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Might There Be a Medical Conscience?

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Abstract: I defend the feasibility of a “medical conscience” in the following sense: a medical professional can object to the prevailing medical norms because they are incorrect *as medical norms*. In other words, I provide an account of conscientious objection that makes use of the idea that conscience can issue true normative claims, but the claims in question are claims about medical norms rather than about general moral norms. I further argue that in order for this line of reasoning to succeed, there needs to be an internal morality of medicine that determines what medical professionals ought to do *qua medical professionals*. I utilize a constructivist approach to the internal morality of medicine and argue that medical professionals can conscientiously object to providing treatment X, if providing treatment X is not in accordance with norms that would have been constructed, in light of the end of medicine, by the appropriate agents under the appropriate conditions.

Keywords: Conscientious Objection; Normative Truth; Internal Morality of Medicine; Constructivism; Patient Involvement

1. Introduction

Mahatma Gandhi declared that “in matters of conscience, the law of majority has no place.” Martin Luther King declared that “an individual who breaks a law that conscience tells him is unjust [...] is in reality expressing the highest respect for law.” It seems that both men had the following thought in mind: an important aspect of conscientious objection is to allow individuals to resist the prevailing moral attitudes and laws because those attitudes/laws might be *incorrect*.¹ Now consider a soldier who is entertaining the thought of taking a shot at an enemy combatant during battle while concealed high up in a bell tower. Let us assume for the sake of argument that the war she is participating in is a just war, taking the shot is a morally permissible action, and current military norms state that the soldier can, and is even required to, take the shot. Nevertheless, the soldier in question might refuse, on conscientious grounds, to take the shot, arguing that the prevailing military norms are *incorrect*, and that they are incorrect *as military norms* rather than as general moral norms. This might be so because, for example, a correct code of military honor would be one in which soldiers should not be concealed when firing from a distance at other soldiers. Importantly, this soldier is not arguing that the current war is unjust or that killing the enemy combatant is morally impermissible. Indeed, the very same soldier might have no objection to killing enemy combatants in face-to-face combat in the current war. Rather, the soldier is objecting to killing the enemy combatant because it is the wrong thing to do *qua*

¹ I use these two examples merely to illustrate the idea that conscience can discern normative truths. To be sure, there are a couple of differences between these examples and the medical context that I will be discussing. First, during the 1930 Salt March, Gandhi challenged what he deemed to be an unjust law by violating it and suffering the consequence of imprisonment. In the U.S., in contrast, medical professionals invoking conscience clauses are not violating any law to protest its injustice: they have a legal right to refuse to provide abortion and related services by invoking the conscience clause. However, this difference does not alter the fundamental philosophical point: conscience can be used as a faculty for discerning normative truths, truths that may not be consistent with prevailing norms. The fact that some societies have enacted laws that allow citizens to conscientiously object to performing actions otherwise required by the law does not change this fundamental point. Second, it is probably the case that neither Gandhi nor King endorsed the type of constructivist picture of morality that I will utilize in this paper (indeed, King’s protest against Jim Crow laws was predicated on natural law theory). However, again, the important philosophical point is that conscience can discern normative truths, whatever metaethical views one happens to hold.

soldier.² While Gandhi and King utilized a general moral conscience in order to resist the prevailing attitudes and laws of their respective societies, the soldier under consideration is using what we might call a “military conscience” in order to resist the prevailing military norms.

My aim in this paper is to provide a defense of the feasibility of a “medical conscience” in the following sense: a medical professional can object to the prevailing medical norms because they are incorrect *as medical norms*. In other words, I will provide an account of conscientious objection that makes use of the idea that conscience can issue true normative claims, but the claims in question are claims about medical norms rather than about general moral norms.³ I will further argue that in order for this line of reasoning to succeed, there needs to be a morality of medicine that is not reducible to more general moral principles, a morality that determines what medical professionals ought to do *qua medical professionals* and that has often been called an “internal morality of medicine.” I proceed as follows. I first discuss three conceptions of a medical conscience, which I call the redundant, the *ad hoc*, and the aspiring conceptions, and argue that all three are inadequate (section 2). I then provide what I argue is an adequate account of a medical conscience based on the idea that there is a morality that is internal to medicine. In particular, I build on my constructivist approach to the internal morality of medicine and argue that individual medical professionals can conscientiously object to providing treatment X, if providing treatment X is not in accordance with norms that would have been constructed, in light of the end of medicine, by the appropriate agents under the appropriate conditions. I also argue that my account of a medical conscience can take patient interests into account (section 3).

