



Protection of Conscience Project

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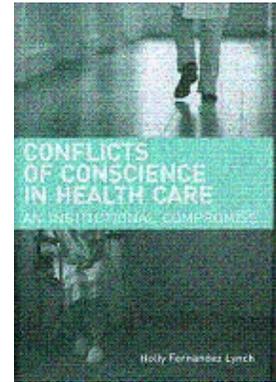
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Conflicts of Conscience in Health Care: An Institutional Compromise

Holly Fernandez Lynch
Cambridge, Mass.
The MIT Press 2008



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Introduction

Conflicts of Conscience in Health Care was published in 2008 as the 24th volume in the Basic Bioethics series from the Massachusetts Institute of Technology. It is an American book dealing with the American political and legal controversies over freedom of conscience in health care. However, the discussion of the American experience by Holly Fernandez Lynch is relevant elsewhere, since the United States has the most extensive and varied network of protection of conscience legislation in the world.

While acknowledging that freedom of conscience is of concern to all health care workers and institutions, Fernandez Lynch focuses exclusively on physicians.¹ This carefully and deliberately restricted focus is one of the strengths of the book.

After a preface and introduction, discussion and argument occupy about 260 pages, supplemented by 53 pages of end notes, many of which offer expanded comment on the text. A good 12 page index has been included, as well as four pages of cited statutes and cases. The earliest source found in a list of 300 references is from 1951; the rest date from 1972 to 2007.

Goal

The author introduces her subject with a statement from Pope John Paul II:

... to refuse to take part in committing an injustice is not only a moral duty, it is also a basic human right. Were this not so, the human person would be forced to perform an action intrinsically incompatible with human dignity, and in this way human freedom itself, the authentic meaning and purpose of which are found in its orientation to the true and the good, would be radically compromised.²

Fernandez-Lynch does not argue from a Catholic or even religious perspective. Nonetheless, she describes this as “a powerful statement about

the nature of conscience, complicity in morally objectionable actions, and avoidance of injustice.” She adds that it is generally acceptable to religious and nonreligious people alike, regardless of their political views.³

This reflects the spirit in which she pursues her project. As the subtitle of the book indicates, she is seeking a compromise that will provide “maximal liberty for all parties.”⁴ She believes that freedom of conscience for physicians and the provision of legal medical services are both important social goals, and that they are not incompatible.⁵ Thus, she rejects “all-or-nothing” strategies that seek “total victory.”⁶ Ultimately, quoting the Protection of Conscience Project,⁷ she affirms that all legitimate concerns can be met by “dialogue, prudent planning, and the exercise of tolerance, imagination and political will.”⁸

Context of the discussion

The author recognizes that she writes with the abortion controversy more or less continuously in the background. But she insists - correctly, in the Project’s view - that “limiting the debate to tired abortion rhetoric could be quite dangerous if it prevents meaningful discussion” of broader issues.⁹ Referring to a number of other controversial issues and the impact of ongoing technological developments,¹⁰ Fernandez Lynch predicts that these, combined with “increasing diversity of health-care providers” have “the potential to create a perfect storm.”¹¹

Overview

The shape of the compromise proposed by Fernandez Lynch can be outlined while describing the book’s structure. It consists of three main parts.

The first reviews American protection of conscience laws and examines four paradigms of medical professionalism.¹² The author selects one of these paradigms - physician as gatekeeper - as most suited to the compromise she seeks.¹³

In Part II, Fernandez Lynch explains what she believes to be the source of the current controversy. Applying the professional model of physician as gatekeeper, she observes that an objecting physician may sometimes be the only available “gatekeeper” who can open the gate to a desired service. Her solution: tell patients about other gates and gatekeepers, redistribute them, and, if necessary, provide more gates and more gatekeepers.¹⁴ Or, to paraphrase anti-euthanasia activists, if access is the problem, eliminate barriers to access, not objecting physicians.

To accomplish this, the author suggests that a designated institution ensure access to services through effective distribution of health care resources and connect patients with willing physicians.¹⁵ Hence, the subtitle of the book: an *institutional* compromise. Fernandez-Lynch identifies state licensing boards as the institutions best placed to accomplish this.¹⁶ The last two thirds of the book describes how the compromise might be implemented in practice. It includes a model statute and extended discussions about calculating patient demand and meeting it through the supply of willing physicians.

The structure of the compromise

Fundamental requirements

Compromise can be defined as a solution that is equally unacceptable to all parties, and the author recognizes that her proposal may be viewed in that light.¹⁷ She also warns that “no compromise . . . can fix every problem for every party.”¹⁸

Fernandez Lynch identifies two key conditions for compromise: avoiding harm to patients,¹⁹ and ensuring “access to desired services,”²⁰ including a guarantee of access to abortion,²¹ whether for medical or social reasons.²² She suggests that the public will support freedom of conscience for objecting physicians as long as the services to which they object can be obtained elsewhere.²³ Indeed, she describes concerns about patient access as lying “at the very heart of the conscience clause debate.”²⁴

But if patient access *is* the heart of the issue, why compromise with objecting physicians?

The reasons for compromise

The author asserts that physician freedom of conscience provides important social goods, that the costs of suppressing it would outweigh the benefits, and that denying it to physicians might actually diminish patient access to services.

Before turning to these arguments, one should note what the author identifies as “the driving force and strongest argument” for preserving freedom of conscience for physicians.²⁵ One word sums it up: ignorance. More specifically, the ignorance consequent upon moral pluralism - which she celebrates -²⁶ and her view - but by no means hers alone - that “no one has special access to knowledge about what is right and wrong.”²⁷

Fernandez Lynch admits that if we do not know what is truly right and truly wrong, we cannot accuse an objecting physician of wrongdoing. Her clarity on this point is refreshing.

If we cannot be *completely* sure that *we* have gotten it right . . . there is a *distinct* possibility that the *refusers* are right, leaving no legitimate grounds on which to exclude them from the profession. The problem is that *we often just do not know*. (emphasis added)²⁸

That is because, she says, the moral questions involved often cannot be answered by “empirical testing or any other comprehensive doctrine for distinguishing right from wrong.”²⁹

Preserving moral diversity

In this situation, the just and prudent course, she argues, is to preserve moral diversity by protecting freedom of conscience. She believes that this will ensure a continuing debate within the medical profession, inspired by the collision of conflicting ideas, thus helping us to avoid error and to identify “the most accurate version of moral truth.”³⁰

Moral diversity in the profession offers another potential benefit. Fernandez Lynch suggests that

“patients may prefer to be treated by physicians with similar values.” Physician-patient matching based on shared values would minimize the likelihood of conflict, and might well contribute significantly to meeting patient needs.³¹ This can be understood as simply another aspect of culturally competent medical practice.

