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PHYSICAL CONSIDERATIONS

Medical complicity and the legitimacy of practical authority

Complicité médicale et légitimité de l'autorité pratique

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Summary If medical complicity is understood as compliance with a directive to act against the professional's best medical judgment, the question arises whether it can ever be justified. This paper will trace the contours of what would legitimate a directive to act against a professional's best medical judgment (and in possible contravention of her oath) using Joseph Raz's service conception of authority. The service conception is useful for basing the legitimacy of authoritative directives on the ability of the putative authority to enable subjects to comply better with reasons that already apply to them. Hence, the service conception bases the legitimacy of practical authority on a certain kind of greater knowledge or expertise. This helps to focus the conundrum regarding complicity on the clash of expertise between the medical expert and the governing body tasked with coordinating behaviour and otherwise devising rules for the social good. The ethical dilemma presented by a hypothetically legitimate directive to act against a professional's best medical judgment also serves to highlight the moral dimension of one's duty to obey a legitimate authority.

MOTS CLÉS
Joseph Raz ;
Légitimité ;

Résumé Si la complicité médicale est comprise comme le respect d'une directive visant à agir à l'encontre du meilleur jugement médical du professionnel, la question se pose de savoir si elle ne peut jamais être justifiée. Ce document tracera les contours de ce qui légitimerait une directive visant à agir contre le meilleur jugement médical d'un professionnel

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(et contrevenant éventuellement à son serment) en utilisant la conception de l'autorité de Joseph Raz. La conception du service est utile pour fonder la légitimité des directives faisant autorité sur la capacité du gouvernement à permettre aux sujets de mieux se conformer aux raisons qui leur sont déjà applicables. Par conséquent, la conception du service fonde la légitimité de l'autorité pratique sur un certain type de compétences. Cela permet de centrer l'énigme en matière de complicité sur le conflit d'expertise entre l'expert médical et l'instance dirigeante chargée de coordonner le comportement et de définir par ailleurs des règles pour le bien social. Le dilemme éthique présenté par une directive hypothétiquement légitime visant à agir à l'encontre du meilleur jugement médical du professionnel sert également à mettre en évidence la dimension morale de son devoir de respecter une autorité légitime.

In most discussions of medical complicity (at least since World War II), the focus is on more egregious uses of medical skill in ways directly harmful to the patient [1—4]. In more recent years, there has been an understandable focus on the participation of medical professionals in torture thought to be necessary to save large numbers of innocents [5—8], and on the force-feeding of hunger strikers [9—11]. These cases are certainly more challenging to reach the morally correct conclusion than instances in which the medical professional is co-opted for inhumane experimentation or in a quest of enhancing harm for military success [12—14,15 p. 3].

However, if we are going to explore the moral contours of when such complicity might possibly be justified, we need an understanding of complicity that doesn't automatically lead us to assume that no justification can be found. After all, if we define medical complicity in such a way that it is conceptually impossible to justify as a necessarily wrong act, we are begging the question of whether any government directive to act against the patient's interests can be legitimate. Nevertheless, complicity clearly must involve some notion of moral compromise on the part of the medical professional, some contravention of the standard medical oath[1].

For the purpose of this paper, I will define medical complicity as compliance with a demand that a medical professional act against her best medical judgment with regard to an actual or potential patient, where that demand is coming in the form of a lawful directive on the part of her legally constituted and recognized government. This understanding is in keeping with one made by Edmund Pellegrino, that the more morally problematic instances of such complicity were any instance in which the physician[2] is required to use her medical knowledge for a purpose other than the welfare of the patient [13 p. 372—3]. This understanding clearly side-lines some instances of concern, such as those in which the medical professional is faced with the question of whether to use medical knowledge obtained through past immoral actions for the benefit of the patient facing her. It also marginalizes instances where the medical professional is faced with a simple conflict between her medical duty and her own reasons of prudence. While some instances in which a government is demanding an act or information from a physician will be ones in which the government is making threats to the physician as well, we will assume that those threats do not themselves bear upon the morality of the decision the physician faces[3]. The definition I suggest will help us to focus on the tension between what might be legitimate governmental interests and the interests of the patient facing the medical professional.