² I am indebted to David Sussman for this example.

³ I discuss how conscience can discern normative truths more generally in Ben-Moshe, N. The Truth Behind Conscientious Objection in Medicine. *Journal of Medical Ethics* (forthcoming).

2. Three Approaches to a Medical Conscience

I wish to commence by discussing three ways in which medical norms and values in medicine have been associated with conscientious objection. First, Holly Fernandez Lynch has argued that conscientious objection in medicine should include refusals grounded in values that are widely held within the medical profession. She provides the following example to illustrate her point: consider a surgeon who refuses to accept a patient unless she agrees to undergo a screening that carries risks of its own in order to rule out greater risk factors that could complicate the surgery. The surgeon's conscientious refusal to give the patient what she wants is guided by prevailing professional standards pertaining to the level of acceptable risk. Lynch calls this refusal a conscientious objection made "at a professional level."⁴ Note, however, that the medical professional's conscience is not doing any work in this example; rather, this professional is not willing to give the patient what she wants simply because it is not in accordance with the profession's prevailing norms. In other words, this medical professional is merely doing his job. An analogous non-medical case will make the problem clearer. Consider a citizen of a certain country, A, who refuses to kill B even though B has requested of A that A kill him. If the laws of the country specify that X must not kill Y even if Y requests of X that X kill him, then A's conscience is not doing any work in this example. Rather, A is simply following the rules of the land. He is doing his job as a citizen of the country, as it were. Therefore, the mere fact that a medical professional refuses to give the patient what she wants because it is not consistent with prevailing medical norms is not sufficient to render the refusal in question an objection issued from a medical or professional conscience. Rather, an objection that stems from a "medical conscience" would need to satisfy the following condition: the medical professional refuses to

⁴ Lynch, H. F. (2008). *Conflicts of Conscience in Health Care: An Institutional Compromise*. Cambridge, MA: The MIT Press, at p. 34.

give the patient what she wants, *despite* the fact that the patient's request is consistent with prevailing medical norms, *because* the professional has determined that these norms are incorrect as medical norms. Since conscience is redundant in these types of scenarios, I will call this position "the redundant conception of medical conscience."

The next two ways in which medical norms have been associated with conscientious objection have been championed by those who justify conscientious objection by appealing to respect for the moral *integrity* of the medical practitioner. The key idea in the integrity approach is that the medical professional has core ethical values that are integral to her self-conception or identity, and when we ask the professional to do something that is incompatible with these values, we are essentially asking her to perform an action that would lead to self-betrayal and to a loss of self-respect.⁵ Thus, Mark Wicclair has argued that, in order to have significant moral weight, an appeal to conscience needs to be based on values that correspond to medical values. According to Wicclair, this claim can be elaborated in the following way: (a) when there are significant differences among appeals to conscience from the perspective of recognized professional norms, there are corresponding differences in their moral weight; (b) conscience-based objections have more moral weight when they are grounded in the physician's conception of herself as an *ethical physician* and less moral weight when they are grounded in the physician's conception of herself as an ethical person or a member of a certain group.⁶ It is

⁵ This conceptualization of the integrity approach is taken from Wicclair, M. R. (2000). Conscientious Objection in Medicine. *Bioethics*. 14(3), 205-227. For further conceptualizations of the integrity approach and arguments supporting it, see Blustein, J. (1993). Doing What the Patient Orders: Maintaining Integrity in the Doctor-Patient Relationship. *Bioethics*. 7(4), 289-314 & Brock, D. W. (2008). Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why? *Theoretical Medicine and Bioethics*. 29(3): 187-200.

