PAPER

Conscientious objection in healthcare and the duty to refer

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ABSTRACT
Although some healthcare professionals have the legal right to conscientiously object to authorise or perform certain lawful medical services, they have an associated duty to provide the patient with enough information to seek out another professional willing to authorise or provide the service (the 'duty to refer'). Does the duty to refer morally undermine the professional's conscientious objection (CO)? I narrow my discussion to the National Health Service in Britain, and the case of a general practitioner (GP) being asked by a pregnant woman to authorise an abortion. I will be careful not to enter the debate about whether abortion should be legalised, or the debate about whether CO should be permitted—I will take both as given. I defend the objecting GP's duty to refer against those I call the 'conscience absolutists', who would claim that if a state is serious enough in permitting the GP's objection in the first place (as is the UK), then it has to recognise the right to withhold any information about abortion.

Conscientious objection (CO) in healthcare has its opponents[1–3] and its defenders,[4 5] including myself.[6] By far the subtlest, most wide-ranging discussion and most empirically-informed account (although focusing mainly on the USA) is that of Wicclair.[7] In this paper, I do not want to enter this debate, and will assume throughout that CO is morally justifiable. Since there seem to be different kinds of CO among different healthcare professionals in response to different services or procedures (not to mention non-health contexts), I will narrow my discussion to the general practitioner's (the GP) objection to authorising an abortion in Great Britain.[i] I will not enter the substantive debate about abortion, and will accept the current situation in Great Britain,[ii] where abortion is available more or less on demand up until the 24th week of gestation, and where—unlike the USA—there has not been any significant political debate among politicians or among the general public about its legality for the past 50 years. In addition, in taking the British context, I am assuming a context where the vast majority of the population is provided with healthcare, free at the point of delivery, paid by general taxation through the National Health Service (NHS). (I accept that the issues surrounding the CO of private doctors are more complicated).

Legally, the British GP's objection is permitted by the 1967 Abortion Act, section 4, but is subject to a compromise (henceforth the 'compromise'), according to which the objecting GP is obliged to provide the patient with reliable information of where the service will be authorised or performed. The idea behind this compromise is, as far as possible, to preserve both the moral integrity[iii] of the objecting doctor and the patient's access to the lawful service. This obligation is sometimes known as the 'duty to refer', although it should be immediately distinguished from a *formal* referral, whereby the objecting professional would sign a relevant bureaucratic form, resulting in the patient being formally transferred within the healthcare system (with the important corollary, for my purposes, that there is no other way for a patient to reach the service except by formal referral).[iv]

This paper will examine this duty to refer, and my aim is to defend the present compromise in the NHS, and argue that the duty does not morally undermine the CO. I will mainly be arguing against the 'conscience absolutist',[v] who believes that if CO is to mean anything at all, it means permission to refrain from having anything to do causally with the abortion, that is, permission to refrain from authorising, performing or even informing the patient, in order to avoid complicity in what the GP considers a grave wrong. The absolutist position is powerfully summed up by Michael Bayles:

> If a physician sincerely believes abortion in a particular case is morally wrong, he cannot consistently advise a patient where she may obtain one. To do so would be to assist someone in immoral conduct by knowingly providing a means to it. The physician would bear some responsibility for the wrongful deed. Believing the abortion to be morally wrong, he believes that it is wrong for

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[i]In 2007, the prochoice Marie Stopes charity published a survey entitled *General practitioners: attitudes to abortion*. According to the survey, 20% of GPs declared themselves to be anti-abortion. See: http://www.shnwales.org.uk/Documents/485/Report,%20GPs%20attitudes%20to%20abortion%202007%20Marie%20Stopes.pdf (accessed September 2016).
[ii]Not including Northern Ireland, where the law governing abortion is different.
[iii]Personally, I do not like the term 'moral integrity' and I do not think it can ground a moral argument in defence of conscientious objection, as I argue in Cowley.[6] However, it is well established in the literature and for the sake of brevity I will use it too.
[iv]Chervenak and McCullough[8] call such referring *indirect*, and only comprises the provision of 'enough information' for the patient to seek out another doctor.
[v]I am borrowing the term 'absolutist' from Wicclair,[7] although I am using it in a more limited sense in this paper, to mean only the rejection of the duty to refer.

