

The Effect of Integrity on Conscientious Objections in Healthcare

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Summary

This thesis contributes to the discussion of integrity in the context of conscientious objections to abortion and physician assisted suicide in Canada. An evaluation of Cheshire Calhoun's 1995 theory of social integrity is provided and arguments in support of this theory are outlined. Consideration is given to the arguments in favour of the right of physicians to conscientiously object, including the harm that is experienced by physicians made to act against their will and the value of fostering integrity among healthcare professionals. An examination of the harms experienced by women and healthcare institutions as the result of conscientious objections is unpacked. This includes discussion of oppressive social structures which encourage and amplify harm to pregnant women who are denied access to abortions. Finally, it is made clear that, in light of these harms, and in understanding integrity as a social virtue, Canadian lawmakers ought to remove the right of physicians to conscientiously object to abortions and physician assisted suicide.

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Introduction

Protecting the right of physicians to act with integrity has been a core argument in favour of the right to conscientiously object (Blustein 1993, Pellegrino 2002). However those affected by conscientious objections include more than the objecting physician; the requesting patient is also affected as well as the larger community via the precedence that is set for the healthcare institution by our response to conscientious objections. Little has been said about patient and institutional integrity in these instances in comparison to what has been said regarding the integrity of physicians in connection with conscientious objections. One reason for this may be that arguments against allowing conscientious objections tend to focus on harm, conceived of as unrelated to integrity, that is done to the patient and institution when legal medical treatments and procedures are withheld (Brock 2008, McLeod 2010).

It is essential, however, that a clear picture of integrity for all relevant subjects of conscientious objections be developed. The legal framework in Canada which regulates conscientious objections as well as the two medical procedures which I focus on – abortions and physician assisted suicide – has remained ambiguous and open-to-interpretation about the morality of these subjects. Each of these subjects – conscientious objection, abortion and physician assisted suicide – have been legalized and decriminalized but not protected. Abortions and physician assisted suicide are legal, and patients have a right to seek these procedures, but their ability to access them is not guaranteed nor protected. This is because competing interests and actions of health care professionals, which have also been made legal (but are still not guaranteed or protected) prevent patients from being able to access services. Conscientious objections allow physicians to refuse to provide abortions and physician assisted suicide when doing so would conflict with their personal and moral convictions. This is only made possible

because neither abortion nor physician assisted suicide are seen as rights. This means that, while we are free from legal persecution as a result of accessing them, we do not have any protected legal claim to these procedures, and our pursuit of them is not protected against interference. Several previous court decisions made in Canada have contributed to a legal framework which does little to protect the rights and interests of both patients and health care professionals.

The first regulation of abortion in Canada occurred in 1869 when Parliament made it illegal under all circumstances and assigned a penalty of life in prison for transgressors (ARCC 2017, pg. 1). This decision went unchallenged for nearly 100 years. Finally, in the 1960s and 1970s professionals in the legal and medical fields as well as women's and social justice advocacy groups garnered enough undeniable support that the pressure to de-criminalize could no longer be ignored by legislators. This led to the Canadian government's 1969 decision which decriminalized abortion but made it incredibly difficult to access by requiring that abortions only be permitted when the woman's health was at risk and assembling therapeutic abortion committees which determined whether or not this requirement had been met. However, availability of abortion committee reviews led to long wait times and varied across Canada (ARCC 2017, pg. 1) Additionally, ambiguous and non-comprehensive definitions of health and well-being meant that committee decisions were not uniform and often did not take into account every way a woman's health could be affected by pregnancy. Among the groups advocating for abortion law reform was Doctor Henry Morgentaler's Humanist Fellowship of Montreal. Morgentaler illegally and indiscreetly provided abortions through his medical practice and clinics which he opened in Montreal in 1969 and which eventually spread to other locations across Canada. After several charges, trials, acquittals and over-turned rulings beginning in 1970, Morgentaler appealed to the Supreme Court of Canada in 1988. The court's ruling, which is

influential to this day, found that abortion laws had been in conflict with section seven of the Canadian Charter of Rights and Freedoms which guarantees life, liberty and security of person (R. v. Morgentaler, 1988) Since 1988 continuous efforts from pro-life groups have resulted in the introduction of amendments and bills, such as Bill C-43 and Bill C-484, which would jeopardize the legality of abortion, however all have failed (ARCC 2017, pg. 3-4). Today, because of the Supreme Court's decision in R. v Morgentaler, abortion remains a legal medical procedure.

The legal framework surrounding physician assisted suicide is different than that of abortion. It was propelled by patients seeking medical assistance in dying, and the landmark Canadian court decision governs current treatment of physician assisted suicide did not occur until 2015 in Carter v Canada (Attorney General). In this case, Kay Carter, a woman living with spinal stenosis argued that the ban on physician assisted suicide violated sections 7 and 15 of the Charter of Rights and Freedoms, which guarantee the right to life, liberty and security of person and protects against discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. Her case was successful, the trial judge found that charter violations were occurring as a result of the ban on physician assisted suicide and that these violations were unjustifiable (Carter v Canada, Attorney General, 2015). As a result of this ruling, Canadian parliament passed Bill C-14 which currently governs our approach to physician assisted suicide. This bill permits medical assistance in dying but limits eligibility to persons over the age of 18 who are grievously ill, whose death is reasonably foreseeable and who have voluntarily, consensually and without coercion, requested physician assisted suicide (Nicol, Tiedemann, 2018, web).

While both of these decisions were paramount in progressing a patient's ability to access an abortion or medical assistance in dying, neither were successful in securing either of these

procedures as a right. In failing to do so, Canadian courts created opportunity for health care professionals whose religious or moral convictions contradicted the procedures to prevent patients from accessing them by conscientiously objecting. Respect for and allowance of conscientious objections to medical procedures followed from the same reasoning which originally supported conscientious objections to participation in military combat. Based on the right to conscience and the protection against discrimination based on religion which is afforded by section 15 of the Canadian charter, physicians have a right to conscientiously object and refuse to provide legal medical services. However, in 2018, a decision took place which altered the legal framework surrounding conscientious objections, and this decision was upheld more recently in the Spring of 2019. This decision affirms a policy from the College of Physicians and Surgeons of Ontario which states that, when physicians refuse to provide a service or procedure on the grounds of conscientious objection, they are required to provide their patient with an effective referral (Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2019) . The College of Physicians and Surgeons of Ontario defines an effective referral as one that is made in good time to an available and accessible physician who is known to not object to the treatment at hand. This decision, which clearly states the legal requirement for referrals, is essential, especially given previous misunderstandings or unfamiliarity with the requirement to refer.

