Vol. 35:3 Fall 2019

Professional Objections and Healthcare: More Than a Case of Conscience

MICHAL PRUSKI, PHD, MA, AFHEA, MRSB

Abstract

While there is a prolific debate surrounding the issue of conscientious objection of individuals towards performing certain clinical acts, this debate ignores the fact that there are other reasons why clinicians might wish to object providing specific services. This paper briefly discusses the idea that healthcare workers might object to providing specific services because they are against their professional judgement, they want to maintain a specific reputation, or they have pragmatic reasons. Reputation here is not simply understood as being in good standing with a professional body. Rather, reputation is treated in the sense that a craftsman might wish to be known for providing a specific type, quality, and style of service. Professionalism is understood as acting according to the philosophical and scientific principles that are the basis of healthcare (such as acting for the benefit of the patient's health and following well-evidenced treatment pathways).

Prologue

I wish to start by highlighting what this paper is not about, why it has been written, and what I think it contributes to the discussion of healthcare objections. This paper does not tackle the issue of what we as healthcare professionals (HCPs) are meant to do; it is not about how we can follow Christ's footsteps by making patients whole and growing in virtue. Rather, this paper is a response to the need for us to protect ourselves from cooperation with evil, particularly in places where there are no rights to conscientious objection (CO) and where objections might be best phrased in a way that utilizes secular, liberal, and pluralist train of thought. Hopefully, this will allow some to more effectively justify their objections in a CO hostile environment.

As such, this paper will frame the issue of healthcare objections as professional objection (PO). The article will outline four categories that can be utilized to make a PO, and in this process, it will rely heavily on the craftsmanship analogy. These four categories should enable one to raise a PO to a wide variety of procedures, for which one would want to raise a CO. PO, nevertheless, is not promoted as a form of deception. Rather, reasons that fall into these four categories are what make us conclude that something is either bad medicine, and hence should not be done, or makes us refrain from specializing in these types of activities.

While the PO framework does not justify healthcare anarchy, it certainly lacks the tools to signify what good healthcare is. Perhaps it is a vain hope, but the realization of the consequences of a PO framework might prompt some who largely subscribe to a secular worldview to reflect upon the teleology of medicine and moral absolutes.

Yet, as Christianity itself is not monolithic, these points should still be acceptable, at least to an extent, by a Christian audience.[i]

Introduction

This article briefly discusses POs and how they might relate to a HCP's right to express professional freedom. By professional objections, this article refers not to what is often discussed as CO but to a wide variety of other reasons that might motivate HCPs to object to participation in certain procedures, often ignored in the CO debate. It is the point of this article to demonstrate that objections can be raised, utilizing reasons that do not involve deontological religious commandments; these are:[ii]

1. Clinical judgments based on a philosophical understanding of healthcare
2. Clinical judgments based on the evidence of healthcare science
3. A right of HCPs to shape their professional practice and reputation
4. For pragmatic reasons relating to running their institutions

While these have been listed as distinct points, there is overlap and interdependence between these categories. The latter part of this paper will demonstrate the value of these specific points, as well as their interdependence.

Within the current CO debate, these reasons have not been featured prominently. While the British parliament is debating changes in the legislation governing CO,[1] it is important to acknowledge that HCPs are not only moral agents but also professionals dedicated to caring for their patients. It is, hence, imperative that the CO debate is not limited to matters of freedom of religion, but the debate should include the four aforementioned points. This will not only acknowledge the reality of the work of HCPs but will also make the legislation more applicable to those who profess no religion.

Professional Judgement and the Essence of Healthcare

Philosophical understanding of healthcare relates to the scope of practice one believes he/she should undertake as a HCP.[iii] This might relate to the pursuit of particular goods one believes healthcare is concerned with (e.g. the good of the patients holistically understood).[2] These goods relate to what one believes healthcare is—a therapeutic art and science concerned with the restoration of health.[3,4,5,6] Based on such an understating of healthcare, HCPs might refuse certain services that are generally thought to fall within their scope of practice, for they do not believe that these services are compatible with the goals of healthcare. Even those who object to CO do accept such an objection (i.e. based on an understanding of what a HCP's job entails), and they even accept that there are certain goods people seek to pursue through healthcare.[7] Force-feeding prisoners can be regarded as torture rather than healthcare, and it is not something that HCPs should be forced to do.[8,9] While some might argue that this is an example of CO, a HCP might not object to law-enforcement agencies using torture to defend a nation's interest but might simply not want to participate in the process, as they do not perceive it as falling within one's scope of practice. Another such procedure that many HCPs could potentially engage based on their skillset—but might not regard it as part of their job—is the provision of purely

