

CONSCIENTIOUS OBJECTION:

PERSONAL AND PROFESSIONAL ETHICS IN THE PUBLIC SQUARE

Summary

English law expects health professionals to have, and act upon, consciences, but formal conscience clauses are not the main legal recognition of this expectation. Rather, they should be regarded as an anomaly with roots in very specific political settlements between society and health professions, whose legitimacy is historically contingent, and as aspect of the 'price' to be paid for securing services. There are sound reasons for the protection of conscientious discretion as an aspect of professional identity, but specific rights of personal conscientious objection are difficult to reconcile with legitimate public expectations of comprehensive and non-discriminatory services. Professional identities include moral commitments, such as the privileging of patient safety over administrative convenience. These should not be permitted to be overridden by personal moralities during the course of service delivery (as opposed to debating in the abstract what the proper courses of action should be). Consequently, formal conscientious objection clauses should be reduced to a minimum and regularly revisited. It is generally more satisfactory to address clashes between the personal moralities of professionals and public expectations through more flexible means, enabling accommodation of a plurality of views where possible but acknowledging that this is a matter of striking an appropriate balance. Employment law rather than health care law provides the best mechanism for regulating this process.

Key Words: Abortion; Conscientious Objection; Personal Beliefs; Professional Ethics; Professional Discretion; Social Contract

This paper is concerned with whether rights of conscientious objection vested in professionals are best seen as a private or public issue, and the significance of this distinction. It reflects on how issues of professionalism are connected with matters of conscience. I argue that the law expects health professionals to have, and act upon, consciences, but that formal conscience clauses are not the main legal recognition of this expectation. Rather, they should be regarded as an anomaly with roots in very specific political settlements between society and health professions, whose legitimacy is historically contingent. To assess whether they continue to be appropriate, an account needs to be given of the difference between the roles of both professional and personal values. I shall argue that there are sound reasons to support the protection of conscientious professional discretion, but this is different from the debate that is needed about 'rights of conscientious objection'. Such specific rights are difficult to reconcile with legitimate public expectations of a service, especially in a system of socialised medicine, and it is argued that they should be revisited. The specific rights are also somewhat arbitrary as protections of personal conscience, which needs to be recognised on a wider basis, although less rigidly. I shall suggest that the decision of the UK Supreme Court in *Greater Glasgow Health Board v Doogan* is consistent with this approach, and seeks to limit the scope of rights to conscientious objection under the Abortion Act 1967. It does so while also diverting consideration to the wider issues of balancing religious freedoms with service needs within employment law.¹

The importance of the point that the legal provisions that are being discussed in this article are historically and socio-politically specific can be seen in some salient differences between the way in

¹ [2014] UKSC paras [23]-[27], noting issues that were 'distractions' for the disposition of the case, but anticipated to provide a way forward for individuals in the future, see para. [24].

which issues around conscientious objection arise in England, Scotland and Wales when compared to discussion in the international bioethics literature.² The Abortion Act 1967 does not extend to Northern Ireland, and the legal position there is not specifically addressed in this piece.³ The first key difference between the legal position under consideration here and discussions based on the law in other jurisdictions is that it is common for that literature to examine conscientious objection in relation to procedures beyond abortion, and in particular emergency contraception. This is not the case in the UK, where rights of conscientious objection are limited to statutory provisions in relation to abortion, embryo research and the provision of fertility services.⁴ Further, those rights are not in fact defined by reference to professional status, although the interpretation of their limited scope means that they will most commonly be claimed by health professionals. In addition, while there is professional guidance that explores a wider scope for conscientious objection, it makes it clear that this is subject to employment obligations and is understood to be in a very different legal category to a 'right' to opt out of services.⁵

This draws attention to a second feature that is different from some jurisdictions; the employment status of doctors. In many jurisdictions, doctors have privileged status and do not find themselves in a 'master and servant' relationship with the institutions in which they work. In private medical care in the UK, this is often the case; visiting medical staff in independent health providers in the UK will not normally be employees, although this is not automatic and will depend on the nature of the contractual arrangements in question.⁶ However, within the hospital sector of the National Health Service, where the vast majority of doctors work, medical practitioners are employees in the same way as other staff and subject to the same fundamental principles of employment law,⁷ including the expectation that they follow 'lawful and reasonable instructions'. The idea that hospital doctors were independent contractors over whom the hospital had limited control did not survive the creation of the NHS.⁸ The language of 'independent contractor' survives in relation to general medical practice because GPs are not employees of the NHS. However, they deliver services under a statutory contract, with core services that all provide, with provision to extension to additional services against commissioners' specifications. This does not permit doctors to pick and choose which services they are prepared to provide within those specified terms. Failures to supply the services would be a breach of these contracts. This means that a number of issues that arise in non-socialised medicine systems about professional autonomy, including conscientious objection, do not manifest themselves in the same way in the NHS.

For similar reasons, those problems that arise in systems where hospitals are managed by organisations that object to the provision of legally permissible services are less apparent in the UK. The vast majority of health care is funded, although not necessarily provided, through the NHS

² For an overview of this literature, see L Kantymir and C McLeod 'Justification for conscience exemptions in health care' (2014) 28(1) *Bioethics* 16-23.

³ See *Family Law Planning Association of Northern Ireland v Minister of Health, Social Services and Public Safety* [2003] NIQB 48 and *Re Society for the Protection of Unborn Children's Application for Judicial Review* [2009] NIQB 92 (QBD). A further judicial review is underway at the time of writing, see Richard Martin, 'Northern Ireland's Human Rights Commission Granted Leave for Judicial Review to Challenge the Country's Near-Blanket Ban on Abortion' (OxHRH Blog, 9 February 2015), <http://ohrh.law.ox.ac.uk/northern-irelands-human-rights-commission-granted-leave-for-judicial-review-to-challenge-the-countrys-near-blanket-ban-on-abortion-2/> (last accessed 24 February 2015).

⁴ Abortion Act 1967, s 4; Human Fertilisation and Embryology Act 1990, s 38.

⁵ This is discussed below, see the text at footnote 49.

⁶ *Hospital Medical Group Ltd v Westwood* [2012] EWCA Civ 1005.

⁷ For recent cases, see *McMillan v Airedale NHS Foundation Trust* [2014] EWCA Civ 1031; *Chakrabarty v Ipswich Hospital NHS Trust* [2014] EWHC 2735 (QB).

⁸ For discussion of this and related issues about the legal structure of medical power within the demarcations of health professional work, see J Montgomery 'Doctors' Handmaidens: the legal contribution' in S McVeigh and S Wheeler (eds) *Health, Health Regulation and the Law* (1992) pp 141-68.

against standard service specifications, often in the context of clinical guidelines established by the National Institute for Clinical and Care Excellence. In the case of services for the termination of unwanted pregnancy, the obligation to commission services falls on Clinical Commissioning Groups each of which must commission services, including abortion services, 'to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility' (usually patients registered on the lists of GP practices which are members of the CCG, but in relation to emergency care 'every person present in the area').⁹ There is a model 'integrated sexual health services: national service specification' that explains what is expected to be commissioned and includes access to abortion services.¹⁰ The NHS system therefore means that the problems faced in predominantly private health systems, about securing access to abortion services from service providers who are reluctant to offer them, do not manifest themselves in the UK context.

