PAPER

Conscientious objection and healthcare in the UK: why tribunals are not the answer

Christopher Cowley

Correspondence to
Dr Christopher Cowley, School of Philosophy, University College Dublin, Dublin 4, Ireland; Christopher.cowley@ucd.ie

Received 26 January 2015
Revised 7 March 2015
Accepted 2 April 2015
Published Online First 17 April 2015

ABSTRACT
A recent issue of the journal *Bioethics* discussed whether conscientious objectors within the healthcare context should be required to give their reasons to a specially convened tribunal, who would have the power to reject the objection. This is modeled on the context of military conscription. Advocates for such a tribunal offer two different justifications, one based on determining the genuineness of the applicant's beliefs, the other based on determining their reasonableness. I limit my discussion to a doctor's objection to abortion in the UK, and argue against both justifications: I thereby defend the status quo, where such doctors are not formally required to defend their beliefs. My argument has to do with the particular nature of the abortion debate in the UK, and the more general nature of ethical disagreement.

In debates about conscientious objection, the most familiar two contexts are those of military conscription and healthcare. The two contexts are different in all sorts of ways, but I want to concentrate on one important difference: typically the objector to conscription had to appear before a specialised tribunal to give his reasons. The tribunal evaluated the reasons, together with other evidence, and either granted or refused the objection. In the event of the objection being granted, the applicant may then have been assigned to some 'alternative service'; if the objection was rejected by the tribunal, then the applicant either had to enlist, or risk arrest and imprisonment for desertion.

In contrast, let me take the example of the doctors who object to abortion in the UK. Here abortion is legally permissible more or less on demand up until the 24th week of gestation. The pregnant woman requires two signatures of doctors, and often these will be that of the General Practitioner (GP) who first sees her, and that of the obstetrician who performs the procedure. According to Section 4 of the 1967 Abortion Act, however, 'no person shall be under any duty' to 'participate' in a non-emergency abortion if they have a conscientious objection. Other than in rare cases of legal proceedings, there is no formal context in which the objector can be required to give her reasons for the objection, nor any formal tribunal convened to evaluate such reasons.

It is clear that many draftees will have strong non-moral reasons for resisting military service, and hence the need for such a tribunal, once the national parliament has lawfully decided that the war and the draft are necessary. Whereas if the numbers of non-objecting doctors can meet the demand for abortion services, then there might be no need for any tribunal procedures. However, there remain important arguments in principle for requiring objecting doctors to give their reasons, and for them to face the very real possibility of their reasons being rejected; and such arguments can draw support from the military example. A number of recent authors have called for this, albeit for different reasons. Robert Card[1] would require:

> that medical professionals state succinctly their reasons for refusing to serve and be open to these reasons being evaluated as part of institutional practice, similar to the manner in which determinations of conscientious objector status work within the military.

In this paper I want to survey and respond to some of those authors' arguments, in order to defend the current British arrangement of not requiring objecting doctors to give reasons formally. My responses will partly depend on important disanalogies with the military example, and partly on the peculiar nature of the abortion debate in the UK.

Before I begin, let me spell out three caveats required to keep my focus narrow. First, I shall not be taking sides in the hugely complex and ramified abortion debate itself. Although I will be focusing on those who object to abortion, some of my arguments could perhaps be modified to support Vera Drake's covert 'conscientious' abortions in 1950s Britain. Second, I shall not be taking sides on the permissibility of conscientious objection itself in healthcare. Julian Savulescu[2] famously argued that Section 4 should be removed from the Abortion Act precisely because doctors could not be allowed to 'cherry-pick' those medical services they were willing to perform from those they were not. Since nobody was forced to become a doctor, and no doctor was forced to become a GP or obstetrician, then it was easy to avoid the situation where one would be expected to authorise or perform abortions. Third, I shall assume that the objection of a particular doctor does not impede the pregnant patient's convenient access to a non-objecting doctor. This might be an issue in some remote rural parts of the UK, and it might become an issue in the future if there are too many objecting doctors.