Our definition of complicity includes the stipulation that the directive which creates the challenge of complicity is lawful and coming from an otherwise legitimate government. This also needs to be unpacked a bit. In saying that it is a ''lawful directive'', we are assuming that the directive is legally valid, in keeping with validity conditions for that medical professional's legal system, that it is constitutional and was issued following proper legal procedures. In saying it is legally valid, we are not thereby assuming anything about

[1] Since this paper may reach legal professionals and academics, I have been advised to include the caveat that we are not here talking about complicity as a concept or offense within criminal law, although there are some obvious areas of overlap [16 p. 132]. We are dealing specifically with complicity on the part of medical professionals with (we will assume) lawful directives of their otherwise legitimate governments.

[2] I will use ''physician'' and ''medical professional'' somewhat interchangeably. Of course, not all medical professionals are physicians, and there may be aspects of the moral calculation that are more applicable to physicians, and others more applicable to psychologists, nurses, paramedics, etc. Where these distinctions are relevant, they will be highlighted, but otherwise the two will be treated as equivalent. One additional factor we will discuss briefly is whether the medical professional has taken an oath not to do harm.

[3] This assumption is very likely counterfactual. Where the physician's profession garners a livelihood upon which others depend, threats to that livelihood certainly have moral implications for the physician's non-professional duties. Similarly, threats to the physician's person or liberty may have implications for the wellbeing or happiness of others. But we will bracket these considerations in order to focus on the conflict between the directive and the physician's medical duties.

the morality of the directive itself. Some might think this commits us to a legal positivist way of looking at the law [17,18]. But it would also be consistent with some weaker versions of natural law (in which immoral positive laws are still legally valid, though defective) [19,20]. In saying that the government is ''otherwise legitimate'', I simply mean to assume away cases in which the government is so morally defective that none of its directives can possibly obligate. We will see shortly that legitimacy is not an all-or-nothing affair when it comes to political obligation[4]. By focusing only on those cases where it is possible for the government to issue morally binding directives, I am hoping to focus on the instances in which medical complicity is a moral conundrum for the medical professional. If the government was incapable of issuing morally binding directives, then its directive for the professional to do something against her better medical judgment could only give a prudential reason (e.g., to avoid sanction), which we have already assumed does not itself present a moral reason that needs to enter our consideration here. Furthermore, we would be back in the position of begging the question against the possibility of a morally binding obligation to be complicit.

The question is then essentially what could make a legal directive to a medical professional to act against her better medical judgment morally legitimate. The focus on legitimacy is apt because we are concerned precisely with what could be the moral justifications for compliance with these directives. That is, a concern for the conditions of legitimacy of a legal directive is one that focuses on its moral justifiability, its moral authority, what gives the commander a right to issue the directive and thereby give the subject the duty to comply[5] [33—35]. Hence, we are not concerned with mere power (understood as the ability of the commander to get others to comply). Nor are we concerned with de facto authority understood as the belief that the commander has the right to command. We are concerned with what people are attempting to track with their judgments about legitimacy, rather than the beliefs that are a result of those judgments. Some might think that de facto authority is the only kind of authority that need concern us. Even if there is something that people are trying to get right in their beliefs about legitimacy, it is not something to which we have reliable access; we cannot be sure that these judgments are ever correct. Hence, under this view, de facto authority is the only thing we can really talk about. But in asking when complicity might be morally justified, we are assuming already that there is an answer to this question that people can get right or wrong. We are asking for an analysis of what it is to be morally justified and not merely to be believed to be justified. Our question would otherwise be what makes people believe that complicity is morally justified, rather than what makes those beliefs correct or incorrect. In effect, it would all just be a matter of subjective opinions about legitimacy; there would be no right answer[6]. Furthermore, if want therefore to say that our analysis of what might make medical complicity morally justified is tracking something other than the psychological fact of beliefs about that justification, we are thereby relying on the conceptual possibility that the directives demanding the complicity are themselves potentially morally legitimate.

