improved health care, but will probably force you to deal with increasingly frequent or complex conflicts of conscience in your work. It is becoming more important - not less - to talk about freedom of conscience in health care.

Today I am going to focus on the terms in the title of this presentation - freedom, conscience, and needs - touching, in one place, upon ethics, and concluding with a reflection upon faith and the notion of moral neutrality.

Needs

Three years ago there was a conference of hospital pharmacists here. An ethicist put to the group the hypothetical case of a 16 year old girl who goes to the town's only pharmacist for the morning-after-pill. In the ethicist's scenario, the pharmacist is morally opposed to dispensing the drug, there are no other health care providers available, and no other town within a day's travel. When the assembled pharmacists could not reach a consensus on how their luckless colleague should respond, the ethicist gave them the 'correct' answer. . "From an ethical standpoint, regardless of your beliefs, in that situation your responsibility is to the patient and patient care, to address that patient's needs."[3]

A nice, neat answer, but one that illuminates the hidden faith of the ethicist rather than ethical principles.[4]

Loosely defined, a need is some good that is essential for the good of the patient. If the morning-after-pill is not a *bona fide* need, pharmacists are not obligated to dispense it. On the other hand, if it is a *bona fide* need, it is possible to argue that, at least in some circumstances, such as those in the ethicist's myth, pharmacists *are* obliged to dispense it. The same principle applies to other medical procedures or services.

It all depends upon what one means by "need", and this is where the faith of the ethicist came in. He believed that the morning-after-pill was essential for the good of the hypothetical 16 year old girl, and his ethical conclusion was based upon that belief. Substitute some other morally controversial procedure for the morning-after-pill, and you will see what I mean.

Let's suppose what was wanted was not the morning-after-pill, but something else. I'm afraid that I will have to get into something here that I'd really rather avoid: apotemnophilia - the overwhelming desire to become an amputee for purposes of sexual gratification or to conform to one's self-image as someone without a leg, or an arm, or other appendage.

Consider the case of Ronald Brown. In 1998 Brown amputated the healthy lower leg of apotemnophiliac Phillip Bondy, whose desire to become an amputee arose from a sexual fetish. When asked by a journalist why he had cut off Bondy's leg, Brown explained that he was doing only what any good doctor would do; he was responding to the needs of his patient. [5]

Consistent with the World Health Organization's definitions of health, Bondy no doubt perceived that the amputation of his healthy lower leg would lead to an improvement in his "mental and social well-being."[6] Had Brown been a competent surgeon, the amputation might have helped Bondy to 'realize his aspirations and satisfy his needs.'[7] Unhappily, Brown was an incompetent butcher, and Bondy died of gas gangrene two days after the operation.[8]

Was Brown - a defrocked practitioner with dubious qualifications as a surgeon[9] - correct in his judgement that amputation of a healthy limb is an ethical response to apotemnophilia?

That was the view of Dr. Robert Smith of the Falkirk & District Royal Infirmary in Scotland. The year after Bondy's death, he disclosed that he had performed single leg amputations on two apotemnophiliacs, whose desire for amputation was not sexually motivated. The surgery was performed with the permission of the Medical Director and Chief Executive of the hospital, in a National Health Service operating theatre with NHS personnel, after consultation with the General Medical Council and professional bodies.[10] Dr. Smith described it as "the most satisfying operation I have ever performed,"[11] and it is clear that he derived his satisfaction from his perception that he had met the needs of his patients.[12]

If we take the ethicist's advice that one is obliged to address patients' needs regardless of one's

beliefs, and if we accept Dr. Smith's view that the amputations did just that, does this not imply that health care practitioners may be required to perform or assist in such surgery, especially if one is the only surgeon in an isolated community, and the patient may, if denied surgery, resort to self-amputation with a chain saw or log splitter?[13] Should the medical profession, if it advocates a policy of non-judgemental harm reduction, not ensure that apotemnophiliacs have timely access to safe amputations?

The principles of bioethics seem to support this conclusion. Clearly, Dr. Smith respected the autonomy of his patients. Assuming that he adhered to the principle of informed consent, no injustice was done to them. Nor did injustice arise from the imposition of additional costs on the public health care system, since the patients paid for the surgery. One could argue that this was a particularly egregious example of the injustice of two-tiered health care, but the argument is hardly conclusive, and could be answered simply by adding elective amputations to the list of approved surgery. The patients themselves would argue that the principle of non-maleficence was not offended. On the contrary, they would assert that the amputations had a beneficent effect.