Consistent with this, she would prohibit ethical profiling of applicants for medical school; moral objections to procedures would not be grounds to deny admission or to set admission quotas. Nor would willingness to perform controversial procedures be an advantage; she does not approve of selective recruiting. Instead, she would (with rare exceptions) leave the profession equally open to all, regardless of beliefs.³²

The social goods of freedom of conscience in medicine

In addition to what might be called the argument from ignorance, Fernandez Lynch asserts that physicians cannot be expected to “check their personal religious and moral beliefs at the door”³³ since “the segmentation of one’s personality demanded by secularization may be utterly impossible.”³⁴ Such a policy would turn physicians into technical automatons who are fully responsive to patient requests but “detached from potentially appropriate moral qualms.” This, she says, would “corrode the humanity and compassion patients expect and need from their doctors.”³⁵

Society benefits from having morally serious people in the profession who are unwilling to just follow orders and who contribute to the rich moral debate that helps avoid blindly accepting the normative permissibility of whatever is technically possible and has not been legally prohibited.³⁶

She points out that society has not been well served by physicians without moral qualms. Consider, as the author does, the Tuskegee study: almost 400 black men in Alabama, deceived and denied treatment for syphilis so that physicians could study the disease.³⁷ Or consider Canadian physicians, who, executing orders from the Alberta Eugenics Board, sterilized over 4,500 Albertans purported to be “mentally defective.”³⁸ Some of these people were also used as guinea pigs in drug tests and as sources of tissue for research.³⁹

Fernandez-Lynch asks the reader to imagine the consequences if only “morally insensitive” applicants were admitted to medical practice. It would, she believes, lead to a shortage of physicians. And she is concerned that such a policy could destroy the reputation of the profession. She warns that people might come to view physicians as they view lawyers.⁴⁰

Instead, the author - - herself a lawyer - - adopts the reasoning of attorney Howard Lesnick:

A polity that encourages its citizens to bring to bear their own serious moral reflections on the morally significant decisions they face will be more likely to grow in justice and humanity.⁴¹

Lesnick argues that the “varying religious scruples” of individual professionals act as “a counsel of restraint” in the prevailing pluralist ethos, and that this has a broader social value.⁴² Fernandez Lynch identifies a social benefit provided by objecting physicians as their “counsel of restraint” in the face of demands spawned by technological developments.⁴³

She acknowledges that some people consider patient access to services more important than any of

the goods she describes; they would like to force objecting physicians out of the profession.⁴⁴ But she challenges this approach on its own terms.

Suppose that a patient who is denied a service sues a physician or makes a formal complaint. The physician would probably continue to refuse.⁴⁵ If the patient obtains the service at all, it will be through a willing physician, and it will not be because of the complaint or lawsuit. The

objecting physician might be suspended or struck from the register, or leave the specialty or the profession. In all such cases, access to medical services will suffer.⁴⁶

If the *real* goal is to ensure access to services, says the author, punishing unwilling physicians is likely to be counterproductive. If the *real* goal is to ensure access - not to punish objecting physicians - that goal is best served by connecting patients with physicians willing to help them.⁴⁷

She devotes much of the book to explaining how this might be achieved.

Facilitating access

In brief, Fernandez Lynch proposes that the professional regulatory authority (in the United States, physician licensing boards in each state), assisted by other players and stakeholders, formulate a rational plan to provide adequate access to defined health care services offered by physicians within its jurisdiction. The plan would be based on estimates of demand for the defined services and the supply of willing physicians.⁴⁸ Two thirds of the book is devoted to working out the details of this scheme. The author repeatedly emphasizes that it is always preferable to solve access problems by using incentives, not repressive measures.⁴⁹

But we are reminded that there can be no intelligent discussion of concerns about patient access unless we first define key terms, including “access,” “timely,” “prompt,” “inconvenience” and “medical necessity.”⁵⁰ While the author does not make the point, one might observe that the rhetorical impact of these words when used in sloganeering is not readily translated into useful standards of measure. This is also true of other relevant concepts that she goes on to examine, among them: “risk,”⁵¹ “harm,”⁵² “need” and “preference.”⁵³

Patients having difficulty accessing defined services for any reason - not just conscientious objection - would contact the regulatory authority for assistance. Should the defined service not be provided - for any reason - a patient could file a claim for compensation from the regulator - not from a physician.⁵⁴ The author argues that this would avoid the counterproductive effect of punitive sanctions, and she believes that patients would be compensated for most denials resulting from conscientious objection.⁵⁵

Fernandez Lynch notes that a patient who is successful in a civil case against a physician receives only monetary compensation. That being the case, a patient would be no worse off if the money came from the regulator rather than the physician, and she believes that a claims system would operate more efficiently and with less expense than an adversarial legal process. Moreover, the claims system would provide a continuing incentive for the regulator to rectify problems with access. It makes sense, she says, to make the regulator accountable in this way, since it has the leverage to address such problems, while individual physicians do not.⁵⁶

Professional regulators, in her view, have several tools at their disposal to ensure access to services:

hotline referral services and websites,⁵⁷ economic incentives for physicians,⁵⁸ increasing use of “telemedicine,”⁵⁹ modification of rules governing inter-jurisdictional practice, “circuit-riding” doctors, subsidies for patient travel, the provision of services by non-physician specialists,⁶⁰ and the encouragement of professional immigration.⁶¹

The author suggests that medical schools can help. They can encourage student interest in unpopular or controversial services through special programmes. They might, for example, open clinics in places where patient access has been a concern. Citing the impact of legal aid clinics on law students, the author believes that many medical students, if exposed to access problems during their education, would develop professional practices particularly responsive to patient requests.⁶²

Protection of conscience

Conditions of protection

Under the terms of the compromise, objecting physicians are offered protection on three conditions: notice, registration, and acceptance of non-negotiable duties.

Notice

Fernandez-Lynch insists that physicians fully disclose their objections to patients when they first accept them, reiterate them if they become relevant to treatment options, and notify patients if their views change.⁶³ Her model statute extends this obligation to include notification of “employers, employment agencies, and labour organizations.”⁶⁴

Registration

Objecting physicians would also have to register with the regulator, listing the services they are unwilling to provide and the reasons for their refusal, and update the regulator on any changes in their practice.⁶⁵ The regulator would verify the validity and sincerity of their objections.⁶⁶ The registry of objecting physicians would facilitate physician-patient matching and evaluation of the availability of services.⁶⁷

The non-negotiable duties

All physicians would have to accept what Fernandez Lynch calls “non-negotiable” duties. There are four of them. At first glance, all four are unobjectionable.⁶⁸

- First: physicians must not engage in what the author calls “invidious” discrimination.⁶⁹
 - They may object to a procedure or service for reasons of conscience,⁷⁰ but not to the patient or the patient’s lifestyle.⁷¹
- Second: physicians must give timely notice of services they will not provide, and timely notice of changes in their views.⁷²
- Third: physicians must respect the principle of informed consent by advising patients of all legal treatment options, including those to which they object.

- They must provide accurate information about all options.⁷³
- Fourth: physicians must provide emergency treatment.⁷⁴

Referral is not among the author's list of non-negotiable duties. There is good reason for this.

Although Fernandez Lynch cites and quotes several commentators to the effect that an objecting physician should refer a patient to a willing provider,⁷⁵ she also notes opposing arguments,⁷⁶ and acknowledges that the issue is “among the more difficult aspects of the conscience clause debate:” in the words of one clearly frustrated professor, “absolutely intractable.”⁷⁷ This is because, as Fernandez Lynch acknowledges, referral imposes “the serious moral burdens of complicity.”⁷⁸

Fernandez Lynch suggests a range of options when an objecting physician is asked by a patient for information about willing providers, acknowledging that the options involve different degrees of complicity.⁷⁹ The least demanding of these is that the physician should direct the patient to the regulator.⁸⁰ However, she also suggests that objecting physicians might be made to do more for “highly vulnerable patients,” like helping them to make an appointment with a willing provider.⁸¹

Extent of protection of conscience

Under the terms of the compromise, an objecting physician who fulfilled the requirements of notification and registration and who discharged the four non-negotiable duties would be immune from discipline and civil liability, even if he were the ‘last doctor in town’ facing a hard case.⁸²

Fernandez-Lynch holds that refusal in such a case would be a grave breach of professional obligation.⁸³ However, she concludes that it would be a mistake to try to enforce the duty with punitive sanctions. She asserts that public denunciation and other adverse social consequences would be appropriate, but that the objecting physician should not be disciplined or sued⁸⁴ because that would ultimately cause more harm than good.⁸⁵

One important point: the author acknowledges that protection of conscience laws would still be necessary “in some form,” presumably the kind of law exemplified by her model statute.⁸⁶

Project Comment

Introductory observations

The first point that warrants comment is the general tone of the book. Fernandez Lynch advises readers to strive to consider the issues from a perspective opposite their own, or at least to take a neutral position, and she adopts this approach herself. She does not always succeed in this, but her effort has produced a book that is notably free of the self-righteousness and rancour one sometimes encounters in this debate. This should be kept in mind when considering one of her lapses that is of particular interest to religious believers.