To begin our discussion of the legitimacy of authority, we need to recognize first that authority comes in two flavours. Sometimes we use the word ''authority'' to refer to the greater knowledge of an expert. Generally, when we think of the medical professional herself, we think of her as an authority on the subject of health and disease or injuries to the human body. When the physician gives a directive to a patient, we usually think of that as a form of advice, giving information about what course of action would be most beneficial to the patient. While we might take it quite seriously, we don't usually conceive of the directive of the physician to the patient as akin to the orders of military commanders, parents, or government officials. In those latter cases, we say instead that a person is ''in authority'' or ''in a position of authority'' rather than saying that the person is ''an authority'' on a given subject — which is what we say of the physician. In the literature on authority, this distinction is explained by saying that the authority of the expert is 'theoretical'' or ''epistemic'' in that the expert's pronouncements give you reasons to believe a given piece of information or interpretation of information, while the authority of the commander is ''practical'' or ''deontic'' in that the commander is giving you reasons to act in certain ways [30 p. 8, 43, 44 p. 399, 45]. So, the challenge of legitimating medical complicity is in navigating a clash between the practical authority of the state and the theoretical authority of the physician.

While this is an important distinction, especially for our purposes, a quick look at the authority of parents and of military commanders shows that sometimes the legitimacy of practical authority can be based on theoretical authority. That is, one reason among others that we might have for saying that parents have the right to give directives that ought to be obeyed by their children (where the children are old enough to bear this duty) is that parents know better than the children what is best for them. Similarly, military commanders are thought to be in a position of greater knowledge of the goals of military action and facts salient to the attainment of those goals. Even though they may not be directing their subordinates in ways that are best for those subordinates individually, we would still say that the subordinates have a duty to sacrifice their own interests for those of the wider community (assuming that the military action

[4] While Jospeh Raz distinguishes between political obligation and the obligation to obey the law [21 p. 127], we will treat these as equivalent here, following the majority of the literature [22 p. 217, agreeing with Raz but noting the prevalence of the conflation, 23].

[5] Some people suggest that the right to command and the duty to obey can come apart [24—29]. But we will follow Raz in seeing the right to issue commands and the duty to obey them on the part of the audience of those commands as two sides of the same coin [30 p. 235, 31 p. 6, 32 p. 1012].

[6] There are metaethical positions in which there can be no correct moral judgments. Some say that moral claims are not judgments at all, merely expressions of emotion [36,37]; some say all such judgments are wrong [38,39]; some say there are no moral truths on the basis of which such judgments can be true or false [40—42]. I admit I may be treating some or all of these metaethical positions as incorrect in making the assumptions I do in this paper.

is itself justified), and that following those commands is the substance of that duty.

A word of caution, however: to say that practical authority can be based on theoretical authority is not to say that it can be reduced to theoretical authority. If we were to say that practical authority is reduced to theoretical authority [25 p. 14,46], we would be saying that no one ever really gets the right to tell others what to do. Instead, putative commanders are merely giving people information about what is in their interests or meets their pre-existing duties. This position is perfectly coherent and can likely be accommodated by the analysis of this paper, although it implies a certain kind of philosophical anarchism. If all instances of supposedly legitimate practical authority are merely instances of legitimate theoretical authority, then the commands of putative authorities are not giving their subjects any new reasons they didn't already have. The most they can do is inform them of pre-existing reasons to behave in certain ways. With this understanding, a legal directive, for example, is generally just informing us how to avoid sanction by telling us which behaviours will incur it. We will be engaging with a theory that holds what legitimates practical authority is its ability to get those subject to it to comply with the best balance of reasons. A view that reduces practical authority to theoretical authority is simply holding that that best balance of reasons cannot be changed by the issuance of the directive itself. But since it is very unlikely that a demand for the medical professional to act against her best medical judgment will be morally justified unless there is an already existing set of serious reasons to do so, it is highly likely that the legitimating conditions of such a demand will be the same whether we believe it possible for the commander to issue new practical reasons or only to report those pre-existing reasons.

While there have been many attempts to justify the possibility of legitimate political authority throughout the ages, we will focus on a more contemporary theory, the service conception of authority advanced by Joseph Raz [21,30—33,47—52]. Raz's theory has a number of advantages. First of all, his theory is non-voluntarist in that it doesn't require consent of the person subject to the directive for it to be legitimately authoritative [53]. Some might find it a bit surprising that I cite this as an advantage. But consider whether we really think that all instances of practical authority are only legitimate when the subject consents. I don't think consent is necessary for parental authority to be legitimate. Similarly, I can imagine situations in which the authority of military commanders would be legitimate even if those subject to that authority were conscripted against their will. Finally, even when it comes to governments, we might wish to say generally that government authority is limited to governments that rule with the consent of the governed, but I'm not sure that is always the case. We can imagine situations in which, because of some national emergency threatening many lives, the directives of an otherwise authoritarian or undemocratic government become legitimate, at least when concerning that emergency and for its duration.