These are distinctive features of the UK health system that need to be recognised before we turn to the statutory conscience clauses. The nature of socialised medicine as manifest in the NHS is thus built on a vision of comprehensive services, framed by the NHS Constitution in terms of a social contract between citizens and the state, into which health professionals are bound.¹¹ The usually vague idea of a contract between the state and those professions, under which status and privilege is conferred in return for the provision of services, has a very concrete reality in the NHS, with collective employment agreements for professional staff.¹² The most important feature of the settlement between the state and the professions for understanding the approach to conscientious objection, however, is the general approach of English law to clinical discretion.

Part I: Law and Professional Discretion: the conscientious exercise of power

English law has framed 'objection' as a key professional role. It has consistently rejected the idea that health care law is a matter of consumer rights, in which patients demand and receive the service that they want. This is in part a consequence of the fact that most health care in the UK is provided through state commissions and the vast bulk of English health law is concerned with NHS treatment.¹³ Even the concept of 'prescription-only medicine',¹⁴ generally justified in terms of the need to restrict access to dangerous substances to situations where they have been judged clinically appropriate by a duly accredited health professional,¹⁵ has been extended in popular usage into a

⁹ NHS Act 2006, s 3 (as amended). See also 'The Functions of Clinical Commissioning Groups (updated to reflect the final Health and Social Care Act 2012)' available at <http://www.england.nhs.uk/wp-content/uploads/2012/06/ccg-functions-document-june2012.pdf> (last accessed 24 February 2015).

¹⁰ Available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210727/National_integrated_sexual_health_services_specification_2013.rtf (last accessed 24 February 2015).

¹¹ See Health Act 2009, s1, NHS Act 2006 (as amended) ss 1B, 13C, 14P and the documents themselves at <https://www.gov.uk/government/publications/the-nhs-constitution-for-england> (last accessed 24 February 2015).

¹² See J Montgomery, 'The virtues and vices of professionalism'. In D Bhugra & A Malik (eds) *Professionalism in Mental Healthcare: Experts, Expertise and Expectations* (2011) 17-31, esp. 25-28.

¹³ For a discussion of the ability of this universal system to accommodate varieties of beliefs, see J V McHale, 'Faith, Belief, Fundamental Rights and Delivering Health Care in a Modern NHS: An Unrealistic Aspiration?' *Health Care Analysis* (2013) 21:224-236.

¹⁴ Medicines Act 1968, s 58, 58A; see E Jackson, *Law and Regulation of Medicines* (2012) 92-3.

¹⁵ Human Medicines Regulations 2012, SI 212/1916, Reg 214.

funding mechanism – the prescription that ensures that the NHS pays for treatment. These two intertwined usages of ‘prescription’ both share a key characteristic; the professional plays a gatekeeping function. Thus, the professional is expected to object to ‘inappropriate’ access to the treatments sought.

In a very clear assertion of this approach, Lord Donaldson summarised the position as follows:

The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer.¹⁶

This seems to identify conscience as an independent reason for declining to give patients what they seek. It also draws on the tacit understanding that runs through English law that health professionals are ethically as well as scientifically orientated. This is a view held generally by the judiciary, but perhaps most explicitly set out in judgments from Lord Donaldson. It leads to an approach premised on the integration of medical ethics and the law, in which professional discretion is protected in order to ensure that professional morality can prevail and not merely because of deference to technical skill.¹⁷ From this perspective, it does not seem inappropriate to leave areas for professional but not legal regulation. Lord Donaldson extolled the virtue of the position he crafted on concurrent consents in relation to treatment decisions for young adults as ensuring that ‘the doctor will be presented with a professional and ethical but not a legal problem.’¹⁸ Indeed, the judicial defence of some of the implications of this view was that ethical restrictions would ensure that doctors refrained from abusing the licence that the law permitted, for example in the hypothetical situation of the law permitting an unwanted abortion.¹⁹

The most direct judicial discussion of this general position is probably that in the *Burke* litigation. Leslie Burke challenged part of the GMC guidance on *Withholding and Withdrawing Life-prolonging Treatments: Good Practice in Decision-making* that made it a matter of medical discretion whether artificial nutrition and hydration should be offered to patients. Although Burke succeeded at first instance,²⁰ the Court of Appeal made it clear that doctors were expected to review requests by patients for particular treatments against their clinical judgment about what would provide overall clinical benefit for them, but the decision what to offer remained a professional one:

If, however [the patient] refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.²¹

The Court of Appeal in this case did not allude to any expectation of bringing morality to bear, merely noting the importance of accepting clinicians’ rights to make judgments on likely clinical benefit.

¹⁶ *Re J* [1991] 3 All ER 930, 934.

¹⁷ See J Montgomery, ‘Law and the Demoralisation of Medicine’ (2006) 26(2) LS 185-210, esp. 199-206.

¹⁸ *Re R* [1992] Fam 11, 22.

¹⁹ See *Re W* [1993] Fam 64, see Lord Donaldson at 79 and Balcombe at 89-90. In *Re X (a child)* [2014] EWHC 1871 (Fam), the patient’s consultant indicated ‘that it would not be right to subject X to a termination unless she was both “compliant” and “accepting”’. This could be interpreted as evidence to support the assumption that medical ethics would prevent abuse of the potential for parental consent. Munby P may have regarded this need for acceptance as a legal requirement, see para [12].

²⁰ *R (Burke) v General Medical Council* [2004] EWHC 1879 (Admin).

²¹ *R (Burke) v General Medical Council* [2005] EWCA Civ.1003, para [50].

In *AVS (by his litigation friend CS) v A NHS Foundation Trust* the reference to conscience was restored, but with an implicit, subtle, but important difference of emphasis - 'It is trite that the court will not order medical treatment to be carried out if the treating physician/surgeon is unwilling to offer that treatment for clinical reasons conscientiously held by that medical practitioner.'²² The difference here is that the reference to conscience is not to a separate and personal value system of the clinician, but to the fact that the opinion on the clinical reasons for treatment was 'conscientiously held'. This is more an issue of the good faith of the professional than conflicting value systems, a matter that will be seen to have important ramifications for the consideration of terms of the Abortion Act 1967 later in this piece.

This recognition of that judges should not override professional judgments has been elevated into what has become an established judicial practice and almost a point of legal principle:

To use a declaration of the court to twist the arm of some other clinician, as yet unidentified, to carry out these procedures or to put pressure upon the Secretary of State to provide a hospital where these procedures may be undertaken is an abuse of the process of the court and should not be tolerated.²³

More recently, the Supreme Court in *Aintree NHST v James* has reiterated this general position that courts, like patients, do not have the power to require doctors to provide specific treatments, only to accept or reject those which doctors think are clinically indicated.²⁴ There seems no indication in the early cases interpreting the significance of the Aintree decision of judicial anxieties that suggest a desire to change this approach.²⁵

It seems clear, therefore that the judiciary believes that it is right to protect clinical freedom. This pattern is not inadvertent but is a deliberately chosen position. Further, this approach is, at least in part, built on a belief the exercise of medical professional discretion is informed by moral considerations. Jose Miola has shown that this does not lead to a rule based system, in which professional norms operate in a quasi-legal manner to provide a single 'right-answer', but rather are conflicting and indeterminate.²⁶ This analysis does not undermine the picture painted above as a description of judicial attitudes. However, it raises important questions about its normative power and the legitimacy of law based on these premises.

