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Conscientious Objection in Social Work and Healthcare: A Philosophical Analysis

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Abstract

Healthcare and social work would seem to have a lot in common. Both of them involve professional care, even if the methods and the targeted needs are different. However, they differ strikingly in the place accorded to conscientious objection (CO). The right of healthcare professionals to refuse to perform or authorise certain lawful services is well protected by the law of most Western jurisdictions. In addition, these conscience rights have been subject to a good deal of discussion in the medical ethics and medical law literature. In contrast, there seems to be very little scope for CO among social workers and very little discussion about CO in the social work literature. I examine the possible reasons for this difference, and then investigate the sort of things that a social worker might plausibly object to. In the end, I defend the position that social workers should not be permitted to express a CO, although I accept that they have other avenues for expressing legitimate dissent.

Keywords: Conscientious objection, moral dissent, professional judgement

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Healthcare and social work would seem to have a lot in common. Both of them involve professional care, even if the methods and the targeted needs are different. They are driven by similar ethical principles. Students probably choose them as university subjects for similar reasons. In addition, healthcare and social work have to be intimately co-ordinated within a coherent state policy; healthcare professionals and social workers often work on multi-disciplinary teams, and have to refer patient-clients back and forth when necessary. Finally, certain healthcare professionals—e.g. general practitioners and palliative care consultants

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and community nurses—probably carry out many tasks that would also be assigned to social workers.

However, there is one big area where they are not similar, and that concerns a role for conscientious objection (henceforth CO). The right of healthcare professionals to refuse to perform (or authorise) certain lawful services seems to be well protected in law. Perhaps the most famous example is Section 4 of the 1967 UK Abortion Act. There are less formal provisions for a healthcare professional to recuse herself from a care team in the event of the team's decision to withdraw life-sustaining treatment, such as the Section 79 of the GMC Guidance 'Treatment and care towards the end of life: good practice in decision making'. These conscience rights have been subject to a good deal of discussion in the medical ethics and medical law literature (Smith, 2015).

In contrast, there is very little discussion about CO in social work. A literature search on the topic was able to find only two significant articles in the past fifteen years (Sweifach, 2011; Mongan, 2018). Three textbooks on social work ethics (Clark, 2000; Banks, 2012; Beckett *et al.*, 2017) do not mention CO at all. The Codes of Ethics of the British Association of Social Workers (BASW) and of the American National Association of Social Workers (NASW) do not mention CO. The two Codes mention 'integrity' but this seems to refer only to consistency and trustworthiness. In a survey carried out by Sweifach (2011, pp. 3–7), an overwhelming majority (79 per cent) of social workers and social work administrators declared that a social worker 'ought to work with all clients regardless of whether the social worker has a religious/moral objection to the client's issue'.

At first glance, this is a curious difference between healthcare and social work. An easy response to the difference would be to say: good for the social workers; CO should also be eliminated from healthcare too. This sceptical position on healthcare CO was famously advocated by Savulescu (2006), and has gained supporters in the literature (more recently see Schuklenk and Smalling, 2017). According to this position, healthcare professionals should not be allowed to pick and choose which lawful services they will and will not offer, or which patients they will or will not serve. Although CO might have a place in compulsory military service, nobody is forcing people to become doctors and nurses, and nobody is forcing them to train in certain specialisms that might raise ethical difficulties for them.

For my purposes, I want to start with the assumption that CO *can* be justified in the healthcare context. I will not argue for that since others have done so already, most successfully Mark Wicclair in his 2011 book on the subject. My question then becomes: should social workers be allowed to object in the same way as healthcare professionals? In response, I shall defend the status quo, and argue that they should not. However, I will also have to distinguish the various forms of dissent available to social workers, and how those forms differ from CO.