cosmetic procedures, which do not, strictly speaking, fall within the bounds of health care.[10] However, the same procedure might fall within the bounds of healthcare when performed in a different context (e.g. that of a victim of trauma).

Professional Judgement and Evidence-Based Practice

HCPs are competent practitioners of their disciplines. They should understand the efficacy of various treatments and procedures, the risks attached to them, and how they relate to their patients' conditions. In the UK, patients do not have a right to demand a particular type of treatment, especially if it is medically futile.[iv, 11,12] It is the prerogative of HCPs to exercise their clinical judgement, and refusals on these grounds of professional opinion are clearly distinct from those that are conscience-based.[13] Moreover, even those opposed to CO agree that objections based on considerations of beneficence and non-maleficence are valid reasons to refuse a particular treatment, so as to ensure that they are helping patients and not harming them.[14] For HCPs, such a refusal might be primarily about the good of the patient, as well as avoiding future litigation, losing licence to practice, or professional registration. Refusals are also about professional pride and reputation, mainly for those who compete for patients or funding (i.e. related to some of the other aspects of PO mentioned in the introduction.) Examples of such a PO might be the refusal to amputate a healthy limb from a patient suffering from body integrity identity disorder who claims that amputating the limb will improve their wellbeing. It might be the refusal to perform gender reassignment surgery for someone suffering from gender dysphoria. The HCP might refuse these because they believe that the evidence does not indicate that the procedure will solve the underlying problem, but that it will only damage the patient's body and well-being, hence being bad healthcare.[15,16] Similarly, an HCP might object to the provision of homeopathic remedies, even if privately they have nothing against them. HCPs should not be forced to provide treatment that they believe to be damaging towards the patient and which will not provide any real health benefits. Such decisions relating to professional standards of patient care are proper to HCPs[17] and should not be the subject of external coercion.

Shaping One's Reputation

The maintenance of a good reputation is not understood here as the right against slander or as being in good standing with a professional body, but in a wider context like that in which one could understand the reputation of craftsmen (e.g. a tailor or a goldsmith). Some might object to the comparison of a HCP with a craftsman or artist, yet such an understanding of healthcare has been present at least as far back as the writings of Plato and Aristotle.[18,19,20,v] Moreover, in recent times, medicine has also been presented as a craft or art from the perspective of how it is performed in its direct physical dimension and with reference to the type of judgements a practitioner of medicine needs to make.[21,22,23] With its practical application of knowledge and skill, as well as interpersonal interaction aimed at understanding the needs of the patient, healthcare (while operating on a different substance) is not that different from other crafts. This is not to say that the matter with which HCPs deal, (i.e. human health) is equivalent in its gravity to the matter with which other craftsmen deal. That human health is more important is self-evident, and, as such, it is right that the

legal consequences for sloppily making a ring are different from sloppily performing surgery. Yet this does not mean that the craftsman analogy is wrong or demeaning to HCPs, it only highlights the gravity of the considerations that need to be made regarding healthcare.

Good reputation is understood here in the context in which a craftsman can have the reputation of producing high quality products, providing a reliable service, or having products executed in a certain artistic style. Importantly, such a reputation might not be forged to have a universal appeal; quite the opposite—a craftsman might be creating products that appeal only to a specific group, be it because the craftsman shares the group's sense of aesthetics or noticed an unexploited niche. As such, it becomes clear that craftsmen might have various motivations that influence the reputations they acquire. HCPs, like craftsmen, should be able to freely shape their professional associations, practice, and reputation in a pluralistic and liberal society.