⁶ Wicclair (2000), op. cit. note 6, pp. 217 & 222-224. Wicclair justifies the first of the two claims by arguing that "ascribing more weight to conscience-based objections to [...] practices which are contrary to current professional norms can be defended by claiming that recognizing such appeals to conscience promotes the moral integrity of the *medical profession* as well as the individual physician" (Ibid, pp. 222-223). However, there are other ways of preserving the profession's integrity while allowing individual professionals to act according to their claims of conscience, even if these claims are not in line with recognized professional norms. For example, one could see to it

important to emphasize that in contrast to the previous conception of a medical conscience, according to which *some* refusals are entirely grounded in values that are widely held within the medical profession, here the idea is that *all* refusals should be given more weight if they correspond to values in medicine or if they are grounded in the medical practitioner's self-conception as an ethical medical practitioner (where what ultimately justifies the objection is the practitioner's integrity). However, if one is merely interested in the medical practitioner's *integrity*, it is not clear why the question of whether or not the provider's objection is in line with recognized professional norms is relevant for protecting his or her integrity. Moreover, if one is only interested in protecting the integrity of the objecting agent, why should practical identity X have precedence over practical identity Y? If, for example, violation of medical professional A's identity as a Muslim would be most devastating to her self-image and violation of medical professional B's identity as a medical professional would be most devastating to her self-image, why should B's objection have more moral weight than A's objection? Since medical norms are added *ad hoc* onto the integrity approach, I will call this position "the *ad hoc* conception of medical conscience."

The third conception of a medical conscience is, on the face of it, a denial of the very possibility of a medical *conscience*. According to this position, advocated by Daniel Brudney, we need to make a distinction between two types of requests for accommodation in the workplace, that is, for being released from established professional obligations. The first type of request is the type we associate with conscientious objections: when one makes a conscientious objection, one is making a claim about one's own values, the violation of which would violate one's integrity. Such claims are not assessed by their truth, but rather by the agent's sincerity. Now

that there are enough medical professionals who do not object to the treatment and thus allow the profession to fulfill all of its professional obligations.

consider a different type of accommodation: a medical practitioner who objects to performing an abortion because abortions are outside the scope of her professional responsibility. As Brudney notes, this practitioner might provide the following argument: medicine is about curing or preventing disease; pregnancy is not a disease; so it is not part of a medical professional's job to prevent or terminate pregnancy. In this case, the medical practitioner is providing an argument that includes as its premises conceptual claims about medicine and disease. Brudney argues that such claims are assessed by their truth, not by the agent's sincerity, and are thus not appeals to conscience.⁷ This position assumes that in assessing conscientious objections, we only care about the fact that the agent holds a certain belief and that it has an important role in his life, not about the truth of the belief.⁸ However, this distinction, between requests for accommodation that stem from the agent's conscience and are thus not truth-based and requests for accommodation that are truth-based and thus do not stem from the agent's conscience, holds only if we endorse the integrity approach to conscience as the only viable approach to conscience. While I will not be offering a systematic critique of the integrity approach in the current paper, I think that it cannot serve as the only approach to conscience, because, as I have noted, an important aspect of conscientious objection is to allow individuals to resist the prevailing moral attitudes and laws when those attitudes/laws are *incorrect*. Furthermore, the integrity approach leads to a problem in the demarcation of *legitimate* conscientious objection: why, for example, should we not also

⁷ Brudney, D. (2014). "Pregnancy Is Not a Disease": Conscientious Refusal and the Argument from Concepts. *The Hastings Center Report*. 44(5), 43-49. Brudney clearly endorses the integrity approach: "Most human beings have reasons to do or to refuse to do things that derive from being [...] committed to a particular set of fundamental values and beliefs. A good life is often said to involve few or no violations of these values and beliefs. One who leads such a life is said to be living in accordance with his conscience or preserving his integrity, [which is often] the basis for a moral entitlement to accommodation of conscientious refusal" (Ibid, p. 44).

⁸ Brudney argues for this point explicitly: "[When I raise a conscientious objection,] I am saying that I hold a moral or religious belief and that this belief requires that I act or refuse to act in a certain way. I need not defend the truth of my moral or religious belief. My assertion is partly about the belief [...], but it is primarily about me: that I have such a belief and that it plays a certain role in my life. [...] [A]t issue in the claim of a moral entitlement to accommodation is the fact that I hold a belief, not that the belief is true" (Ibid, p. 44).

respect the moral integrity of Adolf Eichmann, who is reported to have followed the dictates of his conscience when implementing the final solution? One could reply that the dictates of Eichmann's conscience are so obviously immoral that we would never dream of respecting them. Note, however, that Eichmann can, and in fact did, use moral terms when defending his claims of conscience. So the reason we do not want to respect Eichmann's claims of conscience is that we think his conscience expresses *false* moral claims.⁹