> anyone to perform it and for the woman to obtain it. If he directs her to a physician who will perform it, then he assists both of them in acting wrongfully.[9]

More bluntly, the duty would be tantamount, in the words of Stein, to the objecting GP saying: "I don't kill people myself, but let me tell you about the guy down the street who does".[10] David Oderberg is a robust defender of this position, basing his argument on the Doctrine of Double Effect (DDE); I will be considering his arguments in detail below.[5]

Opponents of CO will also reject the compromise because they oppose CO in healthcare and also because they believe that the duty to refer so morally undermines the GP's objection that the state might as well prohibit the objection in the first place, and thereby minimise the inconvenience to the patient when accessing a lawful service.

Of course, both CO and the compromise could be defended on purely *political* grounds. There are a number of GPs who are otherwise qualified and experienced, and are morally willing to do 95% of their jobs, and the compromise is necessary to keep them, and this makes the system as a whole better off, and makes patient as a whole better off. Such political calculations will look at the numbers of people involved, the potential costs to the NHS, the potential costs to the patients, the strength of the willingness or reluctance involved, in order to reach the compromise. Many non-objecting healthcare professionals can respect the CO of their colleagues, but might argue that their moral discomfort about complicity has to be 'outweighed' by the risk of inconvenience to the patient in accessing lawful services. This paper, however, seeks a *moral* justification of the compromise. I will argue that it is fair to compel the GP, as a condition of their job, to provide the information to the patient; the corollary is that I consider the CO on its own to be sufficient to protect their moral integrity.

THE COMPROMISE

The situation I have in mind is as follows: a competent adult woman, pregnant to <24 weeks, approaches her GP for assistance in getting an abortion. To keep things simpler, I will assume that the pregnancy is not a result of rape or incest, and that both foetus and woman are healthy.

Formally, the law requires the signatures of two medical practitioners on the relevant HSA1 form. If the GP does not have a CO, she can provide the first signature, and the gynaecologist who performs the procedure in a hospital will provide the second signature. Many conflicts with objecting GPs are easily avoided. There is plenty of information online about specialised clinics,[vi] where the woman can go to get both signatures and the procedure itself. If a GP works in a large surgery, then there may be information on the surgery website, or printed information in the surgery itself, about any of the GPs with a CO. The surgery receptionist can also inform the patient. Despite all this, a particular woman might well find herself asking a GP to authorise her abortion, and the GP may have a CO.

In their 'explanatory guidance' to objecting doctors, the General Medical Council (GMC) declare that:

> 12. Patients have a right to information about their condition and the options open to them. If you have a conscientious objection to a treatment or procedure that may be clinically appropriate for the patient, you must do the following:
>
> a. Tell the patient that you do not provide the particular treatment or procedure, being careful not to cause distress. You may wish to mention the reason for your objection, but you must be careful not to imply any judgement of the patient.
>
> b. Tell the patient that they have a right to discuss their condition and the options for treatment (including the option that you object to) with another practitioner who does not hold the same objection as you and can advise them about the treatment or procedure you object to.
>
> c. Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.[vii]

Before I discuss the duty to refer, it is worth saying a few things about this guidance in order to understand the complexity of the problem here, some of which will be relevant later. First of all, point a. is not quite enough: in explaining that she will not authorise the abortion, the objecting doctor has to make it clear that her objection is *moral*; the patient must not be allowed to think that there might be *clinical* reasons not to have the procedure, for then she might not seek authorisation from another GP. Second, although the objecting doctor might not want to discuss details about the abortion procedure, if the patient is not sure what an abortion is, or if she does not know that it is legal and/or safe in Britain, the objecting doctor does have the obligation to inform her of the option. Third, the words 'clinically appropriate' are a bit unfair. The objecting GP will disagree with such a description and since I have been assuming that the pregnancy is healthy, then abortion is never *clinically* appropriate, since clinical appropriateness has to do with treating a disease, repairing an injury or relieving suffering. It would be more honest to speak of *social* appropriateness, given the status of abortion, in most British people's eyes, as a morally acceptable solution to a particular restriction on their lives.