Before I begin, I will briefly adumbrate one weak argument in order to reject it right away. It might seem that doctors make much more 'serious' decisions, about life and death, and therefore we need a regime of CO to protect those doctors who strongly object to actions that might result in a foreseeable patient death; whereas social workers are involved with the much more 'ordinary' life decisions about resolving the ordinary difficulties of their clients. However, this mischaracterises social work: a lot of their interventions—or their refusals to intervene—might have life and death consequences. Some of their clients are children at grave risk of death by abuse; some have severe mental health issues, and might be contemplating suicide; some have addiction problems that might lead directly to death. So I will take healthcare and social work to be equally serious in this respect.

Dissent, CO and professional judgement

Professionals like doctors and social workers have to deal with a wide variety of morally charged situations, and they can respond in many different ways. It is worth clarifying the options by laying them out along a 'spectrum of dissent', so that we can better understand what CO is in relation to other forms. If social workers do not seem to worry much about CO, it is probably because they have other pathways to express dissent.

One pole of the spectrum of dissent will be characterised by a complete rupture in communication with the organisation; at the other pole will be dissent that is part of regular communication within the organisation, and indeed may even be a sign of the organisation's health. The first pole will include the act of resigning in protest from one's employer, perhaps moving to another jurisdiction to practice, or of resigning from the profession altogether. (For comparison, see Santoro, 2011 for a discussion of 'principled leavers' from the teaching profession.) Obviously, such an option is available to doctors and social workers alike and can be done for moral or for practical reasons. A moral protest resignation would presumably involve a detailed list of moral complaints, perhaps with some attendant publicity, in order to stimulate some changes to policies or procedures or personnel. The NASW Code of Ethics (Section 6.02) states that 'Social workers should facilitate informed participation by the public in shaping social policies and institutions'. When the protest concerns some embarrassing secret compromise or short-cut or corruption posing a risk to the public, such dissent might become whistle-blowing. The BASW Code of Ethics (section 9), states that 'Social workers should be prepared to report bad practice using all available channels including complaints procedures and if necessary use public interest disclosure legislation and whistleblowing guidelines'.

Lawfully permitted CO is still at this same non-communicative pole, but unlike resignation and protest, it is essentially 'personal' and 'quiet': the objector's effort is merely to remove herself from what she considers wrongful complicity, in order to continue practising the rest of her profession. (Although moral protest resignations are often described using the word 'conscience', for the sake of clarity I will avoid doing so.) CO still represents a rupture in communication since it is peremptory: the objector is not interested in defending herself, let alone in persuading others.

The other end of the spectrum comprises routine dissent as a matter of professional judgement and disagreement. Doctors and social workers are regularly asked to do things by their superiors or their patients and clients, or by their families, and they can and do refuse. Or social workers might feel that they are being asked to do something they consider inappropriate for the client (or inappropriate in its timing). Or social workers might be asked to co-operate with certain medical treatments (or a withdrawal of treatment) which they consider inappropriate or ill-timed. Social workers on the same team might disagree with one another about the appropriate intervention and timing, especially in fraught cases of suspected domestic abuse. A social worker may be asked to endorse a Deprivation of Liberty Safeguard, and her dissent might take different forms and different degrees, from verbal protest right through to resignation (Hubbard, 2018). There is an important role for professional dissent and disagreement among the professionals within a system of care, or within a hierarchical organisation bolstered by a loose trade-off between democratic principles and efficiency. A healthy system will allow for a degree of principled insubordination, and should mostly be able to manage the situation informally.

Other kinds of dissent lie alongside professional dissent at this 'communicative' end of the spectrum: all of these apply equally to doctors and to social workers, and none of them are particularly controversial. A social worker might ask to be removed from a case because of a conflict of interest, e.g. if the client is a member of her family. Or a social worker might lack the necessary expertise in, e.g. rape counselling, and so ask to be removed. This is a matter of professionalism, not conscience. Similarly, a social worker might refuse to work with a particular client unless and until he stops racially abusing her. (In such a case she might also refuse to transfer the case to another social worker, since that would be to accede to the client's racist demands.) A social worker might feel physically threatened by a particular client, and so request support or even removal from the case. Again, none of these cases are matters of conscience.