Some of these concern the difficulties that the protection of conscientious discretion creates for holding professionals to account for discriminatory, or otherwise unacceptable, patterns of behaviour. Thus, permitting a high degree of discretion enables the prejudices of professionals on 'deserving' and 'underserving' supplicants for services to go unchecked. The 'tired housewife' might get easier access to abortion services than the 'tart' who is perceived to be reaping what she permitted to be sowed.²⁷ From a different perspective in the battle over abortion rights, it is asserted that the need to demonstrate breaches of 'good faith' permits doctors to offer 'abortion on demand' and bypass the regulatory safeguards with relative impunity. This interpretation of the impact of protecting conscientious discretion was no doubt fuelled by the explanation given by the Director of Public Prosecutions for not prosecuting doctors 'exposed' in a Daily Telegraph 'sting' in which journalists presented seeming to make a request for a termination of pregnancy in order to

²² [2011] EWCA Civ 7, para [35].

²³ Ibid. [38].

²⁴ *Aintree UH NHSFT v James* [2013] UKSC 67, approving the earlier statements to this effect by Lord Donaldson in *Re J* [1991] Fam 33, at 48, and *Re J* [1993] Fam 15, at 26-27.

²⁵ *United Lincolnshire Hospitals NHS Trust v N (Official Solicitor)* [2014] All ER (D) 251 (Jul), para [53].

²⁶ J Miola, *Medical Law and Medical Ethics: A Symbiotic Relationship* (2007). See also J Harrington, 'Of Paradox and Plausibility: The Dynamic of Change in Medical Law' (2014) 22(3) *Med Law Rev* 305-24.

²⁷ See Sally Sheldon's *Beyond Control: Medical Power and Abortion Law* (1997) esp. chapter 3 - 'Tarts and Tired Housewives'.

avoid giving birth to a girl.²⁸ The DPP reasoned that proceedings would have been unlikely to have succeeded because of the challenges of proving bad faith.²⁹ In different ways, each of these positions raises questions about the compatibility of the recognition of conscientious discretion with the rule of law. First, the inability to control unlawful discrimination and, second, the limitation of judicial oversight to check that the statutory tests are applied in clinical decision making.

It is clear from this analysis that, in the area of abortion, the degree of medical control over terminations lies much less in the rights of conscientious objection in section 4 of the Abortion Act 1967 than in a much broader recognition of conscientious discretion. The fact that the legality of an abortion depends on the good faith of doctors rather than whether the tests set out in the legislation were met in the judgment of either the woman, prosecutor or court provides the main scope for the exercise of conscience. Thus, in *Re X Munby P* made it clear that the question of whether the grounds in the Act were satisfied by the clinical circumstances was a matter for the doctors, not the court.³⁰ He adopted the words of Holman J in *Re SB* that terminations can only happen 'if a doctor or doctors, in the exercise of their own professional judgment, voluntarily decide to perform the abortion.'³¹ It is this protection of clinical freedom, not the specific conscience clauses that needs to be explained and justified.

This does not, however, equate to the protection of personal morality but rather to the promotion of clinical judgment exercised in the course of a morally suffused activity. The legal protection of professional discretion exists in order to facilitate the delivery of care, not merely to prevent external scrutiny.³² Two models might be used to explain how this is compatible with the rule of law. The first of these might be characterised using a metaphor of the doctor as playing a quasi-judicial role, applying normative principles to cases that come before them in attempt to adjudicate on a dispute over the proper conclusions to be drawn on the application of the law to the facts presented. The second can be seen as representing the doctor as the incarnation of a form of public authority, entrusted with an administrative discretion in a demarcation of spheres of legitimate authority.

Under the first model, we might consider whether we should expect doctors to exercise their discretion in accordance with rules or principles (and perhaps values) that are implicit within the law, as Ronald Dworkin argues that judges should do in a 'Hard Case' where there is no straightforward answer from previous legal authority.³³ Here the compatibility with the rule of law comes from the denial that cases will be resolved by forward looking policy judgments based merely on predicted and desired outcomes. Rather, decisions are shaped by drawing on pre-existing normative resources which are then applied to the new circumstances without bias. If the argument summarised above it is accepted, that the judges have adopted an approach in which the normative resources of the health professions have been integrated into the architecture of the law, then this would seem to place the doctor into the role of a judge in the Dworkinian vision.

²⁸ 'Abortion investigation: doctors filmed agreeing illegal abortions 'no questions asked'' <http://www.telegraph.co.uk/health/healthnews/9099511/Abortion-investigation-doctors-filmed-agreeing-illegal-abortions-no-questions-asked.html> (last accessed 13 January 2015).

²⁹ *Statement from Director of Public Prosecutions on abortion related cases* <http://blog.cps.gov.uk/2013/10/statement-from-director-of-public-prosecutions-on-abortion-related-cases.html> (last accessed 13 January 2015). A view that was substantially vindicated in the cases discussed in the next paragraph.

³⁰ [2014] EWHC 1871 (Fam), para [6].

³¹ [2013] EWCOP 1417, para [6].

³² J Montgomery, 'The Virtues and Vices of Professionalism' in D Bhugra & A Malik (eds) *Professionalism in Mental Healthcare: Experts, Expertise and Expectations* (2011) 17-31.

³³ R Dworkin, 'Hard Cases' in *Taking Rights Seriously* (1978).

Alternatively, it might be suggested that the role that the law expects doctors to take is more akin to that of a public authority, which has been allocated the power to make decisions according to its own expertise, or other independent legitimacy (e.g. democratic), subject to procedural rather than substantive legal constraints.³⁴ On this view, there is a demarcation of decisions as a being matter of professional discretion and conscience, drawing on a discrete and separate set of normative resources, rather than quasi-judicial determination on the application of the law. The key issues will concern the delineation of the expected processes, so that the law can exercise some degree of oversight without trespassing on the territory marked out for clinical discretion. Judges need to be able to determine whether those expected processes have been followed, but steer clear of interfering with the exercise of the substantive discretion that has been marked out as being beyond the 'competence' of the court. This might be termed a strategy of displacement from legal to medical systems for resolving difficult decisions. The normative principles on which doctors draw in this model come from outside the law, but there is an implicit expectation that discretionary powers will be exercised consistently with the rationale for conferring them on the doctors.