While there are many facets to the issue of professional reputation, they can be broadly divided into the issues concerning institutions (both private and public) and individual HCPs. In some of these settings, reputation is more important, as those working in small private practices (e.g. physiotherapists, general practitioners, and dentists) need to compete for clients much more intensively than anaesthetists at a big tertiary centre. Similarly, healthcare organizations often compete for patients (e.g. private clinics or even NHS Trusts), and hospital units might be paid for the number of patients or procedures they have performed. As such, even big nationalized institutions do not want to fall into disrepute, as this might negatively affect their funding and the likelihood of private donors (such charities) supporting them or lead to penalties imposed by regulatory bodies. Moreover, institutions might rely on their reputations to attract the best specialists in their field to further raise the profile of their departments. Medical organizations, small or big, private or public, might limit the type of service they provide to be able to specialize in certain procedures and develop a reputation as centres of excellence for it. As such, they may not carry the relevant equipment needed to perform a procedure outside of their expertise. Centres or practices might also refuse to perform a type of procedure they deem them too risky, though, technically, they might have the resources to perform it. Rather, they refer the patient to a different centre.

There are several reasons why reputation might be important for HCPs beyond those that are important for institutions. HCPs might perform auxiliary jobs aside from their main occupations, such as expedition or sports medics, into which they might be recruited based on their reputation. A HCP might refuse to work in a hospital with a bad reputation or participate in a procedure that will risk creating scandal, as it might leave a permanent mark on their CV and affect their future employability and career progression.

Professional reputation might influence whether one gets the patient or becomes unemployed. HCPs (and centres) can already specialize in various fields, and HCPs often further specialize to become experts in a specific procedure (e.g. orthopaedic surgeons specializing in operations on a specific limb). Being able to refuse certain procedures (e.g. to maintain a reputation among a specific clientele or to devote one's time to master a particular procedure) is not much different from being allowed to work (or train) within a particular specialty. Similar to the development of healthcare

specialties, this might benefit patients. While a group of HCPs running a palliative care centre in a country where euthanasia is legal might themselves be in favour of euthanasia, they might have discovered that some patients prefer to be treated in centres where this procedure is not undertaken. These patients (and their relatives) might be more comfortable knowing that they will not be offered a procedure with which they fundamentally disagree, even in a moment of weakness, and might take comfort knowing that the HCPs taking care of them do not engage in an activity the patients themselves regard as unethical.[24,vi] Similarly, some women (e.g. those holding strong pro-life views) might be more comfortable knowing that abortions are not performed in the clinic in which they are about to give birth.[vii] If individuals are allowed to run groups that pursue specific goals (even if the purpose of the group is to restrict its membership to people of a legally protected characteristic, such as sex and ethnic group[25]), then HCPs should be allowed to set up clinics that cater to those who follow a particular worldview (even if the HCPs themselves do not follow that worldview). This includes the right of Christian HCPs to develop their reputations in a manner that will attract Christian patients or gain influence in Christian professional bodies.

Pragmatism

Additionally, medical institutions might refrain from performing certain procedures on pragmatic grounds. These might relate to the complex socioeconomic situation, liability, and other practical issues originating from the specific work environment in which certain HCPs and institutions operate.[26,27,28,29] Hence, even if the institution or the HCPs are allowed to provide the service in question, it might be more pragmatic for them not to provide it. Compelling HCPs or institutions to provide such a service (even if they are not morally opposed to it) might have a negative impact on their work (such as costs, stress, or dissatisfaction), manifesting itself in, for example, moral distress.[30,31,32] Therefore, while some pharmacists in regions where they can prescribe contraceptives might not morally object to such prescriptions, they might still refrain from providing these services.[33,34,35] While some services are clearly linked with each other (such as the provision of postoperative care to the provision of surgery) others, such as the provision of good antenatal care, does not depend on the provision of abortion services, and, for pragmatic reasons, a centre that wishes to provide the best possible antenatal care might not have the resources to provide abortion services.