More generally, such professional dissent differs from CO in two ways. First, the dissent is usually justified in terms of the patient's or client's best interests, about which most professionals would be in broad agreement; whereas a gynaecologist's objection to abortion will be an

objection to a procedure, regardless of the patient's interests. (Although if pressed, the objecting gynaecologist would presumably say that no abortion can be in the patient's 'moral' interests, regardless of what the patient says she wants or needs.) Secondly, professional dissent is usually particular to the patient-client or to the situation, whereas CO is paradigmatically universal in scope: a doctor objects to participation in 'all' abortions, just like a pacifist would object to participation in all wars.

In between the two ends of the spectrum lie a variety of cases of 'moral distress', a term first introduced in the context of nursing by Andrew Jameton in 1984, and which he defined as 'when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action' (Jameton, 1984, p. 6). Some healthcare professionals and social workers might avoid—or try to avoid—moral distress by adopting a pragmatic approach to the institutional constraints (money is the obvious one, but other constraints would include time, personnel, training, as well as unjust constraints such as prejudice, vindictiveness, etc.). They will ask themselves: 'what is the right thing to do in this situation "given" the constraints?' But the pragmatic approach might fail at the 'coalface', when presented with the suffering patient or client face to face, and having to give her the bad news of the institutional decision. One classic case for a social worker would concern the timing and the type of intervention in a child protection case, for example; the social worker might find herself resenting the ignorance and incompetence of her superiors, not to mention their racism and elitism (Haight *et al.*, 2017). Whether the moral distress is enough to result in open protest, or even resignation will depend on the person, and the person's history of such distress in such situations.

There is obviously much more to say about these various kinds of dissent, but that is not my focus here. Suffice to guide the reader to the three aforementioned social work ethics textbooks. In what follows, for the purpose of clarity in my discussion of CO, I am going to assume that the social worker's primary duty is to ascertain the needs of their client, to help them with those needs and to act as an advocate for the client within 'the system'. Of course, the social worker is also required to enforce social cohesion and social policies and government spending priorities, and this aspect of their job leads more naturally to speak of dissent rather than CO.

What might a social worker conscientiously object to?

In order to explore whether social workers should have a legally protected right to conscientiously object, we first have to ask what sorts of things they might plausibly wish to object *to*. I see three classes of situations.

The first type of objection

I will mention the first sort of situation in order to dismiss it quickly: the social worker might object to working with certain people, not because of who they are but because of what they have done or are doing, or because of their opinions. So a client might be known to have murdered a child, or to be a ruthless gangmaster or drug dealer, or to have abhorrent white supremacist views that he regularly expresses. The general public would find it quite plausible to refuse to work with such individuals and to leave them to the crude criminal justice system to deal with after they break the law.

The answer—and morally it is an easy answer, even if it might be difficult to carry it out in practice—is that the social worker has no moral right to object to working with such clients, subject to the various kinds of conflict listed above (racist abuse, threat to personal safety, etc.). The social worker has to accept her client entirely as she finds him, and has to strive to assist him in solving the problem that brought him to her, or that resulted in the assignment of her to him—within the limits of real or likely harm to third parties. (Clearly a social worker cannot take an abusive parent as she finds him, since she will also be responsible for the child's welfare; nor can a social worker take a racist client as she finds him if it is likely to lead to racist violence against a third party.) We might call this an aspect of social work professionalism.

In order to deal with this situation professionally, the social worker requires a much deeper commitment to helping suffering humanity, no matter what they have done and no matter what their opinions; indeed the social worker has to genuinely believe that the client's abhorrent actions and beliefs are the result of a deeper anger and ignorance partly caused by social circumstances, and that the client can in principle be helped (Oliver, 2013).

The same point about deep care applies in general to doctors. Whatever their rights to CO with respect to certain procedures or treatment decisions, they must not object to treating any patient, regardless of what that patient has done or what opinions she might hold, subject to the same types of professional conflict outlined above. So in this way, social work and medicine are the same.