John Harrington has suggested that we might usefully understand this area of law as a specific example of a more general problem of managing an inherent paradox in the operation of legal systems. Such systems depend on the binary division of circumstances, into being either lawful or unlawful, if they are to achieve closure on concrete decisions through the application of legal doctrine to resolve specific disputes. Yet, courts find themselves dealing with a multiplicity of contingent and complex interactions across many domains of reasoning (e.g. legal, social, moral, and political). As a result there is a paradox; actual decisions are highly contingent, yet the normative legitimacy of the law is thought to lie in its objectivity and predictability. As he points out, 'paradoxes are a source of persistent embarrassment for theories that ideally equate law with logic and which take consistency as the system's overarching value.'³⁵ To manage this, the law seeks to suppress the visibility of its inherent paradoxes. Various programmes enable this, including displacing the messy contingencies into non-judicial processes in order to make it plausible to sustain the systemic purity of legal doctrine. Applying this to the context of Abortion, Harrington suggests 'the Act effects a deparadoxification by displacement: legal contingency in this sensitive area is absorbed by the 'black box' of professional opinion. The precise form of this deferral has been upheld and enforced in the relevant case law. While courts are reluctant to investigate the specific content of the medical decision, they have stipulated that an authentic clinical evaluation must be made in every case.'³⁶

³⁴ For a general study of the conceptual issues, see D Galligan, *Discretionary Powers* (1986). For analysis of the more recent literature see J King, *Judging Social Rights* (2012). There is a possible judicial analogy too, in relation to welfare decisions in relation to child-rearing in broken families. Here, the grounds for appeal are circumscribed in a similar way in order to recognise that there may be range of permissible decisions, see *G v G* [1985] 1 WLR 647.

³⁵ J Harrington, 'Of Paradox and Plausibility: The Dynamic of Change in Medical Law' (2014) 22(3) *Med Law Rev* 305-24, 312. Of course, not all scholars believe that logic is a hallmark of the law. Indeed, Oliver Wendell Holmes Jr. famously claimed that 'The life of the law has not been logic; it has been experience' in the first paragraph of *The Common Law* (1881). Nevertheless, in his judicial practice, Holmes demonstrated the point that law should defer decisions to other more suitable authorities; for example in his famous dissent in *Lochner v New York* 198 US 45 (1905). The theory of judicial deference espoused by Holmes was based on a position of moral relativism, even possibly nihilism (see Allan C Hutchinson 'Oliver Wendell Holmes Jr: the Magnificent Yankee' in *Laughing at the Gods: Great Judges and how they made the Common Law* (2012)). It therefore adopts a rather different position from that being set out here, which is deference to a specific value system rather than to a process for dealing with a multiplicity of values. I am grateful to an anonymous reviewer for the *Medical Law Review* for suggesting that I consider the contrast with Holmes' position.

³⁶ *Ibid.* 317. I am very grateful to John Harrington for his stimulating discussion of the idea of the 'black box' with me over a conference dinner.

There is an important common feature to both these approaches that requires the person exercising the discretion to be able to articulate the legitimacy of their decision by reference to positional rather than personal authority. For Dworkin's Hercules, it is showing how decisions are not matters of policy but the principles of law. This protects the judge from the suggestion that they are exercising a personal discretion but instead acting in a constrained professional role, as the spokespeople of the inherited legal tradition. There is little doubt that judges feel this particularly acutely when asked to operate in contested moral areas, seeking to explain how they should avoid allowing their personal opinions to intrude into their professional work. It is less clear that their practice is consistently restrained, and this is an area that requires more detailed analysis.³⁷

The second model requires the decision-maker to show that they have exercised their discretion in accordance with the structure that conferred it upon them. This enables the courts to identify ways in which discretionary powers might be exceeded and abused. Examples include the introduction of personal bias, systematic unlawful discrimination, irrelevant considerations (which requires an assessment of which considerations are deemed relevant by the framework that confers the discretion), and failure to consider relevant factors or evidence. As with the judicial analogy, there is a requirement to show that the authority has exercised its discretion in accordance with the public 'role' that it has undertaken. Thus, the decision whether to offer a woman an abortion within the legal framework of the Abortion Act 1967 is to be made in the role of doctor, not as an individual citizen.

This analysis suggests that the consistent and persistent protection of clinical judgment in medical and health care law, and thus the scope of the general conscientious objection, is related not to the personal expertise and morality of doctors, nurses, midwives and other recognised professional groups, but to the way in which they are thought to embody a tradition of both technical expertise and moral values. The normative legitimacy of this extensive respect for professional discretion lies principally in the belief that protecting this embodied tradition provides a reliable protection for patient interests. These are understood as being more than merely the expression of individual patient wishes. Some desires that patients might have are not respected by the law, such as requests for ineffective treatments, see *Burke v GMC* as discussed above. Consequently, the choices available to patients can be properly be limited to those offered by professionals. For this reason, the legal construction of the relationship between patients and health professionals is one in which the conscience of professionals is generally privileged over that of patients. Such an approach, which allows for a degree of indeterminacy, is preferred by English judges to a rule-based system of accountability that reduces the discretion of clinicians by requiring them to apply an algorithmic logic that generates clear and consistent responses to presenting facts. This accounts for the persistent use of the *Bolam* test in the English health care law.

The general framing of the Abortion Act 1967 through the filter of 'good faith' is a specific, and unusually explicit, expression of this approach. The Act can be seen as enshrining a set of positions on the lens through which it is thought by Parliament to be appropriate to consider a decision to terminate a pregnancy (i.e. what constitutes a legally acceptable ground for an abortion). This is partly constructed by reference to clinical issues about risk and prognosis, and partly by reference to social judgments (e.g. about which injuries are 'grave', what constitutes an 'abnormality', the 'seriousness' of 'handicap'). These frame the choices that are to be made available to women, setting boundaries of acceptability. The guardians of these boundaries are to be the medical profession. Clinical discretion, exercised in good faith, links the political settlement reached by Parliament with the decisions in individual cases. The grounds for abortion are to be neither a

³⁷ See J Montgomery, C Jones, and H Biggs, 'Hidden Law-Making in the Province of Medical Jurisprudence' (2014) 77 *MLR* 343-78 at 360-4 for examples of judicial articulations of these concerns and discussion of the extent to which they are reflected in judicial practice. NB that analysis predated the decision of the Supreme Court in *Nicklinson* [2014] UKSC 38 which may indicate a more interventionist approach.

personal judgment of the clinician, nor an unrestricted choice of the woman. Rather, the medical profession is to be the collective guardian of the political settlement reached through the legislative process.³⁸

The specific statutory conscience clauses in the Abortion Act 1967 (and the similar clauses in the Human Fertilisation and Embryology Act 1990) play a very different role in this political compromise. They enable individual clinicians to exempt themselves from playing this guardianship role, at least in part. Only in part, because the scope of the conscience clause set out in section 4 of the Abortion Act 1967 is determined by society, not the individual position of the professional. Thus, professionals with a 'conscientious objection' to abortions may opt out of some of those to which they object, but not all. For example, under section 4(2), it is not permissible to exercise an objection based on the fact that it is unacceptable to the professional to kill an 'innocent' unborn child to save its mother from a grave permanent injury to her mental health.