Some physicians, she says, assert that it would be wrong for them to do X, but not wrong for someone else. Sincerely motivated by nothing more than a personal “idiosyncratic understanding of morality,” they make no broader moral claims.⁸⁷ It appears that they attract the author's sympathetic notice because they do not challenge the hegemony of moral pluralism.

But Fernandez Lynch seems troubled by physicians who adhere to what they consider to be “God’s absolute standards” that apply to everyone. She observes that they not only refuse to provide a service they believe is wrong, but say that no one else should provide it either.⁸⁸ She seems to agree that this reflects an agenda that is really “all about the control of others.”⁸⁹

Here the author has fallen into absurdity. Anyone who believes that something is truly wrong - murder, for example - will also believe that no one should do it. The author herself takes exactly this position with respect to discrimination.⁹⁰ Elsewhere, in a passage that could have been written by an objecting physician, she asserts, as a matter of “fact,” that “there is never an obligation to participate in genuine wrongdoing.”

It is certainly the case that no professional obligation could rightfully include a duty to engage in true moral transgressions, regardless of voluntary entry into a profession or the existence of a professional monopoly.⁹¹

However, she immediately denies that physicians should be allowed to act on these principles. That would, she claims, “permit the physician’s conscience to become a law unto itself” and impose views on patients “with which they may reasonably disagree.”⁹²

It would seem to follow from the author’s reasoning that a physician must not be forced to provide a service he believes to be immoral, but must not be allowed to assess the morality of the service he is asked to provide. He is free to act on his conscience - except in questions of morality. This kind of incoherent conclusion is the result of the corrosive effect of the author’s espousal of moral pluralism, which precludes any personal identification of *genuine* wrongdoing or *true* moral transgression. What begins as a high-sounding statement of moral principle at once dissolves into meaningless cant.

This incoherence also undermines her principal argument for maintaining moral diversity in the profession. As noted above, she posits that the debate engendered by such diversity will allow us to “siphon out the most accurate version of moral truth.”⁹³ But we cannot recognize “the most accurate version of moral truth” unless (a) moral truth exists, and (b) we least have an accurate idea of what it looks like. If moral truth does not exist, or if we cannot recognize it, no amount of debate within the profession will tell us whether or not we have “the most accurate version” of it.

The most plausible explanation for this lapse is anti-religious prejudice, if not against religion generally, then against religions that profess the kind of moral certitude that the author demonstrates when she denounces racial discrimination. Her position seems to be that moral absolutism is acceptable as long as it does not depend on religious belief.

Conflicts of Conscience in Health Care has much to offer, but an attentive reading must take into account the effects of these two underlying elements: some form of anti-religious prejudice, and dogmatic moral pluralism.

Implementation

Fernandez Lynch’s extensive discussion of practical issues is commendable, and she offers what appear to be novel suggestions. For example, she discusses how anti-trust law enforcement practices might be adapted to measure supply and demand in health care.⁹⁴ Others can and should consider

what she has to say about this and other things related to implementation, but comments in this paper are confined to topics that have special relevance to preservation of freedom of conscience.

The institutional compromise

Professional regulators are identified as the institutions best placed to balance the interests of physicians and patients. While not beyond criticism, the suggestion is basically sound.⁹⁵ It addresses an objector's concern about complicity by making someone else morally responsible for access to a service. This kind of arrangement has worked successfully for objecting pharmacists whose employers have assumed the kind role she proposes for state boards.⁹⁶

Referral

Fernandez Lynch correctly identifies perceived complicity in wrongdoing as the key issue in referral, a point that other authors often fail to notice or dismiss with contempt. The author suggests that objecting physicians should at least direct patients to the regulator if they are asked to identify a willing provider. It has not been the experience of the Project that objecting physicians would be unwilling to do this, so this appears to be a workable compromise.

However, her suggestion that objectors might be made to facilitate services for "highly vulnerable patients" is not acceptable and demonstrates an absence of reflection that is uncharacteristic of her work. It ignores the issue of complicity and demands that physicians accept patient "vulnerability" as justification for setting aside their moral convictions. The tendentious nature of this reasoning becomes apparent within the context of end of life care. Many physicians would consider patient vulnerability near the end of life a strong reason to *oppose* euthanasia, not a reason to help the patient make an appointment for a lethal injection.

Registration of objecting physicians

The maintenance of a College registry of physicians willing to cooperate in the provision of defined services is a sound strategy that may have many applications. For example, the author describes a register of health care providers in Texas who are willing to accept patients who want treatment or care either continued or discontinued near the end of life. A similar concept underlies the institution of the Hippocratic Registry.⁹⁷

However the registration of objecting physicians in the manner proposed by the author is not acceptable. Citizens in a liberal democracy should not be required to register their intention to exercise fundamental freedoms, and to submit to cross-examination to prove that they can do so responsibly. No professional or social group should be subjected to such intrusive and paternalistic state supervision.

Moreover, to claim that a regulatory authority is competent to judge the validity or sincerity of the moral or religious beliefs of physicians is at least extravagant. It is certainly inconsistent with the prevailing ethos of moral pluralism recognized and celebrated by the author.

Finally, advance registration of all objections of conscience is also impracticable. Physicians cannot accurately identify - in advance - all services to which they might conceivably object on moral grounds, especially when one takes into account the ethical conundrums continually spawned by technological development. Moreover, the facts in a particular case may modify a physician's moral

evaluation of an act. The author herself not only recognizes the possibility of this kind of re-evaluation, but insists that it is a serious and continuing obligation.⁹⁸ It thus would be unfair to make advance registration of objections a condition for the exercise of freedom of conscience by physicians.

Non-negotiable duties

With respect to the proposed "non-negotiable duties," some important qualifications are in order.

No "invidious" discrimination.

"Invidious discrimination" is a legal term of art that appears to have originated in a 1942 decision of the US Supreme Court. The Court agreed that some kinds of discrimination are acceptable; the law is not required to treat "things which are different in fact or opinion . . . as though they were the same."⁹⁹

Having made this clear, the Court denounced the discrimination it found in an Oklahoma statute as "invidious," describing it as the kind of discrimination characteristic of racism:¹⁰⁰ that is, inviting indignation and resentment. The comparison was legitimate, but the discrimination denounced by the court was not unjust because it was invidious; it was invidious because it was unjust, and it was unjust because of its unequal and capricious treatment of crimes of roughly equal gravity.

Such distinctions have since been lost. Anything described as "invidious discrimination" is now presumed to be unjust discrimination.¹⁰¹ For example, Fernandez Lynch does not object if a physician refuses to offer artificial reproductive services to anyone at all. But she is clearly indignant about the refusal of such services to same-sex couples or single individuals and describes this as "invidious discrimination,"¹⁰² which, in her words, is evil.¹⁰³ That judgement is widely shared in some circles, but it is far from universal, even among those who have no moral objections to homosexual conduct or lifestyles.