The second type of objection

The first possible type of CO is not very plausible. Under the second type, the social worker would conscientiously object to discussing certain treatments as viable options. So a client might feel quite ambivalent about her early pregnancy, and she may want to ask her social worker about getting an abortion. The social worker might have strong moral

and/or religious views about abortion, and might be reluctant to do anything that she would see as collusion with such an immoral act.

It is important to remember here that we are talking about informing, not about authorising. In the UK, only a medical practitioner can authorise an abortion, in the sense of providing the first of the required two signatures. And here the GP will have the legal right to object to authorising the abortion. However, the GP's possible role in authorising is to be distinguished from the GP's duty to inform patients about any procedures that are legally available in that jurisdiction, about the medical and logistical details of the procedure, and, most importantly, about another particular medical colleague (or dedicated clinic) who is willing to authorise or perform it. Here no CO is possible.

So the social worker would have the same duty to inform as the GP does. There is a question of whether the duty to inform morally compromises the doctor or social worker with strong anti-abortion views. However, it is important to remember that, in Britain at least, both the doctor and the social worker are most often public servants, or at least are reasonably perceived by the wider public as representatives of the state. For that reason, if a patient approaches the doctor or social worker as their first state representative, I would say the patient has a right to the relevant information about what the state offers. Moreover, to refuse such information would risk distressing an already vulnerable patient-client, and could well accentuate divisions (between the professional and the patient-client) of class, ethnicity and gender.

What if a client asks the social worker for information about euthanasia? There are actually two contexts. The first context concerns an enquiry into 'suicide tourism', most famously through the Dignitas clinic in Switzerland. Here there is clearly no legal duty on the British social worker to inform her British client about such options, let alone to assist him in travelling abroad; so refusing to inform would not really be a case of CO. The second context concerns the guidance published by the British Director of Public Prosecutions (DPP) on the non-prosecution of suicide assistance (DPP, 2010). Normally assisting suicide is illegal under the 1961 Suicide Act, but the 2010 Guidance lists a number of 'public interest factors tending against prosecution'. For example, if a person is terminally ill and in great pain, they might ask their healthy spouse for physical assistance in committing suicide. If it is clear that the healthy spouse was motivated only by compassion, then the DPP might decline to prosecute them. So if a client asks their social worker about the DPP Guidance, would the social worker have a duty to inform them? My first answer would be no, simply because the social worker is not a lawyer. My second answer would also be no, because the social worker should immediately focus on the question of why the client (or a client's relative) wants to commit suicide, and on the supports available to them, including medical treatment of depression. If the client insisted, then,

following the above logic with regard to abortion, I would say that the social worker *would* have a duty, as a representative of the state, to at least inform the client about the DPP website, or to steer him to a legal aid adviser; in other words they would not be allowed a CO to informing.

(I have been discussing the 'duty to inform' as over-riding the social worker's wish to avoid collusion by remaining silent about lawful policies and procedures. But the opposite situation occurs as well—when a social worker's superior tries to prevent disclosure to clients about, e.g. the client's right to appeal, on the grounds that the agency lacks the money to process the appeal. Here the social worker could appeal to a duty to inform as a form of principled insubordination, and can expect protection when doing so. Again, however, I would not call this CO.)

The third type of objection

Here a social worker objects to a client not because of what they have done (e.g. the child murderer), not because of what they want (e.g. an abortion), but because of who they are. This is ambiguous, so let me first consider a more straightforward example. Throughout this article, I have been assuming a reasonably just society in the modern West. But there have been situations in recent history where social workers have been co-opted by the state to carry out clearly unjust policies. I have in mind, for example, the Australian policy of forcibly removing children from mixed-race families for adoption in white families, carried out through much of the 20th century. Social workers were involved at every stage. This would seem to be a classic forum for a robust right to CO; however, since these sorts of policies were carried out semi-secretly, it is unlikely there was ever an explicit debate in the Australian Parliament about whether to formally allow CO. More often social workers would be judged suitable and then quietly recruited to the programme.