Fourth, let me return to point a. The objecting doctor must 'be careful not to cause distress', and must avoid 'imply[ing] any judgement of the patient'. This is tricky. Certainly, some patients will not be distressed by the doctor's CO, although they may feel a brief surprise and annoyance. And insofar as they might feel judged, they will shrug it off: they know that abortion is a contentious issue for some, but they know where they stand and they are not interested in a debate. Other patients might be genuinely unsure of what to do, may come to the objecting doctor for moral advice and may explicitly ask to hear the doctor's reasons for her objection (especially if the doctor knows the patient well). Here the doctor could argue her case, but must avoid pressure or proselytisation. However, one can also imagine a third kind of patient, young and vulnerable and already socially disempowered, finding it very difficult to visit the GP under these circumstances, only to be met with a blunt refusal that could easily be distressing. Moreover, it is hard to

[vi]Such as those run by the charities Marie Stopes, or by the British Pregnancy Advisory Service.

[vii]The GMC regulates the medical profession in the UK. This quotation is taken from the section entitled 'Personal Beliefs and medical practice' (2013). Available at: http://www.gmc-uk.org/guidance/ethical_guidance/21177.asp (accessed September 2016). The Royal College of General Practitioners, in its *Good Medical Practice for General Practitioners*, puts it more forcefully, in terms of the patient's *right* to see another doctor: "If you have a conscientious objection to a particular form of treatment, you should explain this to the patient, and ensure that they have sufficient information to exercise their right to see another doctor without delay". See: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Good_Medical_Practice_for_GPs_July_2008.ashx (accessed February 2017).

know how the GP can express her objection without implying a moral judgement: after all, the objecting GP considers what the patient is requesting to be at the very least manslaughter.[viii]

To reduce this risk, it is important to distinguish the exercise of conscience from the activity of moral protest. As Blustein puts it, "it is part of the logic of the concept of conscience that my conscience can only forbid *me* from acting in certain ways or instruct *me* to act in certain ways, not other people".[11] Phrased that way, the patient should not interpret it as a moral protest against *her* and *her intentions*. On the other hand, this can go too far. The language of the GMC Guidance seems to be asking objecting GPs to downplay and to personalise their objection, as if saying "I'm sorry, this is just a little quirk about me, you mustn't worry, go and see my colleague"—in the spirit of a GP who might say "I'm sorry, I'm not feeling well, I need to go home and rest, my colleague will sort you out". Downplaying and personalising the objection in this way would surely be difficult for the objecting doctor. The question is whether a balance can be struck in allowing the doctor to express her moral objection *as* a moral objection, clearly and firmly, but without distressing the vulnerable patient, or exerting significant moral pressure on her.[ix]

MORAL COMPLICITY

The conscience absolutist will say that the duty to refer involves complicity with wrong, to such a degree as to morally undermine the CO: insofar as a state accepts the right to CO, then it cannot simultaneously insist on the duty to refer. A recent and detailed account of complicity comes from Lepora and Goodin.[12] They offer the following formula to calculate an accomplice's moral blameworthiness vis-à-vis the wrong performed by the principal actor:

> The *pro tanto* blameworthiness for an act of complicity=function of (badness of principal wrongdoing, responsibility for contributory act, extent of contribution, extent of shared purpose with principal wrongdoer).[x]

Their account is very general and they examine many different kinds of more or less blameworthy complicity, especially in the context of humanitarian aid. For our purposes, how would the GP's duty to refer fit into the above formula? First, the GP clearly does not share the purpose with the pregnant woman seeking an abortion, so that would reduce her complicity. Second, the GP is clearly responsible for her contributory act (informing the patient) in the sense that the GP understands that the information is useful and how it will be useful, so that would increase her complicity. After that things become more complex. In providing the patient with information which the patient did not already have, the GP is contributing to a process which may well lead to the patient going to another GP for authorisation and/or to an abortion clinic for the abortion. The GP knows the information is useful and surmises that the patient is very likely to make use of it. Lepora and Goodin go on to discuss the extent of the contribution in terms of how proximate and necessary it is to the final wrongdoing.

