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Selective Conscientious Objection in Healthcare

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Most discussions of conscientious objection in healthcare assume that the objection is *universal*: a doctor objects to all abortions. I want to investigate *selective* objections, where a doctor objects to one abortion but not to another, depending on the circumstances. I consider not only objections to abortion, but also objections to the withdrawal of life-saving treatment at the request of a competent patient, which is almost always selective. I explore how the objector might articulate the selective objection, and what impact it might have on the patient, within the conceptual space of relevant statutes and professional guidelines.

KEYWORDS Conscientious objection, abortion, withdrawal of treatment, moral disagreement

Most of the literature on conscientious objection (CO) in healthcare is about *universal* objections: the GP who refuses to authorize any abortion, the pharmacist who refuses to sell emergency contraception to anyone. In contrast, I want to look at objections or refusals that are *selective*: the agent refuses in one situation but not in another, similar situation.[1]

I will limit my discussions to two specific situations. In the first, a British general practitioner (GP) authorizes some abortion requests but not others. In the second, a hospital consultant accedes to a competent patient's informed wish to withdraw life-sustaining treatment (LST), foreseeably resulting in the patient's death – again, in some contexts but not in others. Although there are many relevant situations for selective CO in healthcare, I will only concentrate on these two in order to allow a certain depth and some instructive contrasts. My overarching concern is to explore how such selective objections play out,

[1] There has been very little discussion in the medical ethics and law literature about selective conscientious objection, with the exception of two rich articles by Stephen Smith (2015 and 2018), which influenced a good deal of this paper. I also thank Smith for discussion on this topic, and for his comments on an earlier draft.

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and how the ethical issues raised are different from those associated with universal objections.[2]

Let me declare some assumptions before I begin. First of all, I will not engage in the debate surrounding abortion itself, nor in any debate about abortion policy. I will situate my discussion in the UK where it is legally available more or less on request before the 24th week, and where this availability is not politically contentious. At the same time I will take it as a topic about which equally well-informed, reasonable people of good faith can disagree deeply. Second, I will not engage in the debate surrounding euthanasia or physician-assisted suicide, and will again take the British situation where euthanasia remains legally prohibited. Third, I will not engage in the debate surrounding the general permissibility of conscientious objection in healthcare, and will take it as *prima facie* permissible, legally and morally. If I discuss some of the problems with selective CO, a natural response would be 'then get rid of all CO, both selective and universal'; but I will resist that line.[3]

By way of one final assumption, I should distinguish between a conscientious objection, a general moral judgement, and a prudential-legal judgement. This distinction will become relevant as we go along. When I make a general moral judgement, for example that 'abortion is wrong', then I am condemning everyone who requests or authorizes or performs an abortion; I may even be inclined to prevent or obstruct others from performing it. In contrast, a CO is essentially 'inward-looking', to use Smith's (2015) term: that means that the objector is only interested in her own actions and omissions, rather than in anybody else's. A gynaecologist can conscientiously object to performing an abortion without necessarily condemning her colleague for being willing to perform them, without obstructing the patient's search for a willing doctor, and without feeling obliged to attend an anti-abortion protest before Parliament. There is a question about whether a CO to a practice, without a general moral condemnation of that practice, is rationally coherent; but I will not enter that debate here.

In contrast to both the above, a prudential-legal judgement concerns an interpretation of the law (or of professional or trust guidelines), such that I then comply with my interpretation in order to avoid sanction and penalty. Such compliance makes no necessary reference to my moral views: I may fully endorse the law or guidelines, or I may think that the law or guideline is morally cruel and

[2] There is a separate and long-standing debate surrounding military conscription, and whether conscientious objection, if permitted, can be selective or must be universal. Philosophical discussion reached a head during the Vietnam War in the 1960s and 70s. Traditionally, conscientious objection was only available to universal objectors who could demonstrate a religiously-grounded pacifism. The US Supreme Court's *Seeger* (1965) decision expanded this to a universal objection based on an articulate and coherent secular pacifism. The SC's *Gillette* (1971) case then allowed a *selective* (and secular) objection to the Vietnam War (coupled with Gillette's declared willingness to fight a defensive war). See Malament (1972) and more recently, Yiannaros (2018) for discussion. Clearly the military context differs from the healthcare context because of the element of compulsion; in contrast, nobody is forced to become a doctor, or to become a specialist in a context that would raise issues of conscience.