For the rest of this section, however, I am going to consider contemporary cases of explicit discrimination against homosexuals. The social worker's objection might take the form of a request to be removed entirely from the case of a homosexual client; or it might take the form of refusing to process a homosexual couple's application for adoption. Such discrimination would normally be 'justified' with reference to certain Church doctrines.

This type of objection might not be controversial at all. In the UK at the moment, no social worker—and no doctor—is legally permitted to discriminate on any grounds defined by the 2010 Equality Act. Such discrimination is of a piece with other kinds of invidious discrimination on the basis of, e.g. gender or disability or race or religion. The BASW Code of Ethics, section 2.2 (1) explicitly states: 'Social workers have a

responsibility to challenge discrimination on the basis of characteristics such as ability, age, culture, gender or sex, marital status, socio-economic status, political opinions, skin colour, racial or other physical characteristics, sexual orientation or spiritual beliefs'. (See also Section 6.04 (d) of the NASW Code of Ethics for a similar statement.)

The UK legal system has spoken clearly in two analogous cases. First, in *Ladelle* [2009], a marriage registrar was dismissed from her job with Islington Borough Council for refusing to register a lawful homosexual partnership, and her dismissal was upheld by the Court of Appeal. Secondly, and closer to social work, *MacFarlane* [2010] involved a psycho-sexual counsellor who was dismissed from the NGO Relate for his reluctance to counsel homosexuals. The outcomes of both cases (and two others) were endorsed by the European Court (in the case of *Eweida and Ors v UK* [2013]), who declared that the dismissals did not breach ECHR Article 9 on freedom of conscience.

If we look across the ocean, the situation is less clear-cut. Both Mississippi House Bill 1523 and Tennessee House Bill 1840 have recently passed bills that would allow therapists and counsellors to conscientiously object to treating homosexual patients (although both bills include a duty to inform or refer). The two-page Tennessee Bill actually makes no effort to describe what sorts of things the counsellor might object to. That would seem to allow counsellors to claim an objection to almost anything or anybody, and it is not clear how this is to be squared with the State's anti-discrimination legislation. According to Mongan (2018), there will soon be pressure to allow social workers in those states to discriminate on the same basis, and Mongan argues that the social work professions have to decide now how much and how best to resist that pressure.

The American picture is more complicated for all sorts of reasons (especially the different kinds of public, semi-private and private agencies in healthcare and social work), and I do not have the space to get into it here. Without more knowledge and perhaps direct experience of the role of the religious right in the USA, it is hard for British readers to know where to begin. Most would see such discrimination as straightforwardly wrong, not to mention unprofessional. Indeed, even if a therapist would see homosexuality as a sin or a disease, surely that is not enough of a reason to 'avoid' such clients, when other 'sinners' and 'diseased' clients can expect service.

And without wishing to enter too far into the debate about why the religious believer objects to homosexuals, the grounds for such objection seem a lot more flimsy than the grounds for objecting to abortion. To put it bluntly, abortion is a matter of life and death, and about a doctor's self-understanding as a healer. In contrast, a person's sex life with consenting adults really is nobody else's business, and it takes a highly

selective and arbitrary Biblical exegesis to override what should surely be Christianity's primary emphasis on loving one's neighbour.

A comparison with homophobic bakers

However, there might be good pragmatic reason to allow social workers to conscientiously object to homosexual clients. Andrew Koppelman (2019) argues that bakers who object to providing cakes for homosexual weddings on the basis of First-Amendment freedom of religion and speech (e.g. the Supreme Court case of *Masterpiece Cakeshop v. Colorado* [2018]; cf. the Ashers bakery case in Belfast in the same year) were right to be granted an exemption from anti-discrimination legislation, *even if* their views are morally equivalent to racism. His strategy is to look at the purpose of anti-discrimination legislation. In the case of American racism, systemic and prolonged injustice in the past has produced a situation of continuing wide-spread injustice today when it comes to certain individual citizens getting fair access to certain basic goods: public services, a fair trial, equal consideration in employment and university admissions, etc. Therefore, robust legislation is necessary to restore those individual citizens to the level playing field where they can contract at will. Such is the legacy of formal and informal racism, and such is the strident public activism by racist groups, that a robust message needs to be sent from the legislature.