It appears, then, that voluntary amputation of healthy limbs is not inconsistent with the World Health Organization's definition of health, nor with bioethics principlism. This was, perhaps, why professional and regulatory authorities in the United Kingdom supported Dr. Smith. Yet all of this was quite lost on the doctor who learned, at the last moment, that Brown wanted him to assist in amputating a healthy limb. He told the patient (in a fit of 'strong paternalism') "This isn't right! You don't want this!" and stormed out of the room.[14] Conscientious objection in the raw, one might say. Or was he, as others would have it, "imposing his values on the patient"?

Now, I am not asking you to accept this or that view of the ethics of voluntary amputation. But I am directing your attention to the way in which the definition of "needs" controls subsequent ethical discussion, and - more important - that our definition of needs depends entirely upon what we believe to be conducive to human well-being.

This brings us to the essential point. What is conducive to human well-being is determined by the nature of the human person.[15] We cannot agree upon what is good for the patient without first agreeing upon that. That is what determines not only how we define the needs of the patient, but how we approach every moral or ethical problem in medicine. Doctors Brown and Smith believed that they did nothing contrary to the essential nature of their patients by cutting off healthy limbs, and were thus acting morally. The doctor asked to assist Brown had quite the opposite view.

What must be emphasized is that when we cannot achieve a consensus about the morality of a procedure, it is frequently because we are operating from different beliefs about the nature of the human person. Disagreement is seldom about facts - the province of science - but about what to believe in light of them - the province of philosophy and religion. Hence the term "hidden faith".

Unfortunately, this is frequently obscured in scenarios like that proposed by the ethicist, which

demand that everyone accept the hidden philosophical or religious faith-assumptions of the presenter in order to reach the 'correct' ethical conclusion. And if they refuse to abandon their own philosophical or religious convictions in favour of those of the presenter, they are likely to be accused of 'imposing their morality'. To clear the air during such discussions, it is frequently helpful to substitute a different moral problem for the one being considered. Replace the morning-after-pill with something more controversial - voluntary amputations of healthy limbs - and reflect on how the change affects the positions taken, and why.

Well, I suppose I have not precisely defined what is meant by the needs of the patient. But, in what might prove to be an arduous dialogue, we must start somewhere. To make a start, it is enough to point out what must be attended to in discussion between moral strangers.

Ethics-as-tools and ethics-as-identity

Among the points that must be attended to is the distinction between what Professor Frederic Hafferty and Dr. Ronald Franks have identified as "ethics-as-tools and ethics-as-identity". How often have you heard someone say, "I am personally opposed to X, but I can't let my personal morality influence my public or professional responsibilities"?

This statement reflects, in the words of Hafferty and Franks, "a view of ethics that frames ethical principles as *tools* to be employed . . . something that can be picked up or put down, used or discarded, depending upon the situation or circumstances involved . . . an instrument for manipulation much like any of the more technological tools medicine has at its disposal."[16]

One keeps several ethical toolboxes on the shelf by the back door: one for the home, one for the office, another, perhaps, for the political arena. Use the right tool for the right job, and don't embarrass yourself and your colleagues by bringing the wrong toolbox onto the ward. Hafferty and Franks observed that this "rather limited and task-oriented view of ethics" is the "prevailing sentiment, at least within the basic science faculty of medical schools."[17]

In contrast, a conscientious objector does not instrumentalize moral and ethical norms, but *internalizes* them. They are not tools for solving problems, but form part of his identity. And a human person has only *one* identity, served by a single conscience that governs his conduct in private and professional life. We identify this as the virtue of personal integrity.[18]

The ethics of the profession

Unfortunately, personal integrity is challenged by claims to moral supremacy (if not absolute ethical infallibility) that are made, not only by some ethicists, but by some professional organizations. This is reflected, for example, in a statement that appeared in a controversial bulletin from the Ethics Advisory Committee of the College of Pharmacists of British Columbia:[19]

> The moral position of an individual pharmacist, if it differs from the ethics of the profession, cannot take precedence over that of the profession as a whole.