Building on the Craftsman Analogy

While HCPs are subject to more scrutiny than goldsmiths or tailors, due to the nature of the subjects of their trade, the craftsman analogy provides a convenient framework for discussing the reasonableness of PO. Goldsmiths might refuse to use materials unless they have been ethically sourced, yet they might have no moral interest in the provision of such materials. They provide them to attract customers that do care about the source of the materials or to get some form of certification or guild membership that would professionally benefit them. A tailor might refuse to make a jacket according to the customer's design, for the design is such that the jacket is likely to fall apart soon. This, in turn, might lead to someone claiming that the tailor produces poor quality clothing or try to get a refund for the product. The tailor might

refuse this commission simply out of professional pride or to avoid deterring future customers or to not have to commit time to then pay the customer a refund (or for all of these reasons simultaneously). Bakers might wish to avoid certain associations between their product and a particular event, even though, under other conditions, they might be willing to provide the product to the same customer.[36,37] Their decisions might be based on CO reasons but could also be understood as the exercise of a "right to freedom of dissociation."[38] Such a freedom of dissociation could be invoked in some situations to, for example, avoid discouraging a specific group from using one's services, for campaigners from a wide spectrum of ideological and political backgrounds have tried to persuade businesses, through various campaigns and petitions (including boycotts), to cease or commence different practises.

Craftsmen express their professional freedoms and take care of their businesses by both providing what their customers want or by not engaging in commerce with them, and they are motivated to do this by a wide variety of reasons. But each of these reasons to act in a particular way does not always operate in isolation. The craftsman who uses ethically sourced gold might do it for both ethical reasons and the professional advantages associated with it. Tailors who refuse to make a jacket to the client's specification might not do it as much out of concern for their reputations, for they would simply hate for their customers to experience disappointment. The baker might have as much acted out of religious convictions as from reasons related to reputation. Who, in a liberal society, is to decide that one reason is better than another (though some limits relating to such actions will be discussed further down) or that CO is more convincing than PO? Certainly some of the aforementioned PO decisions are easier to comprehend from a secular standpoint than some CO decisions, at least partly due to a lack of a shared moral vocabulary between those invoking CO for religious reasons and their audiences in the secular space.[39]

To build on the types of PO mentioned throughout this paper and to relate it to the parallel of craftsmanship, it is worthwhile to analyse in more detail an example of an HCP objecting to a specific procedure—abortion.[xiii] For pragmatic reasons or reasons relating to reputation, a medical centre might not wish to provide abortions; the centre might only have facilities to provide antenatal services or might not deal explicitly with issues relating to maternity, and in order to expand the provision to such services, they would have to jump several administrative hoops and dedicate funds that they wish to spend on more pressing needs. Ophthalmologists might refuse to perform an abortion—a procedure outside their specialty—not necessarily because of lack of competence in the procedure (they might have previously worked as obstetricians) but because they chose not to pursue a career in obstetrics. Further, even those without a religious belief might regard every human as a person, and, hence, view foetuses as deserving healthcare.[ix] HCPs caring for pregnant women and subscribing to the aforementioned definition of personhood might wish to not perform treatments that are harmful to the foetus. For them, a pregnancy presents two patients whose goods should be sought. This is a professional statement, supported by science and a long standing philosophical tradition, and while arguments to the contrary exist, it is certainly a reasonable opinion to hold. Finally, HCPs' CO against abortion due to a religious commitment does not exclude a simultaneous PO to abortion for any of the aforementioned reasons. It is more than likely that their religious CO is accompanied by a philosophical understanding of medicine that is incompatible with abortion. In

such situations, it seems unreasonable to understand their objection only from the perspective of CO.

Discussion

Those who work in healthcare, like in any craft, should be free to take pride in their work and shape their practices in a way that accords with their professional judgements and preferences, so as to gain a reputation that ensures patients will willingly use their services and so that they can find professional fulfilment. Objections based on professional opinion and ones that support specialization (for the benefit of patients requiring a specific service provision or to develop a sustainable business model for those working in private practice) should be understandable by legislators, other HCPs, and the general public. This might be easier to realize in independent practices than in big, private hospitals, where private contracts between the HCP and the institution might wish to restrict the HCP's freedom. While in such instances the freedoms of the HCP are balanced against those of their employers, it would be odd for the government to compel all HCPs to take up one philosophical view of medicine versus another, saying, for example, that vasectomies are a healthcare service and, as such, a trained HCP should provide them. Such compulsion would deprive HCPs of professional integrity.[40] A vasectomy is not a health restorative treatment, and HCPs might prefer to aid sick patients and participate in medical research or relief work, and are uninterested in providing services that they believe to damage patients' normal bodily functions.