If conscience does not merely pertain to the person's integrity but can discern normative truths, the second type of objection—according to which it is not part of a medical professional's job to prevent or terminate pregnancy because medicine is about curing or preventing disease and pregnancy is not a disease—could be a legitimate conscientious objection assessed by its truth and the validity of argument supporting it. Indeed, consider a medical practitioner who makes the following argument: persons should not be killed unjustly; abortion is an unjust killing of the fetus; fetuses are persons; so abortions should not be performed by anyone; so it is not part of a medical professional's job to prevent or terminate pregnancy (since abortion is morally impermissible). This practitioner has reached the same conclusion as the conclusion of the first argument, provided by Brudney, by a set of premises that does not appeal to what medicine is all about, but rather to more general moral principles. If this practitioner presents the conclusion of this argument as his conscientious objection, in conjunction with the supporting premises, are we really not interested in the *truth* of this conclusion? Would we not be interested in the question of whether or not the premises are true and support the conclusion? Would we only be interested in the question of whether or not the medical professional is sincere in claiming that he holds this belief? If you think both that the conclusion of this second argument, which appeals to the

⁹ I discuss these issues in more detail in Ben-Moshe, *op. cit.*, note 3.

impermissibility of abortion quite generally, could be a claim of conscience *and* that the truth of this claim and the validity of the argument are relevant, why then would you think differently about the first argument, provided by Brudney, which arrives at the very same conclusion from different premises? What Brudney's original suggestion gets right is that this type of argument, and hence this type of objection, has the potential of transcending the prevailing norms of the medical community. Indeed, recall that this is how the problem was initially set up: presumably the medical practitioner is claiming that it should not be part of a medical professional's job to prevent or terminate pregnancy precisely because it currently *is* part of the medical professional's job to prevent or terminate pregnancy. Therefore, I wish to argue that, despite Brudney's own convictions, the second type of request for accommodation that he discusses lays the foundations for a conception of a *medical* conscience, because, if conscience can discern normative truths, Brudney's position affords us an understanding of the *possibility* of a medical conscience that can transcend the current medical norms and values of medicine. I will thus call this position "the aspiring conception of medical conscience."

3. The Internal Morality of Medicine and the Possibility of a Medical Conscience

If we acknowledge that at least one of the roles of conscience is to discern normative truths, then a case could be made for the existence of a medical conscience analogous to a moral conscience: as Gandhi and Luther King utilized their conscience in order to ascertain that the prevailing societal norms ought to be defied because they fell short of the correct moral norms, so the medical practitioner can utilize his or her conscience in order to ascertain that the prevailing medical norms ought to be defied because they fall short of the correct medical norms. In other words, this conception of conscience makes use of the idea that conscience can issue true

normative claims, but the claims in question are claims about medical values rather than general moral values. So, for example, even if abortions in the first trimester are permitted according to the prevailing medical norms, a medical practitioner might conscientiously object to performing abortions, because, according to the *correct* medical norms, medical professionals *qua medical professionals* should not be performing abortions. Note two important features of this example. First, the medical practitioner is not simply objecting to the moral permissibility of abortion quite generally, since then she would be appealing to a *moral* conscience, rather than a *medical* conscience. Indeed, this individual might very well believe that first trimester abortions are morally permissible. Second, the medical practitioner is objecting to the prevailing medical norms, because she believes that these norms fall short of the correct norms of medical practice. This medical practitioner is, therefore, using a specifically *medical* conscience, a conscience that allows her to identify the correct *medical* norms and values. In order for this reasoning to succeed, there needs to be a morality of medicine that is not reducible to more general moral principles, a morality that is definitive of medical practice and that determines the norms that dictate what medical professionals ought to do *qua medical professionals*. Only if such a morality exists would it make sense to say that the prevailing medical norms and values fall short of the correct medical norms and values, and they do so not merely because of general moral considerations but because of considerations that are definitive of what medicine is all about.