On the other hand, there could be no objection to a duty to avoid "unjust" discrimination. Of course, it would then be necessary for an adjudicator to consult some standard beyond indignation. It would be necessary to ask if it is reasonable to believe that, other things being equal, the needs of children are best served in the moral environment of a family sprung from the marriage of a man and woman. It would be necessary to ask if it is reasonable to believe that the needs of children should not be subordinated to the desires of adults.¹⁰⁴

The author seems to consider objecting physicians who hold such views to be bigots deserving denunciation, not accommodation,¹⁰⁵ and one reason for her plan to have regulators pass judgement on their views is to ensure that they are not accommodated.¹⁰⁶ If so, "invidious discrimination" as a term of art serves this purpose very well. It effectively precludes serious consideration of the very point she makes elsewhere: that objectors might be right.

"Discrimination" has become a highly elastic and politically charged term. Accusations of discrimination are too often used to launch inquisitions to purge the public square of heretical opinions that challenge the dominant ethos. The strategy is, even now, being proposed as a means of purging the medical profession.¹⁰⁷ It must be vigorously opposed.

Second: timely notice

Concerning notice to patients, it is common ground that conflicts should be avoided, especially in circumstances of elevated tension, and that they often can be avoided by timely notification of patients, erring on the side of sooner rather than later.¹⁰⁸

However, inflexible notification protocols like that proposed by the author do not serve the interests of either patients or physicians. For example: it would probably be unnecessary for a physician who accepts a 55 year old single woman as a patient to begin their professional relationship by disclosing objections to abortion, and it could well be unsettling for the patient if her medical history includes abortion. And, while it is possible that the woman might, six months after being accepted as a patient, ask for an embryo transplant, it does not follow that the mere possibility of such a request imposes a duty on the physician to disclose moral objections to artificial reproduction at their first consultation.

Interests of patients and physicians are better served by open and continuing communication. On the part of the physician, this involves a special responsibility to be attentive to the spoken and unspoken language of the patient, and to respond in a caring and truthful manner. Notice should be given when it would be apparent to a reasonable and prudent physician that a conflict is likely to arise. In some cases - but not all - this may, indeed, be when a patient is accepted. The same holds true for notification of patients when a physician's views change significantly.

Third: informed consent

It is necessary to distinguish explicitly between two kinds of information. First: a patient needs information in order to make an informed decision about treatment: options available, potential harms and benefits and so forth. Second: when an objecting physician declines to provide a service, a patient who is seeking it may need the name and address of a willing provider.

Respecting the principle of informed consent by providing the first kind of information does not, in the Project's experience, generate "moral distress" among objecting physicians. However, they often refuse to provide information about where to obtain a procedure to which they object because they consider that to be a form of unacceptable complicity in an immoral act. One finds this reflected in the policies of some regulatory authorities. If a physician in British Columbia were to give her the address of someone willing to provide a *sex selective* abortion, he would risk prosecution for professional misconduct by the College of Physicians and Surgeons. The College believes that sex selective abortion is "socially repugnant" and that "it is unethical for physicians to facilitate such action."¹⁰⁹

Nonetheless, objecting physicians who provide all information relevant to a decision to have an abortion are sometimes accused of unethical conduct on the specious ground that their refusal to provide the address of an abortion facility violates the principle of informed consent.¹¹⁰ Such accusations seem designed to pervert the principle of informed consent in order to force objecting physicians to do what they believe to be wrong.

Fourth: emergency treatment

That physicians have a duty to provide emergency treatment is not disputed. What can be disputed, as Fernandez-Lynch explains, is the definition of “emergency,” especially if, as in the case of “informed consent,” activists deliberately broaden the definition for the purpose of forcing physicians to provide treatment to which they object.¹¹¹

Limitations of the book

Having considered the key elements of the author’s proposal, it is now necessary to consider the limitations of the book.

The author warns the reader that her book is not about moral philosophy.¹¹² She does not try to understand the origin of conscience, does not attempt to define it, and does not consider its nature. All she offers is speculation that conscience is "a slippery concept," something in the way of an "ethical tug", a "motivator,"¹¹³ some fuzzy feeling, or an "interior voice."¹¹⁴ Nor does she, at any point, consider the origin, definition, or nature of freedom. She explains that she wants to leave philosophy to philosophers.

She has a more modest goal. It is sufficient, for her purposes, to acknowledge that conscience is "an incredibly powerful force in our lives," and that it is causing problems in modern health care. All she wants to do is solve those problems "in as comprehensive a manner as possible," and, for that reason, her book has a strictly "legal trajectory."¹¹⁵

The practical consequence of this modesty is that the author has compiled over three hundred pages of discussion, argument and supporting materials, but the best and most patient of readers will, reaching the end of the book, have no clear idea about what all of it means. We cannot possibly know whether or not what the author proposes will safeguard freedom of conscience if we do not know what it is.

The author states that her solution "preserves the moral integrity of physicians in most circumstances."¹¹⁶ But how can we be sure of this, if we don't know what freedom of conscience is or how it relates to moral integrity?¹¹⁷ And what could "moral integrity" possibly mean within the context of moral pluralism?

The author states that the book seeks a "middle ground."¹¹⁸ The middle ground between access to services and - what? Jiminy Cricket's "still small voice that people don't listen to"?

The author declares that her proposal is "the right answer."¹¹⁹ But if we don't know what freedom of conscience is, how can we be sure that we are even asking the right questions?

The nature of the book

This is not to imply that Fernandez Lynch has written a couple of hundred pages of nonsense. Regardless of their perspectives on the issues, readers will welcome many of the author’s trenchant observations. However, it is necessary to acknowledge what the author herself admits. In her view, the heart of the conscience clause debate is patient access to services.¹²⁰ She has written a book about how to help patients obtain services when some of the gatekeepers who control access to them are uncooperative.¹²¹ It is not a book about freedom of conscience.

This can be illustrated using what might be called a Microsoft model of her proposal:

- Each medical gatekeeper has a computer chip implanted in his head that contains a personal Conscience Programme. Personal Conscience Programmes come from many different sources. In the health care environment, they help gatekeepers decide when to open a gate to the health care network.
- However, clients are becoming dissatisfied because older versions of the Conscience Programme generate “close gate” messages in response to valid client network requests. Since the principal concern is client access, and clients depend on gatekeepers for access, the author has developed a fix to help clients work around frustrating “close gate” messages.
- When they are hired, gatekeepers upload a copy of their Conscience Programme to a central server. If they get a new Conscience Programme or an upgrade, they must update the central server. The network administrator ensures that the gatekeepers’ Conscience Programmes are, if not the latest available version, at least compatible with the existing system.
- Gatekeepers are notified if they are using incompatible versions (very rare) or if their chips are infected with the Invidious Virus. Gatekeepers are replaced only if they do not upgrade to a compatible version of the Conscience Programme or remove the Invidious Virus.
- Gatekeepers are also required to advise clients which requests will trigger a “close gate” response, and to send them updates. This allows clients to know in advance what to expect from their personal gatekeepers. The medical network maintains a website that identifies gatekeepers known to have “close gate” issues, so that clients can direct access requests without having them bounced.

This fix does not require any special knowledge of programming or personal programme chips, beyond a most basic understanding of what the Conscience Programme is supposed to do and how it actually functions in a network environment. And this is equally true of the author’s proposal. She has observed how conscience operates in the medical environment, and concludes that we do not need philosophy to solve access problems. All we need is a strategy.

A new level of discussion

In fact, the author has been remarkably successful. The strategy she proposes is very promising in its broad outlines. And, within the context of a book about patient access to services, she has offered arguments about the importance of freedom of conscience that are accessible and that many people will find convincing. It would be unfair to use the admitted limitations of the book as an excuse to diminish what she has accomplished. Instead, her work should be engaged and the discussion raised to a new level.

The first step in this process is to recognize that philosophy cannot be left to philosophers. That is impossible. Every proposal for the just ordering of society rests upon some kind of philosophy or constellation of philosophical ideas. That is why, despite the author’s disclaimer that she is leaving philosophy aside, social contract theory¹²² permeates the book.¹²³ It is also why the author has, in the Project’s view, failed to correctly identify the central issue.