[3] A number of philosophers, most famously Julian Savulescu (2006), have argued that conscientious objection to a lawful request for an abortion is never permissible for healthcare professionals with the authority and/or expertise to authorize or perform abortions. This is because (i) no individual was forced to become a doctor, to train for a particular specialism, or to work in a particular jurisdiction; (ii) no doctor should be able to pick and choose those elements of her job description that she will or will not perform; (iii) any doctor who is opposed to a particular law or to a particular health policy has other democratic channels in which to voice her protest and seek change, while performing all the tasks she is paid to provide during working hours.

unfair or bad in other ways, but I comply with it out of laziness, cowardice or self-interest. Clearly we need laws and guidelines in healthcare, but I will be taking these as providing the conceptual space within which conscientious objections are made and engaged with.[4]

Part A. The abortion situation

In the UK, the provision of abortion is governed by the 1967 Abortion Act, which stipulates that two registered medical practitioners must authorize the abortion. Many pregnant women go directly to specialist clinics, where they get both signatures and the procedure. A different route is for a pregnant woman to request her GP for the first signature and a referral to a hospital, where a gynaecologist will provide the second signature and the procedure. For the sake of simplicity, I'm going to focus on a GP who might object – universally or selectively – to authorizing the requested abortion. Section (4) of the Act governs CO in non-emergency cases:

> 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.[5]

The 'any treatment' here is ambiguous between token and type, and so the overall wording would *seem* to permit both a universal or a selective CO to that treatment. In practice, it seems that any GP ready to invoke the words 'conscientious objection' will be expected – by colleagues, patients and employers – to harbour a universal objection. That expectation is mirrored in the philosophical and legal literature on the topic. Medical students aspiring to become GPs will have to decide sooner or later whether to become an objector once in practice, and this fact will then be advertised by the practice; and this will be an all-or-nothing decision. (The GP may of course change her mind mid-career.)

Even if the Act does seem to permit selective objection, I suggest this has not happened because *de facto* selective objection is already allowed elsewhere, through Section (1) rather than through Section (4) – even if a Section (1) refusal is not called a conscientious objection. Section (1) permits abortion if the GP (and later the second doctor) is of the opinion that at least one of four listed situations obtains. Given the widespread reasonable belief among the general public that abortion authorization is available more or less on request from any GP (who has not formally declared themselves a universal objector), then a GP's interpretation that

[4] As a philosophical aside, it could be argued that *all* CO is selective, since the possibility remains of a doctor with a putatively universal CO encountering a patient or situation that is so morally distressing to the doctor that it leads her to countervail her CO and authorize the abortion. Moving in the other direction, a doctor might have a more-or-less articulated selective CO, but who finds after many years of practice that no patients have fulfilled her conditions, and therefore her CO has become effectively universal.

[5] The section continues with the following clause: 'Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it'. In practice, it is enough for a GP to declare their CO. Some philosophers (e.g. Card 2016) have called on doctors to defend their CO before a dedicated tribunal, much as American draftees were required to do so during the Vietnam War. I will not enter that debate here, although I will return to one aspect of it later. Suffice to say that the motives for lying about a CO to military service (cowardice, comfort or civilian ambition) are much clearer than any motives about why a doctor would lie about a CO to authorizing abortion.

none of the four situations obtain might well have a semantic *effect* on the patient similar to the effect of a CO. For example, the patient might be annoyed or embarrassed by what she sees as an arbitrary assertion of power.