The development of such an “internal morality of medicine” is associated with Edmund Pellegrino, who argued that there is an end to medicine that is not a social construction, but rather the “definition” and “essence” of medicine. This definitive end of medicine determines, in conjunction with certain standards of excellence, goods that are internal to medicine as well as

medical practitioners' obligations.¹⁰ What is the status of the end of medicine and the norms to which it gives rise? Pellegrino insisted that his account is "realist" and defined the nature of medicine as "something in the real world independent of the construction society might put upon that reality."¹¹ Indeed, Pellegrino argued that the internal morality of medicine is not defined by physicians and is "independent of whether or not physicians accept or reject it." Rather, the normative authority of the morality of medicine arises from "an objective order of morality that transcends the self-defined goals of a profession."¹² Pellegrino's realist conception of the internal morality of medicine is conducive to the idea that there is a medical conscience based on identifying *correct* medical norms: those medical professionals who can identify the definitive end of medicine and act on the norms to which it gives rise have identified the correct medical norms, *even if* the medical profession endorses different norms. Indeed, given the fact that medicine's morality is not a function of what medical practitioners accept or reject, it can easily make sense of the idea that the medical norms that are currently being endorsed are *incorrect*.¹³

¹⁰ See, for example: 1) Pellegrino, E. D. (1999). The Goals and Ends of Medicine: How are They to be Defined? In M. J. Hanson and D. Callahan, *The Goals of Medicine: The Forgotten Issue in Health Care Reform* (pp. 55-68). Washington, D. C.: Georgetown University Press; 2) Pellegrino, E. D. (2001a). Philosophy of Medicine: Should it be Teleologically or Socially Construed? *Kennedy Institute Journal of Ethics*. 11(2), 169-180; 3) Pellegrino, E. D. (2001b). The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions. *Journal of Medicine and Philosophy*. 26(6), 559-579. Pellegrino utilizes Alistair MacIntyre's conception of a practice, according to which a practice is a "coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity." MacIntyre, A. (2007). *After Virtue: A Study in Moral Philosophy* (3rd Edition). South Bend: Notre Dame University Press, at p. 187. MacIntyre calls these goods "internal," as they cannot be had independently of the practice and are only realized when trying to attain the standards of excellence that define the practice (Ibid, pp. 188-190).

¹¹ Pellegrino (1999), op. cit. note 10, pp. 56-57 & Pellegrino (2001a), op. cit. note 10, p. 171.

¹² Pellegrino (2001b), op. cit. note 10, pp. 564-565.

¹³ Pellegrino tends to discuss, not conscience, but, instead, the virtues that physicians should acquire in order to further medicine's ends and thus be good physicians. See Pellegrino, E. D. (2007). Professing Medicine, Virtue Based Ethics, and the Retrieval of Professionalism. In R. L. Walker & P. J. Ivanhoe, *Working Virtue: Virtue Ethics and Contemporary Moral Problems* (pp. 61-85). Oxford: Oxford University Press. Indeed, when Pellegrino does discuss conscientious objection, he does so in a way that is unrelated to the internal morality of medicine: "We have in the medical relationship two interacting moral agents, each of whom most [sic] respect the dignity and values of the other. A logical consequence is that at times the physician is morally impelled to remove himself or herself from the relationship when he or she differs on a matter of moral principle with the values the patient expresses."

However, Pellegrino's realist conception of medicine's internal morality raises well-known metaphysical, epistemological, and practical problems associated with realism.¹⁴ And the corresponding account of conscience is such that conscience turns out to be a mysterious faculty that has direct access to mind-independent moral facts. Furthermore, Pellegrino argues that "the good of the patient," which is the end of medicine, includes both the patient's medical good, which aims at the restoration of the well-functioning of mind and body, and the patient's perception of the good, which concerns his values and preferences.¹⁵ However, as I have argued elsewhere, Pellegrino's realist picture of the end of medicine and its internal morality cannot account for the importance of patients' perception of the good in medical practice. In particular, even if Pellegrino were right that an objective moral order can be informative vis-à-vis patients' medical good and its role in medicine—perhaps by appealing to natural norms—it is far from clear how such an order can show us anything about patient values and their role in medicine.¹⁶

But one does not have to endorse Pellegrino's realist conception of an internal morality of medicine. For example, according to an "evolutionary," non-essentialist approach to the internal morality of medicine, the goals of medicine and its morality are not timeless, but rather evolve over time together with human history and culture. In particular, there is a core ethic that is internal to medicine and that develops historically in the interactions between the medical profession and society.¹⁷ More recently, I have developed a constructivist account of the internal morality of medicine. According to constructivist reasoning, it is the appropriate agents under the

Pellegrino, E. D. (2006). Toward a Reconstruction of Medical Morality. *The American Journal of Bioethics*. 6(2), 65-71, at p. 69.