The limited scope of the legal right of conscientious objection is a significant factor in understanding its normative basis, which lies in the interrelationship of professional and personal ethics. Some issues about which individual health professionals have strong moral concerns are captured within the scope of the conscience clause, but not all. The statutory conscience clause is not concerned with those personal concerns, but with the relationship between the professions and wider societal decisions. As Lady Hale put it in the *Doogan* decision: 'The conscience clause was the *quid pro quo* for a law designed to enable the health care profession to offer a lawful, safe and accessible service to women who would previously have had to go elsewhere.'³⁹ It follows that the rationale of the clause lies neither in the special status of the embryo, nor in the personal interests of clinicians, but in the idea of professionalism and the social contract under which professional power is permitted to operate. The second part of this paper explores features of that implicit social contract that relate to the continuing legitimacy of conscientious objection in the context of abortion services.

Part 2 A Politics of Professional Identities: Personal and Professional Ethics

The analysis set out above, of the way in which the role of medical discretion is integrated into the normative structure of the law, draws more on the professional identity of clinicians than on their personal values. The legitimacy of the individual clinician's decisions within abortion services is drawn from their operation of the 'proper' role assigned to them within this constitutional settlement. Two implications of this analysis will be drawn out here.

The first concerns the normative significance of the clustering of potentially discrete values into an identity, with at least some degree of coherence and stability. This notion of identity is linked with the idea that power is granted to health professionals in order to embody a value tradition (whether rooted in legal normative resources or professional ethics). Individual professionals may find some values easier to accept than others, but they are to be treated as part of a single package insofar as they constitute the professional identity (or role). It will be argued that conscientious discretion should be protected when within this professional identity but that 'conscientious objection' as set out in section 4 of the Abortion Act needs to be understood as an act of heresy – a departure from

³⁸ The term 'settlement' is preferred to compromise(s) because it more accurately reflects the complexities of negotiations, trade-offs, and compromises that enable sufficient closure for the position to 'settle' into a legislative formulation. See S McGuinness and M Thomson, 'Medicine and Abortion Law Reform: complicating the professions' (2015) *Med L Rev* **.

³⁹ Para [27].

the orthodox professional identity. It therefore needs to be justified by reference to the possibility of accommodating heterodox positions without undermining the identity of the profession. .

The second issue concerns the inherently political nature of professional identities. Such identities are not fixed, but fluid. They are forged through the dynamics of inter- and intra-professional rivalries, health care delivery and payment systems, changing social status and wider clashes of cultures and values in the societies within which the professionals operate. Legitimation strategies take various forms and address a range of contexts. An appeal to professional identity rather than personal ethics may serve to articulate a rationale for the prevailing settlement on abortion and help ascertain the limits of what is implicit in that settlement. However, it does little to explain how it came about and how it might change. An awareness of the politics of professional identities is needed to understand the (in)stability of the current settlement.

In his discussion of conscientious objection, Daniel Weinstock draws an important distinction between arguments for respect for conscience that are based on the recognition of the moral agency of the objector and those that are derived from claims for religious freedom as the manifestation of objectors' identity as part of a value tradition.⁴⁰ He suggests that the principle of respect for the ability of people to act freely and with integrity, by following the dictates of their conscience, provides a reason to allow conscientious objection. He categorises this as an 'internal' reason, because it relates to the interests of the person making the decision, and roots it in the practice of being a moral agent. Weinstock also recognises an 'external' reason for respecting the conscientious refusal of moral agents, which is based on the interests of liberal democracies in encouraging and enabling citizens to think for themselves about complex issues of political morality. This is an 'external' interest because it relates to the state's interest in the citizenry being possessed of certain dispositions and can be seen as an essential pre-condition of a pluralistic democratic state.

Weinstock suggests that there is also an 'internal' interest of agents in being able to live in accordance with their religious creed, but he explains that the interest that it protects is not agency but identity. This interest is concerned with the agent's ability to 'identify' themselves with values that endure beyond the specific decision to allow integrity over time. He suggests that this is important because it protects 'the agent's ability to continue to participate in rites and practices and to follow communal rules... in order to forge a stable sense of identity.'⁴¹ He argues that there are 'external' interests connecting religious freedom and pluralist democracy, but these are different in kind to those generated by the importance of moral agency. They are not generated by the ideal of democratic deliberation but by the proper recognition of pluralism in liberal societies. In the particular context of health care, he suggests that accommodating the religious concerns of health professionals may make the professions more attractive to those from different faiths. This, in turn, might increase trust in public health institutions from faith communities, and promote toleration by professionals and even in wider society.

Weinstock suggests a number of 'external' reasons for respecting conscientious objections by health professionals deriving from the importance of moral agency within the professional role. Health services benefit, he suggests, from empowering doctors and nurses to make moral judgements on the complex problems that their clients face. This is analogous to the protection of conscientious discretion that has been discussed above. He also suggest that we should also respect the moral agency involved in deliberating on the content of their professional codes of conduct. Health professionals must be empowered to reflect on the norms that govern their work. He follows his analysis of the benefits of nurturing the moral agency of professionals with a discussion of the problem of dissent from 'a medical practice around which there is a very broad consensus.' He

⁴⁰ D. Weinstock, 'Conscientious refusal and health professionals: does religion make a difference?' (2014) 28(1) *Bioethics* 8-15.

⁴¹ At p 11.

argues that the acceptability of such dissent should not be based merely on prevailing consensus, but on 'reasonability'. This includes remaining within the conception of medicine as being scientific ('the dissenting judgment not be contrary to the best available scientific evidence'). He also suggests that there is a 'core of services that are to some degree definitional of certain roles in the health sector that one cannot dissent from... without at the same time dissenting from the role itself.'⁴² He includes dispensing contraception in a family planning clinic as an example of such a core role. It is hard to see how this account of reasonability can be limited to the requirements of logic and agency. It seems far more closely connected to Weinstock's discussion of identity grounds for respecting conscientious objections.

His argument was concerned to elucidate the difference between claims that conscientious objection should be respected on grounds of moral agency and those based on maintaining a *religious* identity. However, they also arise in relation to *professional* identity. His examples of assessing how to respond to dissent are intimately connected to the way in which the health professions have ensured that the values on which their decisions are based endure over time so as to create a collective integrity that makes up the prevailing professional identity. On his account, the current identity is non-negotiably scientific and includes contraception but not abortion as core activities. However, from an historical perspective it can quickly be seen that this has not always been the case (and so might arguably change).⁴³

We have seen that English law has developed a strongly protective stance to a general conscientious discretion based on the image that it has of the current identities of the health professions. This image includes the view that they are the embodiment of a collegiate ethical tradition. Conscientious objection clauses seem to make some aspects of that tradition open to individual dissent. If they serve to undermine the overall professional identity, then they may be inherently destabilising for the social contract on which professional privileges and services are based. Possibly, however, they should be understood as clauses within that contract, which (although not entirely consistent with the overall character) enables it to hold despite the instability of the professional identity. They emerge to deal with particular historically contingent pressures. If this is the case, attention should be paid to the way in which their significance for this social contract changes over time.