Here is the first of the four Section (1) conditions:

> (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family;

The 24-week limit does not allow much interpretative leeway; perhaps the idea of a sufficient risk to physical health would also garner widespread agreement among doctors. In fact, it could be argued that this wording allows abortion *on request* precisely because abortions are so safe and childbirth remains physically risky in many ways.

The mental health clause in sub-section (a) is vague because of the concepts of risk and of mental health, and this allows more interpretative leeway. Cases of rape and incest would be uncontroversial enough under this criterion, as would cases of the pregnant girl's extreme youth. After that, however, cases of 'social' abortion are more controversial. Imagine that the patient genuinely dreads the thought of pregnancy and childbirth and motherhood at her particular situation of her life. The GP might not be persuaded, however, that there was a sufficiently high risk of a sufficiently serious mental health problem to justify abortion. The GP might say something like: I'm sorry but I cannot be a party to this. I know you are dreading the pregnancy and the childbirth, I realize it's not going to be easy, but I am confident that you can do it. But you are welcome to a second opinion from my colleague next door. At the same time, this GP does not have a universal CO to all abortions, and has authorized many in the past. (And importantly, the patient knows that the GP is not a universal objector.)

Recall the distinction I drew between general moral judgements, conscientious objections, and prudential-legal interpretations. The above Section (1) refusal might seem like a prudential-legal interpretation, and technically of course it is. But I suggest that *given* the widespread reasonable assumption of abortion on request, given that the GP knows she can authorize the request without worrying too much about formal compliance with Section (1), then her choice to refuse the request is not merely procedural but carries a moral charge. At the same time, the refusal is more like a conscientious objection than a general moral judgement because the GP uses the words 'I cannot' – she is removing herself from the situation without condemning abortion itself, and without condemning her GP colleague next door whom she knows will approve the patient's request. To put it another way, she is not trying to *obstruct* the patient from getting the abortion, she is removing herself from complicity.[6]

[6] Later in the same clause, the reference to 'any existing children of her family' might refer to a situation where e.g. a single mother already has one or more children and simply does not have the time, energy or money to be good enough parent to another one. Once again, the GP might have interpretative leeway in judging whether this is enough of a reason to terminate the pregnancy. This condition differs from the 'mental health' condition, however. While the GP has some expertise to diagnose mental health, she may lack the expertise and information to evaluate the particular patient's socio-economic situation. This would suggest that she should defer to the patient's understanding of her needs, or at least defer to e.g. a proper assessment by a social worker.

The key to understanding the difference between a CO and a general moral judgement is to use Bernard Williams's (1993) concept of a 'moral incapacity', which he contrasts to a psychological incapacity on the one hand, and to a moral duty on the other. Consider a genuinely psychological incapacity such as vertigo, which has a clear meaning of 'cannot'. There are no reasons for vertigo, some people simply experience it, others do not; and there is nothing further to explain about the vertigo. There I am, I *know* the balcony is safe, I *want* to go onto the balcony to grab my bag, but I find I 'cannot' since I can see the ground far below and my head starts spinning. There is no way to rationally persuade me to go out, since there is nothing new you can tell me about the situation. It might be possible to train me or condition me (non-rationally) through some form of therapy, however.

The key distinction between a psychological and a moral incapacity, for Williams, has to do with the second-order attitude to the incapacity, and with the direction of my subsequent effort. On the one hand, I am embarrassed about my vertigo, which I take as an external constraint to my will; I am determined to *try* to overcome it, and I hope to succeed. On the other hand, the GP *identifies* with her conscientious objection: insofar as it is a constraint, it is internal to her moral view of the world, and she refuses to 'try' to overcome it since it is a matter of moral integrity.[7]

Now consider an uncontroversial moral duty, such as the duty to give to charity. Many of us would say that we have such a duty, and yet we are also able to ignore it. There is nothing incoherent in saying 'I ought to put a fiver in this Oxfam tin, but I think I'm going to buy me a sandwich instead'. In contrast, it *is* incoherent to declare an incapacity (moral or otherwise) and then to intentionally ignore it.