¹⁴ See, for example, Mackie, J. L. (1977). *Ethics: Inventing Right and Wrong*. New York: Penguin Books & Korsgaard, C. M. (1996). *The Sources of Normativity*. Cambridge & New York: Cambridge University Press.

¹⁵ Pellegrino (2001b), op. cit. note 10, pp. 565-569.

¹⁶ Ben-Moshe, N. (2017). The Internal Morality of Medicine: A Constructivist Approach. *Synthese*. Published Online First: 13 September 2017. doi: 10.1007/s11229-017-1466-0.

¹⁷ Miller, F. G., & Brody, H. (2001). The Internal Morality of Medicine: An Evolutionary Perspective. *Journal of Medicine and Philosophy*. 26(6), 581-599.

appropriate conditions who determine the correct norms in a given normative domain: the fact that the constructivist procedure was carried out in the appropriate way is supposed to guarantee that the results of the procedure are in fact correct. In particular, I argue that the norms of medicine should be constructed by medical professionals, other professionals, and patients, given medicine's end of "benefitting patients in need of *prima facie* medical treatment and care." This end is not an arbitrary choice. First, the constitutive end of medicine, without which the practice would not exist, needs to make mention of the fact that this practice advances *medical* treatment and care. Second, the constitutive end needs to mention the fact that the relevant treatment and care *benefits* its recipients because this is how medical practitioners have understood their craft ever since the introduction of the Hippocratic Oath. I further argue that the diverse representation of those taking part in the constructivist procedure would ensure that participants in the deliberations have the relevant knowledge, such as medical knowledge, knowledge of philosophical theories, sociological and legal knowledge, and knowledge of patient interests. Finally, given the various viewpoints that these participants have, dialogue between them would minimize biases and lead to greater impartiality. As I emphasize in the original paper, this constructivist picture is an account of an *internal* morality of medicine for two reasons. First, medicine's values are developed in light of medicine's end, namely, "benefitting patients in need of *prima facie* medical treatment and care." Second, it is a morality that is determined in part by medical professionals, whose judgments can be given substantial normative weight. This procedure thus *constitutes* the appropriate and inappropriate in the medical realm and sets the standard of correctness for normative judgments within medical practice. This means that the results of this procedure are authoritative in the sense that medical professionals can justify to

society and to their patients why there are certain things they can and cannot do *qua medical professionals*.¹⁸

So what would a specifically medical conscience look like on this account? Individual medical practitioners can conscientiously object to providing treatment X, if providing treatment X is not in accordance with norms that would have been constructed, in light of the end of medicine, by the appropriate agents under the appropriate conditions. Moreover, medical practitioners could go one step further and utilize hypothetical reasoning in order to ascertain what the correct norms ought to be: which norms, pertinent to the situation at hand, would be constructed by the relevant agents who had all of the relevant knowledge and who deliberated in light of the end of medicine? So to return to our example of abortion and make use of the argument that Brudney suggested, the medical practitioner who argues that it is not part of a medical professional's job to prevent or terminate pregnancy because medicine is about curing or preventing disease and pregnancy is not a disease, would have to consider if these premises and hence this conclusion would be endorsed as part of the constructivist procedure that determines the internal morality of medicine: Could the claim that "medicine is about curing or preventing disease" be made consistent with the end of medicine understood as "benefitting patients in need of *prima facie* medical treatment and care"? Would participants in the constructivist procedure agree that pregnancy is never a disease (consider, for example, cases in which the mother and/or child will incur substantial physiological or psychological harm)? Would representatives from the patient population agree to endorse the conclusion about abortion not being part of a medical professional's job or would they provide alternative arguments that would lead to potentially different conclusions? Note that it might not be easy to ascertain the truth of the claims of what I

¹⁸ The claims in this paragraph that pertain to the constructivist approach to the internal morality of medicine are taken from Ben-Moshe (2017), *op. cit.* note 16.

have been calling a medical conscience (this is also true of a moral conscience more generally). I am not claiming that ascertaining the truth of claims of conscience, any kind of conscience, is an easy endeavor. This should come as no surprise. Moral reasoning, including reasoning about medicine's morality, is difficult and there are many unknown variables. Therefore, there is and might continue to be intractable disagreement. However, this fact should not detract from the fact that claims of conscience can, in principle, be true, even if the prevailing norms state otherwise. What matters for our purposes is that I have shown the possibility of a medical conscience.