In 2013, Jocelyn Downie, Carolyn McLeod and Jacquelyn Shaw argued in an essay for the Canadian Medical Association Journal that physicians are morally and legally required to provide referrals when refusing to provide legal medical services themselves. They were met with several letters from the CMA and members of parliament asserting that referrals are neither morally nor legally required (Downie, McLeod, Shaw, 2013). In response to the unfamiliarity of

CMA and parliamentary members with the legal necessity of physician referrals, Downie, McLeod and Shaw proposed to the Canadian College of Physicians and Surgeons a model policy for conscientious objections. This surprising response, not only from other philosophers and academics but from CMA members and members of parliament, illustrated that the policy regarding conscientious objections in healthcare was in need of attention and clarification. The need was made even more dire when one considers the technological advancements which have garnered moral aversion from physicians that are slowly becoming available to patients and healthcare professionals such as embryonic research and cloning. Integrity as a concept and a value is integral to our response to conscientious objections. Protection of physician integrity is perhaps the most influential reason one can provide in support of allowing physicians to conscientiously object.

Yet, our understanding of what integrity is and why it may be valuable is ambiguous; is integrity a virtue, is it identifiable as consistency among one's principles, or the distancing of oneself from actions which one has determined to be wrong, or is it something else? Therefore the first section of this thesis will survey the work of various philosophers who have offered definitions of integrity. Conscience will also get attention, as it will be argued in this first section that one requirement of integrity is that one acts in accordance with a moral conscience. However, I will focus on the work of Cheshire Calhoun who has presented, in "Standing for Something" (1995), a social understanding of integrity as a virtue. This is the basis for my evaluation of physician, patient and institutional integrity; do each of these subjects stand for, as opposed to simply stand by, their moral principles? Other conceptualizations of integrity seem to miss this essential social aspect of what integrity is. Although philosophers such as James Childress (1979), J.J.C Smart and Bernard Williams (1973), Daniel Sulmasy (2008), Jeffrey

Blustein (1993), Jeffrey Blustein (2011) have provided pictures of integrity which accurately discuss certain essential aspects of integrity, each one fails to acknowledge that integrity also involves a social aspect. All of these theories fall into one of three categories identified by Calhoun; “the identity”, “integrated self” and “clean-hands” pictures of integrity (Calhoun, pg. 252). These views suggest that integrity should be exercised in order to protect some feature of ourselves: autonomy, character, agency (Calhoun, 253). They understand integrity as being valuable in only a personal sense, and fail to acknowledge that integrity is most valuable because it allows us to properly conduct ourselves among others and participate in social relations (Calhoun, 253).

Secondly, I address harms to integrity as experienced by the objecting physician. However, before this, I discuss the benefits for physicians, healthcare institutions, patients and the community of having physicians who are permitted or encouraged to practice integrity. Without demonstrating that physician integrity is valuable, any argument which supports the right to conscientiously object by outlining the harm that would result to a physician’s integrity if they were not allowed to do so will fail. The cases of conscientious objection that I address here include refusals to provide abortions and physician assisted suicide only. I, in part, address abortions and physician assisted suicide exclusively to maintain a reasonable scope. Also, as I will illustrate, these are the cases in which harm resulting from the loss of integrity is most comparable between the physician and the patient. Articles from Christopher Crowley (2016), Edmund Pellegrino (2002) and J.F. Peppin (1997) specifically address the integrity of the physician and the arguments that have been put forth which use physician integrity to support the right to conscientiously object.

The third section discusses integrity from perspectives from which it has not been closely evaluated in bioethical discourse; that is, from the perspectives of the patient and the healthcare institution. This section begins with a brief discussion of the harms that are experienced by patients when they are denied legal medical services to which they have a right, and arguments which support the right of the patients to access these services, even if it means compelling a physician to do that to which they conscientiously object. I include discussion of harms and rights because it is integral to the debate surrounding conscientious objections; discussion of both are at least minimally present in nearly all relevant work I have come across. They also may be the reasons that deliberators have such strong principles regarding access to services and conscientious objections and why they feel they must maintain their integrity and stand for those principles. Next I argue that one of the harms that a patient suffers as a result of being denied legal medical services is to her integrity. The patient is being denied the opportunity to practice integrity at a personal level – to advocate for her principles, or distance herself from ones which she believes are morally wrong. Therefore her integrity is harmed in that what she advocates for publicly (access to legal medical procedures) and what she accepts privately (being denied said services) are contrary.

My discussion of institutional integrity is small in comparison with my focus on personal integrity. My focus here is to evaluate how conscientious objections affect how hospitals run and how well they are able to care for patients. Aspects which are integral to most theories of integrity, such as cohesion and consistency, are also present in institutional integrity. If principles which are compatible are advertised, present in policies and acted upon by professionals, this seems to achieve some basic level of integrity. Institutions can also achieve integrity in Calhoun's social sense. Moral or religious principles which are determined by a group of

individuals and are conscience-based can be enforced in an institution and promoted in the community. For example, Mark Wicclair argues that catholic healthcare institutions are a good example of this (Wicclair pg 131, 2011).

Why is institutional integrity valuable? Wicclair says that the comfort of health care professionals and patients to work and be helped in an environment which supports principles which match their own is valuable (Wicclair, 131), perhaps in the same way that having physicians who are allowed and encouraged to exercise their integrity is valuable. However, public healthcare institutions have not endorsed moral principles regarding services like physician assisted suicide and abortion. There are no consistent principles that are present in policy or the actions of healthcare providers. In surveying institutions other than abortion clinics which provide abortion in Ottawa and Ontario, very few hospitals or private practices were found that were clear about whether or not they would provide the service. For example, the website for the Shirley E. Greenberg Women's Health Centre at the Ottawa Hospital says nothing about the centre's stance on abortion, nor does it indicate whether any physicians who practice at the clinic provide abortions. In being unclear or inconsistent about the availability of certain services within a hospital, for example, we can expect more instances in which patients are refused legal medical services and professional disagreement occurs between healthcare providers.