Back to the Abortion Act Section (1). Sub-sections (b) and (c) are perhaps not controversial, referring to the risk of grave permanent injury or of death to the woman. Sub-section (d) is notorious, however, and reads as follows:

> (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.[8]

I say 'notorious' because 'seriously handicapped' is not defined in the Act, and presents obvious interpretative leeway. There will be paradigm cases of serious handicap (e.g. Tay-Sachs) and paradigm cases that would not be a 'handicap' in this context, even if the parents find it distressing enough to request a termination (e.g. minor polydactyly). But the boundary between the two is not at all clear. The BMA offers the following criteria that 'may' be used to assess the seriousness of the handicap:

- the probability of effective treatment, either in utero or after birth;
- the child's probable potential for self-awareness and potential ability to communicate with others; and

[7] Another way to put this distinction is in terms of autonomy. Vertigo constrains my autonomy; whereas a moral incapacity expresses my autonomy. On this see Gerald Dworkin (1988).

[8] According to the Brook website, just over 1% of all abortions were carried out on these grounds. See: https://www.brook.org.uk/our-work/abortion-law-and-disability [accessed May 2019].

- the suffering that would be experienced by the child when born or by the people caring for the child.[9]

These criteria still leave a good deal of interpretative leeway. In 2003 West Mercia Police decided not to prosecute a doctor for performing an abortion under the (1)(d) on the grounds that the foetus had a cleft lip and palate; the Police decision was famously and unsuccessfully challenged by Revd Joanna Jepson.[10] The doctor in that case was legally entitled to refuse to authorize or perform the abortion, saying that this particular cleft palate was not a sufficiently serious handicap (while being willing to authorize abortion for genuine serious handicaps). As before, this would not formally be a case of CO, but the effect would be the same; refusing to abort a cleft palate foetus would not be a clinical but a moral decision. Again, a moral decision might be what I am calling a general moral judgement about 'what ought not to be done' – clearly Revd Jepson was articulating a general moral judgement – but it might also have amounted to a selective conscientious objection to authorizing the request, in the knowledge that a colleague will authorize it.

Now given the climate of abortion more or less on request, a pregnant woman does not actually need to claim any of the Section (1) conditions if the gestation is less than 24 weeks: it suffices that the pregnancy is inconvenient to her for whatever reason. Nor is there anything to prevent a woman e.g. requesting an abortion on the basis of an ultrasonic determination (after 18 weeks) of the sex of the foetus. Again, my aim is not to challenge the reality of abortion provision in the UK. My aim is only to suggest that some GPs might selectively conscientiously object to authorizing an abortion for reasons of inconvenience or for sex selection, and could do so by invoking the failure to fulfil the Section (1) conditions.[11]

Let me draw attention to an important difference between a GP's universal and selective CO, and that has to do with the conversations likely to ensue with the patient upon the declaration of the objection. A universal Section (4) CO is likely to be *peremptory*. Perhaps the CO is already publicized on the GP surgery website or on the GP's office door, and this might go a long way to avoid awkward conversations. (Of course the woman might well bypass the GP surgery altogether and go directly to a clinic.) But when an unknowing patient comes before the GP to request the abortion, the GP will declare her objection without inviting discussion of it, and will move on swiftly to the question of where the patient can get the authorization (which might well be a neighbouring colleague). In contrast, a selective CO cannot be advertised because it is mostly unpredictable.