The bulletin demanded that pharmacists who had conscientious objections to services refer patients to someone who would provide them, "and in the end deliver these services themselves if it is impractical or impossible for patients to otherwise receive them."

The Ethics Committee listed a number of services then available that might give rise to conscientious objection. Consistent with our theme of *New Developments - New Boundaries*, the Ethics Committee also put pharmacists on notice:

> In future these services might expand to include preparation of drugs to assist voluntary or involuntary suicide, cloning, genetic manipulation, or even execution.

Yes, *involuntary* suicide. The College Registrar continued the thought in correspondence, observing, however, that "there are strong ethical arguments that could be made against participating in . . .involuntary suicide . . ."[20]

But don't be alarmed. This was, the Registrar later explained, a slip of the pen. What was really meant was "involuntary *euthanasia*".[21]

Well, I suppose you needn't be concerned about euthanasia, voluntary or otherwise. In your field, you deal with far less complicated and controversial issues: simple things like genetic screening, cloning, embryo research, stem cells, diagnostic ultrasound, life and death before birth, and so forth.

Are you not, all of you, perfectly at ease in surrendering your conscientious convictions about these things and accepting "the ethics of the profession" - whatever those might happen to be, from time to time? After all, how can one justify applying his personal or private morality in health care, especially in *public* health care?

The question is framed so as to portray conscientious objectors as narrow-minded, eccentric, and even selfish, attempting to discredit them precisely because theirs is a minority view. But this approach cuts both ways. The beliefs of many conscientious objectors, while certainly personal in one sense, are actually shared with tens of thousands, or even hundreds of thousands or hundreds of millions of people, living and dead, who form part of great religious, philosophical and moral traditions. If theirs is a 'private' morality, that of an early 21st century profession with several thousand members is not less so.

The question does not turn on privacy, but truth. If "the ethics of the profession" express a truer moral vision than the ethics of the objector, then it is clear that "the ethics of the profession" ought to prevail. Those who would suppress the conscientious convictions of their colleagues should be able and willing to explain first, why they are better judges of morality, and, second, why their judgement should be forced upon unwilling colleagues. Avoiding the issue by hiding behind noble sounding phrases like "the ethics of the profession" will not do.

Freedom and autonomy

We have had an example of "conscientious objection in the raw". How about freedom in the buff,

courtesy Christie Blatchford of the National Post, reporting on a protest demonstration last month in downtown Toronto? Two minutes after watching two protesters drop their trousers and defecate on a public sidewalk, she encountered other protesters, faces concealed by balaclavas and kerchiefs, dragging news and mail boxes into the street and throwing them into traffic.

> [A] grown man about my age with long white hair and a beatific attitude burbled with delight and remarked, because he simply could not help himself he was so delighted, "Isn't it beautiful?" . . ."I meant democracy," the man said. "I meant, isn't democracy beautiful?"[22]

The story illustrates how the concept of autonomy dominates our understanding of freedom. Freedom is interpreted almost exclusively as freedom *from*: freedom from constraint, from rules, from direction, from guidance, from immutable principles - even from good manners.[23] This cultural obsession with autonomy introduces two complications into discussion about freedom of conscience in health care.

First: just as some ethicists reject freedom of conscience in health care in order to defend *patient* autonomy, some health care workers defend conscientious objection as an expression of *professional* autonomy. Both approaches are to be rejected. As lawyer and social critic Iain Benson observes, conflicts about involvement in a procedure cannot be settled by unilateral claims to autonomy because the autonomy of two parties is involved. In such conflicts, one applies principles of justice, not autonomy.[24]

The second complication is a tendency to politicize the concept of freedom of conscience. This occurs because we habitually associate freedom with *political* freedom: freedom from constraint by more powerful interests or the state. But this political interpretation of freedom, so esteemed by the white-haired gentleman in Toronto - and by others with more sense and better reasons - is actually very narrow.

The more liberal and profound interpretation of freedom is freedom *for*: for discerning the good that needs to be done, for choosing the good, for doing good. This kind of freedom is the condition necessary for the internalization of ethical and moral norms that shape the identity of the person. This freedom is liberating, but it is also confining, for it imposes an obligation to distinguish true goods from false, higher goods from lesser. It demands that one form convictions about what is truly good, and live accordingly. One is not free to believe that truth doesn't matter.[25]

And that is a source of conflict, for the prevailing cultural sentiment is that truth doesn't even exist.