My final chapter surveys the aforementioned arguments – considering the experiences of both physicians and patients as well as the influence that conscientious objections have on healthcare institutions and their ability to care well for patients – and concludes that Canada's current way of addressing conscientious objections is wrong. In understanding integrity as a social virtue, and as important in that it contributes to and allows for discussion among

deliberators regarding what is worth doing, we have to subject the reasons that physicians and patients have for supporting the principles that they do to critical discussion. I think critical discussion of these reasons and principles, including discussion of the harms and rights experienced by both sides, will conclude that assuring simple access to services such as end of life care and abortions is more worth doing than protecting the integrity of physicians who conscientiously object to these services.

I do not believe that requiring physicians to provide services to which they conscientiously object is contrary to integrity. In other words, I think that the respect and open-mindedness towards the views of physicians which integrity demands can still be achieved by law makers and the public even if they are requiring physicians to provide services with which they disagree. During the honest, open discussion between deliberators about what is worth doing in cases of conscientious objections, respect and consideration are given to the views of physicians as well as patients. Respect is afforded again to the views of physicians by using the proper channels to influence changes in legislation, instead of protesting at their practice, or challenging their refusal to provide a certain service during a doctor's appointment. Calhoun agrees that "acting on one's own best judgement is integral to some common projects (such as the search for truth or co-legislable principles) or to a way of comporting ourselves among others" (Calhoun pg 256, 1995). This means that integrity doesn't have to require that we allow individuals to act in accordance with any principle that they view is moral. Especially when that principle is in conflict with other principles which the community has determined are worth supporting.

Chapter One: Defining Integrity

The need to protect one's integrity is, arguably, the most salient defense of conscientious objections there is. However the definition of integrity is ambiguous. Can a person have integrity, or simply act with integrity? Are moral topics the only sorts of things about which integrity is properly applicable? Or can one have integrity or act with integrity regarding more superficial matters? Is acting with integrity the same thing as acting in accordance with one's conscience? What sorts or restrictions, if any, can reasonably be applied to integrity and how do we know when it is justifiable to apply them? Several theorists have offered answers to these questions. Jeffrey Blustein, for example, argues that integrity is achieved when we act in accordance with our conscience (Blustein, pg 297, 1993). According to Blustein, integrity is a duty one has to herself to take herself seriously by making choices which reflect what our conscience dictates. This falls into a category of theories of integrity which Calhoun refers to as "integrated self" pictures of integrity. In providing examples of physician integrity, Blustein writes that physicians often make conscientious objections to medical procedures based on certain value considerations such as the no-harm principle, standard of good medical practice and fairness for other patients (Blustein, pg. 291, 1993). He further argues that conscientious objections in these cases – which may very well include physician's religious or moral conscientious objections to provide abortions or physician assisted suicide – are the result of a "considered position that has definite implications for the physician's conduct in other similar situations." (Blustein, pg 291, 1993) and that when conscientious objections are made in this way, with regard for one's integrity, that proper consideration is given to "the rights and interests of others" (Blustein, pg. 294, 1993). However, as I will illustrate in my full discussion of integrated self pictures of integrity, simple consideration of others in our moral decision making

does not sufficiently account for the facts that integrity is inherently social and that this social component is what makes integrity valuable (Calhoun, pg. 253, 1995).

James Childress, in “Appeals to Conscience” (1979), argues that integrity is similar to inner harmony, and that it can be lost when we violate, or act against our conscience. (Childress, pg. 318, 1979). Childress claims that integrity is inherently subjective and personal, and does not require that we stand for our principles by engaging with others to convince them that they too should adopt these principles (Childress, pg 318, 1979). In fact, on this view, it is illogical for someone to say that their integrity has been negatively affected or that they have suffered a guilty conscience as a result of the actions of another person. I think that Childress’ mistake here is using the term “guilty” (Childress, pg. 319, 1979). Surely, guilt implies our own wrong-doing, and so it would follow that feeling guilt for others’ actions is illogical. However, Childress fails to acknowledge that inaction, or our failure to prevent the wrong-doing of others, is a decision we make that can lead to conscientious guilt. He also does not recognize that our conscience can be negatively impacted by states other than guilt. For example, there may be things that we morally disagree with, however we may not be able to do anything about them, which can result in a conflicted, frustrated and discouraged conscience.

Christina Lamb defines integrity in her essay “Conscientious Objection: Understanding the Right of Conscience in Healthcare Practice.” (2016) as “the ability for a person to function in a state of moral unity between personal and professional values and responsibilities.” (Lamb, pg. 35, 2016). This is an example of what Calhoun calls an identity picture of integrity; it requires that we are able to continue as the same self in situations which may otherwise cause us to make choices which conflict with our established principles. In this case, Lamb suggests that integrity

is achieved when we make consistent choices in accordance with our principles which are not affected by whether we are in a personal or professional setting.

In “What is Conscience and Why is Respect For it So Important?”(2008), Daniel Sulmasy argues that integrity can be summarized as “moral wholeness” (Sulmasy, pg. 138, 2008), and that it is achieved when we act in accordance with our principles. While Sulmasy does not completely capture the social aspect of integrity, he comes close to communicating the commitment to “standing for our principles” that Calhoun argues is required by integrity. He writes:

It is a commitment to uphold one’s deepest self-identifying moral beliefs; a commitment to discern the moral features of particular cases as best one can, and to reason morally to the best of one’s ability; a commitment to emotional balance in one’s moral decision making, to being neither too hard nor too soft; a commitment to make decisions according to the best of one’s moral ability and to act upon what one discerns to be the morally right course of action. Conscience arises from this meta-moral commitment to morality. (Sulmasy, pg. 138, 2008).

His focus on acting upon the right course of action and the commitment to morality that all people of integrity must have implies more than ensuring that our own actions match up with what we, personally, have decided is right. A commitment to morality suggests that one has regard for the morality, not just of themselves and their judgements, but their communities as well.