The existence of specific conscience clauses can, thus, perhaps best be seen as a particular example of a more general pattern of the way law in one of the fields in which the boundaries of professional power and monopoly are established. Michael Thomson has shown how this is persistently demonstrated in the history of Abortion Law in the UK from its emergence as a legal concept at the beginning of the Nineteenth Century with the first statutory offence in 1803. He shows how the history of abortion law can be told as part of the professionalization project of medicine that extends beyond the Nineteenth Century, where it has been extensively explored, into the Twentieth.⁴⁴ The medicalisation of decision-making, through definitions over whose meanings the medical profession exerts control, has provided doctors with monopolistic power. It was justified by a rhetoric of 'ethicality', but Thomson shows that the safeguards implicit in this rhetoric did not reflect practice.

For the purpose of this piece, the interest of this historical perspective lies in the significance of the conscience clause in enabling the provision of abortion services to remain medicalised. When the profession is divided in its stance on an issue, it cannot speak with a single voice in protecting the service as a medical monopoly. As Sheelagh McGuinness and Michael Thomson demonstrate in their

⁴² At p 12.

⁴³ See, for example, Penney Lewis's study of the way in which non-therapeutic sterilisation became legally acceptable, 'Legal Change on Contraceptive Sterilisation' (2011) 32 *J Leg Hist* 295-317.

⁴⁴ M Thomson, 'Abortion Law and Professional Boundaries' (2013) *Social & Legal Studies* 22(2) 191-210.

analysis of the origins the 1967 Act, pro-choice campaigners judged that it was necessary to accept medicalisation in order to secure support from the medical establishment for reform. They also show that the internal divisions of the profession were intense. In this context, the conscience clause enabled the establishment to secure support for the regularisation of medical involvement even from members of the profession who were opposed to abortion by reassuring them that they would not be required to be involved personally.⁴⁵

We should therefore recognise that conscience clauses are historically situated and part of the ebb and flow of professional boundary work by which professional identities are constituted and reconstituted. They are not free standing provisions that can be explained anachronistically as justified by some particular moral status of the embryo or moral nature of the actions. If that were the case, we might expect to see formal conscience clauses in relation to family planning services, gene therapies, intensive care practices that involve the withdrawal of life-sustaining medical treatment. However, these are matters that fall within the general protections of professional discretion. It is common to anticipate that if assisted dying were legalised, the relevant statute would include some form of conscience clause,⁴⁶ but this is not because there is something special about the issue of dying but because medical support for legalisation is dependent upon doctors not being required to be part of the practice.

The principal questions we need to ask about the proper limits of discretion in the name of conscience are how we wish to hold professional power to account. I argued in the first section that the law reflected a position that clinical discretion, conscientiously exercised, was something judges aimed to protect in order to bring the normative resources of the professional traditions to bear. I suggested that the statutory conscientious objection clauses disrupted this by protecting the personal rather than professional consciences of practitioners. In this section, I have adapted a distinction between reasons for respecting conscience that are based on promoting agency and those which are based on protecting identity to argue that it is the latter that explains the rationale behind the general legal position. Professionals claiming rights of conscientious objection to participating in care that the profession would, in standard circumstances, provide are therefore to be understood as heretics. They are dissenters from the orthodoxy of the very calling that is thought to justify their privileged, discretionary based, accountability system. The general arguments for respecting professional discretion do not apply in these circumstances because they involve deploying personal values not those enshrined in the tradition of the professional in question.

It followed that whether we had accepted their claims for conscientious objection to be respected was essentially a matter of the price we were prepared to pay as a society to secure the services that we wanted. From the perspective of reformers, the abortion conscience clause was part of the price for securing medical support for change (although it also was part of the price the medical establishment paid for carrying the wider profession with it in order to preserve abortion as a medical monopoly).

Taken in a Twenty-First Century context, it becomes necessary to consider whether that price still needs to be paid. The argument of the final section of this piece is that once the historical contingencies of the Abortion Act conscience clauses are recognised, the case for a specific exemption is dramatically reduced. It is no longer necessary for such a clause to be in place to secure collective medical support for abortion services. Even if it were needed in the past, it is no longer necessary to have that support to provide effective services because of the development of independent niche providers of family planning services (including terminations). Instead, the issues

⁴⁵ S McGuinness and M Thomson, 'Medicine and Abortion Law Reform: complicating the professions' (2015) *Med L Rev* **.

⁴⁶ See e.g. clause 5 of the Assisted Dying Bill 2014-15 HL Bill 24 (the Falconer Bill); clause 7 of the Assisted Dying for the Terminally Ill Bill 2004 HL Bill 4 (the Joffe Bill).

should be reframed into a question about the balancing of personal concerns of health professionals (of which abortion is only one example) with service needs and the rights of service users.

Part 3 A politics of the personal: a synchronic perspective

It is a common feature of legal analysis that it seeks to establish meanings synchronically – within the system of law at a particular moment in time, seeking to account for all its components as equally ‘valid’. It does this interpreting the relationships between contemporary prevailing authorities, doctrines and terms in ways so as to construe the law as a coherent and consistent whole. Outdated legal rules and principles cannot simply be abandoned or ignored, and if they cannot be made to fit, they must be changed in a legislative or quasi-legislative law-making process. Such a perspective encourages us to seek an explanation for rights of conscientious objection that makes them consistent with the current legal position. The previous section has argued that the statutory conscience clauses should, in fact, be considered diachronically – across time rather than within the snapshot of the ‘present’.⁴⁷ On this view, our interpretation of the significance of the clauses should be strongly influenced by our understanding of the fluidity of meaning over time rather than its crystallisation in present usage.

In this part of the paper, I bring the question whether conscientious objection is concerned with identity or agency together with the idea that we might treat them differently in the synchronic and diachronic spheres of meaning. The essence of the argument is that we should only protect the personal *moral agency* of professionals (by recognising the importance of them being able to engage with debates about their proper role, with strong rights to reject prevailing professional values) when we are concerned with the diachronic perspective – What should the law be? How and why is it changing? Here we should ensure that individuals are not constrained by their professional identities when they seek to change the ground rules within which they operate. As moral agents, they should be as free as other such agents to contribute. However, this is a sphere of objection which needs to be constitutionally framed with an established legitimate authority to alter the scope of professional or legal norms. The clinic is not such a sphere of activity, and it is constitutionally unacceptable to enable individual professionals personally to shape the scope of acceptable and available abortions on moral grounds when within a doctor-patient relationship. That is a matter for the democratic sphere. Conscientious objection within the clinic should only be permitted where it is in the name of an *identity* claim, which is a matter of belonging to the value tradition of the profession and therefore not a matter of personal preference.

Two examples will be used to explore this approach. First, analysis of GMC guidance on personal beliefs draws out the range of conflicts between personal morality and professional identity. Second, discussion of a case on the obligations of health professionals to follow lawful and reasonable instructions shows how they can be expected to comply with such directives during the delivery of patient care even when they have principled objections. This will set the scene for a brief discussion of the decision of the Supreme Court in *Doogan* to show how its narrow construction of the Abortion Act conscience clause is compatible with the thesis that professional and personal morality should be understood as operating in different spheres.