Unless, of course, the protester is defecating on my living room rug.

Well, I have failed to define the needs of the patient, given you two different views of ethics and two different notions of freedom. If you are not yet confused, be patient. I'm about to describe three different ideas about conscience.

Conscience

The first, and traditional view, is that conscience is an intellectual faculty that judges whether an act is morally good or evil. The conscience judges correctly only when the judgement accords with objective reality and an objective standard of morality. Thus, one is first obliged to ascertain relevant facts - say, what correct science tells us about stem cells - and then determine what objective moral principles apply.

This means, of course, that conscience can err in two ways; it can be mistaken as to the facts, and it can be mistaken in its choice of principles.[26] In view of this, one must not act on a doubtful conscience, for if one acts on a doubtful conscience, one will be morally responsible for any evil that follows. Is the movement in the bush a moose or my hunting partner? Clear up the doubt before pulling the trigger; 99% probability isn't good enough. Is deliberately killing an innocent human being in order to put an end to his suffering a good or an evil thing to do? Clear up the doubt before lethally injecting the patient. Some mistakes can't be corrected.

The obvious corollary is that one may be prevented from acting on an erroneous conscience in order to prevent harm to others.

The second, and probably the prevailing understanding of conscience, is that it is an intellectual faculty that independently constructs personal moral norms. One's conscience actually *creates* right and wrong. Conscience becomes the great liberator, to which one appeals against any restrictive moral precept on the ground that my conscience has determined that this is "right for me," or at least "right for me in these circumstances." Taken to its logical conclusion, this means that conscience - which *makes* the rules about right and wrong - cannot err, and we are left to deal with freedom of conscience as it was understood by Adolph Eichmann and Dr. Karl Brandt, both of whom were hanged for their part in Nazi atrocities.[27]

The third idea about conscience is that it is simply a faculty that senses one's 'comfort level'. Whether comfort or discomfort is related to the morality of a procedure is beside the point - especially when one does not want to offend one's colleagues. On the other hand, sacrificing one's personal 'comfort' to help the patient can be portrayed as the noble thing to do - or, perhaps, the only ethical thing to do. That was why you became a doctor, wasn't it? Again, one is not faced here with the possibility of error. Feelings are never wrong.

Now, to be quite clear, the Protection of Conscience Project understands conscience in the first sense, which, as you have noticed, admits that conscience can err. Nonetheless, we do not fear freedom of conscience, for objective reality and objective moral standards provide both the means to determine that it has erred, and the justification for limiting it when necessary.

On the other hand, people who think that conscience creates right and wrong or merely monitors personal comfort levels, quite logically fear freedom of conscience. Since their understanding does not include the possibility of error, they acknowledge no principle by which such freedom can be

limited, and cannot conceive of a society that could survive if conscience, as *they* understand it, were to be let off its leash. Neither can I.

There is a consensus, then, that freedom of conscience is not unlimited. The disagreement, when it arises, is about how to fix its limits, and why. How are we to do this, especially in a pluralistic society?

I believe that Dr. Morcos has made a start by offering this forum for discussion, and I thank them for their invitation to speak. Constructive dialogue, with particular attention to discovering the roots of disagreement, is indispensable. That should continue.

Implicit and explicit faith

But constructive dialogue will not take place unless we are prepared to recognize the faith-assumptions of all parties in dialogue. I mentioned the key concept of the human person, but there are other 'articles of faith'. One of the most widespread dogmas is that faith has no place in public and professional life. Faith, so the argument goes, is unreliable and divisive because it is unscientific, and must be confined to the strictly private sphere in the interests of social harmony and progress.

But that human dignity exists -or that it does not - or that human life is worthy of unconditional reverence - or merely conditional respect - and the principles of beneficence, non-maleficence, justice and autonomy, are all held on faith.

They may held by religious believers as derived from divinely revealed truth, by principled moralists (whether religious, atheistic or agnostic) who have derived them from various sources, or by the indifferent, who have them from traditions they do not understand. But in all cases we are dealing with belief, not facts that have been or can be established by science.