Professionalism is not the centre

Fernandez Lynch asserts that everything relevant to the discussion of freedom of conscience in health care turns on a correct understanding of medical professionalism.¹²⁴

With respect, that is not true. Everything does not turn on a correct view of professionalism.

Everything - including one's view of professionalism - turns on an adequate understanding of the nature of the human person.

Everything proposed by Fernandez Lynch is based on the understanding of the human person that she brings with her to the table to discuss the terms of her compromise. And this is very evident in *Conflicts of Conscience in Health Care*, beginning with the statement from Pope John Paul II in the introduction: "the human person" must not be forced to commit an injustice because that would be "intrinsically incompatible with human dignity." The author seems to have agreed with this statement without comprehending the fullness of its meaning.¹²⁵

Later, as she develops her proposal, she is unable to find a standard that can be used to decide what services ought to be guaranteed by a regulatory authority.¹²⁶ She remarks that it is impossible even to agree on what services are "controversial."¹²⁷ She struggles - without success - to find broadly acceptable definitions for critical concepts: "harm,"¹²⁸ "needs and preferences"¹²⁹ - even "emergency."¹³⁰

All of these concepts depend upon an understanding of the nature of the human person.¹³¹ We cannot agree upon what is good or bad for the patient - or the physician - without first agreeing upon that. That is what determines not only how we define medical necessity or emergency, but how we approach every moral or ethical problem in medicine - including freedom of conscience. Fernandez Lynch encountered this assertion more than once while researching the book, but does not appear to have recognized its significance.¹³² That significance may be outlined in a series of four hypotheses.

First hypothesis: the person is at the centre

First: fundamental disagreement about the nature of the human person is what lies at the centre of disputes about freedom of conscience. The nature of the human person - not professionalism - must be the focus of our attention.

And when we shift our focus to the notion of the human person that informs the work of Fernandez Lynch, we encounter much that is very familiar. We discover that it identifies autonomy as the essential characteristic of the human person.¹³³ One increases one's autonomy by being "empowered" to get what one wants or to do what one wants. For this, freedom of choice is essential.¹³⁴ Thus, one must eliminate factors that might restrict freedom of choice, like restrictive beliefs.¹³⁵ Even religious beliefs are understood and valued primarily as expressions of autonomy.¹³⁶

The pursuit of autonomy is potentially limitless, but resources and opportunities are finite. Thus, human interactions come to be seen primarily in terms of power.¹³⁷ People can, of course, consent to co-operate with one another to satisfy their respective interests.¹³⁸

But the key word is consent. Consent justifies any action that might otherwise be held to violate personal autonomy,¹³⁹ like euthanasia..¹⁴⁰ Autonomy is violated not only when consent is improperly

obtained,¹⁴¹ but whenever someone's interests are adversely affected without his consent.¹⁴²

Finally, when pursuit of personal autonomy is the dominant ethic, it is socially critical to maintain a balance of power. Hence, maintaining equality - understood as an equitable balance of power - becomes the dominant concern.¹⁴³ This readily translates into 'respecting boundaries' and 'respecting choices.' The notion of boundaries provides each person with a sphere of influence within which to exercise power without coming into conflict with others.

Second hypothesis: the ideology of the autonomous person

It is reasonable to believe that the emphasis placed on power and autonomy in contemporary thought is the product of an ideology, as defined by Hannah Arendt: a system of thought in which everything that needs to be explained can be explained "in the consistent process of logical deduction" from a single controlling idea.¹⁴⁴ And with this we come to the second hypothesis. The ideology of the autonomous person (to give it a name), while it fits well with utilitarianism and social contract theory, does not comport with the concept of the human person that informs the statement by John Paul II in the introduction to the book. It does not have room for all that is contained in concepts of the human person that come to us from the patrimony of great religious and philosophical traditions.

Historical notes

The third hypothesis is best understood in an historical context.

The notion of freedom of religion could not take root in Europe prior to the Reformation. From that point it became possible to think of freedom of religion in some form, and increasingly necessary to do so as an important element in maintaining civil order. Freedom of conscience was the necessary (though not sufficient) condition for the exercise of freedom of religion, since the decision to convert from one religion to another depended on the judgement of conscience.

For the next four hundred years, freedom of religion made its way forward in the realms of politics and law, but freedom of conscience lingered in the provinces of philosophy and theology. Thus, when "freedom of conscience" appeared in the statutes and constitutions of this period, it was always in its Reformation context, linked to freedom of religion.

The proclamation of the *Universal Declaration of Human Rights* in 1948 marked the first time that freedom of conscience and religion were clearly distinguished in law.¹⁴⁵ Since that time, it has appeared in numerous national constitutions that used the *Declaration* as a template.

But the *Declaration* had a limitation that has been inherited by subsequent constitutions and charters. Jacques Maritain, one of the driving forces behind the *Declaration*, identified it at the time. He explained that the *Universal Declaration of Human Rights* was, in a sense, only an action plan. It was an agreement only about how people and states ought to behave. There was no agreement about why they should behave that way: no agreement about the nature of the human person, and - important in the present context - no agreement about the origin, definition or nature of freedom of conscience.¹⁴⁶

Maritain was, nonetheless, optimistic, convinced that much could be accomplished even with what he called "the last refuge of intellectual agreement."¹⁴⁷ His optimism was not misplaced. Much has been accomplished. But his optimism was also based on a key premise: that no "genuine

democracy” would demand conformity to “any philosophic or any religious creed.” Such demands, made by totalitarian states, had produced, he said, only an “inhuman counterfeit of civilization.”¹⁴⁸

Third hypothesis: rights charters transformed.

What Maritain appears not to have foreseen is a possibility that is stated here as a third hypothesis: that charters and bills of rights can be used to impose the ideological conformity Maritain feared. This can be done by defining and interpreting human rights to fit a particular view of human nature, while excluding other views. Not one word of the law need be changed to accomplish this; it will continue to appear to protect fundamental rights and freedoms. But this will be true *in fact* only if the concept of the human person that informs the official interpretation of the law is at least adequate.

Fourth hypothesis: charters of destruction

With the fourth hypothesis comes controversy. If the underlying concept is not adequate - and especially if it is erroneous - human rights law will not sustain or protect authentic human rights and freedoms. Quite the reverse. It will become an instrument of their destruction, working through the key disciplines of education, law and medicine.

In this case, the effect on the body politic will be analogous to the effects of HIV on the immune system. Institutions meant to preserve and protect human society will not just fail. Like infected immune cells, they will become the very means by which that failure spreads. Ultimately, they will produce the kind of oppressive counterfeit of democracy that Maritain feared. Perhaps John Paul II had something like this in mind when he observed that a democracy without values can easily become an "open or thinly veiled totalitarianism."¹⁴⁹

Closing

In the sixty years since the 1948 *Universal Declaration of Human Rights*, the phrase “freedom of conscience” has been cut and pasted into countless charters and bills of rights, but there is yet no common and coherent agreement about what freedom of conscience is, and how it is related to the good of the human person and human society. We have carried on for sixty years as if this were of no practical consequence. This cannot continue indefinitely.

The appearance of *Conflicts of Conscience in Health Care* is a warning. We are approaching a time when, in different countries, handfuls of judges, academics and bureaucrats will be asked to impose their dogmatic definitions of freedom of conscience upon their fellow citizens, and to give those definitions the force of law.

In so doing, will they, in the name of “human rights,” blithely apply inadequate or erroneous notions of the human person that they bring with them from their social or professional circles, thus subverting the very rights and freedoms they profess to uphold?