The first example concerns the guidance from the General Medical Council that has emerged to deal with complaints from patients that doctors have been improperly imposing the beliefs on patients (for example suggesting prayer as a therapeutic intervention) and from doctors’ concerns about their personal beliefs being restricted. In this circumstance, the GMC has suggested that ‘personal

⁴⁷ This distinction between synchronic and diachronic axes of analysis is drawn from Saussurian semiotics.

beliefs' cannot be pursued where they are in conflict with the principles of 'good medical practice', treat patients unfairly, deny patients access to appropriate treatment or services, or cause patients distress.⁴⁸ This can be seen as an example of rejecting moral agency conceptions of clinical judgment in favour of those based on the moral identity of the profession. However, it is also clear that the content of the 'moral identity' being asserted by medicine is now quite limited.

The key document, *Good Medical Practice*, sets out what is expected of doctors by way of conduct and values. It can be seen as an expression of the professional moral identity of medicine. It has a long pedigree, having developed from the old 'Blue Book', which was essentially a catalogue of misbehaviours that might lead doctors to be 'struck off' the register. It became recast into a set of values and standards to which doctors should aspire as well as adhere in the first edition under the title of *Good Medical Practice* in 2005. The current revision of the guidance, dating from 2013,⁴⁹ has sought to return to a more focussed and limited account of issues that might reflect on continuing registration and is therefore less aspirational, but it is still about good medical practice rather than bad. Under this umbrella, the GMC issued document initially entitled *Supplementary Guidance on Personal Beliefs* and now known as *Personal Beliefs and Medical Practice*,⁵⁰ which required doctors to 'set aside their personal beliefs where this is necessary in order to provide care in line with the principles in GMP.'

The current version of *Good Medical Practice* (2013) addresses potential problems about bringing personal views into the clinic by warning against expressing personal beliefs in a way that exploits patients' vulnerability or is likely to cause them distress (para 54) and setting out a prohibition on 'unfairly discriminating' by allowing personal views to affect treatment (para 59). So the harms are exploitation, distress and discrimination – defining limitations on the acceptable use of discretion rather than indicating how to exercise it. Against this background, *Personal Beliefs and Medical Practice* uses the term 'conscientious objection' in ways that go significantly beyond the statutory legal recognitions. It includes as examples the signing of cremation certificates, referral for treatments that cause infertility, contraception (including emergency contraception),⁵¹ and withdrawal of life-prolonging treatment.⁵² These are recognised as personal to individual doctors and are balanced against professional responsibilities that need to be met when exercising personal conscientious objection – making patients aware of objections in advance when possible; being open with employers, partners and colleagues; telling patients that you are exercising an objection, that they have the right to see another practitioner and providing them with enough information to make arrangements to do so.⁵³ Finally the GMC guidance identifies that employers and those contracting for services 'are entitled to require doctors to fulfil contractual requirements that may restrict doctors' freedom to work in accordance their conscience.'⁵⁴

⁴⁸ http://www.gmc-uk.org/Personal_beliefs_and_medical_practice.pdf_58833376.pdf (last accessed 10 January 2015) para 4.

⁴⁹ See http://www.gmc-uk.org/guidance/good_medical_practice.asp (last accessed 10 January 2015).

⁵⁰ http://www.gmc-uk.org/Personal_beliefs_and_medical_practice.pdf_58833376.pdf (last accessed 10 January 2015).

⁵¹ http://www.gmc-uk.org/Personal_beliefs_and_medical_practice.pdf_58833376.pdf (last accessed 10 January 2015) footnotes on p 2.

⁵² *Ibid.* para 25, see also paras 79-80 of the Guidance *Treatment and Care Towards the End of Life: good practice in decision making* (2010) http://www.gmc-uk.org/static/documents/content/Treatment_and_care_towards_the_end_of_life_-_English_0914.pdf (last accessed 10 January 2015).

⁵³ http://www.gmc-uk.org/Personal_beliefs_and_medical_practice.pdf_58833376.pdf (last accessed 10 January 2015) paras 10-11. NB this falls slightly short of an obligation actually to refer patients for treatment to which you conscientiously object as is sometimes assumed by judges to be a legal obligation, see e.g. by the UK Supreme Court in *Doogan* (para [40]).

⁵⁴ *Ibid.* para 9.

This takes us to questions of the nature of employment contracts for health professionals, the second area for consideration. If we accept that exercise of conscience is expected, and that this may conflict with institutional priorities, how can we reconcile the tensions that will inevitably emerge in contested areas of treatment? Such a problem arose in the employment law case of *Owen v Coventry HA*,⁵⁵ concerning a nurse who had principled objections to the use of electro-convulsive therapy (ECT) but who was working in a unit where doctors used it. The case elicited a distinction between circumstances when it was reasonable for nurse to refuse to co-operate with medical instructions and those when it was not. This was cast in professional identity terms - conflict between the duty as an employee to follow employers' instructions and that as a professional to protect the safety of patients

Owen was dismissed for refusing to co-operate with ECT treatment for a patient in his care. He argued that his objection to it was based on his professional judgment and that it was unreasonable to expect him to follow medical orders to participate in the treatment. In legal terms this was because, in the light of his claimed right to object, the doctors' treatment proposal did not constitute a 'lawful and reasonable instruction' that his contract of employment obliged him to obey. The case concerned the care of a Mrs M who on 27 July 1982 was scheduled for ECT, when Owen was looking after her. He formally requested to be excused from this, writing that 'I am convinced she is dying and that therefore this treatment is inappropriate.' The situation was reviewed by the nursing officer who did not accept this assessment. Two days later, Mrs M was again scheduled for ECT and Owen refused to take any part in the procedure. The Court of Appeal's judgment notes pithily that 'the Industrial Tribunal found that this refusal, at an hour's notice, caused some disruption.'

This was not the first time the ECT issue had arisen. In earlier disciplinary proceedings Owen had received a formal written warning that he had been 'repeatedly requested to carry out a reasonable instruction, namely to undertake clinical nursing duties in the ECT Department, to which you refused, stating that you objected to ECT as a treatment for patients and wished to be excluded from nursing duties in that department' and he had been warned that this amounted to serious misconduct. In the subsequent enquiry into his refusal to take part in Mrs M's care, which also sought to explore whether there was scope for Owen to be employed in roles that would avoid contact with ECT patients, he stated that 'ECT was not a form of treatment with which he could agree in that it offended against his beliefs.' He was dismissed.

His dismissal was upheld by the Court of Appeal, noting the distinction between two claims about professional judgment. The first concerned patient safety. Owen claimed that this was 'the real issue... Did the applicant act unreasonably in refusing to take part in the treatment of Mrs M on 29th July 1982 when his reason for refusing was his judgment as a professional staff nurse that such treatment for that patient on that occasion was not in her best interests?'

The Court of Appeal rejected this analysis of the facts:

The applicant's case might have been that he had deep and insuperable misgivings about taking part in the treatment of Mrs M on 29th July and that he had accordingly felt unable to assist but that, save in that case and on that occasion, he was willing to perform his nursing duties on any other occasion. That, however, was not the case which the applicant presented ... at the enquiry on 31st August. It was not his case to the Appeal Tribunal... It was not the case raised in his originating application to the Industrial Tribunal, where his objection to ECT was put in general terms without reference to any particular patient and it was not his case put to the Industrial Tribunal, where his case was that he should have a conscientious right to object to ECT as he would have to abortion.