Proximity is hard to measure, morally. There are several steps that remain for the patient and other healthcare professionals to take before the principal act is carried out; but the conscience absolutist will say that even a remote contribution undermines the CO. More important is the question of how necessary the duty to refer is to the principal act. Even if the GP discourages the abortion by refusing the authorisation, it could still be argued that the provision of information is a necessary link in the chain leading foreseeably to abortion.[xi] Necessity is ambiguous, however. In a general sense, the GP's informing the patient is not necessary at all, given how widely available the information is about abortion services in Great Britain, and given that the GP is not being asked to provide a *formal* referral, but only information. Nevertheless, once *this* patient comes to *this* GP, and then uses this GP's information to eventually get *this* abortion, that would seem to make the information-provision necessary, and therefore would make the GP morally complicit in *this* chain of events. Call this the problem of the necessary contribution, and let me park it for the moment. Once I have discussed the Doctrine of the Double Effect in the next section, I will return to address it.

The final element of Lepora and Goodin's formula is 'the badness of the principal wrongdoing'. However, most of the examples by Lepora and Goodin involve uncontestable cases of wrongdoing—there is a whole chapter on the different kinds of complicity with the Rwandan genocide. In contrast, however, the badness of abortion is *essentially contestable*. There are many people in Britain who are well informed, morally serious and open-minded, who do not see abortion (before 24 weeks) as morally wrong. Of course, the objecting GP considers abortion wrong, and that is not a contestable matter *for her*. Call this the problem of essential contestability, and once again I will park it until after the next section.

ODERBERG'S ARGUMENT AGAINST THE DUTY TO REFER

Now that we have a better understanding of the duty to refer, and the objecting GP's possible understanding of that duty as complicitous, let me now explore a strong and systematic argument for conscience absolutism, from David Oderberg,[5] who draws on the long tradition in Catholic moral theology of the DDE. Some of this we already saw in the Lepora and Goodin. In its basic form, the DDE starts with an agent who freely and knowingly performs an act, intending to bring about a result A, but reliably foreseeing (not intending) that a bad secondary consequence (B) will also be brought about in the process. The doctrine explores the conditions under which the agent might not be absolved of responsibility for result B. The doctrine has wide application in many contexts. For example, during a just war, a pilot fires her missile on an enemy munitions factory (a legitimate target), reliably foreseeing that innocent civilian factory workers will be killed in the process.

Oderberg describes a refinement of the DDE, which has to do with cooperation. An agent can knowingly and freely perform an act, intending to bring about one result, but reliably foreseeing that their act will have a second effect of assisting or

[viii]I use the word 'manslaughter' in order to avoid the shrill connotations of the word 'murder' when used by prolife lobby groups. Presumably, the objecting doctor would consider the patient to be ignorant of the moral nature of what she is asking, and therefore, strictly speaking, not guilty of *murder* when going through with the abortion.

[ix]A lot more could be said about the specific conversations between the objecting GP and her patients. Nordberg *et al*[13] interviewed seven Norwegian GPs about their conversations, about fitting their objections with their role as professionals and about the impact of such objections on their patients.

[x]Lepora and Goodin,[12] p. 98.

[xi]Fovargue and Neal are conscience absolutists in my sense of the term. They argue that 'the physician's role […] is a *sine qua non* in the chain of events, which culminates in the immoral action, regardless of whether she counsels against the immoral choice'.[4]

encouraging another person in their performance of a separate wrong act. So a pacifist ground technician can fix the bomber aircraft, reliably foreseeing that this will assist the pilot in killing enemy civilians. In the language of the DDE, the technician makes a 'material' as opposed to 'formal' contribution, since he does not share the bomber's intention to bomb the factory; and he makes a 'mediate' as opposed to an 'immediate' contribution, since he does not take direct part in the bombing. The DDE also generates the problem of necessity (which Oderberg calls 'dispensability'). However, the most important and the most complex criterion of the DDE is that of 'proportionality'. If the objecting GP has to choose between remaining in her job and being occasionally complicit in what she considers a grave wrong, then she has to compare that complicity to the moral benefits—to herself, to her family, to her present and future patients, and to the system as a whole—of remaining in the job.