My proposed account of a medical conscience has an important upshot. One of the worries in debates about conscientious objections in medicine is that if such objections are allowed and patients do not receive treatment that is legal and beneficial, patients' interests will be undermined.¹⁹ While my aim in this paper is not to settle the question of the status of conscientious objection in medicine more generally, when it comes to a specifically medical conscience, my account does take patient interests into account. Recall that I noted that representatives from the patient population should be involved in the constructivist procedure. When I first presented my constructivist approach to the internal morality of medicine, I argued that patients should be involved in the constructivist procedure of this morality for two reasons (above and beyond the fact that patients are stakeholders in the results of this procedure). First, since the end of medicine is "benefitting patients in need of *prima facie* medical treatment and care" and since there is no *a priori* reason to limit what constitutes patient benefit, it should include both patients' medical good and their perception of the good. While the medical practitioner might be the expert when it comes to the patient's medical good, it is the patient who has intimate knowledge of his perception of the good. Hence, patient values and preferences are

¹⁹ See, for example, Savulescu, J. (2006). Conscientious Objection in Medicine. *British Medical Journal*. 332(7536), 294-297.

an integral part of the medical professional-patient relationship. Second, medicine is a special type of craft in the sense that it is a *relational* enterprise: rather than being an enterprise in which the craftsman produces a product that is independent of the relationship between craftsman and consumer, medicine is an enterprise in which the relationship is a constitutive component of the craft itself. This is because it is in the context of the relationship between medical practitioner and patient that what will benefit the patient in need of *prima facie* medical treatment and care is *jointly* determined by practitioner and patient, who, *together*, have the knowledge needed to attain this end. I further argued that if the relationship between medical professional and patient is a constitutive component of the craft, it also constitutes in part the internal morality of the craft, in the following sense: the interactions between individual professionals and individual patients factor into determining the norms that govern the craft. Thus, patients and their values should be part of the constructivist procedure that determines the internal morality of medicine, since patients, in their relationship with medical professionals, have a legitimate role in determining the norms of medical practice.²⁰ Therefore, the medical professional who is utilizing her medical conscience to question the prevailing norms of medicine is not arguing for norms that disregard patient interests. Rather, the medical norms that this medical practitioner is applying would be ones that incorporate qualified deference to patients' values and preferences.

4. Conclusion

I have defended the feasibility of a “medical conscience” in the sense that a medical practitioner can object to the prevailing medical norms because they are *incorrect* as medical norms. I further argued that in order for this line of reasoning to succeed, there needs to be a morality of medicine

²⁰ The claims about patient involvement in the constructivist procedure are taken from Ben-Moshe (2017), op. cit. note 16.

that is not reducible to more general moral principles, a morality that determines what medical professionals ought to do *qua medical professionals*. Put differently, these two claims amount to the thought that there can be a person of medical conscience who can identify that the medical profession is falling short of an *ideal* of medicine, just as there can be a person of moral conscience who can identify that their society is falling short of the *ideal* society. I also argued that the person of medical conscience need not identify mind-independent normative truths, but rather has to imagine being in the relevant conditions in which his claims of conscience would be true, and he can conscientiously object to providing treatment X, if providing treatment X is not in accordance with norms that would have been constructed under those conditions. Moreover, the conditions that I have offered, which include input from the patient population, allow for a medical conscience that takes into account patient interests. It is worth noting that I did not offer a detailed defense of constructivism, and proponents of various forms of meta-ethical realism might maintain that this anti-realist position cannot really account for normative truth. My aim in the paper was merely to offer a version of a truth-based account of a medical conscience, while utilizing constructivist reasoning. Furthermore, I have not offered motivations for postulating the existence of an internal morality of medicine.²¹ Given the various associations between medical professionals' conscientious objections and medicine's values which are found in the literature, my aim was merely to present a more interesting connection between these two sets of values, *on the assumption* that (a) an important function of conscience is to ascertain normative truths, and (b) the postulation of the existence of an internal morality of medicine is well-motivated.

²¹ See Pellegrino (1999), *op. cit.* note 10, Miller and Brody, *op. cit.* note 17, and Ben-Moshe, *op. cit.* note 16.

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