The theory which I accept, defend and contribute to was developed by Cheshire Calhoun in “Standing For Something” (1995). However, before I fully unpack this theory, it will be valuable to fully address other theories of integrity, in addition to those from Blustein, Childress, Lamb and Sulmasy, which Calhoun and myself reject. These theories have been labeled by

Calhoun as the integrated self, identity and clean hands pictures, and it is worth spending more time examining some of these accounts of integrity.

Integrated Self Picture of Integrity

We intuitively think of integration as a necessary, if not cardinal aspect of integrity. That the most important requirements of integrity are that things fit together and are working towards a common cause are reasonably easy notions to accept. For example, when we talk about the integrity of a house we are referring to the supportive and structural elements – the soil, foundation, frame, etc. – working together to achieve the strength, safety and function of the house. The same can be accepted about integrity in reference to a person.

Essential to the integrated self picture of integrity are the ideas of self and deliberation. Calhoun begins her discussion of this picture by outlining Harry Frankfurt's idea of the "wanton" (Calhoun, pg. 236, 1995 and Frankfurt, 1971). These are "individuals who either lack the capacity or simply fail to deliberate and make up their minds about which of their desires they want to be volitionally effective" (Calhoun, pg. 236). In other words, the choices that wantons make are not based on their principles at all. They are based on whichever whim is most prevalent at the time of the decision. This creates problems in connection to the ideas of deliberation and self. If the choices one makes are not the result of internal deliberation in accordance with established principles, but instead the result of an external force – as whims or moods often are – then it can be argued that these "choices" do not stem from that person at all. And, while I am not able to dive into a full investigation of the definition of the "self", it is reasonable to accept that the ability to make decisions which correspond to our principles is a necessary aspect of the self.

Yet, making decisions in accordance with one's principles is not the only requirement for integrity in the integrated self picture. In addition to making these cohesive decisions in accordance with pre-determined principles, the person of integrity must be "true to his commitments" (Taylor, pg. 144). Gabriele Taylor in "Integrity" (1981) argues that this requires the following: first, that the person is not a hypocrite – that they do not only make certain decisions in an effort to convince those around them that they have certain principles and commitments (Taylor, pg. 145). The reason for making these decisions must be motivated by that principle itself, not by the interest in having others believe we act in accordance with that principle. In this case, the way one appears to others is actually more important than the principle they *pretend* is most important to them. The second requirement is sincerity to one's claimed principles or commitments. (Taylor, pg. 145). A person of integrity acts with consistency – they do not change their principles or commitments frequently and impulsively. Taylor does of course allow and account for changes in one's principles when, upon deliberation, they have recognized a reason for the change. However, when one's principles are so fragile as to change depending on their company and surroundings, it is clear that this person's commitment to these principles is not sincere. Thirdly, a person of integrity does not allow themselves to be influenced or coerced into acting in such a way that contradicts their defined principles and commitments. In other words, they do not act with cowardice or a weak-will (Taylor, pg. 146) The weak-willed and the coward are aware that their actions do not align with their principles. They are aware of their failure and that they are accepting something as true and reasonable that they would rather reject. A key difference between the insincere and the weak-willed is that the weak-willed are aware that they are not acting with integrity, while the insincere is unaware of their failure to do so.

Finally, self-deception prevents one from being true to their commitments. Taylor takes this to be the most troublesome barrier to true commitment to principles because it can encompass the three previous barriers and the failure to act with integrity in this case is not recognized by the person. (Taylor, pg. 146). Therefore, Taylor uses the example of Mr. Casaubon from George Eliot's "Middlemarch" (1871-1872) to properly unpack the barrier of self-deception. Mr. Casaubon seems to live in accordance with the principle that scholarship and academia are of the greatest value. He sees himself as a great scholar, as do those around him. However, his actions and decisions are not conducive to actually excelling in scholarship, they are only conducive to what he has persuaded himself scholarship entails. He isolates himself and ignores research that is relevant to his field. While he is true to his commitments, his characterization of these commitments as stemming from the principle of scholarship is false. Therefore, he is deceiving himself and others and his commitment to scholarship is not true.

Now that we have established how people with integrity *do not* act, according to the integrated self picture, we can begin to discuss how they do act. Taylor points out that integrity, as a moral value, provides no descriptive account of how we can expect people to act. She compares integrity to bravery and generosity (Taylor, pg. 151). When one possesses bravery, we can expect them to act certain ways (i.e. bravely) in certain situations. The same can be said regarding generosity. However, when someone possesses integrity, how can we expect them to behave? Are they intact or integrated? Even if so, these are not descriptive in the sense that we can infer someone's behaviour from them. Someone could potentially be acting with integrity whether they are brave or cowardly, generous or selfish, and so on. When we picture someone who is known to have integrity, we might intuitively picture someone who adheres to the "socially accepted code of morality" (Taylor, pg. 143). For example, someone who is honest,

keeps their promises, etc. However, “integrity does not generate its own motive” (Taylor, pg. 151). Adherence to a certain set of principles is not necessary. What is necessary is that the set of principles one does adhere to (whether they are included in the socially accepted code of morality or not) is cohesive, sincerely committed to, and not the product of self-deception. In other words, we cannot determine from the fact that someone has integrity what sort of principles they subscribe to or how they will act. Therefore, according to Taylor, integrity, if it is a moral virtue at all, must be some sort of second-order virtue because it involves possessing other virtues such as bravery, generosity, honesty, trustworthiness, etc. Integrity is something that we aim to have as a result of being virtuous.

Taylor writes that “we should be much more reluctant to regard someone as having integrity if he did so for his own gain, irrespective of whether he regards his reasons as sufficient.” (Taylor, pg. 153). It seems here that Taylor suggests that motive matters in determining whether or not someone acts with integrity. She also argues that we demand of people of integrity that they “get their values right” (Taylor, pg. 153). This is another claim that suggests that there is more to integrity than cohesive action in accordance with one’s principles. Someone can sincerely and non-deceptively live their life committed to principles which fit together and are conducive to a common goal, yet they can still fail to meet the requirements of integrity. However, Taylor’s theory – the integrated self picture – fails to account for such requirements as motive, and the morality of the values and principles that one holds. In addition to this, Calhoun provides an example which illustrates that, contrary to the integrated self picture of integrity, integration is not always a necessary aspect of integrity.