So you are believers - all of you. You believe that today is November 11th, because that is what you have been told. You believe that something momentous occurred on this day in 1918, because that is what you have been told. You believe that you were born on a certain day in a certain place and in a certain year, to a particular mother and father, because that is what you have been told. And you believe in human dignity, equality and justice, but not because they are scientific facts that have been established by experiment. The most momentous decisions in life - to marry this particular man or woman, to have children, to choose a life of service - are not only acts of love, but great acts of faith. Banish faith from life and you will banish with it the possibility of human society and much that contributes to human happiness.

So, we are believers, all of us. Some of us profess explicit religious beliefs, others live by implicit non-religious beliefs. But, "[e]veryone 'believes'," writes Iain Benson. "The question is what do we believe in and for what reasons?"[28]

The myth of moral neutrality

Finally, we will make no progress in dialogue unless we abandon claims to moral neutrality.

Something that is good may be done; so, too, may something that is morally neutral. Only if something is evil is one obliged to avoid participation in it.[29] But the statement that a procedure is good, neutral or evil presumes a moral standard against which the procedure has been measured, and a conclusion that one may do X is necessarily based upon that moral standard.

Thus, the dogmatic claim that "secular ethics" or "the ethics of the profession" are morally neutral is to be rejected not only as a fiction, but, to quote Professor J. Budziszewski, as "bad faith authoritarianism . . . a dishonest way of advancing a moral view by pretending to have no moral view."[30]

Closing

You will note that I have not attempted an apology for freedom of conscience, so you will not leave here with slogans to brandish, a handy list of pros and cons or practical advice on how to avoid being sued. Instead, I have offered a number of observations and reflections on words that we too often take for granted, and cause us to stumble: needs, ethics, freedom, conscience, and faith.

In preparing this presentation, my goal has been to establish the foundation for constructive reflection and respectful discussion over the longer term. Ultimately, I hope that your discussions with colleagues will be more productive and your disagreements more fruitful for having considered the points I have put before you.

Once more, I thank Dr. Morcos for providing this opportunity to speak, and I thank you for your attention.

Notes

1. Walker, Robert "MDs face Internet restrictions: Prescription ban Canadian first". *The Calgary Herald* 10 June, 2000. The practice is endorsed by the College of Physicians and Surgeons of Alberta. Its introduction followed a controversy about infant deaths at the Foothills Hospital. Ko, Marnie, "Personal Qualms Don't Count: Foothills Hospital Now Forces Nurses To Participate In Genetic Terminations." *Alberta Report Newsmagazine* (now *The Report*) 12 April, 1999. (http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-01.html)

2. For an analogous situation, see Murphy, Sean, *Nurse Refused Employment, Forced to Resign: A Two Tiered System of Civil Rights*.
(http://www.consciencelaws.org\Repression-Conscience\Conscience-Repression-03.html)

3. Thatcher, Chris, "The Pharmacy Conscience Clause: Coming to Terms with an Ethical Dilemma." Canadian Pharmaceutical Journal, March, 2000, P. 28.

4. Lawyer Iain Benson, Executive Director of the Centre for Cultural Renewal, calls this "the hidden faith of the new secularity." Benson IT. Notes Towards a (Re) Definition of the "Secular". (2000) 33 *U.B.C. Law Review*. 519-549, Special Issue: "Religion, Morality, and Law", P. 521.

5. "In cosmetic surgery we do things all the time for which there is no need. We are constantly rearranging what God gave us." Ciotti, Paul, *Why Did He Cut Off That Man's Leg? The Peculiar Practice of Dr. John Ronald Brown.* (http://www.ampulove.com. Accessed 4 October 2001)

6. In 1948 the World Health Organization defined health as " a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Quoted in Dugas, Beverly Witter and Emily R. Knor, *Nursing Foundations: A Canadian Perspective*. Scarborough, Ontario: Appleton & Lange Canada, 1995, P.9.