In contrast, writes Koppelman, (i) homophobic bakers do not really restrict homosexuals' freedom of contract since there are few such bakers and many other non-homophobic bakers on the market; (ii) the homophobic bakers are not agitating for further restrictions on homosexuals, they just want to refuse certain customers under their own conception of freedom of contract; (iii) the only constraint that Koppelman would place on such bakers is that they advertise their 'conscientious objection' in a spirit of fair warning, i.e. in order to avoid demeaning face-to-face rejections. This is preferable, concludes Koppelman, to invoking the heavy-handed anti-discrimination legislation to make public martyrs of a small group, with unpredictable results on the resulting effective rights and well-being of homosexuals.

If we accept Koppelman's reasoning, can it be applied to social workers as well? As with the bakers, a lot will depend on numbers. A certain amount can be learned from the therapists of Mississippi, and the real impact on homosexuals seeking therapy, but it is too early for reliable empirical data. If there are many 'liberal' social workers available, then the few homophobic social workers can discreetly request reassignment without the indignity of clients being overtly refused. This would be compatible with taking a hard line in response to any reassignment requests from racist social workers—again, it is the particular history of

public systemic racism that makes the 'meaning' of the racist objection much more offensive in comparison.

Ultimately, however, I think the analogy with the bakers has to be rejected. Central to the bakers' claim is the fact that there is no sense in which they 'owe' any potential customers anything, beyond (i) the minimal respect of non-interference and (ii) basic principles of non-coercion and non-deception that are central to fair business. A social worker, simply in virtue of having chosen to become a social worker, owes potential clients much more. There is room for a discussion within the social work profession about just how much a social worker owes; but here I would repeat my earlier argument that the good social worker (and a good therapist and doctor, for that matter) must have a fundamental attitude of acceptance of the other human being, in all his otherness, and this is bluntly incompatible with the legal recognition of 'conscientious' homophobia.

Two more arguments against a general right to CO for social workers

So far I have been focusing on the 'content' of the CO, in order to argue that the doctor should be allowed to object to certain things, but that the social workers should not (while accepting that the social worker will have other ways to express legitimate dissent). I have two additional and inter-related arguments that concentrate on the distinct 'status of the relationship' between social worker and client, as compared to the relationship between the doctor and the patient. And I want to claim: *even if* a social worker might have a recognisable claim to a CO with a particular content, we should not accommodate it because of the nature of the relationship. The first argument has to do with the 'focus' of the relationship; the second has to do with what I will call the 'semantic location' of the encounters comprising the relationship.

Let me again acknowledge that my distinction between social work and healthcare is not clean: there is broad and deep overlap between the two (and other) caring professions. Some doctors will have the 'focus' and the 'semantic location' of a social worker, and vice versa: mental health care and small-town general practice particularly evade this distinction. But I think there is enough of a distinction to make a useful philosophical point.

The focus of the relationship

At the risk of a huge over-simplification, I think there is enough truth to the following picture. The doctor (with the exception of the psychiatrist) is essentially focused on disease or injury or physical pain. Typically, the

patient presents to the doctor with symptoms; the doctor examines the patient's body, asks the patient about pain, makes a diagnosis, attempts to treat the symptoms, and maybe refers them to a different specialist. The natural end point, as far as possible, is the restoration of bodily function and/or the elimination of the pain, at which point the patient is discharged from the medical world and returns to their own life without further involvement, at least until the next symptoms arrive. According to this basic scenario, the patient only requires the doctor's technical knowledge and skill; and the doctor only requires information useful for diagnosis, treatment or management. In short, the doctor is essentially interested in the body and in the patient as the 'owner' of that body—the doctor is not directly interested in the patient's *life*, unless, e.g. lifestyle can provide clues about injury or pain. However simplistic, this picture is somewhat corroborated by the heavily scientific nature of medical school admissions and of the medical curriculum, by the much smaller emphasis on the psycho-social and the ethical aspects in the curriculum, and by the absurdly brief timeslots that GPs allow for each patient.