This paper has shown that there are several reasons why an HCP might want to object to certain procedures on professional grounds and that these reasons should be respected in a secular and liberal society where people can freely associate and dissociate.[41] As respectable professionals, HCPs should not be compelled to forced labour, but should be allowed to specialize and use their professional judgements to build their reputations, as long as they do it without malice.[42] As such, we should not limit acceptable objections to just the issues of abortion, euthanasia, and assisted reproductive technologies. A wide range of possible objections would ensure respect for HCPs' professionalism and not treat them as mere automatons dispensing clinical procedures.

What this paper has not argued is that ethical and religious reasons do not play a role in a HCPs decision-making process. Indeed, there are good ethical reasons why a craftsman might wish not satisfy their customer; a military equipment provider might refuse to provide a customer with a suicide vest on ethical grounds, and a HCP might refuse participation in abortions and euthanasia on religious grounds. Ethical and religious considerations are of utmost importance, but the practice of objection cannot be limited to these considerations. CO and PO are both valid grounds for raising objections.

Addressing Potential Objections

One could raise an objection to the argument presented above and state that an HCP might wish to gain a reputation amongst members of the anti-vaccination movement by not providing vaccinations to patients requesting them and discouraging them from seeking them elsewhere. While the reasoning above would concede that the

HCP could not be obliged to provide a vaccinations service (e.g. a GP might only wish to provide a house call service and not keep a stock of vaccines),[x] it would not concede to the HCP advising any patients against vaccinations (presuming no established medical contraindications, such as an allergy to one of the components of a vaccine).

It is one thing to facilitate people's preferences, and it is another to deceive them. While many procedures to which PO can be raised are either non-controversial (such as the example involving the use of Botox for aesthetic purposes) or are generally regarded as matters of debate in a liberal society (such as the personhood of foetuses), in certain areas medical science has well established evidence of what constitutes best practice (e.g. with regards to vaccination). While science is in the habit of overthrowing previously established facts, HCPs are not clairvoyant and should only act on the facts they have in front of them. While the arguments utilized throughout the article favour a greater freedom of professional practice, they do not imply that anarchy should reign in healthcare. Though there is no facility to compel an HCP to provide treatment they deem medically futile,[43,44] giving advice contrary to scientific evidence would be valid grounds for questioning an HCP's fitness to practice and hence striking them from the register. If an HCP would knowingly encourage a patient in their mistaken belief (e.g. that vaccinations cause autism),[45] they would be acting in a maleficent manner towards their patient, contrary to the foundations of healthcare practice. Fulfilling malicious desires and fraud are not things that should be facilitated in a free society and should, at least in the sphere of healthcare, be grounds for criminal prosecution.[46]

Another potential objection is that if there is only a blurry line between PO and CO, could this not create a situation where an HCP could try to pass one off as the other? But this is the point on which we should refrain from judgment, for a HCP might simultaneously hold a CO and a PO against a specific procedure. Moreover, if neither of the two modalities hold a privileged status over the other, then does it matter whether an objection is presented as one or the other, as long as the statement is truthful? A doctor might have started work in an antenatal clinic (one that did not provide abortions) for matters of pure convenience—it was close to her house. Later, she espoused a pro-life perspective. Similarly, a doctor might have decided to work at such a clinic because of her religious views on abortion, which also translated to a philosophical outlook about the purpose of healthcare. Someone who objects to euthanasia on moral grounds (CO) is likely to also view killing as something that is not part of a HCPs job (PO category 1) and as something that has no scientifically proven benefit to the patient (PO category 2).[47] There is no way of judging that one of these aspects is more important than the other or that the pro-life view of one of these doctors is more genuine than the view of the other. This, though, warrants the conclusion that the practice of healthcare cannot be reduced to the professional matters discussed in this paper. But it does not warrant the conclusion that professional matters are meaningless or that PO is indistinguishable from CO—only that it is possible (and even likely) for a person to hold CO and PO views that coincide with each other.