7. "Health is defined as the extent to which an individual or group is able, on one hand, to realize aspirations and satisfy needs . . ." (World Health Organization, 1984) Quoted in Dugas, *supra*, P.20

8. Ciotti, *supra*.

9. Brown graduated from the University of Utah School of Medicine in August, 1947, and spent 20 years as a general practitioner before obtaining formal surgical training. He failed to become certified by the American Board of Plastic Surgery. In 1977 his licence to practise was revoked by the California Board of Medical Quality Assurance for "gross negligence, incompetence and practising unprofessional medicine in a manner which involved moral turpitude." After losing licences to practise in Hawaii, Alaska and St. Lucia he set up an unlicensed practice, living in southern California and performing sex-change surgery in Mexico. He was eventually jailed for 19 months for practising medicine without a licence. He had resumed his unlicensed practice when Bondy was introduced to him. (Ciotti, *supra*)

10. Ramsay, Sarah, "Controversy over UK surgeon who amputated healthy limbs". *The Lancet*, Volume 355, Number 9202, 05 February 2000. Dr. Smith waived his fee and the patients paid for the surgery. (http://www.thelancet.com. Accessed 4 October, 2001)

11. ABC News Internet Ventures, *Surgical Questions Raised Over Amputations of Two Healthy Legs.* (http://www.ampulove.com/ Accessed 4 October 2001.)

12. "I have no doubt that what I was doing was the correct thing for those patients . . . Following amputation, they both made a rapid and satisfactory recovery without complications. At follow-up both patients remain delighted with their new state." Ramsay, *supra*.

13. Bioethicist Carl Elliott, discussing the phenomenon of apotemnophilia, reported that one woman had unsuccessfully tried to induce gangrene in her legs, and was considering other self-inflicted injuries -like lying under a train - that would necessitate amputation. In researching his article he interviewed an amputee who had used a log splitter to precipitate eventual surgical amputation. Elliott, Carl, "A New Way to be Mad". *The Atlantic Monthly*, December, 2000. (Digital Edition: http://www.theatlantic.com/issues/2000/12/elliott2.htm. Accessed 4 October, 2001.)

14. The patient was apotemnophiliac Gregg Furth. The abrupt departure of the doctor forced cancellation of the surgery, and by the time Brown had found a replacement, Furth had changed his mind about amputation. He suggested his friend, Bondy, as a substitute. Ciotti, *supra*.

15. One must make a critically important distinction between human *being* and human *person*. In Canadian law, *human being* is defined by section 223 of the Criminal Code as a child who has "completely proceeded, in a living state, from the body of its mother". Canadian jurisprudence indicates that the term *human person* and *human being* (as defined in section 223) are synonymous. There are historical, legal and political reasons for this, but I am not, in the present context, concerned with law. The subject here is the relationship between science and philosophy.

It is the province of science to determine when a human individual begins to *be* - that is, to exist. The existence of a human *being* is a purely biological matter. Standard texts on human embryology are clear on this point, and there is no need to go into that here. (Carlson, Bruce M. *Human Embryology and Developmental Biology.* St. Louis, MO: Mosby, 1994, P. 31; Moore, Keith L. and T.V.N. Persaud, *The Developing Human*. Philadelphia: W.B. Saunders Company, 1998, P. 2; Müller, Fabiola and Ronan O'Rahilly, *Human Embryology & Teratology*. New York: Wiley-Liss, 1994, P. 19-20; Larsen, William J.,*Human Embryology.* New York: Churchill Livingstone, 1997, P. 1. See also Irving, Dianne N., When do Human Beings Begin? "Scientific" Myths and Scientific Facts. *International Journal of Sociology and Social Policy 1999, 19:3/4:22-47*, also available at
http://consciencelaws.org\Examining-Conscience-Issues\Background\GenScience\BackGenScience01.html

However, science cannot determine what moral obligations are called forth by the existence of a human being. Equally important, while science can establish that a human *being* is in existence, it cannot determine that the individual is a human *person*. That is a philosophical question, and science is not competent to decide philosophical questions. Its correct and limited role is to provide factual data that philosophers and ethicists incorporate into their deliberations.

16. Hafferty, Frederic, PhD, and Ronald Franks, MD, "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education." *Journal of Academic Medicine*, Vol. 69, No. 11,

November, 1994, P. 862. The identity considered by the authors is a *professional* identity, and, to the extent that they separate personal and professional identities in the same person, they actually adopt the "ethics-as-tools" approach that they critique. Nonetheless, the author is indebted to them for their insight, which is applied here in a manner that is probably different from what they intended.