So my question will be: *given* that abortion on demand is legal, and *given* that British doctors are allowed to conscientiously object to abortion

Linked

▶ http://dx.doi.org/10.1136/medethics-2015-102782
▶ http://dx.doi.org/10.1136/medethics-2015-102797
▶ http://dx.doi.org/10.1136/medethics-2015-102798
▶ http://dx.doi.org/10.1136/medethics-2015-103037

CrossMark

To cite: Cowley C. *J Med Ethics* 2016;**42**:69–72.

without impeding patient access, should they be required to give their reasons to a tribunal?

MILITARY TRIBUNALS

Let me first consider the conscription example in more detail. The most famous group of conscientious objectors to conscription is the Quakers. Before the days of tribunals, the strength and sincerity of their pacifism could be tested by their widespread willingness to go to prison rather than carry a weapon. Since such a draconian response to otherwise law-abiding citizens became clearly inappropriate, it became the norm by the time of World War I to exempt Quakers from military service, as long as the draftee could demonstrate (by documentation or collegial testimony) that he had been a member of sufficient duration and commitment.

There existed two kinds of borderline cases: recent converts to Quakerism, and more mainstream Christians, and such applicants were interrogated before the tribunals. Typically the tribunal would ask them what they would do if the enemy was threatening their child and could only be stopped by force of arms. This is of course an unfair question, since there is nothing that the pacifist can respond *directly* that will satisfy that kind of unsympathetic questioner. So the response has to be indirect. That is, the pacifist has to repeat that instead of resolving conflict, violence merely begets further violence; if there were more pacifists in the world, there would be less violence. If the tribunal then suggests that such a notion is fanciful, evasive and self-deluding, the Quaker could respond that their approach is no different from Christ's, and that Christ is not normally rejected as fanciful, evasive or self-deluding.

The result is that the tribunal interrogations involved little more than impassioned reaffirmations from two very different worlds, and all the tribunal was left to evaluate was the applicant's apparent sincerity and depth of feeling. Of course, the original test of motivation remained: if the applicant was rejected, but then refused to enlist, he could be arrested and imprisoned. So one measure of the tribunal's success would be to reduce the number of false negatives. During World War I, it could be said that the tribunals were not very successful in this regard. For every three objections they permitted, they rejected two who then chose prison.[3]

In response to the unpopular Vietnam War in the USA, there were many more applications for conscientious objection. In two landmark Supreme Court cases, the tribunals started accepting the possibility of a secular pacifism, without requiring regular church attendance. In *Seeger* (1965), the court required tribunals to grant objections based on a pacifist ideal of goodness that was 'sincere and meaningful' and occupied 'a place in the life of its possessor parallel to that filled by the orthodox belief in God of one who clearly qualifies for the exemption'. Interestingly, Seeger 'cited such personages as Plato, Aristotle and Spinoza for support of his ethical belief in intellectual and moral integrity'. So Seeger still had to couch his objection in religious terms, even though he denied that he himself was a believer; and he relied on certain *academic* arguments to support his objection. A consequence of this was that such objections were not available to people who were less educated, less articulate, and less reflective. In the subsequent case of *Welsh* (1970), however, the Court went one step further and accepted the objection of a man who denied that his moral objections were religious in any way. It was enough that applicants held a conscience that, 'would give them no rest or peace if they allowed themselves to become a part of an instrument of war'. The question here is why a tribunal should be concerned about the psychological discomfort of the moral objector, without a similar concern for the discomfort of the coward, or the discomfort of the draftee more interested in a civilian career.

I do not want to pursue this question, however, nor do I want to argue against military tribunals—I only hope to introduce some of the difficulties for any tribunal to make fair and reliable judgements of the draftee's conscience. And I will claim that any proposed tribunal for medical objectors would face even worse problems.