Given the gravity of the wrong in question, however, the DDE would seem to support conscience absolutism, unless it can be shown that the contribution is not sufficiently proximate or indispensable or disproportionate. To explore both possibilities, Oderberg considers a recent UK Supreme Court case of CO, that of *Doogan and Wood*.[xii] Doogan and Wood were two experienced midwives, acting as managers of the Labour Ward of the Southern General Hospital in Glasgow. As such, they were employees of the Greater Glasgow Health Board, and therefore of the NHS. They both had a CO to abortion, and when working as midwives were allowed to opt out from participation in abortion procedures. When they were hired as managers of the labour ward, only regular births were performed at the ward, and their job was to organise the rota, that is, to allocate the midwives under them to the various births. After a hospital reorganisation, their ward was to accommodate abortions as well.

According to the 1967 Abortion Act, section 4, 'no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to *participate* in any treatment authorised by this Act to which he has a conscientious objection'. The key word here is 'participation'. Doogan and Wood objected to 'delegating, supervising and/or supporting staff to participate in and provide care to patients throughout the termination process'. The UK Supreme Court ruled that 'participation' involved only direct, immediate involvement with the abortion procedure, and that Doogan and Ward were not proximate and immediate enough for participation and therefore for their objection to be recognised.[xiii]

Oderberg argued that the Supreme Court should have drawn from the tradition of interpreting 'participation' in the legally wider context of aiding and abetting (cooperation), and using the more subtle conceptual tools of the DDE. The pregnant woman seeking an abortion is formally admitted to the hospital by the Health board, without any decision by Doogan and Wood. The patient is allocated to Doogan's and Wood's ward, and then to a surgical operating theatre. A gynaecologist is allocated to the theatre, and needs assistance from a midwife. Here, the women's dual role is *prima facie* important: *as midwives*, Doogan and Wood can object to assisting the surgery; but *as managers*, they would have to allocate the midwives working under them. It would then be up to the Court to determine whether Doogan's and Wood's managerial roles were indispensable to the abortion (or whether a midwife could be allocated in any other way) once the patient had been admitted to the Southern General Hospital and the standard process set in motion.

MY ARGUMENTS IN FAVOUR OF THE DUTY TO REFER

I have spelled out Oderberg's reaction to the *Doogan* decision so that I can then ask: could the same logic apply in the case of our objecting GP and her duty to refer? I would argue not. My first argument makes reference to the *confined patient trajectory*. In *Doogan*, the pregnant woman turns up at the front desk of the Southern General Hospital, where she is formally admitted. Once admitted, she has no further choice about where to go and when, save for toilet breaks and for her general right to discharge herself. Once she is admitted, she is confined both to the hospital premises and to the hospital procedures right through to the abortion and beyond; she has no say about which particular surgeon will carry out the procedure or which particular midwife will assist.

Similarly, Doogan and Wood have no choice but to receive her on their ward when she is sent there by the hospital reception; they have no choice but to look after her, either directly or to allocate their midwives to look after her. When the operating theatre is ready, they have to send the patient there, and they have to allocate a midwife to go with her. Their role in the procedure is clearly necessary, and this would make them morally complicit in what they considered to be the grave wrong that would foreseeably take place at the end of the procedure.

In contrast, the pregnant woman comes to visit the objecting GP, and asks the GP for her authorisation, together with information about the process. The GP explains that she is a conscientious objector and cannot provide the authorisation, but then tells her patient to go and see her colleague down the hall, who will give her what she wants. And here is the important part: the pregnant woman *leaves the GP's office*, and returns to the public space of the surgery waiting room. At that point, she is free to come and go as she pleases, without asking anyone's permission, she is not confined to a building or to a procedure. Importantly, she is also free to use the information and seek out the abortion, or to use different information to the same end, or to change her mind about the end. The GP has provided her with information, information which she can use, but once she leaves the GP's office, she leaves the NHS, and it will be up to the woman to *return* to the NHS by seeking out the GP's colleague down the hall, or seeking out the abortion clinic down the street. Either way, the woman goes there *on her own*. I claim that this breaks the chain of cooperation, collapses the putative necessity of the GP's contribution and means that the GP's objection is not morally undermined by her providing the information.