17. *Ibid*, P. 864.

18. The notion that one person can maintain two different moral identities was explored by Robert Louis Stevenson in *Dr. Jekyll and Mr. Hyde.* "Though so profound a double-dealer, I was in no sense a hypocrite; both sides of me were in dead earnest; I was no more myself when I laid aside restraint and plunged in shame, than when I laboured, in the eye of the day, and the furtherance of knowledge or the relief of sorrow and suffering . . . I thus drew steadily nearer to that truth by whose partial discovery I have been doomed to such a dreadful shipwreck: that man is not truly one, but truly two . . . others will outstrip me on the same lines; and I hazard the guess that man will ultimately be known for a mere polity of multifarious, incongruous and independent denizens." Stevenson, Robert Louis, *Dr. Jekyll and Mr. Hyde & The Merry Men and Other Tales and Fables*. Ware, Hertfordshire: Wordsworth Classics, 1999, P. 42.

Also relevant here is the theory of 'doubling' proposed by Robert Jay Lifton as an explanation for the participation of German physicians in Nazi medical atrocities. While not suggesting that they suffered from some kind of multiple personality disorder, Lifton explores the process by which men, who, in their 'personal or private lives', perhaps enjoyed reputations as caring, sensitive, etc., could have committed atrocities in the discharge of their public functions. His disturbing conclusion: (P. 427) "most of what Nazi doctors did would be within the potential capability - at least under certain conditions - of most doctors and of most people." Lifton, Robert Jay, *The Nazi Doctors: Medical Killing and the Psychology of Genocide.* Basic Books, 1986, P. 418-465.

19. College of Pharmacists of British Columbia Bulletin, *Ethics in Practice: Moral Conflicts in Pharmacy Practice*. March/April 2000, Vol. 25, No. 2, P. 5. For further information about the bulletin and related issues, see Project Report 2001-01, *College of Pharmacists of British Columbia: Conduct of the Ethics Advisory Committee,* 26 March, 2001. (http://www.consciencelaws.org/Conscience-Project-Reports/Report-2001-01.html)

20. Letter from the Registrar of the College of Pharmacists of British Columbia to the Project Administrator, 19 April, 2000.

21. Letter from the Registrar of the College of Pharmacists of British Columbia to the Project Administrator, 9 May, 2000.

22. Blatchford, Christie, "Post-Sept. 11, clowns' antics deplorable: Protesters burn U.S. flag, slash tires: 'This is what democracy looks like'". *National Post*, 17 October, 2001.

23. Certainly, freedom *from* may be a condition necessary to pursue some good, as when one must be free *from* some commitments in order to pursue others. The point here is that our cultural obsession with autonomy encourages the feeling that freedom is synonymous with escape and with limitless possibilities. In contrast, writes Professor Robert Spitzer, S.J., "one *feels* unfree, hemmed in, or even enslaved when new responsibilities are "imposed", or when one is forced to focus on one course of action rather than another." Spitzer, Robert J., with Robin A. Bernhoft and Camille E. De Blasi, *Healing the Culture: A Commonsense Philosophy of Happiness, Freedom and the Life Issues.* San Francisco: Ignatius Press, 2000, P. 209-210) The author follows Professor Spitzer, S.J., in his development of the theme of freedom *from* and freedom *for*.

24. "In medicine where two people are involved, autonomy is always a two-way street. Yes, the patient or "client" has his or her autonomy; but so, too, does the practitioner. There is no good reason (except perhaps one grounded in an anti-religious bias) to advocate that a patient's autonomy should trump the autonomy of the professional health-care worker just because the two views conflict. What is needed . . . is an examination of how to accommodate conscience and religious views within the contemporary technocratic and often implicitly anti-religious paradigm of certain aspects of modern medicine. In case anyone has missed it, the question of whether anything is "given" with respect to human persons is going to be, in many cases, *the* issue in coming decades as various issues in human genetics begins to unroll their discoveries and possibilities into the various areas of society (medicine, ethics and law included). An analytical framework of some sophistication is necessary to ensure maximal respect for and accommodation of differing views in society."