Or will they, recalling Fernandez Lynch’s warning that the dissenters may be right, ensure that their dogmatic definitions leave room in their countries for more than one understanding of the human person - for more than one philosophy of life?

Notes

1. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise*. Cambridge, Mass.: The MIT Press, 2008, p. xii-xiii (hereinafter “*Conflicts*.”)
2. John Paul II, *Encyc. Evangelium Vitae* (25 March, 1995) 74.
(http://www.vatican.va/edocs/ENG0141/_PS.HTM) Accessed 2009-09-16)
3. Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise*. Cambridge, Mass.: The MIT Press, 2008, p. 1. (hereinafter “*Conflicts*.”)
4. *Conflicts*, p. 256
5. *Conflicts*, p. 33, 241, 257
6. *Conflicts*, p. 245
7. Murphy, Sean, *Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers*. (<http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical48.html>)
8. *Conflicts*, p. 256
9. *Conflicts*, p. 38. Exclusive focus on abortion was one of the criticisms of an American health care reform bill (HR 3590:) by the US Conference of Catholic Bishops. “[C]ritically important conscience protections on issues beyond abortion have yet to be included in the bill,” they wrote. “To take just one example, the bill fails to ensure that even religious institutions would retain the freedom to offer their own employees health insurance coverage that conforms to the institution’s teaching.” Letter to the United States Senate from the US Conference of Catholic Bishops, 20 November, 2009.
(<http://www.usccb.org/sdwp/national/2009-11-20-ltr-usccb-health-care-to-senate.pdf>) Accessed 2009-12-05
10. *Conflicts*, p. xiv
11. *Conflicts*, p. 38
12. *Conflicts*, p. 19-75
13. *Conflicts*, p. 70, 74
14. *Conflicts*, p. 146, 165-193
15. *Conflicts*, p. 14, 74-75, 97, 112, 146, 165-193
16. *Conflicts*, p. 111-113

17. *Conflicts*, p. xi
18. *Conflicts*, p. 228
19. *Conflicts*, p. 24, 99, 256
20. *Conflicts*, p. 56, 80, 245
21. *Conflicts*, p. 129, 172
22. *Conflicts*, p. 167, 227. Note that she rejects the demand that all physicians should be made to achieve technical competence in the procedure. This requirement, too, would seriously undermine the compromise she proposes. *Conflicts*, p. 205
23. *Conflicts*, p. 75. She later cites a survey that found “four out of five women supported policies allowing individual pharmacists to refuse to dispense contraceptives when the pharmacy bore the obligation of assigning another employee to fill the prescription.” The results were reversed when the obligation was removed. *Conflicts*, p. 104
24. *Conflicts*, p. 99
25. *Conflicts*, p. 84
26. However, the author perceptively notes that the pursuit of moral pluralism has generated conflict, which many have tried to avoid by forcing people “to restrict their beliefs to their personal lives.” *Conflicts*, p. 22
27. *Conflicts*, p. 135
28. *Conflicts*, p. 85
29. *Conflicts*, p. 84. “No one can empirically prove that abortion kills a person with full moral status,” she writes, “or that contraception is an offense against God.” *Conflicts*, p. 148. Similarly - though she does not say it - no one can, in her terms, prove that abortion does *not* kill a person with full moral status, or prove that contraception is *not* an offense against God.
30. *Conflicts*, p. 85.
31. *Conflicts*, p. 87-88, 90-93
32. *Conflicts*, p. 182-84. The author cites a refusal to provide prescription drugs as an example of the the kind of rare exception she has in mind.
33. *Conflicts*, p. 10
34. *Conflicts*, p. 22-23

35. *Conflicts*, p. 80-81.
36. *Conflicts*, p. 86
37. *Final Report of the Tuskegee Syphilis Study Legacy Committee* (May 20, 1996). University of Virginia, Claude Moore Health Sciences Library. (http://www.hsl.virginia.edu/historical/medical_history/bad_blood/report.cfm) Accessed 2009-09-17. She also refers to human experimentation on concentration camp inmates during the Holocaust (Lifton, Robert Jay, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*. New York: Basic Books, 2000) and the participation of physicians in abusive interrogations and torture *Conflicts*, p. 82, citing Matthews, Richard G., "Indecent Medicine: In Defense of the Absolute Prohibition against Physician Participation in Torture," *Am. J. Bioethics* 6, no.3 (2006):W34
38. Marsh, James H., *Eugenics: Keeping Canada Sane. The Canadian Encyclopaedia* (<http://www.thecanadianencyclopedia.com/index.cfm?PgNm=ArchivedFeatures&Params=A2126>) Accessed 2009-09-17
39. *Muir v. The Queen in right of Alberta*, 132 D.L.R. (4th) 695. Court File No. 8903 20759, Edmonton, Alberta. Court of Queen's Bench, Veit J. January 25, 1996 (<http://aix1.uottawa.ca/~srodgers/3375/muir.rtf>) Accessed 2009-09-17
40. *Conflicts*, p. 82
41. Lesnick, Howard, "The Religious Lawyer in a Pluralist Society," *Fordham Law Review* 66 (1998), 1469, 1489-1490. Quoted in *Conflicts*, p. 81
42. Lesnick, Howard, "The Religious Lawyer in a Pluralist Society," *Fordham Law Review* 66 (1998), 1469, 1489-1490. Quoted in *Conflicts*, p. 81
43. *Conflicts*, p. 81
44. Identifying Julian Savulescu and Rosamund Rhodes in particular. *Conflicts*, p. 58, 62
45. *Conflicts*, p. 101
46. *Conflicts*, p. 80
47. *Conflicts*, p. 206-207, 214
48. *Conflicts*, p. 13-14, 97, 117-143. She specifies that the goal is "meaningful, not merely nominal availability." 168. The author acknowledges that delivery of health care involves other professions and entities, so implementation of the compromise would require its adaptation and application to them. *Conflicts*, p. 286 note 38.
49. *Conflicts*, p. 181, 184, 188

50. *Conflicts*, p. 117-118
51. *Conflicts*, p. 125-126
52. *Conflicts*, p. 127-129
53. *Conflicts*, p. 130-132
54. *Conflicts*, p. 14, 112, 211-212
55. *Conflicts*, p. 213
56. *Conflicts*, p. 101, 111-112, 208
57. *Conflicts*, p. 230
58. *Conflicts*, p. 181-182
59. *Conflicts*, p. 185-186
60. *Conflicts*, p. 186-187
61. *Conflicts*, p. 189
62. *Conflicts*, p. 184
63. *Conflicts*, p. 217-219, 222
64. *Conflicts*, p. 254
65. *Conflicts*, p. 145
66. *Conflicts*, p. 147-163
67. *Conflicts*, p. 147
68. *Conflicts*, p. 215
69. *Conflicts*, p. 153-155
70. *Conflicts*, p. 151
71. *Conflicts*, p. 156
72. *Conflicts*, p. 215, 217-219, 222-223
73. *Conflicts*, p. 215, 219-223

74. *Conflicts*, p. 215, 223-228
75. *Conflicts*, p. 231-232
76. *Conflicts*, p. 229-231
77. *Conflicts*, p. 233. Quoting Veatch, Robert M., *The Patient-Physician Relation: The Patient as Partner, Part 2*. Bloomington Indiana University Press, 1991, p. 152
78. *Conflicts*, p. 229
79. *Conflicts*, p. 233-235
80. *Conflicts*, p. 236
81. *Conflicts*, p. 244
82. *Conflicts*, p. 14, 214
83. *Conflicts*, p. 196-201, 203
84. *Conflicts*, p. 207
85. *Conflicts*, p. 204- 207, 214
86. *Conflicts*, p. 14
87. *Conflicts*, p. 23
88. *Conflicts*, p. 24
89. *Conflicts*, p. 23
90. “. . . preferences based on racist, sexist, homophobic, or other sorts of bigoted views can be appropriately excluded from legitimate discourse as entirely illogical and not even arguably correct.” (*Conflicts*, p.92). “. . . invidious discrimination is clearly an evil . . .” (*Conflicts*, p. 155)
91. *Conflicts*, p. 201. Similarly, she agrees that a physician would be justified in refusing to assist a patient to do something “truly wrong.”(*Conflicts*, p. 84).
92. *Conflicts*, p. 201
93. *Conflicts*, p. 85
94. *Conflicts*, p. 168-172

95. A more extended discussion of the proposal than is attempted here would necessarily involve more detailed critical evaluation. For example: while the author's plan is designed to permit objecting physicians to continue in the profession, it would appear that they (and others who share their convictions) may be excluded from the government of the profession, at least to the extent that it would make them complicit in the provision of services to which they object. It is not clear what long term consequences this might have for the profession and the viability of the compromise.