As a way of testing the idea of consent being unnecessary for legitimate authority, away from governmental situations, consider the following thought experiment owed to Edna Ullmann—Margalit [54 p. 350—1]. You are in a room with two doors, marked (on both sides of the door) ''A'' and ''B'' respectively, each on the opposite side of the room from the other. There are 100 people inside the room and 100 people outside of the room, spread out relatively uniformly inside and outside the room. Because of some unspecified emergency, all 100 inside the room need to get out and all 100 outside the room need to get in. If everyone simply learned of the emergency at the same time, you can imagine what would happen: everyone would run to the nearest door and no one would be able to enter or leave. But now, imagine someone jumps up on a table and says in a voice loud enough to be heard inside and outside, ''Use door A to exit the room and use door B to enter the room!'' No one inside or outside the room consented to this person's right to issue commands. Yet, everyone now is under a moral duty to comply with that command as it solves the collective action problem caused by the emergency.

Another advantage of Raz's theory is that it legitimates authority in a piecemeal way. Just as in our thought experiment, we don't imagine the person's authority extending beyond the emergency or to matters not covering the emergency, there doesn't seem to be a prima facie reason to think that once a government possesses legitimate authority, it must extend to all of the government's directives. Again, we are conceiving of authority as a right to control the behaviour of others corresponding to a duty on their part to obey. It therefore seems more reasonable that the legitimacy of that authority is to be assessed on a directive-by-directive basis, rather than in a blanket way. Granted, we are used to thinking about government's authority extending to all of its directives[7]. But upon reflection, we don't really think even the most legitimate government has a right to command whatever it wants. Many situations can undermine the legitimacy of a command for certain people and/or at certain times. Where a directive couldn't have considered a certain exigency, we think we are in an exception to the legitimacy of that directive. Even if the law against violating posted speed limits did not include an exception for when you are rushing someone to the hospital, we would still believe that the law against speeding is not morally binding on the person rushing to the hospital. We might say that certain people are in situations of morally more pressing duties that justify their disobedience.

One way to address this is to say that the directive is legitimate but outweighed by those other considerations. However, if we are serious about seeing the right to command and the duty to obey as opposite sides of the same coin here, then someone in a situation where his duty of obedience is outweighed is no longer bound by that duty. That would be akin to saying that the command was not issued with a right in that instance. A person to whom the duty no longer applies because of more pressing concerns is one for whom the command was illegitimate. If these considerations are leading us in the right direction, we would want a

[7] Raz captures this intuition by saying that governments claim that all of their legally valid directives are morally binding, but we assess that claim on a case-by-case basis. Each directive is to be assessed for legitimacy with regard to each subject each moment, such that the claim could be true of a given directive for me but not you, or true now for me but not in ten minutes for me [33 p. 69].

theory of legitimate practical authority that explains why a given directive might be legitimate for me but not for you, or legitimate for me now, but perhaps not in ten minutes. Raz's theory does just that.

Raz's theory captures the idea that legitimate authority must be exercised for the sake of those subject to it, either in the service of their interests, or in the service of their pre-existing moral responsibilities, without making it depend upon their consent. After all, if we take seriously the value and requirements of autonomy, the only thing that could overcome the right to self-determination that is generated by that value is something that appeals to a value that is more basic or of greater import. Raz's answer is to base the legitimization of authority on the overriding concern we have to act on the best balance of reasons. That is, the value of autonomy stems from the fact that we are generally in the best position to assess what is best for us, given our own personal ambitions, projects, and goals, which are themselves based upon our individual talents, tastes, and desires, as well as our pre-existing moral duties. But all of those talents, desires, ambitions, goals and duties give us reasons to act in certain ways. Our talents and tastes, along with our pre-existing duties, give us reasons to adopt certain goals over others. When we decide which goals to adopt, we are trying to assess what the best balance of those reasons are. Once we adopt those goals, they give us further reasons about how to pursue those goals. We decide on the means to pursue those goals by again trying to assess the best balance of reasons that apply to us.