In addition, a selective CO is *focused* on the patient, and on her reasons (or on her perceived lack of good reasons) for seeking the abortion. There is more of a conversation, and it might well be unpleasant for the patient. The patient might already be vulnerable because of the pregnancy and any stigma within her family; she might

[9] The BMA Ethics Department, 'The Law and Ethics of Abortion', November 2007. Available at: http://www.bma.org.uk/-/media/files/pdfs/news%20views%20analysis/lawethicsabortionnov07.pdf [accessed May 2019].
[10] http://news.bbc.co.uk/2/hi/uk_news/england/hereford/worcs/4354469.stm [accessed May 2019].
[11] In a separate but not unrelated context, the Human Fertilisation and Embryology Act 1990, schedule 2, s. 3.1ZB states: 'A licence under paragraph 1 cannot authorise any practice designed to secure that any resulting child will be of one sex rather than the other'. The only exception to this are sex-linked genetic diseases.

already be vulnerable if she is young or from a marginalized social or economic group, facing a middle-class GP in the GP's office; and given the severe limits on GP visit timings, the GP is unlikely to know much about the patient's social and family circumstances anyway. More than that, the patient might be unprepared for such a conversation, unprepared to defend herself morally.

The GMC Guidance entitled 'Personal beliefs and medical practice' warns the doctor (para 12 (a)) to

> 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.

Paragraph 16 states 'Whatever your personal beliefs about the procedure in question, you must be respectful of the patient's dignity and views'.[12] The concern here is that the articulation of the selective CO will be challenging for the patient in both respects.

So while I am minded to allow Section (1) 'refusals' to continue, I am unsure about the reality of such conversations, just as I am unsure how well GPs are trained to lead such conversations. More empirical work would be needed here.

Let me conclude this section by throwing out a tentative suggestion: to set up a special multidisciplinary committee to process and discuss 'social' abortion requests, similar to a hospital clinical ethics committee or to other social care teams set up within social services. Such a committee could still include a GP, but alongside a social worker, a psychologist, or a lawyer, all carefully trained to avoid embarrassing the patient while letting her give her reasons. The patient could be assisted by a social worker to act as her advocate – so unlike the ethics committee the discussion would not be 'about her without her'. This would address the problem, in the case of healthy pregnancies, of medical professionals being asked to authorize 'medical treatment' for a *non*-medical problem. It would also address the GP's possible ignorance of relevant social issues, possible lack of ethical training, and possible ignorance of the particular patient.

Robert Card (2016) has also argued that medical professionals who wish to avail of the right to universal CO ought to be required to defend their beliefs in front of a tribunal formed for that purpose, just as objectors to military conscription had to do (see fn. 6). Although I am not sure whether there would be much point in a tribunal for *universal* CO, I think that a committee for *selective* CO would be more profitable because of the patient's involvement. However, the process might become expensive, complicated and slow, and this could make the distress and discomfort worse for the patient. And I dare say most abortion rights advocates would find it all intrusive and unnecessary. In political terms, this idea might have worked in the 1970s but perhaps not now. At any rate it would need a lot more detail to make it workable. I want to leave this proposal for now, but I will return to it briefly in the end.

[12] GMC 'Personal beliefs and medical practice'. See: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice [accessed June 2019].

Part B. The end of life situation

The abortion situation was complex because of the central distinction between universal and selective CO. In contrast, a doctor's conscientious objection at the end of the patient's life seems to be almost always selective. This makes things simpler in one dimension, while making it more complex in other dimensions, as I hope to show.

There are various scenarios at the end of life, but I will take the patient's dependence on life-sustaining treatment (LST) as essential. The ethical dilemma is about whether and when to withdraw that LST in the foreknowledge that this will inevitably, and within a brief period, lead to the patient's death.[13] Unlike with abortion, there is no legislation directly governing CO in the context of end-of-life healthcare. So a good place to start is with the GMC guidance expressed in *Treatment and care towards the end of life: good practice in decision making* (henceforth the 'Guidance'). Paragraph 79 says this about 'objection':

> 79. You can withdraw from providing care if your religious, moral or other personal beliefs about providing life-prolonging treatment lead you to object to complying with:
>
> (a) a [competent] patient's decision to refuse such treatment, or
>
> (b) a decision that providing such treatment is not of overall benefit to a patient who lacks capacity to decide.[14]

I will call this a 'Paragraph 79 objection'. The Guidance speaks about '*a*' patient, which assumes selectivity in two respects: not only the particular *medical situation* she finds herself in (prognosis, remaining treatment options etc.) at a particular time, but also this particular *patient* (with a particular set of values, hopes, relationships – and wishes).