MEDICAL TRIBUNALS

Let us return to Card's suggestion to set up a system of tribunals for doctors to explain their reasons for objection—for simplicity, I'm going to call these 'medical tribunals'. Card's thought is that without such a tribunal, it would be 'too easy' to object. However, while it is clear why a draftee would lie to conceal his non-moral reluctance, it is less clear what sort of non-moral reluctance a doctor could have. In a small-scale American survey, Meyers and Woods[4] describe the possible *financial* motives that a doctor might have, given the particularities of funding in the American system; however, these can be disregarded in a state-funded near-monopoly system such as the National Health Service (NHS). Meyers and Woods also mention *aesthetic* motives for obstetricians to resist performing second-trimester abortions: they are 'complex and frankly ugly. They are most unpleasant for everyone involved'. I am not competent to judge the complexity and ugliness of the procedure, but I find it hard to believe that they are any uglier—in terms of blood and gore—than other surgical interventions. If, however, the ugliness amounts to a moral qualm with the procedure, especially at the moment when the human-looking fetus is removed for destruction, then this would suggest the beginning of a genuine conscientious objection. At any rate, such a motivation will not apply to first-trimester abortions, and would not apply to British GPs who are only required to sign the authorisation form.

Some of the authors adduce other non-moral motivations. Marsh[5] suggests that the aim of a tribunal would be to expose 'unjustified biases,' but this is more relevant to, for example, a civil registrar's refusal to process homosexual applicants; whereas the objecting GP is refusing to authorise abortions to *anybody*. Kantymir and McLeod[6] worry about allowing objections that are 'based on incorrect empirical beliefs,' and they cite conscientious objections by parents to having their kids vaccinated based on the false belief that Measles, Mumps and Rubella (MMR) can cause autism. However, in the case of abortion the same empirical facts are accepted by both sides: they disagree only about the metaphysical and moral aspects of those facts.

So as a first defence of the absence of medical tribunals in Britain, I would argue that the number of false positives would be very small, and not enough to justify the cost of running the tribunals. As such, doctors can be trusted to voice their objections sincerely. What's more, we as a society *already* trust doctors so much when it comes to placing our health and our lives in their hands, that it would be highly inconsistent to then suspect an individual doctor's declared objection to be insincere.

However, assuming that there is a real risk of many false positives, there is still a question of whether a medical tribunal is the best way to distinguish applicants. In recent philosophical literature, there seem to be two options. Either the objector has to demonstrate that her beliefs are (1) 'genuine' (and deep), or that they are (2) 'reasonable'. That is, beliefs that either have the

required place in the objector's life, or beliefs that are independently worthy of respect. Let me discuss these in turn. (Kantymir and McLeod[6] also offer a third, hybrid option, but I will not discuss this).

Objection based on 'genuine' and 'deep' beliefs

Two proponents of this position are Meyers and Woods.[4 7] They begin with the assumption that the antiabortion beliefs in question are inherently intelligible and respectable. The belief that abortion is morally wrong, the belief that the fetus has the full moral status of a human being, or the belief that a normal pregnancy is not a disease and abortion is not a medical treatment—all of these beliefs are intelligible and respectable. So we are not talking about doctors with beliefs that are unintelligible (they object to working on Friday 13th) or based on unjustified biases.

The question is whether these beliefs are genuinely held, and run deep in the applicant's life. But how is the proposed tribunal meant to determine this? In the same way that a well documented, long-standing church-going Quaker is an easy case for the military tribunal, it might seem that a church-going Catholic would be an easy case for the medical tribunal. However, while pacifism is essential to being a Quaker, the opposition to abortion is not so essential to being a Catholic. Evidence suggests that most UK Catholics do not oppose abortion, even when the Church is officially against it.[8] So even this putatively easy case would require further discussion.

Perhaps the doctor could adduce evidence of her attendance at some sort of antiabortion protest, either on the streets on in a more academic venue. Perhaps she might have engaged in debate on the subject in the press or in academic journals. But it is surely possible to have a genuine and deep moral opposition to abortion without public protest or academic engagement. Perhaps one is simply not extroverted or confrontational as a personality; perhaps one is more interested in various hobbies than in spending one's free time at the barricades.