My second argument concerns essential contestability. Earlier I argued that the Rwandan genocide was uncontestably wrong, and so complicity in it would always be *prima facie* wrong. Similarly, the death of the civilian factory-workers is uncontestably wrong, although the bombing of the factory may still be morally justified. In contrast, abortion is not *uncontestably* wrong. First, as a 'live' issue in applied ethics, across the world, it is an issue about which well-informed, reasonable and goodwilled people, can and do disagree. I hasten to add that I am not making a cheap relativistic point designed to eliminate moral disagreement by eliminating objective morality. After all, I

[xii] *Greater Glasgow Health Board v Doogan and Anor* (2014) UKSC 68.
[xiii] In this, the Supreme Court confirmed the House of Lords ruling in *R v Salford Health Authority; Ex p Janaway* (1989) AC 537. Janaway was a secretary working at a GP surgery, and she tried, unsuccessfully, to claim a conscientious objection to writing abortion referral letters.

have enough respect for the objecting doctor's view of abortion that I would support her CO.

Second, it is an issue that is no longer subject to serious debate in the British Parliament (unlike in some US states), where there is no significant political grassroots movement to repeal the legislation, and where there is no serious move by the GMC or BMA to change the involvement of the medical profession. The GP does not live and work in a vacuum, she is a citizen in a particular democratic country, an employee of a particular employer and a member of a particular professional body. And what is more, when she decided to become a GP (rather than a dermatologist, say) in the NHS (rather than private practice) in Britain (rather than Ireland), she knew what the legal and political situation with abortion was. That means that the GP's CO cannot hinder the patient's access to the abortion she is entitled to expect *given* the decisions that have already been made by the UK Parliament, by the NHS and GMC, and by the British public as a whole, decisions that have achieved a certain amount of moral legitimacy simply in virtue of enduring 50 years without serious political challenge.[xiv] However, despite the consensus in favour of abortion, the state is prepared to recognise the essential contestability by allowing CO.

There are two issues that follow on from the above. First, the GP has two roles, that of doctor and that of representative (even if not an employee) of the state's public health service; the patient is legitimately entitled to expect, from any health service representative, *at the very least* information about how the health system works, and about where certain services are provided. Whether this particular GP has a *moral* objection or a *clinical* inability is, in a sense, all the same to a patient who does not know her way around the health system, as long as she eventually receives the service that she is entitled to seek.[xv]

Second, in seeking respect for her moral views as a conscientious objector, the GP has to respect the moral views of her colleagues, her employers and her patients. There is a larger point here, and that has to do with what the GP *allows herself to think*: about the pregnant patient seeking an abortion, about her colleagues who are willing to authorise it or perform it, about her employers (the NHS), indeed about her fellow citizens. She has chosen not to live in a cave, but to live in civil society, to work in a practice, to make herself available to these patients.

'Allowing oneself to think' might sound a bit strange: surely one either thinks of something or one does not. But I have in mind the way that one can *endorse* or *repudiate* a thought that pops into one's head. For example, I might have a fleeting racist thought, and promptly repudiate it, as something inappropriate to think, and as something that does not correspond to my own ideal of myself.

What does it mean to respect one's colleagues and one's patients? The GP owes more than grudging liberal tolerance, and should do more than merely excuse them for what she sees as their moral ignorance. Indeed, the GP cannot see it consistently as ignorance but as profound ignorance, and this would make it very hard, without crushing dissimulation and self-deception, to deal with that abortion-seeking patient in all other routine health matters and to deal with her non-objecting colleagues in the day-to-day business of running the practice, let alone to engage in friendly banter around the water cooler.