The last objection is that medicine is practiced in a community and that practitioners should meet the standards expected by the community. Surely, these are the standards that allow for someone who seeks medical care to obtain it in a manner intelligible to them. Yet it is not the argument of this paper that HCPs have

the right to change the whole process of commerce or human interaction. Rather, that a degree of diversity within healthcare is the norm. For example, in the U.S.A., some physicians graduate with a M.D. degree, while some with a O.D. degree, where the philosophical assumptions about the practice differ. These together might have a different viewpoint on how health should be managed, compared to a chiropractor. Similarly, some pharmacies will sell certain products and not others, and certain specialists will provide some services and not others. Moreover, the literature is rich with varying opinions on how certain diseases should be treated. As such, the only thing that is needed to make PO comprehensible by community standards is an honest description of the services provided.

Conclusion

The debate surrounding the scope of an HCP's right to object to the provision of particular treatments should not be limited to matters of conscience, though professional opinions might often overlap with one's ethical viewpoint. HCPs are professionals who should be free to exercise their expertise in a manner respecting their wider worldview and scientific knowledge, allowing them to find fulfilment in their job and not burdening them disproportionally. Nevertheless, HCPs should not be free to harm their patients. While HCPs should not be compelled to provide all that a patient might seek, HCPs should provide healthcare and not act to the detriment of their patients' health. This is not to say that ethics is not important in healthcare but that there are other legitimate reasons for objecting to the performance of certain practices that are not within the scope of traditional CO objections.

Epilogue

While I believe that the arguments presented in this paper offer a useful tool for HCPs to object to certain treatments, it is somewhat obvious that this is not a model for how healthcare should be done and that, even within the context of objections, it is an impoverished model. It certainly does not tell us much about what we must do for our patients, for this a teleological framework is needed to direct HCPs towards their purpose. But this is not the subject of this paper. Moreover, the framework runs at the risk of proving too much, for how far should the freedom of dissociation extend? Perhaps this is a signpost to the limits of a liberal and pluralistic framework that was used here. But if a secular institution rejects the arguments presented here, they will have to explain why healthcare is different from other crafts or acknowledge that there are issues with their own arguments. As such, my hope is that this paper will also be a prompt for reflection on the philosophical basis of medicine for those who accept the arguments here presented and who recognize that there is more to healthcare than business and expression of personal choice.[xi]

References

1. Baroness O'Loan. 2017. Conscientious Objection (Medical Activities) Bill [HL] 2017-19. June 28.
2. Pellegrino, Edmund D. 2001. The internal morality of clinical medicine: a paradigm for the ethics of the helping and healing professions. *The Journal of medicine and philosophy* 26: 559–579.
3. Ibid.