For the purposes of this paper I will concentrate only on the competent patient. Mainly this is for reasons of space, but partly also because we have been discussing abortion requests by competent patients in Part A, and so this will allow some useful contrasts.[15] For a start, it will normally be clear in both cases what the competent and informed patient wants. Even if it is not clear what the patient wants, at least there are clear procedures for trying to determine what she wants.

A classic example here is that of *Ms B* [2002]. Ms B was a competent 43-year-old inoperable tetraplegic, dependent on a ventilator to breathe, and with the prospect of many more years of life in that condition. However, she no longer wished to live

[13] I say 'lead' rather than 'cause' in order to keep things as neutral as possible for the moment. There is an open question whether the withdrawal causes the death that would otherwise not have occurred at the moment it did.

[14] The General Medical Council (2010) *Treatment and care towards the end of life: good practice in decision making*, available at https://www.gmc-uk.org [accessed January 2019]. I describe Paragraph 79 objections as 'almost' always selective, because there might be some doctors (sometimes called 'vitalists') who object to *ever* removing LST: patients should be treated right up until they die of organ failure. I will assume that such universal objections are rare, and will ignore them for the rest of this paper. Even strongly Catholic doctors can accept that the patient is dying and that it might be morally (and theologically) permissible to remove the LST before death. But there remains a question of *timing*, and this is where the selectivity may come in.

[15] A typical scenario with an *incompetent* patient might run as follows: a multi-disciplinary team, led by a consultant, makes a decision to withdraw LST from a patient in a PVS, with the approval of the patient's family. A nurse on the team declares a CO and recuses himself, believing the withdrawal decision to be premature. A nurse's CO is governed by paragraph 4.4. of *The Code* of the Nursing and Midwifery Council. See: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf [accessed June 2019].

like that, and repeatedly requested that the ventilator be switched off. She declared herself fully aware of the fatal consequences this would have for her. One of her attending physicians, known as Dr C in the judgement, declared that 'She [Dr C] did not feel able to agree with simply switching off Ms B's ventilation. She would not be able to do it. She felt she was being asked to kill Ms B' (para 57). The matter had to be resolved by the High Court, who declared it legally permissible for Dr C's employer to arrange for Ms B to be transferred to the care of another doctor who was ready to accede to her wishes. That second doctor was located, formally accepted Ms B into his care, switched off her ventilator, and Ms B died.

Dr C's language is interesting. Once again we have the use 'not be able' rather than 'X is wrong', so that suggests a moral incapacity rather than a general moral judgement. Second, her description of the request as a request to 'kill' is interesting. If intentionally withdrawing LST at a competent patient's request was *really* a matter of killing, then it would be murder; and yet in such a situation no court would convict Dr C of murder, and Dr C knows that. Although Dr C did not use the words 'conscientious objection', I will treat it as such because of this inward-facing element. Dr C is not declaring that whoever accedes to Ms B's wish will become a killer; Dr C is recusing herself from attending Ms B, but without preventing Ms B's access to the second doctor who, Dr C knows, will accede to Ms B's request. And this conscientious objection is essentially selective. Presumably Dr C has withdrawn treatment at a competent patient's request many times before.