One could take a hard line, as Brownlee[9] seems to, and say that any putative conscientious objection that does not lead to public engagement and activism is not worth accommodating, for it reveals a special kind of double standard: the objector would refrain from complicity with what she considers wrong, but would seem to tolerate others performing the act. But this seems unfairly demanding, especially when one considers how small a part of the GP's job involves authorising abortions. And chances are that any putative objector has demonstrated a general moral seriousness that would otherwise greatly benefit the profession and her patients.

There is also another important reason why an objecting doctor might not engage in protest: she might see it as *pointless*. The striking fact about the UK is that there is no real political debate about abortion. Since the Act became law in 1967, it has been tweaked but never seriously challenged in Parliament or in the press. In many states in the USA, despite *Roe v. Wade* (1973), there is intense political debate, and the two sides are much more closely balanced, so it is much clearer that there is a cause worth fighting for. In Britain, it is therefore understandable that a British doctor would opt for a quiet but deep refusal of complicity. This is not to say that the moral beliefs in question are private and incommunicable—the objector is only too willing to discuss her views with those who come and ask her advice, either formally or informally.

Of course, the UK pro-choice consensus might be taken as increasing the burden of proof on the doctor who would refuse to give the patient what they can lawfully expect. The burden of proof would be increased further by the fact that British doctors are mostly trained in publicly-subsidised universities and hospitals. In both cases I would agree with respect to the vast majority of NHS clinical services, where health-related and resource-constraint criteria should fully determine provision. Non-emergency abortion is a unique kind of service, however, because of its essential moral contentiousness and complexity. And this reference to proof takes us away from the 'genuineness' criterion and towards the 'reasonableness' criterion, which I consider below. For the moment, however, I suggest that there might be a real problem for the tribunal to reliably establish the genuineness and depth of a politically inactive applicant.

Objection based on 'reasonable' beliefs

The main proponent here is Card.[1 10] In this case the tribunal's aim would be to distinguish those applicants with inherently reasonable (ie, intelligible and respectable) beliefs from those applicants with unreasonable beliefs—for example, superstitious or racist—without enquiring into the actual place that such beliefs hold in the applicant's life. An issue of abortion happens to be one where opposing beliefs are widely taken to be equally reasonable. The word 'reasonable' admits of different degrees, however. In the most extreme, it could mean that the reasonableness of the objector's belief would have to result in the tribunal being *persuaded*—but Card rightly rejects this as too stringent.

For Kantymir and McLeod,[6] the objector would have to show 'that what grounds the objection is as likely to be true as what grounds the standard of care for patients'. But this language of truth, and greater likelihood of truth, is most at home in the empirical sciences; it cannot be so directly applied to moral enquiry and disagreement in cases such as these, where the objector holds a passionate commitment to a moral position. An astronomer might conclude that it was more likely to be true, on the basis of evidence, that there was once water on Mars: the conclusion is essentially tentative, and open to counter-evidence. The objector's strong moral belief, that abortion is wrong, is not similarly tentative and is not vulnerable to counter-evidence because all the possible evidence is already in (I will return to this in a moment). In addition, Kantymir and McLeod speak of what grounds the standard of care for patients—the objecting doctor would say that the abortion is morally bad not just in itself, but also bad *for the patient*, and this would be part of their intelligible and respectable belief.

There are two other problems with Card's reasonability view. First, since this version is about the beliefs themselves rather than the applicant's relationship to those beliefs, then the tribunal experience would become essentially no more than a memory test, to see if the applicant can cram and regurgitate one of the many 'reasonable' arguments. Card would presumably respond by requiring the tribunal to challenge the objector. In practice, however, debates about abortion tend to founder quickly on dogmatic foundational stances with only intuitive authority: for example, it is very hard to 'prove' what sort of moral status the fetus has. (There are of course other loci of disagreement in the abortion debate, mostly involving similarly unprovable claims on both sides.) So this would be similar to the Quaker being bullied with an unanswerable question. Moreover, there is the same problem as with the 'genuineness' criterion: an intellectual debate on the details of the applicant's antiabortion position would favour those GPs who were articulate and combative. Surely it is too much of a burden to ask the GP, on top of her existing professional commitments, to prepare for a test on material that remains so complex and contentious

even among professional philosophers. (Marsh[5] makes this point as one horn of his dilemma.) Many GPs, just like many ordinary people, have an unreflective opposition to abortion as just obviously wrong because the fetus is 'obviously' a child. If pressed for further reasons for thinking this, they will say that the ordinary discourse among happily pregnant women is of a 'baby' inside them; and that mothers tell their children 'when you were inside me, you were only this big'. That hardly constitutes 'proof', but it might be the best that the objector can do.