4. Eijk, Willem Jacobus Cardinal. 2017. Is medicine losing its way? A firm foundation for medicine as a real therapeia. *The Linacre Quarterly* 84: 208–219. doi:10.1080/00243639.2017.1301112.
5. Saad, Toni C, and Gregory Jackson. 2018. Testing conscientious objection by the norm of medicine. *Clinical Ethics*: DOI: 10.1177/1477750917749952. doi:10.1177/1477750917749952.
6. Wiesing, Urban. 2018. From art to science: a new epistemological status for medicine? On expectations regarding personalized medicine. *Medicine, Health Care and Philosophy* 21: 457–466. doi:10.1007/s11019-017-9820-z.
7. Savulescu, Julian, and Udo Schuklenk. 2017. Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception. *Bioethics* 31: 162–170. doi:10.1111/bioe.12288.
8. Rosenberg, Carol. 2016. Navy reinstates nurse who refused to force-feed at Guantánamo. *Miami Herald*, May 5.
9. Savulescu, Julian, and Udo Schuklenk. 2017.
10. Saad, Toni C. 2018.
11. Selinger, Christian P. 2009. The right to consent: Is it absolute? *British Journal of Medical Practitioners* 2: 5.
12. NHS Choices. 2015. Can I demand a specific treatment? June 10.
13. Saad, Toni C. 2018.
14. Fiala, Christian, and Joyce H. Arthur. 2017. There is no defence for 'Conscientious objection' in reproductive health care. *European Journal of Obstetrics & Gynecology and Reproductive Biology* 216: 254–258.
15. Müller, Sabine. 2009. Body Integrity Identity Disorder (BIID)—Is the Amputation of Healthy Limbs Ethically Justified? *The American Journal of Bioethics* 9: 36–43. doi:10.1080/15265160802588194.
16. Dhejne, Cecilia, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Långström, and Mikael Landén. 2011. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLOS ONE* 6: e16885. doi:10.1371/journal.pone.0016885.
17. Beauchamp, Tom L., and James F. Childress. 2013. *Principles of Biomedical Ethics*. 7 edition. New York: OUP USA, p. 126.
18. Pellegrino, Edmund D. 2001.
19. Aristotle. 2015. *Ethics.* Amazon for Kindle, Loc. 343,2243.
20. Plato. 2017. *The Republic.* Amazon Classics Kindle. Amazon, p. 284.
21. Dornan, Tim, and Debra Nestel. 2013. Talking, Touching, and Cutting: The Craft of Medicine. *The Journal of Modern Craft* 6: 35–48.
22. Oxtoby, Kathy. 2016. BMJ Careers - The disappearing craft of medicine. March 29.
23. Wiesing, Urban. 2018.
24. Fitzpatrick, Kevin. 2011. Should the law on assisted dying be changed? No. *BMJ* 342: d1883. doi:10.1136/bmj.d1883.
25. Oderberg, David S. 2017. Should there be freedom of dissociation? *Economic Affairs* 37: 167–181.
26. Rosenthal, Elisabeth. 1995. Finances and Fear Spurring Hospitals To Drop Abortions. *The New York Times*, February 20.
27. Rodriguez, Maria I., K. John McConnell, Jonas Swartz, and Alison B. Edelman. 2003. Pharmacists prescription of hormonal contraception in Oregon: Baseline knowledge and interest in provision. *Journal of the American Pharmacists Association : JAPhA* 56: 521–526. doi:10.1016/j.japh.2016.05.003.
28. Gomez, Anu Manchikanti. 2017. Availability of Pharmacist-Prescribed Contraception in California, 2017. *JAMA* 318: 2253. doi:10.1001/jama.2017.15674.
29. Gonsalves, Lianne, and Michelle J. Hindin. 2017. Pharmacy provision of sexual and reproductive health commodities to young people: a systematic literature review and synthesis of the evidence. *Contraception* 95: 339–363. doi:10.1016/j.contraception.2016.12.002.
30. Rodriguez, Maria I., K. John McConnell, Jonas Swartz, and Alison B. Edelman. 2003.

31. Davis, Shoni, Vivian Schrader, and Marcia J Belcheir. 2012. Influencers of ethical beliefs and the impact on moral distress and conscientious objection. *Nursing Ethics* 19: 738–749. doi:10.1177/0969733011423409.
32. Gonsalves, Lianne, and Michelle J. Hindin. 2017.
33. Rodriguez, Maria I., K. John McConnell, Jonas Swartz, and Alison B. Edelman. 2003.
34. Gomez, Anu Manchikanti. 2017.
35. Gonsalves, Lianne, and Michelle J. Hindin. 2017.
36. Malik, Kenan. 2018. The 'gay cake' fight: why the bakers had a right to refuse this order | Kenan Malik. *The Guardian*, May 6, sec. Opinion.
37. Lee (Respondent) v Ashers Baking Company Ltd and others (Appellants) (Northern Ireland) [2018] UKSC 4.
38. Oderberg, David S. 2017.
39. MacIntyre, Alasdair. 2004. *After Virtue: a study in moral theory*. Second. Norfolk: Duckworth.
40. Beauchamp, Tom L., and James F. Childress. 2013.
41. Oderberg, David S. 2017.
42. Ibid.
43. Selinger, Christian P. 2009.
44. NHS Choices. 2015. Can I demand a specific treatment? June 10.
45. Godlee, Fiona, Jane Smith, and Harvey Marcovitch. 2011. Wakefield's article linking MMR vaccine and autism was fraudulent. *BMJ* 342: c7452. doi:10.1136/bmj.c7452.
46. Oderberg, David S. 2017.
47. Gamble, Nathan. 2018. Can euthanasia be classified as a medically beneficial treatment? *Ethics & Medicine* 34: 9.
48. Fiala, Christian, and Joyce H. Arthur. 2017.
49. Savulescu, Julian, and Udo Schuklenk. 2017.
50. Macintyre, Alasdair. 1990. *Three Rival Versions of Moral Enquiry: Encyclopaedia, Genealogy And Tradition*. First. London: Bloomsbury Academic.
51. Matas, Caroline. 2016. Belgian Court Rules Catholic Nursing Home Cannot Refuse Patients' Euthanization. July 8.
52. Rosenthal, Elisabeth. 1995.
53. Tuathail, Maitiu O. 2018. Abortion is not part of routine general practice. 85% of GPs are of this opinion. *TheJournal.ie*. June 13.