96. See, for example, *Letter to Calgary Co-operative Association*, 19 December, 2001 (<http://www.consciencelaws.org/Conscience-Policies-Papers/PPPSettlements03.htm>)

97. *Conflicts*, p. 146; Hippocratic Registry, <http://www.hippocraticregistry.com/>

98. *Conflicts*, p. 236-237

99. *Skinner vs. Oklahoma* 315 US 535 (1942) FindLaw for Legal Professionals Quoting *Tigner v. Texas*, 310 U.S. 141, 147, 60 S.Ct. 879, 882, 130 A.L.R. 1321. (<http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=US&vol=316&invol=535>) Accessed 2009-09-22

100. “. . . strict scrutiny of the classification which a State makes in a sterilization law is essential, lest unwittingly or otherwise invidious discriminations are made against groups or types of individuals in violation of the constitutional guaranty of just and equal laws. . . . When the law lays an unequal hand on those who have committed intrinsically the same quality of offense and sterilizes one and not the other, it has made as an invidious a discrimination as if it had selected a particular race or nationality for oppressive treatment.” *Skinner vs. Oklahoma* 315 US 535 (1942) FindLaw for Legal Professionals (<http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=US&vol=316&invol=535>) Accessed 2009-09-22

101. Criminal Law Lawyer Source: Discrimination (<http://www.criminal-law-lawyer-source.com/terms/discrimination.html>) Accessed 2009-09-22

102. *Conflicts*, p. 149-150,156-157

103. *Conflicts*, p. 155

104. This kind of alternative view is explored succinctly from a secular perspective in Somerville, *Margaret, The Case Against “Same Sex Marriage.”* A Brief Submitted to The Standing Committee on Justice and Human Rights (FINAL VERSION) McGill Centre for Medicine, Ethics and Law, Montréal, Québec (April 29, 2003) (<http://www.marriageinstitute.ca/images/somerville.pdf>) Accessed 2009-12-09

105. *Conflicts*, p. 92, 149-150,155

106. *Conflicts*, p. 149-150
107. See, for example, See, for example, *Submission to the College of Physicians and Surgeons of Ontario Re: Physicians and the Ontario Human Rights Code*, 8 October, 2008. (<http://www.consciencelaws.org/Conscience-Archive/Submissions/CPSO-2008.htm>)
108. *Conflicts*, p. 217-218
109. College of Physicians and Surgeons of British Columbia, *Fetal Sex Determination*. (<https://www.cpsbc.ca/files/u1/Fetal-Sex-Determination.pdf>) Accessed 2009-09-20. See also Society of Obstetricians and Gynaecologists of Canada Policy Statement No. 198: Statement on Gender Selection (November, 2007) (<http://www.sogc.org/guidelines/documents/guiJOGC198PS0711.pdf>); SOGC Policy Statement No. 192: *Fetal Sex Determination and Disclosure* (April, 2007) (<http://www.sogc.org/guidelines/documents/192E-PS-April2007.pdf>) Accessed 2009-09-20. Fernandez-Lynch comments on the CPSBC policy (*Conflicts*, p. 127-128), but the citation in the end note (no. 27, p. 289) is inaccurate.
110. A document from the American Bar Association, quoted by the author at p. 232, appears to make this claim. Hanlon, Stephen F., American Bar Association Section of Individual Rights and Responsibilities, Health Law Section, Report to the House of Delegates, February, 2005, p. 1. (<http://www.abanet.org/adminlaw/midyear2005/Tab9.pdf>) Accessed 2009-12-09
111. *Conflicts*, p. 226-229
112. *Conflicts*, p. xii
113. *Conflicts*, p. 35, citing [n61, p 270] Eisgruber, Christopher L., Sager, Lawrence G. "The Vulnerability of Conscience: The Constitutional Basis for Protecting Religious Conduct." U. Chi. L. Rev. 61 (1994): 1245, 1291
114. “[T]he interior, quintessentially human voice that speaks to us of goodness and duty, the voice we must obey if we are to keep our integrity.” *Conflicts*, p. 35, quoting Hasson, Kevin Seamus, *The Right to be Wrong: Ending the Culture War over Religion in America*. San Francisco, CA: Encounter Books, 2005. p. 14.
115. *Conflicts*, p. xii
116. *Conflicts*, p. 10
117. For example, having frequently referred to the importance of personal or moral integrity, the author nonetheless asserts that, in what she calls ‘hard cases’, the personal integrity of a physician “can be outweighed by the need for professional integrity.” (*Conflicts*, p. 196-197)
118. *Conflicts*, p. 12

119. *Conflicts*, p. 12
120. *Conflicts*, p. 24, 99
121. *Conflicts*, p. 224
122. Contract, social: The imaginary device through which equally imaginary individuals, living in solitude (or, perhaps, nuclear families) , without government, without a stable division of labour or dependable exchange relations, without parties, leagues, congregations, assemblies or associations of any sort, come together to form a society, accepting obligations of some minimal kind to one another, and immediately or very soon thereafter binding themselves to a political sovereign who can enforce those obligations. Honderich, Ted (Ed.) *The Oxford Companion to Philosophy* (2nd Ed.) Oxford: Oxford University Press, 2005. p. 174
123. *Conflicts*, p. 6, 10, 13, 43, 47, 49, 52, 54, 57, 58, 70-75, 86, 88-89, 111, 120, 123, 124, 132, 136,156, 197, 199, 207, 250
124. *Conflicts*, p. 13, 38-39, 43
125. *Conflicts*, p. 14-15. This probably explains why Fernandez Lynch later applies a statement from Pope John Paul II in support of the polemical assertion that "physicians cannot be permitted to hold physicians hostage to their personal moral beliefs. (*Conflicts*, p. 99; p. 284, n.1; also referred to without citation at *Conflicts*, p. 14-15) "John Paul II observed that 'freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the state is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses.'" The fragment of text chosen by the author is misleading because she has taken it is seriously out of context. Her claim that the Pope "was referring to the dangers of political fundamentalism in denying human rights" is a manifestly inadequate gloss of complex document about freedom of conscience. No one actually familiar with the writings and thought of John Paul II would have attempted such a spurious association. For the source (incorrectly cited by Fernandez Lynch) see John Paul II, *If You Want Peace, Respect the Conscience of Every Person*. Message for the XXIV World Day of Peace, 1 January, 1991. (Accessed 2009-12-09)
126. *Conflicts*, p. 121-127
127. *Conflicts*, p. 133
128. *Conflicts*, p. 127-129
129. *Conflicts*, p. 130-132
130. *Conflicts*, p. 133, 226-229

131. 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. However, science cannot determine what moral obligations are called forth by the existence of a human being, nor can it 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. 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 (<http://www.consciencelaws.org/Examining-Conscience-Background/GenScience/BackGenScience01.html>)

132. Fernandez Lynch cited a paper by the Project Administrator as an example of an unworkably broad understanding of "needs," apparently because the paper did not specifically define "needs." The point of the paper, however, (and the reason for the absence of the kind of definition she was seeking) is precisely the point here: that such a definition presumes some kind of underlying definition of the human person. *Conflicts*, p. 130-131; Murphy, Sean, *Freedom of Conscience and the Needs of the Patient*. Presented at the Obstetrics and Gynaecology Conference New Developments - New Boundaries in Banff, Alberta (November 9-12, 2001). (<http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical23.html>). Exactly same point was made in a second paper [Murphy, Sean, *Service or Servitude: Reflections on Freedom of Conscience for Health Care Workers*. (<http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical48.html>)] cited and quoted twice by the author (*Conflicts*, p. 8, 256).