"The real issue, where there is a conflict of views between people regarding involvement with a procedure or drug, is not settled by reference to one person's "autonomy" but by reference to another principle, that of "justice" (defined as "rendering a person their due……"). For it is there, in the order of justice, that competing claims must be reconciled in a manner that accords with the rule of law (including professional ethics and respect for professional disagreement), the provision of health-care and the developed understanding of a civil society."
Benson, Iain T., *"Autonomy", "Justice" and the Legal Requirement to Accommodate the Conscience and Religious Beliefs of Professionals in Health Care*. (Revised March 2001) (http://www.consciencelaws.org\Examining-Conscience-Issues\Legal\Articles\Legal04.html)

25. "The ignorant man is (in a way) free to think what he likes: increasing knowledge will reduce that kind of freedom. At the moment, I am myself free to believe anything I like about (say) brain surgery, or the economics of Nicaragua. I am also, and for that reason, totally unable

to do anything about either of those important matters. If I chose to get educated about either of them, the process would involve a progressive diminution of my present glorious freedom of belief. I would thus become a free man in fields where I am now crippled and helpless; but for this freedom I would have to pay the price of accepting the determinate and objective nature of reality in those fields and conforming my mind to it. I would become more free in one way, and less free in another." Derrick, Christopher, *Escape from Scepticism: Liberal Education as if Truth Mattered*. San Francisco: Ignatius Press, 1977, P. 70-71.

26. Professor J. Budziszewski identifies four ways in which these two kinds of errors can come about: inexperience, insufficient skill in reasoning, inattention and perversion of reasoning by corrupt habits, customs, impaired dispositions, self-deception, etc. Budziszewski, J., "Handling Issues of Conscience." *The Newman Rambler*, Vol. 3, No. 2, Spring/Summer 1999, P. 3. (www.consciencelaws.org\Examining-Conscience-Issues\Ethical\Articles\Ethical07.html)

27. "I was no more than a faithful, decent, correct, conscientious and enthusiastic member of the SS and of the Reich Security Headquarters . . . I did my commanded duty with a clear conscience and a faithful heart." - Adolph Eichmann. Von Lang, Jochen and Sibyll, Claus (Ed.), Ralph Manheim (Trans.), *Eichmann Interrogated: Transcripts from the Archives of the Israeli Police.* New York: Farrar, Straus & Giroux, 1983, P. 289-290

"I have always fought in good conscience for my personal convictions and done so uprightly, frankly and openly." - Dr. Karl Brandt. The statement was made in June, 1948, before he was hanged for his involvement in the Nazi euthanasia programme. "Brandt is, more than any other doctor, the prototype of what I shall call the 'decent Nazi'. . . The 'decent Nazi' did much of the work of the regime and was indispensable to Nazi mass murder." Lifton, Robert Jay, *The Nazi Doctors: Medical Killing and the Psychology of Genocide.* Basic Books, 1986, P. 117

28. Benson, Iain T., "There are No Secular 'Unbelievers'". *Centrepoints 7*, Vol. 4, No. 1, Spring 2000, P. 3. (http://www.consciencelaws.org/Examining-Conscience-Issues/Ethical/Articles/Ethical10.html)

29. The point being made here does not require an exploration of the more complex approach to the morality of human acts taken by Aristotle and St. Thomas Aquinas.

30. "The question of neutrality has been profoundly obscured by the mistake of confusing neutrality with objectivity... neutrality and objectivity are *not* the same... objectivity is possible but neutrality is not. To be neutral, if that were possible, would be to have no presuppositions whatsoever. To be objective is to have *certain* presuppositions, along with the manners that allow us to keep faith with them. We presuppose that we exist, that our students exist, and that we exist in a really existing world. We presuppose that perception is not wholly illusion, and that the

consequent relation - - 'if this, then that' - - does correspond to something in reality. We presuppose that nothing can both be and not be in the same sense at the same time. We presuppose that good is to be done and truth is to be known. We presuppose that we should never directly intend harm to anyone. And so forth." Budziszewski, J., "Handling Issues of Conscience." *The Newman Rambler*, Vol. 3, No. 2, Spring/Summer 1999, P. 4. (http://www.consciencelaws.org\Examining-Conscience-Issues\Ethical\Articles\Ethical07.html)