Endnotes

i. Christians might be, for example, as much Platonic as Aristotelian in their philosophical outlook and differ in their opinions on the evidence basis for various procedures. They will also differ in the specialisms they wish to pursue in their clinical special interests, and they will be subjects to the same material constraints that non-Hippocratic HCPs will face. Pragmatic (or practical) judgments are still necessary, though they should be prudent (and supported with prayer) and not just be clever in the eyes of the secular world.

ii. It is noteworthy that reasons 1 and 2 seem to be acceptable to at least some authors generally hostile to CO. Fiala and Arthur state that they accept objections based on "an obligation of doctors to their patients and to their professional ethics … based on evidence, medical ethics, and professional obligations" and hence "are not grounded on the individual personal beliefs of HCPs, they do not qualify as CO."[48] See also the later example from Savulescu and Schuklenk.[49]

iii. Scope of practice in general relates to the particular activities that one's professional body and employer has described as one's role. Yet here we emphasise that this is always interpreted by the individual within the context of a metaphysical understanding what healthcare as a craft/practice is (e.g. Hippocratic medicine is about healing, not harming, respecting confidentiality, etc.).

iv. The fact that futility is such a difficult concept, for which it is at times difficult to reach consensus, is part of the reason why such professional objections should be allowed. If it is a matter of licit

disagreement, then why should one be forced to comply with one reasonable opinion over another?

v. The concept of a craft-tradition is also discussed by Macintyre.[50] The notion of healthcare as a profession passed from mentors and professors to students, with its heroes and great discoveries, as well as learned associations with all their traditions, lends itself also to such an understanding of healthcare. But this is a broader concept than the one with which we are concerned in this analysis.

vi. This might be not possible in practice in jurisdictions where only a HCP, rather than an institution, has the right to refuse undertaking a particular procedure, like in Belgium.[51]

vii. Medical facilities have refused to perform abortions in the past for reasons other than ethical.[52]

viii. For an interesting discussion on abortion within the context of the recent referendum in the Republic of Ireland, see the article written by Dr Tuathail.[53] This article mentions some types of PO mentioned in this paper, such as abortions not being a routine part of general practice, as well as limitations relating to a practitioner's fluency in a procedure.

ix. While the pro-life movement tends to be associated in the west with Christianity, secular (https://www.secularprolife.org/) and other non-religious e.g. feminist pro-life groups (https://www.feministsforlife.org) do exist.

x. Objections to the provision of vaccines produced via human cell lines obtained from aborted foetuses are not mentioned here, as this is a matter of CO, not PO, and is strictly speaking not an opposition to vaccination.

xi. For such a teleological analysis of medicine and its relationship to practitioners objecting to the provision of specific services see Gamble, Nathan K. and Pruski, Michal 2019. Medical Acts and Conscientious Objection: What Can a Physician be Compelled to Do? *The New Bioethics* DOI: 10.1080/20502877.2019.1649871.

Michal Pruski, PhD, MA, AFHEA, MRSB, is a trainee Clinical Scientist (according to British nomenclature) in Critical Care Science at the Manchester University NHS Foundation Trust. The theoretical component of the training is undertaken at Manchester Metropolitan University. The author has no conflict of interest to declare and wishes to acknowledge Toni Saad, Daniel Rodger, and the anonymous reviewers for comments and suggestions. He currently resides in Manchester, UK.