Calhoun cites Maria Lugones (Calhoun, pg. 238) in order to show that there can be inconsistencies and incompatibilities between one’s actions, commitments and principles,

however this does not necessarily mean that they do not have integrity. Lugones is both a Latina woman and a lesbian. In fighting against racism towards herself and others based on her Hispanic identification, Lugones fully embraces her Hispanic culture and her identity as a Latina. Similarly, Lugones, as a lesbian, struggles against homophobic oppression by fully embracing her identity as a lesbian and a member of the non-heterosexual lesbian community (Calhoun, pg. 239). However, the prominent values which are central within each of these cultures contradict one another; homosexuality is condemned within Hispanic culture and core values in Hispanic culture are not present in gay culture. Although Lugones fully embraces and endorses her identity as both a Latina woman and a lesbian, it would seem, according to the integrated self picture, that she is constantly failing to act with integrity because her identity and her decision to fight oppression result in her making choices that contradict each other. However, Calhoun argues that there are valid reasons one may have that allow someone to have conflicting values and principles, act in accordance with those conflicting values and principles, and still retain their integrity (Calhoun, pg. 239). While Lugones' actions may seem conflicting and lacking integration and cohesion, her choices were made deliberately, by her. She is not hypocritical (she does not pretend to have the principles that she does – she actually has them), her values are sincere, she is certainly not weak-willed, and she has not deceived herself about her principles, her choices which have resulted from these principles, nor the relation between the values which stem from her Hispanic identity and those that stem from her identity as a lesbian. Further, the parts of her identity which lead to so called contradicting principles (being both Hispanic and lesbian) are aspects of herself which are impossible to change or ignore. Surely, a picture of integrity which refuses to attribute integrity to someone based on principles they hold as a result

of natural, necessary and unchanging aspects of their identity cannot be an ideal picture of integrity.

Identity Picture of Integrity

Calhoun describes the identity picture as “a matter of having a character and being true to it” (Calhoun, pg. 241) and as “fidelity to projects with which the individual deeply identifies” (Calhoun, pg. 242). This account focuses and expands on the “self” aspect of the integrated self picture of integrity by suggesting that integrity is achieved when a person acts in line with projects that have which are inextricably linked to their identity. This picture has mostly been informed by Bernard Williams’ work in “Moral Luck” (1982) and Jeffrey Blustein in “Care and Commitment” (1991). Williams’ goal in his papers was to protect the idea of integrity and individuals’ ability to achieve integrity by living their life in accordance with their established projects even when the moral dictates of utilitarianism and Kantian deontology demand that they abandon these projects, even if temporarily (Williams 1981, pg. 14). One of the strongest aspects of William’s argument is that he discusses the value of having integrity, not just in light of utilitarian and deontological demands, but in general. He argues that when identity-conferring projects are prevented from being acted upon, agents no longer have a reason to care about their future, the future of others, or the future of a system of morality (Williams, PCM, pg. 13-14). If a system of morality doesn’t allow someone to do the things that they identify with so closely and view as their purpose, that person is likely not going to continue living within that system of morality, whether that means ending their own life or not contributing to the maintenance of that moral system in society.

One of the weaknesses of Williams and Blustein's view is that, like the integrated self picture, the identity picture fails to properly account for the moral component to integrity. In other words, someone can have identity-conferring projects which they have committed to and act in accordance with which are immoral according to socially accepted standards of morality. Or, alternatively, one's projects may not necessarily be immoral in and of themselves, however one's identity-conferring projects might conflict with their moral obligations. In these instances, maintaining integrity on this account would require that the agent neglect their moral obligations in order to remain committed to their project.

Another flaw of the identity picture of integrity that Calhoun addresses is that often times, the projects to which we are committed are not necessarily linked to our identity. Similarly, the values that we might expect someone to be committed to given their identity are not always the values that person is actually committed to. Calhoun distinguishes between "psychological identification and endorsement" (Calhoun, pg. 243) to discuss this flaw. Psychological identifications are the aspects of our identity or personality which indicate what sorts of projects or values one might be committed to. For example, returning to Mr. Causabon, given that he is an academic (which is the psychological identification), one could reasonably assume that he is committed to projects and values such as curiosity, learning, honesty, perseverance, etc. Endorsements are the projects and values which the agent is actually committed to. In Mr. Causabon's case, this would include maintaining the appearance of a scholar. Calhoun presents the example of Duberman to illustrate why the difference between psychological identification and endorsement is necessary to understand and take into account in any good understanding of integrity (Calhoun, pg. 243). Duberman is a gay man who for twenty years, accepting the homophobic view that his homosexuality was a barrier to a happy life,

entered into conversion therapy. He quit and re-entered therapy several times, all while beginning and terminating relationships to participate in forced celibacy and frequenting gay bars in New York. It's clear that, although Duberman endorsed the principles of his conversion therapy, he could not identify with them. So, it would seem that the identity-conferring aspect of the identity picture is not a necessary requirement for integrity. It may be the case that the projects to which we are committed are also identity-conferring. However, consistently acting in such a way that is conducive to projects which are not identity-conferring, but which are endorsed by an agent, and which make their life worth living, does seem to be a necessary, yet not sufficient, aspect of integrity.

Finally, a third flaw of Williams' identity picture of integrity is that it does not account for the principles we hold or the choices we make which we do not feel deeply committed to. Being committed to and living in accordance with projects and principles with which one deeply identifies could certainly be argued to be a necessary component of integrity. However, what sort of demands does this account of integrity place on how we live with regard to the principles we hold and decisions we make which are not identity-conferring or deeply felt? Jeffrey Blustein writes that "not every instance of weakness of will, of acting contrary to one's better judgement, and not even repeated akratic failure necessarily indicates a lack of integrity, for what individuals fail to do might not be very important to them." (Blustein, pg. 100). In other words, the way we act and make decisions in relation to matters that are not identity-conferring has no bearing on our integrity. When it comes to what Calhoun calls "peripheral" values and principles (Calhoun, pg. 245), acting against our best judgement and interest, even if one does so consistently, doesn't constitute a lack of integrity. However, this seems counter-intuitive and ambiguous. How does each of us determine which principles we are deeply committed to and are identity-conferring

and which are “peripheral”? Furthermore, how do we infer the answers to those questions about others? For example, suppose almost everyone considers fidelity to their spouse to be a principle or value that they are deeply committed to. Now suppose one person consistently cheats on their monogamous partner. How are we to know if this person is failing to act with integrity or not? Even if it were established that this person holds fidelity to their partner as just a peripheral value, not something identity-conferring, it does not seem right to allow that they are still acting with integrity. Yet, this is what the identity picture allows. Calhoun succinctly summarizes this intuition by writing that “we expect persons of integrity not only to stand up for most deeply held and highly endorsed commitments, but to treat all of their endorsements as ones worthy of being held by a reflective agent” (Calhoun, pg. 245).