Second, one problem with the abortion debate is that the arguments of *both* sides are so familiar. The issues are discussed in university applied ethics courses, and in high school debating clubs and the media. In many informal contexts, people tend to avoid discussing abortion precisely because of the likelihood of stalemate and shrill indignation spoiling an otherwise useful or pleasant relationship. Because the arguments of both sides are so familiar, it is again pointless to engage in debate. Some people, especially when they are young, may be genuinely perplexed about abortion, and may then seek out friends or authority figures to discuss the matter in greater depth—and the nature of the discussion will be one of the young person trying to decide what stance to take on the issue. Here the academic debates are important. Perhaps some GPs are genuinely unsure about their position. But in our scenario, the GP has already come to a position of opposing abortions, and there is no further need to 'test' it. The tribunal would almost certainly be unable to present any *new* evidence or arguments that would change her beliefs.

This is not to say that the objecting GP's position is infallible or defiantly immutable; only that if and when the objecting GP does change her mind on abortion, it will be the result of some sort of startling experience (or series of experiences) that (suddenly or gradually) *move* her rather than *persuade* her. Similarly, a GP may have a *general* opposition to abortion, but then be genuinely perplexed when it comes to deciding what to do with her own accidental and inconvenient pregnancy. And of course the business of moving rather than persuading could go the other way: if and when a staunchly pro-choice GP comes to oppose abortion, I suggest that this change of mind would often not be the result of watching or participating in a debate, and that many of the more ingenious arguments are seized more as post hoc rationalisations.

So far I have been speaking of a GP with a *secular* moral opposition to abortion. The 'reasonableness' criterion becomes even more difficult to apply in the case of a GP whose moral beliefs ultimately flow from a foundational set of religious beliefs. Here the tribunal would have even less point because of the notorious difficulty of justifying religious belief to a non-believer, and it would be too much to expect tribunal members to be theologically educated.

To conclude, any objecting GP could understandably believe an interrogation by a tribunal to be a pointless exercise. And if that is the case, the exchange at the tribunal would descend into a bureaucratic formality that is demeaning to the individuals and to the serious positions on the complex debate.

Competing interests None declared.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

1 Card R. Conscientious objection and emergency contraception. *Am J Bioeth* 2007;7:8–14.
2 Savulescu J. Conscientious objection in medicine. *BMJ* 2006;332:294–6.
3 Braithwaite C. *Conscientious objection to compulsions under the law*. York: William Sessions Limited., 1995.
4 Meyers C, Woods R. An obligation to provide abortion services: what happens when physicians refuse? *J Med Ethics* 1996;22:115–20.
5 Marsh J. Conscientious refusals and reason-giving. *Bioethics* 2014;28(6):313–19.
6 Kantymir L, McLeod C. Justification for conscience exemptions in health care. *Bioethics* 2014;28:16–23.
7 Meyers C, Woods R. Conscientious objection? Yes. But make sure it is genuine. *Am J Bioeth* 2007;7:19–20.
8 Sewell C. Most UK Catholics support abortion and use of contraception. *The Independent* 19 September 2010.
9 Brownlee K. *Conscience and conviction*. Oxford: Oxford University Press, 2012.
10 Card R. Reasonability and conscientious objection in medicine: a reply to Marsh and an elaboration of the reason-giving requirement. *Bioethics* 2014;28:320–6.

FURTHER READING

11 Roe v. Wade, 410 U.S. 113 (1973).
12 United States v. Seeger, 380 U.S. 163 (1965).
13 Welsh v. United States, 398 U.S. 33 (1970).
14 UK Abortion Act 1967.