However, there is a central moral-legal obstruction to Dr C's interpretation: it is a fundamental principle of medical law and ethics that every competent patient can refuse any treatment, even life-sustaining treatment, for any reason (or for no reason at all), provided they fully understand the likely consequences of such a refusal, and provided they are not under 'undue influence' from a third party to refuse it. The clearest expression of this principle is the 1992 case of *Re: T*.[16] The natural extension of this is that the patient's 'right to refuse' would seem to *trump* any doctor's attempted Paragraph 79 objection. As a result, one would think that Dr C's on-going refusal to withdraw LST could legally be interpreted as an on-going battery, and the court might have straightforwardly convicted her instead of considering her re-description of the requested action as 'killing'. So in taking Dr C's description seriously, there is more at stake here than any alleged supremacy of patient rights.

It will be instructive to consider two variations on the Ms B details, in order to narrow in on what Dr C is doing, exactly.

Variation 1: another competent tetraplegic patient, Mr D, does *not* require a ventilator to breathe, declares her informed wish to be directly killed by lethal injection.[17] Clearly, in such a situation, no doctor would be under any legal or moral duty to accede; on the contrary, there would be a legal prohibition against it,

[16] 'An adult patient who, like Miss T, suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered […] This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent' (*Re T (adult: refusal of treatment)* 1992).

[17] I'm thinking of the character of Ken Harrison in the 1972 television play by Brian Clark, *Whose Life is it Anyway*? Harrison was a tetraplegic who could breathe unaided, and was asking to be allowed to refuse food and water, without being resuscitated once he fell into unconsciousness, in order to die.

since the appropriate objective description really would be intentional killing. The reluctant doctor would not be a conscientious objector but simply obeying the law. So the competent patient's wishes do not trump *everything*.[18]

Variation 2: One essential element of the situation is that Ms B would die *immediately* following the withdrawal of the ventilator, and so this raises inevitable questions about the causal power of omissions. Under this second variation, Ms E is competent, but suffering Stage 4 cancer and undergoing chemotherapy. If Ms E requests the withdrawal of the chemotherapy, she would certainly die some time later, maybe days or weeks. Because of the time lag it would be much less plausible to describe the withdrawal as *causing* Ms E's death – for it would be the cancer that killed her. As a result, it would also be much more difficult, ethically and legally, to refuse Ms E's wishes to remove the chemotherapy, despite the foreseeability of the fatal outcome; and in such a case the doctor withdrawing the chemo would be much less likely to see herself as 'killing' the patient.

Ms B's situation lies 'between' the two clear variations, and therefore offers plausibility to the two incompatible descriptions in play. I suggest, however, that *both* descriptions are exaggerated. Against Dr C, I would not agree that withdrawing the LST would necessarily amount to 'killing' because there is, simply, no intention to kill. On the other hand, against Ms B, I would say that withdrawing the LST is more than merely 'acceding to the patient's informed wishes' since in doing so the doctor is directly and causally implicated in an entirely foreseeable and imminent death that was not otherwise likely for many years or decades.

There is a question about Ms B's *interests*. Would that allow a common currency for discussion between Dr C, the second doctor, and Ms B, enough to settle the dispute? Now one reason for my avoiding discussion of *in*competent patients is that any attempt to take account of the patient's interests becomes very complex, and often leads to some paradoxical results.[19] In contrast, a competent, informed patient is allowed to consent or refuse consent to treatment options regardless of anybody else's judgement about her interests. It is important that the 'conversation' between Ms B and Dr C did not, at least according to the court judgement, invoke the language of interests on either side. Ms B was not claiming it was in her interest to die, and Dr C was not claiming it was in her interest to live.

If the language of interests does not help, might there be another re-description that would offer a common language? Here is a tentative suggestion. What did the second doctor do in the end? He *assisted Ms B's suicide*. In saying this I am

[18] Consider the classic counter-example from the euthanasia debate: the lovesick 19-year-old. He is a competent adult, and unlike Ms B he genuinely wants to die. He needs some kind of LST to survive, and asks the doctor to withdraw it. Here we can imagine a strong *moral* case for ignoring the patient's request, even though the continuing treatment would technically constitute a battery. Perhaps it could be argued that the lovesick teenager is not sufficiently free (his will is undermined by lovesickness) or informed (we know the world will get better soon, but he does not), and therefore his request can be ignored.