Instead, the GP has to learn to see beyond the other's moral views, or beyond their moral mistakes, through to the *life* of the other. This might sound like strange advice when so many go into the medical profession precisely because of their profound concern for suffering humanity. However, when the other is suffering in accordance with standard physical or mental diagnostic categories, then the GP knows what to do and what to think; she knows when to empathise, and when to resist the temptation to empathise; she knows when to pry and probe and when to hold back. There is a shared awareness between doctor and patient of physical and mental suffering, and this can result in spontaneous sympathy and in a deeper sense of 'there but for the grace'.

In contrast, dealing with a colleague or a patient or a manager who reveals a profoundly different moral outlook is much more difficult; and it is all the more difficult when the other person might be perfectly likeable, and otherwise morally and intellectually respectable. When encountering such a deep moral conflict, one temptation would be just to avoid the other person. But here is my point: the GP cannot realistically avoid her colleagues in the surgery, cannot avoid her managers and cannot avoid her patients, so she has to learn some kind of deeper respect for them—*regardless* of whether or not she is also attending prolife marches at the House of Commons on the weekend.

She has to start with the assumption—a defeasible assumption—that the patient understands her own life better than the GP does. As Chervenak and McCullough put it in their discussion of the motivations behind abortion: 'Pregnant women appeal to a wide range of cultural, familial, religious and personal beliefs that physicians are not professionally competent in beneficence-based clinical judgement to evaluate'.[8] When the patient is vulnerable and socially disempowered, the doctor's ability to understand might be even more limited by her own class background. Beyond that, each GP has to figure it out for herself, how to remain sincerely civil with her colleagues and managers, and how to remain humanly available to her patients. It requires a special kind of humility: not the humility that says "I might be wrong"—for we are dealing with someone who is very confident she is not wrong—but rather the loving humility necessary to accept the mystery of moral pluralism.

CONCLUSION

I have defended the status quo in Britain: (i) I support the legal provision allowing GPs to conscientiously object from authorising abortion; (ii) nevertheless, I think it is fair that the objecting GP be required to provide information to a patient about abortion, including the specifics of who (and where) will authorise it, and who will perform it; (iii) I disagree that such a requirement morally undermines the CO. In support of my defence, I have argued that the provision of information is not a necessary or indispensable link in the chain of actions leading to the abortion, since, after receiving the information, the patient leaves the NHS space and becomes a free agent, ready to make her

[xiv] Savulescu[1] uses this same argument of democratic participation to argue against the legal recognition of conscientious objection. In response to Savulescu, I have argued[6] that the GP's conscientious objection to abortion should be recognised because it is *not* based on a mere aversion or on a philosophical position, but because it is based on a credible rival conception of the goals of medicine.

[xv] This line of thinking can be strengthened by considerations of probability. Insofar as the woman was approaching the NHS, rather than this particular GP, then it was an accident that this particular NHS representative was one of the minorities holding a CO. As such, the GP as NHS representative owes it to the patient, on behalf of the NHS, to steer her in the right direction to compensate her for her bad luck.

own decisions. Second, I have argued that the GP as a representative of the NHS owes the patient information about how lawful NHS services are organised. Third, I have argued that the GP's own view of abortion as a grave wrong, and her own view of the information-provision as serious moral complicity, has to be balanced against the opposing views of well-informed, morally serious and good-willed people. This is not to argue for the tyranny of the majority, but only for the recognition of essential contestability and moral pluralism on this issue. A corollary of this third point is that the GP also has to find a way to embrace (not just tolerate) this pluralism if she is to cooperate fully with her non-objecting colleagues and managers, and if she is to treat her patients with her full concern despite their deep moral disagreement.

I am not sure the degree to which my arguments could be applied to other contexts of CO, in healthcare or elsewhere. Needless to say, those entirely opposed to CO in healthcare will not be much interested in some of the distinctions I am trying to make in order to defend the duty to refer: such opponents will see me as either introducing needless complexities, or as relying on some arguments—especially those based on respect for patients—as supporting the wholesale prohibition of CO on the grounds of consistency of provision.

In the end, I am acutely aware of my own ignorance of the healthcare world and especially of the conversations that real conscientious objectors have with real patients. My suggestion for further research would be to start there.

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Notes