If autonomy itself is generally subservient to the value of leading one's life according to the best balance of reasons that applies to one, then it can and should bow out in situations where acting non-autonomously would aid in acting according to the best balance of reasons. This is where the service conception picks up. It says that the normal way to justify authority is to say that it is justified where obedience to it helps the subject conform better to the best balance of reasons that already apply to her, than she would be able to accomplish if left to her own devices. Raz calls this the ''Normal Justification Thesis'' (NJT) [33 p. 53].

Now, one might justifiably think that sometimes it's better for people to prioritize autonomy even at the risk of not acting in accord with the best balance of reasons. That is, there are some areas of human life where it is more important to make one's own mistakes than it is for people to reach the right conclusion about what to do. Raz realizes this and gives two examples of where this is likely to be true: certain matters in which children need increasing self-reliance (and so must be allowed to make their own mistakes in order to learn properly), and the decision about whether and whom to marry [32 p. 1015–6]. He, therefore, qualifies the NJT by saying that it is subject to what he calls an ''independence condition'', such that the matter is not one in which it is more important for people to make mistakes than to get it right [32 p. 1014, 33 p. 57, 55 p. 1180]. One might also wonder how these areas are determined. I'm not entirely sure how to answer that but suspect it might have something to do with the balance of reasons requiring that some specific actions be the result of one's own choices.

Since the reasons on the basis of which we are ultimately justifying the authoritative directive here are the reasons that already apply to the subject, there is another condition that is generally necessary for the directive to be legitimate. That is the requirement that the directive be based upon (or at least reflect[8]) reasons that already apply to the target audience of the directive [33 p. 47]. Raz calls this the ''dependence thesis'', conceiving of these particular pre-existing reasons as ''dependent reasons'' for the directive [33 p. 41]. Of course, those dependent reasons need not be ones the subject is aware of, or would agree with, or even that are in her interest (as reasons — usually moral — that apply to her can require a sacrifice on her part).

When a directive is legitimate for a given subject at a given point in time, Raz claims that it presents the subject with ''pre-emptive reasons'' [33 p. 57]. That is, when we imagine undertaking a decision procedure about a contemplated action, we would generally add up all of the pros and cons, thinking of each as a reason in favour or against the action, giving each a weight according to the strength of the consideration in favour or against. In a non-authoritative situation, if someone were to request that you undertake the action, that request would count as an additional reason in favour of the action, with a weight corresponding to how important it is to make the requester happy, how important it is to the requester that the action be done, etc. We might similarly say that if someone were to order you to undertake the action, that would count as some reason in favour of undertaking it, even if we might discount that reason because of thoughts that the person didn't express his desire regarding the action in a very nice way. (Where the order comes from someone whom we wouldn't think of having any right to order us around, we may very well count the order as a reason against the action as well.) But thinking about the dependence and normal justification theses a bit shows that when directives are legitimately authoritative, they are a bit different.

In order for authoritative directives to perform the service that generally determines their legitimacy, they must pre-empt the subject's reasons against the action commanded[9]. They are authoritative to the extent that they pre-empt the reasons that the authority was meant to have considered in issuing the directive [21, p. 140]. That is, if legitimately authoritative directives were simply additional weighty reasons in favour of the action commanded, they couldn't provide the service of helping the person subject to the directive to comply better with the best balance of reasons. She would be left balancing the reasons as she sees fit, putting the directive on the scales in favour of compliance. In order to help her to act according to the best balance of reasons that apply to her, the directive must exclude at

[8] To say that the reasons for the directive must ''reflect'' reasons that already apply to those subject to the directive is not to say that a legitimate directive cannot be based on reasons other than those applying to the subjects. But the actions required by the directive should be ''justifiable by the reasons that apply to the subjects.'' That is, sometimes the authority may need to adopt ''an indirect strategy'' for the subjects to comply with the best balance of reasons [33 p. 51].

[9] For Raz, to say that the directives pre-empt the subject's reasons against the action commanded does not mean that the subject may not still deliberate upon or consider those reasons. The subject simply may not act upon them [33 p. 39].

least some of those reasons (the ones counting against the commanded action) [21 p. 140—1, 33 p. 61].