[19] The classic case here is *Airedale NHS Trust v Bland* (1993). Tony Bland had been in a persistent vegetative state. Throughout the judgement we hear opinions that it would be in the patient's best interests to withdraw artificial nutrition and hydration and to let him die. In *normal* contexts, we can describe option A as being of greater benefit to me than option B if I live on to enjoy the benefit of A. But if the putatively beneficial option A involves my earlier death in order to avoid further unbearable suffering, then although my death will remove the suffering, it does so only by removing the sufferer. This is a relatively narrow point against the language of benefit and best interests; it is not an argument against the *Bland* decision, which might be justifiable in other ways.

making a point about morality, not law. Legally, Ms B was not seeking to commit suicide, and the second doctor would never have been charged with assisting it. I also concede that Ms B might not seem suicidal, in the sense that she is not seeking to annihilate herself, she was not acting out of shame or self-disgust, and would have been only too glad to go on living if some of her limb function could have been restored. Certainly she wanted to avoid any suggestion of the stigma and horror associated with suicide. However, Ms B was seeking to get out of her burdensome physical situation, even if the only way of doing that was dying – so in that minimal sense she was seeking suicide.

With this new description, then, what Dr C was refusing to do, as a matter of conscience, was to assist Ms B's suicide. Suicide has a special status within the law, since it is not illegal (since the 1961 Suicide Act) and yet assisting suicide is illegal, for obvious reasons having to do with the temporary vulnerability and despair and uncertainty of many people who seek, or claim to seek, suicide. Ms B is not vulnerable in this way, but I think we can understand a reluctance to honour even a strong-willed and intelligible suicidal wish precisely because it is so final so quickly. In contrast, when Ms E requests the withdrawal of the chemotherapy, this is easier to accede to because, in principle, there will be enough time for Ms E to change her mind and to renew the chemotherapy. So when time passes and Ms E nevertheless does *not* request the resumption of the treatment, she is taking more and more ownership of the withdrawal decision, and leaving less and less complicity to the doctor. Ms B's request to switch off the ventilator is a request which, if honoured, would not allow any further changes of mind, and there would be a sense in which she will not have time to take ownership. The act that directly and promptly leads to her end of life will be the doctor's act – and this is what Dr C found she could not do.

Describing the situation as Dr C being asked to assist a suicide makes it much more of a balanced moral dilemma, where both decisions are equally morally intelligible. It also makes it more plausible to describe Dr C's refusal as a selective conscientious objection, even if Dr C did not use that term. The High Court gave the only plausible response by declaring the assistance of Ms B's suicide to be lawful, but stopping short of instructing a particular doctor or even a particular healthcare trust to carry out the requested assistance.

By way of concluding this section, let me again suggest the idea of a multidisciplinary committee to hear out Ms B's request. This would have the advantage of providing a forum for discussion of the case without resorting to a court of law with its much more restricted discourse of rights and duties. Such a forum would also allow a more nuanced conversation between Dr C and Ms B to take place, without the antagonism implied in the summary of the court judgement. Again, the model would be something like a hospital ethics committee, but with the involvement of the patient. Looking at existing practice among ethics committees in UK hospitals would be a start, toward seeing how they could be adapted in the way I am suggesting.

Conclusion

I have tried to distinguish universal from selective conscientious objections in healthcare, both in the abortion situation and in the situation of a competent patient

requesting the withdrawal of LST at the end of life. My aim has been to raise interest in selective CO as a real phenomenon, in order to invite further empirical work on how such CO plays out in practice, and further legal-policy work to formulate guidelines for consistent and fair implementation.

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Notes on contributor

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