⁵⁵ (1986) Court of Appeal 19 December, unreported, transcript available in LexisLibrary.

Consequently, the case concerned second category, principled objection to a type of treatment:

Even giving full weight to the applicant's contention that he was professionally bound to express his concern in the interests of the patient if he thought treatment inappropriate, the applicant's conduct went well beyond what his professional duties required or permitted. On 29th July he had not seen the patient nor, as I have said, formed any judgment on the patient. He had not discussed the matter with any medical practitioner and he did not ascertain whether the patient's condition had been re-assessed. He did nothing to bring his misgivings to the attention of those who carried out the treatment. He simply refused to have any part in the procedure.

Consequently, his dismissal was reasonable. While it would have been proper for him to raise concerns about the use of ECT when the policies in the unit were being discussed, it was not appropriate for him to refuse to operate those policies while they were in force.

The position might have been different had there been particular reasons for him to believe that the patient in question was being placed at some specific risk, that had not been taken into account by the doctors when they decided that ECT would be an appropriate treatment. In such circumstances, halting treatment while the situation was reconsidered would have been an appropriate professional response. This is recognised in various ways in early clinical negligence cases, which have noted that junior doctors are expected to refuse to follow instructions that are 'manifestly wrong',⁵⁶ and nurses would be expected to seek confirmation of instructions that they are concerned about before proceeding. Although more recently the issues have been obscured by the operation of NHS Indemnity, which keeps apportionment issues away from the courts, professional guidance recognises the issues by setting out personal accountabilities for checking that patients are safe when implementing care planned by others.⁵⁷ Such actions would involve objecting conscientiously, in accordance with their professional duties to protect individual patients' interests, as required by the moral identity of the profession, irrespective of personal views.

Conclusion: the anomalous nature of the statutory conscientious objection clauses

From this analysis, it seems clear that the statutory conscience clauses (and the suggested extensions of conscientious objection in the GMC guidance) are anomalous when considered through the synchronic lens. They are blanket exemptions, inflexible and insufficiently responsive to circumstances to be understood as relating to the conscientious exercise of professional responsibilities. Instead, they serve to exempt professionals from even considering the situation in which patients find themselves and permit their decision to be based on matters that are unrelated to the specific circumstances of the patient. This prevents the statutory conscience clauses being defended as an example of a quasi-judicial discretion to plug an interpretive gap in the way that the

⁵⁶ *Junor v McNichol* (1959) Times 26 March. See also in relation to a dentist's right to rely on a medical assessment, *Tanswell v Nelson* (1959) CLY 2254, 11 Feb, and for a pharmacist's need to challenge a prescription that was patently erroneous, *Dwyer v Roderick* (1983) 127 Sol J 805.

⁵⁷ See Nursing and Midwifery Council *The Code: Standards of conduct, performance and ethics for nurses and midwives* (2008) <http://www.nmc-uk.org/Documents/Standards/The-code-A4-20100406.pdf> (last accessed 10 January 2015). An earlier version of this Code was noted by the Employment Appeal Tribunal ruling of 7 November 1984 in the Owen case, transcript available in LexisLibrary. Standard 8 of the NMC's *Standards for medicines Management* makes it clear that it is part of the 'professional accountability in the best interests of patients' of registrants to consider dosages personally (<http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-for-medicines-management.pdf>, last accessed 10 January 2015).

‘good faith’ requirement functions because it is not a matter of either interpretation of the legal terms or of examination of the woman’s circumstances. Nor can the clauses be justified on the basis that they protect the exercise of conscientious discretion in the deployment of the moral tradition of medicine, because they permit personal moral agency rather than the following of a professional identity. There is, thus, a radical inconsistency with the reasons for the general respect for conscientious professional discretion.

If the statutory conscientious objection clauses relate to personal moral agency rather than professional identity, then the claims of professionals need to be balanced against the equivalent moral agency of women seeking services and organisations seeking to provide them. While the exclusion of life-threatening emergencies from the scope of section 4 of the Abortion Act 1967 reflects the recognition that they are situations when the needs of women outweigh the conscientious objections of professionals, it does so very crudely. More generally, the availability of the clause leads to an exemption from any balancing exercise as the professional opts out of considering the circumstances of the woman. The implications of this insight can be traced in the Supreme Court decision in the *Doogan* case and concerns the different paradigms of (a) ‘conscientious objection’ under section 4 of the Abortion Act 1967 and (b) claims to exemption from particular practices in the name of freedom of religious and conscience under Article 9 of the European Convention on Human Rights. This Article sets out a qualified right, and the Supreme Court argued that the blanket nature of the conscience clause meant that the provisions of this Article could not help indicate how construction of its scope would be consistent with the Convention. Any assessment about whether the limitations on Art 9 rights were proportionate would be ‘context specific and would not necessarily point to either a wider or narrow reading of section 4.’⁵⁸ The scope of the clause needed to be ascertained by reference to standard canons of interpretation, leaving any questions of compatibility with the Convention open for subsequent scrutiny.

Nevertheless, adoption by the Supreme Court of a narrow construction of the scope of the conscience clause has the effect of displacing, so far as was compatible with the legislation, issues of conscientious objection out of the Abortion Act (and health care law) into the context of employment law. Professionals are entitled to expect their employers to make reasonable adjustments to accommodate their beliefs, whether or not the statutory conscience clause applies.⁵⁹ This brings a different and more flexible legal framework into play. Although the Supreme Court rejected the opportunity to explain where this perspective would lead, it did so specifically because it anticipated that it would be sensitive to local matters and not a single universal opportunity to object to activities of which professionals disapproved.⁶⁰ This will leave matters of personal belief by those undertaking the public roles of the health professions to be considered under the principles explored in the cases concerning civil registrars who have objections to the evolution of legal definitions of the marriages that they celebrate.⁶¹ This approach enables the courts to examine the balancing of the requirements of public roles, personal beliefs, and the rights and freedoms of others. The statutory conscience clauses have the effect of enabling personal beliefs to be automatically privileged over those other factors. As has been shown above, there is no justification for permitting this as an aspect of professional identity. Consequently, it follows that health professionals should be placed in a position that is equivalent to others with personal beliefs that may conflict with public expectations because the claims that they make are based on personal moral agency not the special status of professionals.

⁵⁸ [2014] UKSC 68, [23].

⁵⁹ [2014] UKSC 68, [24].

⁶⁰ [2014] UKSC 68, [23]-[24], [27].

⁶¹ See *Ewieda v UK* (2013) 57 EHRR 213, concerning the applicant Ms Ladele and the case *Ladele v LB Islington* [2009] EWCA Civ 1357. See also the second applicant Ms Chaplin who was a nurse claiming the right to wear a visible cross.

Returning to a diachronic perspective, this leaves open the question whether as a matter of the politics of the social contract between society and the professions it may continue to be an acceptable price to pay to offer doctors and nurses a special recognition for conscientious objection. We should not, however, confuse the messy politics of professional boundary work with the normative arguments around respect for professional identity and for personal moral agency. Statutory conscientious objection clauses belong to the former sphere. The proper recognition of the value of supporting professionals to exercise professional power conscientiously is a different matter entirely.