Furthermore, since in order to be legitimately authoritative, the directive is already based upon a balancing of the reasons that apply to the subject (along with other considerations), to see the directive as simply a weighty reason (rather than seeing it as excluding some), would be to double count the reasons in favour of the action that the putative authority already accounted for. That is, a legitimate directive must be allowed to pre-empt the balancing of reasons that the subject would do (at least in determining the action, if not the deliberation), since otherwise seeing the directive as an additional reason would be to give undue weight to the reasons in favour of the action — they would appear a second time as the basis for the directive [33, p. 58].

A legitimately authoritative directive, therefore, is a reason to act in conformity with the content of the directive, coupled with a reason to exclude certain reasons not to act in conformity with it. We exclude those reasons by not acting upon them.

With this picture of legitimate practical authority in mind, let us return to the situation of the medical professional. Generally, the medical professional's responsibility to her patient is to act always in the patient's best interest in terms of the patient's continued or recovered health or wellbeing [56—58]. An instance of complicity, we have seen, would be where the medical professional is not acting in the patient's best interest as a result of other considerations, here the lawful directives of her government.

As we've seen using Raz's theory, even if we imagine a law that is general in that it is aimed at all medical professionals, or all medical professionals in a certain speciality, or in a certain circumstance, or dealing with a certain kind of patient, if that general law is legitimate at all, it may only be legitimate for a subset of those at whom it is aimed, and/or only for part of the time the law is in effect. It would generally depend upon whether the law is helping the medical professionals to conform better with the best balance of reasons that apply to them than they would be able to do on their own.

Since we generally think that one of the highest responsibilities of the medical professional is to her patient, it would likely be a very high bar that would need to be overcome for a directive to act against that responsibility to be legitimate. The only thing that we usually think can contravene such a responsibility would be a more pressing responsibility, perhaps to another patient whose needs are more severe. Putting aside the government directive for a moment, two kinds of physicians come immediately to mind who must balance the considerations of others against the patient in front of them: emergency room doctors and epidemiologists. Emergency room doctors of course must work on a triage system. It is likely that what is in the best interest of the patient in front of them at the moment is to be treated right away. However, if there are patients with greater needs waiting for treatment, we expect them to put aside the interests of this patient for the one with greater needs [59—62]. While emergency room doctors are the ones we expect to confront this situation on a regular basis, we actually expect almost all medical professionals to act upon this principle, so long as the patient with greater needs is one that the particular professional can treat. Epidemiologists must confront a similar situation, but where the other people to be considered may not yet even be ill. They may be in a situation where little can be done for the patient in front of them, but by acting against that patient's individual interests, a large number of other people may be prevented from becoming ill [63—65]. Indeed, this is one area in which a physician can function as a legitimate practical authority rather than as a theoretical authority. In ordering that a given patient be quarantined, for example, the epidemiologist is exercising practical authority rather than giving advice. This is an order that creates a duty (and one that, in most cases, the state is prepared to enforce). In that, they may be helping the individual infected patient conform better with the best balance of reasons facing him. It is likely his moral responsibility to forgo his freedom, and possibly sacrifice his health and even his life, to prevent others from becoming infected. The directive quarantining the patient is helping him to conform to that overriding reason. The epidemiologist is therefore also prioritizing those who are not in front of her for treatment or protection, over the patient immediately confronting her.

Now, we may be tempted to use emergency room physicians and the epidemiologists as models for when lawful government directives to act against the interests of patients are legitimate. That is, we might start by saying a government directive that is successfully protecting a much larger number from serious risks, or is redirecting the physicians' efforts toward treating those confronting more serious threats to health, is a legitimate directive. It is likely that the government's central position gives it access to information that the individual physician cannot obtain and so directives based on these considerations are helping those individual physicians to conform better to the best balance of reasons than she would be able to do on her own. The problem is that this doesn't look like complicity any more. That is, if we already think of the responsibilities of emergency room workers and epidemiologists as generalizable to all medical professionals when confronting similar situations (even if their speciality is not emergency medicine or epidemiology), then the directive for physicians of other kinds to sacrifice the interests of the patient in front of them is not a moral compromise of the kind that raises the issue of complicity. The directive is not asking the physician to do something that she doesn't already have a direct medical responsibility to do (indeed, that is precisely why we imagine that the directive is legitimate).