133. Fernandez Lynch apparently sees the origin of the current controversy as a conflict between physician and patient autonomy, describing the patient autonomy movement as a "challenge to the autonomy of physicians." (*Conflicts*, p. 22) This is at least in part because some prominent commentators have explained it in those terms. Proponents of what she calls the "patient-centric" approach, she says, leave little or no room for physician autonomy (*Conflicts*, p. 61). In contrast, she quotes Edmund Pellegrino's assertion that an attack on physician autonomy is an assault on "an essential part of the person's humanity. . .". (*Conflicts*, p. 67, quoting Pellegrino, Edmund D., "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician Patient Relationship," *J. Contemp. Health Law & Policy* 10 (1993) 47, 58-59.) She focuses on finding ways to "protect the autonomy of both parties" and "preserve the autonomy of all interested individuals" (*Conflicts*, p. 87, 99). When she argues for that objecting physicians should violate their convictions in hard cases, she appeals to the principle of autonomy: their autonomous decision to enter the profession, and the lesser autonomy of patients (*Conflicts*, p. 196-198). Similarly, she justifies limitations on freedom of conscience by describing them as "essential to the protection of patient autonomy, safety or serious medical interests." (*Conflicts*, p. 229) It is significant that the author repeatedly emphasizes the need to preserve autonomy rather than integrity, and places autonomy - not integrity - on par with safety and "serious medical interests." The author's views reflect the dominant position that autonomy has achieved in contemporary thought.

134. When working out the ethical problem of conscientious objection in hard cases, the author conducts the discussion entirely within the framework of autonomy and choice, concluding that freedom of conscience should be subordinated when it is necessary to preserve freedom of choice for the patient. (*Conflicts*, p. 196-199) Elsewhere she asserts that patient choice must not be compromised by physician views about what services are appropriate or optimal. (*Conflicts*, p. 203)

135. In the author's case, consider her prejudice against religious beliefs that purport to be based on absolute standards of right and wrong. (*Conflicts*, p. 23-24)

136. The tendency of the law to identify religious belief as an expression of personal autonomy is discussed in Berger, Benjamin, L., *Law's Religion: Rendering Culture. Osgoode Hall Law Journal*, Vol. 45, No. 2. (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=961031) Accessed 2009-09-22. The author refers to the importance of "moral autonomy" *Conflicts*, p. xiii-xiv, 7, 196) and agrees with John Rawls that moral pluralism is beneficial because it permits individuals "to pursue their own conceptions of the good." (*Conflicts*, p. 22)

137. The author describes monopoly control of power as characteristic of professionalism (*Conflicts*, p. 10, 69-70, 79, 86, 132, 214), and identifies power and admiration as forms of compensation formerly paid to physicians as part of a purported social contract (*Conflicts*, p. 46). Physician power is offered as one of the explanations for the comparatively recent development of controversy about freedom of conscience in health care (*Conflicts*, p. 19), and resistance of physicians to the patient autonomy movement is explained as an attempt by the profession "to reclaim some of its lost power." (*Conflicts*, p. 22) The author validates professional ethics to the extent that they have "developed as part of the negotiation of power with the public." (*Conflicts*, p. 136)

138. Hence the centrality of social contract theory in the author's approach.

139. The author asserts that failure to obtain the consent of the victims is "a major reason" for the historical and professional condemnations of the conduct of Nazi physicians during the Holocaust and of American researchers involved in the Tuskegee experiment, though this is not stated clearly as her own view. (*Conflicts*, p. 82) She questions the idea that consent is always sufficient to justify a procedure, but the discussion is inconclusive. (*Conflicts*, 83). However, when she later justifies the suppression of what she calls the "moral autonomy" of an objecting physician in a hard case, she does so precisely because of the physician's alleged implied consent to subordinate his "personal integrity" to "professional integrity" upon entering the profession. Alternatively, she alleges that he has a duty to consent in such circumstances. (*Conflicts*, p. 196-197) This seems inconsistent with her earlier rejection of the "consent paradigm" of medical professionalism (*Conflicts*, p. 48-57) That conclusion, however, was based on her belief that physicians could not be shown to have consented to meet all patient demands, not on rejection of the notion of justification by consent.

140. Canada's Chief Justice based a right to assisted suicide (distinguished from murder only by consent) on the fundamental importance of individual autonomy and self-determination" and "the promotion of individual autonomy." *Re: Rodriguez and Attorney-General of British Columbia et al; British Columbia Coalition of People with Disabilities, et al, Intervener*, 107 DLR (4th) 342, Supreme Court of Canada

141. *Conflicts*, p. 223

142. Thus, the author claims that if a large number of physicians were to refuse to provide services demanded by the public, they would act improperly by exercising legislative power without the consent of the governed. (*Conflicts*, p. 69) It would, she asserts, be "an illegitimate imposition of views" on those who disagree. (*Conflicts*, p. 86) Similarly, she describes conscientious objection in hard cases as a political act that usurps legitimate government authority. (*Conflicts*, p. 201)

143. The author appears to accept the view that there is no moral equality (of persons) in the absence of a balance of power (*Conflicts*, p. 198, quoting Fenton and Lomasky). "The power imbalance inherent in the doctor-patient relationship," (*Conflicts*, p. 238) has become a dominant theme not only in the medical profession, but in other disciplines. Consider, for example, the themes of power and control reflected in the philosophy of the McMaster University School of Social Work: "As social workers, we operate in a society characterized by power imbalances that affect us all. These power imbalances are based on age, class, ethnicity, gender, geographic location, health, physical ability, race, sexual preference and income. We see personal troubles as inextricably linked to oppressive structures. We believe that social workers must be actively involved in the understanding and transformation of injustices in social institutions and in the struggles of people to maximize control over their own lives." (<http://www.socsci.mcmaster.ca/socwork/>) Accessed 2007-11-13

144. Arendt, Hannah, "Ideology and Terror: A Novel Form of Government." The citations and quotes attributed to her are from this chapter, which was added to the 1958 edition of her 1951 book, *The Origins of Totalitarianism*. (http://www.cooper.edu/humanities/core/hss3/h_arendt.html) Accessed 2007-11-08

145. *The Universal Declaration of Human Rights*, Article 18. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance. (<http://www.un.org/en/documents/udhr/>) Accessed 2009-12-11

146. Maritain, Jacques, *Man and the State*. Chicago: University of Chicago Press, 1951, p. 77

147. Maritain, Jacques, *Man and the State*. Chicago: University of Chicago Press, 1951, p. 77-78

148. Maritain, Jacques, *Man and the State*. Chicago: University of Chicago Press, 1951, p. 110

149. John Paul II, Encyclical *Centesimus Annus* (1991) 46.
(http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_01051991_centesimus-annus_en.html) Accessed 2007-11-15