Clean Hands Picture of Integrity

While the previous two pictures of integrity have focused mostly on defining integrity in relation to the agent’s motivations and the validity of their commitments to their principles, this picture defines integrity in relation to the agents’ actions. Specifically, it does this in relation to how consistent they are in refraining from participating in the things which contradict their principles. While Williams’ work may have been a key factor in developing theories of integrity which fit into the previous category of identity pictures, it is the clean hands picture of integrity which he endorsed in his writing. In discussing integrity in relation to utilitarianism, Williams focuses on the fact that being a good utilitarian would sometimes require agents to act directly against their own principles (and, therefore, to act without integrity) in order to uphold or contribute to the greatest good for the greatest number. He writes that “A man who has such a ground project will be required by utilitarianism to give up what it requires in a given case just if that conflicts with what he is required to do as an impersonal utility maximizer when all the

causally relevant considerations are in. That is a quite absurd requirement” (Williams, pg. 14). This intuition reveals something we feel is essential to integrity. That is not endorsing or, more importantly to the clean hands picture, not participating in that which contradicts one’s deeply held commitments. Therefore, according to the clean hands picture “integrity is to view some actions as morally disagreeable apart from their consequences and to reflect that view in one’s actions and sentiments” (Calhoun, pg. 247). Given that this view of integrity is directed more towards actions and less towards motivations, it is more akin to Calhoun’s accepted social understanding of integrity (which will be discussed at the end of this chapter) than the previous integrated self and identity pictures.

However, much like the integrated self and identity picture, the clean-hands picture has its weak spots. For example, despite the fact that Williams argued that utilitarian theories were hostile to the notion of integrity (Blustein, *Williams and Integrity*, pg. 2), utilitarianism might actually shed light on a flaw of the clean hands picture of integrity that he endorses. Williams views utilitarianism as hostile towards integrity because it requires that we forfeit acting in accordance with our principles in order to act in accordance with the principle of utility – to maximize good for the greatest number. Sometimes one’s personal principles will fall in line with utility, but sometimes they will not, and it is in these instances in which agents are compelled to act without integrity. However, agents who subscribe to utilitarianism have their own, personal commitments as well as their commitment to the principle of utility. As utilitarians, they accept that their personal commitments will sometimes have to be neglected in order to fulfil their obligation to utility. Therefore, as Calhoun argues (Calhoun, pg. 249), it seems wrong to categorize an agent as not having integrity simply because one of their principles has won out over another, especially when the winning principle (in this case utility) is one

which requires that agent to have such admirable qualities as empathy, generosity and selflessness. This consideration illustrates that neither cohesiveness nor consistent action in accordance with one's identity conferring principles are necessary aspects of integrity.

Another need for clarification within the clean hands picture is outlined by Calhoun as follows: "How does lacking integrity differ from weakness of will?" (Calhoun, pg. 250). If, according to the clean hands picture, acting *with* integrity means endorsing your principles by acting in accordance with them, then acting *without* integrity would occur when an agent fails to act in accordance with their own principles. This echoes what Taylor characterized as "weakness of will" – a failure to act with integrity. Does this mean that every time an agent fails to act in accordance with their principles they are lacking integrity? Calhoun has argued that even "peripheral" values and principles have a bearing on one's claim to integrity (Calhoun, pg. 145). Does this mean that minor lapses in one's willpower regarding more trivial things that they have committed to, such as a diet, constitute a lack of integrity? Does the regret that one feels as a result of this lapse in willpower have any effect on whether or not we can forgive the transgression of the agent and still afford them integrity? In answer to these questions, Calhoun writes that "Integrity becomes an issue – something that one risks losing and must act to preserve – particularly in contexts where there is some incentive to act on someone else's best judgement" (Calhoun, pg. 250). Weakness of will occurs often; cheating on a diet and procrastinating tasks that require one's attention are both examples of a weak will. But giving in to minor weaknesses does not always constitute a lack of integrity. Calhoun is arguing that one is at risk of losing their integrity, *not* when they fail to act in accordance with their principles because of a slight lapse of will power, but when they submit to being coerced away from their principles by outside forces;

when they choose not to act in accordance with their principles to secure some sort of gain, status or approval (Calhoun, pg. 250).

Calhoun uses Williams' example of George the chemist to further illustrate this clarification (Calhoun, pg. 251 and Williams, 1973). George, a chemist and opponent of chemical warfare, is offered a research job in chemical warfare. The utilitarian offers George the job because of his qualifications as a chemist, and says that he should take it to prevent the job from going to the zealous supporter of chemical warfare. George thinks that he ought to refuse to take the job on the grounds that no one should have to develop this sort of research which may lead to terrible consequences. He also wants to avoid taking this job because it would make him complicit in the research to which he is morally averse. On the other hand, there are reasons why he should take the position: 1. Because it will prevent a pro-chemical warfare researcher from accepting the job and doing potentially more harm than George would. 2. To avoid the blame and condemnation that he would receive from utilitarians, other opponents to chemical warfare, and his friends and family who might complain that his actions have caused them to be in danger. On Calhoun's account, to override his personal commitment not to dirty his hands of involvement in chemical warfare is permissible and does not necessarily lead to a loss of integrity if his reason for doing so stems from option one. This is because another principle which George himself has determined is worthy and ought to take priority (the principle of utility – preventing many others from suffering from chemical warfare) was acted in accordance with. However, if he chose to accept the job because he feared reproach from utilitarians, opponents of chemical warfare, and his friends and family, this would constitute a loss of integrity.