In order to reach complicity, therefore, we have to imagine that the directive is issued not for the sake of a greater medical need. Those will certainly be much harder to justify, but perhaps not impossible. First of all, it is clear that the considerations behind the government directive will have to be moral ones, in order to have a chance to be legitimate as against the physician's responsibilities to the patient. We generally think of moral reasons as a kind of reasons that trumps other kinds of reasons. Since the physician's responsibilities to the patient are themselves moral responsibilities, only moral reasons behind the government directive will have any chance of doing a better job of providing a better balancing of the best reasons for action in a given circumstance.

One might imagine here that the physician's oath, if one has been undertaken, is relevant here. After all, if we understand the oath to be a promise to treat patients a certain way, then that would be an additional moral consideration against acting in a way that goes against the physician's best medical judgment of the patient's interest. However, once the physician has the requisite skills to render aid to a patient, it would seem that the responsibilities to do so are already in place and that the oath doesn't add anything to the moral picture [66]. Indeed, if we think of the oath as akin to a promise, it is not clear to whom the promise has been made: other physicians, potential future patients, the physician herself? If the oath does have moral effect, it is likely only to magnify somehow the physician's pre-existing duties, perhaps as against her other responsibilities. Whereas before undertaking the oath, she may have been entitled to discount certain responsibilities towards strangers, in favour of other responsibilities of slightly lesser absolute weight owed to friends and family, now perhaps she must put those strangers' interests in a higher position. So, for example, while non-medical personnel may be permitted to refuse to render relatively minor aid to a stranger where doing so would necessitate missing his child's piano recital, a medical professional who has undertaken certain professional oaths may not have the same moral permission. With these considerations in mind, we will put the oath aside in order to focus more broadly on the legitimizing conditions for government directives that any medical professional act against her better medical judgment, given that not all of those professionals will have taken such an oath.

We have seen that for a government directive to be a legitimately authoritative reason for the physician to engage in complicity, it would have to be based on moral reasons that do not stem from a pre-existing moral duty on the part of the professional to render medical aid to others. This is not to say that medical considerations cannot play into the reasons for the directive at all. But they can't be the same medical considerations that would be directly applicable to the physician such that they would already entail that her medical obligation is to act against the interests of the patient in front of her.

To explore the contours of such a case more precisely, we will resort to a time-honoured technique in moral theory, the thought experiment [67]. But the contours of our thought experiment will not render it the kind difficult to imagine ever taking place in reality. Imagine the legitimate government is concerned about public order in a way that dwarfs its ability to respond to threats. A long-time brutal dictator has recently been deposed and a democratic government has been installed. The problem is that this dictator was very popular among a minority of the country. In one area in particular, the dictator's policies meant for particular hardship and oppression of the majority group in order to keep the minority in that area in relative comfort. Now, this dictator has an illness that is serious and life-threatening, but treatable with very expensive procedures that have not yet begun in earnest. Overthrowing the dictator was possible because of his need to seek treatment and was done while he was in the care of his doctors. Allowing the treatment will induce further hardship for the majority in that particular area. Because of the notoriety of the case and the access of the now-free press, all of this is known and believed across the country, although the tense political situation in that particular area is not widely known. It becomes apparent that if the physician treats her patient, there will be an insurrection in that part of the country and many people will die. Mainly, these will be members of the minority who had benefited from the policies of the dictator, but that includes many young children recently born during the dictator's regime, which encouraged the minority in that area to have as many children as possible. While it would usually be the government's responsibility to keep order and not the physician's, this newly elected government is quite fragile, came to power initially dependent upon the votes of the majority, and does not yet have much independent police power in that area, relying instead on the support of the majority of the local population. The government would not be able to put down the insurrection or prevent it, and we are sure that many innocent people will die as a result. Furthermore, the insurrection, if successful will institute another unjust, authoritarian regime with a racist leader in that part of the country, although this time the policies will be directed against the minority that had benefited before. Giving in to the demands of those threatening the insurrection will lead to so much injustice that resisting the insurrection would clearly be the more just option. If we were to imagine that the government had the patient in question under its direct control, we would say that it would be the correct course of action for the government not to allow the patient to undergo treatment if it would lead to the insurrection. But instead, the patient is not (yet) in government custody and its now re-instituted laws do not allow the government to take custody of any person currently under medical care for a serious illness.