In contrast, the social worker is much more interested and involved in the client's life. Obviously, the social worker is not trained or authorised to provide any complicated technical services, because their role is different. She has to help the client solve a huge range of ordinary problems in living. And to help them solve such problems, the social worker has to learn a good deal about the client's present and past life, about their family and friendships and other relationships, their present and past employment, their plans and ambitions (both realistic and unrealistic). Indeed, not only does she need to know much more about the client's life in order to help them, she also needs to know this in order to act as their advocate in conflicts with various state agencies—with the police and the courts, with the benefits system, with powerful local business lobbies, and indeed with the healthcare system, and even with other elements of social services. Sometimes this advocacy will amount to a robust defence of the client's interests, sometimes it will amount to an extra visit to the client to make sure that his alleged consent is sufficiently informed and free. Sometimes it will amount to defending the client against another family member.

As a result of these very different foci, the *effect* of a CO in healthcare and in social work is very different. Because the patient is looking for a much narrower, and more technical service from the healthcare system, the patient is less essentially vulnerable during the encounter, and the doctor's objection to a particular treatment is less likely to be taken as a personal rejection or condemnation. Although some patients will inevitably be distressed by the GP's objection, in the end, the patient wants a technical service, and this doctor cannot provide it—so ideally the patient shrugs her shoulders and seeks out another doctor. In contrast, because of the much greater intimacy of the social worker's

knowledge of and involvement in the client's life, because of the greater trust placed in the social worker, then any objection will be much more likely to strike the client much more harshly—not just as a condescending moral judgement, but also as a personal rejection and abandonment. Clearly a social worker's CO to a client's homosexuality can only be taken as deeply offensive. But even in the case of a social worker refusing to discuss abortion as an option, I suggest that the client will also be likely to take this as offensive.

(Again, I have been making the simplifying assumption that the social worker's main duty is to ascertain the client's needs, to help the client meet those needs, and to act as the client's advocate. I have mostly ignored that aspect of the social worker's job that has to do with enforcing social cohesion and government priorities. But this aspect of the job also makes the social worker quite different from the doctor in their approach to the client-patient.)

The 'semantic location' of the encounter

When the patient visits the doctor to request an abortion, she usually steps out of her ordinary life: she has a problem, she wants it sorted and she comes to the doctor. In contrast, when the client asks the visiting social worker about an abortion, it will inevitably be within the context of the social worker's existing involvement in her life. The physical and metaphorical 'location' of the encounter between the professional and the client-patient is relevant to the meanings invoked within the encounter. Once again I am simplifying hugely, since both doctors and social workers can meet their patients and clients in a variety of places. But in general, we can say that the patient comes to the doctor's world to talk about a medical problem, whereas the social worker goes to the client's personal world to talk about a personal problem. When the patient visits the GP to request an abortion, and the GP conscientiously objects, then even when the patient is distressed by the objection, she can 'retreat' back into the public space, or back home again, before she renews her search. In addition, in ordinary cases when a patient asks the GP for medical attention, there is no threat of coercion behind the GP's recommendations, since any competent patient can refuse any treatment for any reason. In contrast, when the social worker comes into the client's very home, it is much easier to see her as an invading force, even if she intends only to gather information, or only to help. The social worker is in the client's life-world and there is no further place to retreat. The social worker also brings with her vague powers of coercion, and that influences the dynamic. I suggest that this context changes the meaning of the social worker's CO, making it potentially more forceful, more judgemental and more distressing.

Conclusion

Medicine and social work are so similar in so many ways, and yet there is at least one glaring difference. Most doctors in most parts of the world are allowed to conscientiously object to certain otherwise lawful and appropriate medical procedures, paradigmatically abortion, while most social workers are not allowed to conscientiously object to any procedure or client. I defend this prohibition, while accepting that social workers have other avenues for expressing legitimate dissent in response to requests from their clients or from their superiors.

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