Calhoun's Social Picture of Integrity

The three aforementioned pictures of integrity suggest several reasons for why one should value and strive for integrity. They all present an idea that it is either our autonomy, agency, or character that it is the reason we ought to act with integrity (Calhoun, pg. 253). However, in assessing integrity, particularly in relation to conscientious objections in healthcare, it is important to include an assessment of how our relations to other people are affected by what integrity requires of us. Further, it is essential to understand what sort of bearing those relations have on our integrity. The role of integrity in the case of a conscientious objection has often been to justify the health care professional's right to refuse to provide services to their patient. Therefore the healthcare professional's integrity has a direct and, in this type of setting, very intimate effect on someone else; the patient. The character of the relationship between the health care professional and the patient provides additional reason for assessing the role of integrity here, but that will be discussed in a later chapter. The important thing to observe is that integrated self, identity and clean hands pictures of integrity do very little to recognize that our decisions are not made in a vacuum and that there is a social component to what makes integrity valuable.

Calhoun distinguishes between three different kinds of virtues; personal, social and virtues that are both personal and social (Calhoun, pg. 253). For example, she names temperance as a personal virtue in that it involves the way we act in relation to ourselves. Those who have decided for themselves that they should not drink alcohol act with temperance when they follow through with this decision. The social category includes virtues such as civility. They are achieved by acting appropriately towards our peers. Finally, Calhoun argues that self-respect is an apt example of a virtue that is both personal and social. She writes "Self-respect, for instance, might be thought to involve having both a proper regard for one's own moral status (and thus the

right relation to oneself) and a proper regard for one's place among other moral beings (and thus the right relation to others); it is a virtue exercised both by holding oneself to standards and by demanding rightful treatment from others” (Calhoun, pg. 254). Because the notion of self-respect requires that we regard ourselves as both an individual and as a member of a community, it is both a personal and a social virtue. The three aforementioned pictures of integrity capture the personal aspects of integrity. They place value on personal notions such as autonomy and agency. Character, in comparison to autonomy and agency at least, is more other-regarding. Yet, some of the earliest evaluations of character from ancient philosophers such as Aristotle define character as an individual state of being – dependent on the relation between an agent and certain virtues. “Excellence [of character], then, is a state concerned with choice, lying in a mean relative to us, this being determined by reason and in the way in which the man of practical wisdom (phronimos) would determine it.” (Nicomachean Ethics II.6). However, integrity is both a personal and a social value and these pictures fail to acknowledge and address the ways in which integrity is connected to our relationships with those around us. Calhoun describes this failure in the following way: “Characterizing integrity as a purely personal virtue does not imply that there is anything self-indulgent about striving to have integrity. But it does imply that integrity is not essentially connected to how we conduct ourselves among others and that its fitting us for proper social relations is not what makes it a virtue” (Calhoun, pg. 254). In other words, what is missing from the integrated self, identity and clean hands pictures is an unpacking of the ways that integrity necessarily informs the way that we act towards those around us. And what is also missing, perhaps even more importantly, is that what makes integrity valuable is the fact that it is social – that it properly prepares us for navigating relationships with our peers whether these relationships be personal, professional, etc.

Calhoun puts forth two arguments in support of her claim that integrity is both a personal and a social virtue. The first argument stems from the idea of “standing for something”, which is so often linked with the idea of integrity. For example, the clean hands picture of integrity implies that agents must stand for something by refusing to participate or affiliate themselves with projects which they deem are immoral. However, simply excusing oneself from decidedly immoral projects does not seem like it would necessarily meet the requirements of standing for something. Indeed, arguments which aim to support the right of physicians to protect their integrity by refusing to provide services to which they conscientiously object often include arguments against the requirement to provide referrals for these procedures as doing so would make the physician complicit (Pellegrino, pg. 240). In these cases, the argument made is that, to maintain one’s integrity, it is not enough that the physician refuses to perform the objectionable service themselves, they must also stand for their principle by doing what they are capable of to prevent the service from happening at all, even if not by them. Therefore, perhaps even the clean hands picture of integrity does not properly account for the aspect of integrity that requires that we stand for something.

Calhoun illustrates the difference that standing for something has when integrity is understood as just a personal virtue and as one which is necessarily social with an example from Bill Clinton’s surrender to the homophobic views of the members of the U.S congress over the ban on gay military members (Calhoun, pg. 254). Clinton’s actions lack integrity, not only because he acted contrarily to what we assume his personal convictions were (that there is no reason that gay people should not be allowed in the military), but, most importantly, because he failed to articulate and represent the importance of this conviction to his community. Perhaps in his personal life he stands by his conviction – discusses with friends and family that the right

thing to do would be to allow anyone in the military regardless of their sexual orientation. It seems integrity (understood as a personal virtue) would be achieved by standing by one's convictions this way. However, understanding integrity as a social virtue requires that we consistently stand for our principles – meaning that we endorse them, not only by acting in accordance with them, but by arguing that others should also act in accordance with them. This is because convictions and principles are not only things that we find true *for us*, they are things that we view as true *for everyone*. Integrity in this sense “seems tightly connected to viewing oneself as a member of an evaluating community and to caring about what that community endorses” (Calhoun, pg. 254).

An advantage of understanding integrity as a virtue that is both personal and social as opposed to merely personal is that, in requiring agents with integrity to stand for their principles in front of their peers, we are facilitating communal deliberation about what is worth doing in life. The dialogue which must be present in order for what is worth doing to be discovered must be propelled by individuals' honest and unrestricted endorsement of the principles they have decided should guide what is worth doing. As Calhoun argues: “the discovery of truth would seem to depend not just on the freedom to speak, but also on the integrity of the speakers, that is, on their commitment to publicly standing for their own best judgment of what the truth is” (Calhoun, pg. 456). In standing for our principles, we are acknowledging that we are a part of a community of deliberators; that the way we live affects how others can live, and that the only way we can determine the best way to live is by having genuine discussions about it. Stephen Tyreman further develops this idea by suggesting that arriving at the truth of what is worth doing cannot be accomplished unless integrity is understood socially (Tyreman, pg. 113). It is counter-intuitive to accept that complex moral issues can be sufficiently wrestled with in order to come to

a conclusion about what is worth doing by simply assessing our own principles and conscience. This suggests that our consciences are indicative of universal moral truths, or, at least, truths that might be endorsed by the community of deliberators of which we are a part. Given the variety of perspectives among people, it is reasonable to assume that this will often not be the case. This helps further solidify integrity as virtue, specifically, as a social virtue. It can be difficult to assess the value of integrity when it is understood as a purely personal virtue. However, when we consider the social aspects of integrity; namely the fact that standing for our principles in front of our peers contributes to a common project (which is the discovery of what is worth doing, or, as Calhoun refers to it, “truth or co-legislable principles” (Calhoun, pg. 256).) the role of integrity as a virtue becomes more clear.