In such a case, it would seem that the government's lawful directive to the physician not to treat the patient would be helping the physician to conform to the best balance of reasons. Furthermore, the information that not treating the patient is in conformity with the best balance of reasons is not something that the physician is likely to have direct access to in such a situation, and so the government's directive is helping the physician to conform to the best balance of reasons that apply to her. Finally, it still appears to be a case of complicity since, while the physician refraining from treating the patient will save more lives, those lives are not under immediate medical threat.

We might be bothered by the thought that risk to the lives of the innocents is still a medical consideration and hence this might still not be a case of complicity. While it does seem true that once the fighting breaks out, there would be a medical need to treat the injured, it is not the kind of risk that would count as a medical consideration before the fact. If it helps to sharpen the example on this front, imagine that the insurrection would explode a device that would vaporize all of the threatened innocents in an instant, leaving no injuries. In such a situation, the threat to life is not one that medical expertise can mitigate directly. While we all share the duty to minimize the loss of life, the special duty of medical professionals kicks in when their expertise is necessary to minimize that loss of life. Here, there would be no way that their expertise is being called upon to minimize the loss of life and so their duty would be the same as everyone else's. The point of the thought experiment is to show that it is possible for that more general duty to still be

greater than the physician's professional medical duty, even though we usually consider the physician's medical duty to come before her other moral duties.

We generally think it is the duty of governments to deal with such threats, where possible, and possibly to negotiate around them. It is usually the government's responsibility to do so without interfering with the physician and her patients. But the thought experiment shows the possibility of a legitimate directive that requires complicity on the part of the physician. Again, a virtue of Raz's service conception is that it legitimates such directives on a piecemeal basis. So, it might legitimately obligate certain physicians but not others, perhaps on the basis of whom they happen to be treating and what the particular wider implications of that treatment might be.

Now, one complaint that might arise is that it is hard to imagine a law being drafted that would cover such a situation and be legitimate. That is, if a law were to direct doctors not to treat patients when ordered not to do so by certain government officials given the threat of certain kinds of insurrection, it is very unlikely for such a law to be generally legitimate (although, *ex hypothesi*, still legally valid). The flip-side of the advantage of Raz's piecemeal approach, however, is that even a generally illegitimate law could be legitimate for certain people at certain times. This is one reason that even an authoritarian government may come to have greater legitimacy in times of disasters and emergencies, and more democratic governments may justifiably take authoritarian steps in such emergencies (consider whether you think Lincoln's suspension of habeas corpus during the US Civil War was illegitimate).

One additional issue that should be mentioned is how the physician is supposed to assess the legitimacy of the directive. This is where the clash between the physician's medical expertise and the government's central position becomes most stark. While Raz says that the legitimacy of a directive must be ''knowable'' by its subjects [21, p. 147—8], that does not mean that it must be something about which the subject would always be correct. The key is to remember that legitimacy is a fact about whether the directive is capturing the best balance of reasons that applies to the subject. It is likely to be very difficult to assess this, although if the subject were in possession of the same facts as the putative authority, the idea is that a clear-thinking subject would have reached the same conclusion. The physician has greater knowledge about the condition and needs of her patient. It may be that the government doesn't have access to that information but has other information that militates against the treatment that the physician is contemplating. Each, we assume, is lacking at least some of the information possessed by the other. But there is still a fact about whether the directive is justified based on the correct balancing of those considerations. While neither may have had sufficient information to perform that balancing perfectly, it is possible that the government's considerations would cover a wide range of potential patients and conditions. Where those considerations wouldn't yield to the interests of a given patient, then the directive would be illegitimate, even though the government wouldn't know that and would have still issued the directive.

Another problem is that intuitions might differ about our though experiment. It is true that those with less consequentialist moral intuitions may think that the physician's duty is fixed by the patient's interest regardless of the outcome. In the starkest form, we can lay this intuition aside as begging the question against the possibility of ever allowing for legitimate medical complicity. But as long as one's moral beliefs allow for the possibility of conflicting duties, it does appear possible for certain kinds of more general duties to come into conflict with the physician's medical duties in a way that those more general duties still win out.

What we have seen is that it is possible to justify medical complicity in the face of a government directive not to exercise a physician's best medical judgment with regard to a given patient. While such cases are likely quite rare, complicity would be morally justified where the non-medical considerations upon which the directive was based are ones that would themselves undermine the physician's pre-existing moral duty to treat the patient.

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Informed consent and patient details

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