Not only is it advantageous to acknowledge that integrity is essentially social in nature, but it is necessary in order to determine the truth of what is worth doing. Individuals must accept that their principles and their convictions matter to others, not only because our actions (which, if we have integrity, are informed by these convictions) can directly affect those around us, but because the collective principles of a community are what determine what that community deems worth doing.

Calhoun’s understanding of integrity as a social virtue has many applications to the topic of conscientious objections in healthcare. For example, in closing her essay, she states the following: “acknowledging others are deliberators who must themselves abide by their best judgement seems part of, not exterior to, acting with integrity” (Calhoun, pg. 260). She also writes “if we are not pulled as far as uncertainty or compromise, integrity would at least demand exercising due care in how we go about dissenting” (Calhoun, pg. 260). Calhoun’s view demands that we somehow reconcile the vast differences in views and opinions between co-

deliberators. It also demands that civility and respect for others' opinions be exercised, even when they are deemed unworthy or undesirable. However, this does not mean that others' principles must be honored. In fact, the final chapter of this thesis will illustrate that principles held by physicians which inform their decision to object to providing certain services should not be honored, and their objections should not be accepted. I suggest that my arguments made in favour of this conclusion are stronger because they are made in light of the above-mentioned requirements of Calhoun's view of integrity.

Chapter Two: Physician Integrity

I Harm to Physician Integrity

Given the ambiguous nature of “harm”, it is not immediately evident that requiring physicians to provide services to which they conscientiously object would cause harm to them. In order to properly address the effect of being compelled to act against one’s conscience, we must first unpack and define the notion of harm. This will be accomplished best by explaining the understanding of harm of which I am a supporter, I will first briefly discuss a theory of harm which I do not agree with. For example, I believe that Donald Vandever, in arguing that offence is a harm, misrepresents harm. He writes that “To be offended is, by definition, to suffer distress or anguish and is correctly, for that reason, a case where a harm occurs in one of the traditional understandings of “harm” (though by no means the only one)” (Vandever 1979, pg. 177). It seems more intuitive to me that, while offence and harm can occur in tandem, they are separate; offence is not a harm. Vandever provides an example of a racial slur being directed at a person of colour. What is harmful about this event is not the offence that is felt by this person. It is the reinforcement of racist views which harm individuals personally by suggesting that they are undeserving of basic respect (among countless other things) and socially by promoting these views and contributing to the denial of rights to people of color. This is not to say that the offence in this case is not significant – just that it is not the same as harm.

An understanding of offence and harm which I believe is closer to getting it right is that of Jeremy Waldron. Towards the end of his discussion of offence and whether or not it is a harm, Waldron writes that we ought to “drive a wedge between offence and harm, while at the same time maintaining an intelligent, rather than primitive view of what it is for a vulnerable person to

be harmed in these circumstances” (Waldron 2012, pg. 130). Waldron’s focus on the vulnerability of the harmed person and the circumstances in which harm and offence take place invite us to pay attention to the significance of context and subjective nature of harm. This is more in line with the Carolyn McLeod’s view of harm, given her discussion on how women’s particular station in society makes her more likely to be harmed by being denied emergency contraceptives.

In “Harm or Mere Inconvenience: Denying Women Emergency Contraception” (which will be discussed in the next chapter as well), Carolyn McLeod, in keeping with Joel Feinberg’s definition of harm (Feinberg 1984, pg 32), understands harm to be a “setback to an interest” in which an interest is “something in which we have a *stake*, meaning that we are better or worse-off depending on the condition of this thing (e.g., our reputation, our family)” (McLeod 2010, pg. 17). A physician who conscientiously objects to providing some treatments or services has an interest in distancing themselves from those treatments or services for the purpose of maintaining their integrity. They may also have an interest in preventing patients from accessing such services from other physicians by refusing to provide referrals to patients. This is because, in understanding the treatment or service to be immoral, they are interested in preventing it from being performed at all, whether it be by themselves or others. Being compelled to provide these services or to refer patients to a physician who will constitutes a setback to the aforementioned interests. One who believes and argues to their peers that abortion, for example, is immoral, yet regularly performs or refers patients to colleagues who will perform abortions experiences regular setback to their interest of maintaining their integrity. This harms the physician because (as illustrated in chapter 1) they are made worse off by regularly acting against their conscience and knowing that they do not have integrity.

Further, Feinsein writes “A *harmed* condition of a person may or may not also be a *harmful* condition, depending on whether it has itself the tendency to generate further harm. A blistered finger may be to some small degree a harmed condition, but unless the finger is on the hand of a concert pianist or a baseball pitcher, it may not be at all harmful” (Feinsein 1984, pg. 31) The intention here is to highlight that we determine, in part, whether actions, judgements or states of being are harmful or not based on the context in which they are occurring. Laws which compel physicians to provide legal medical services when they are requested (no matter how divisive they may be) only harm physicians who have moral reasons to avoid providing those services.

For non-religious people, or people whose conscience and moral reasoning indicate to them that medical treatments which are often objected to, such as abortion and physician assisted suicide, are moral or at least morally neutral, the fact that there is genuine harm experienced by physicians when they are compelled to act against their conscience can be unfathomable or difficult to understand. After all, legislators and professional healthcare institutions have affirmed the morality of abortions and physician assisted suicide. Many physicians knew about the legality of these procedures when they were becoming a doctor, and in practice they are sure to have experienced being asked to provide these procedures or to have stood by while their colleagues willingly provided them to requesting patients. However, it ought to be acknowledged that some health care professionals, particularly doctors and nurses (who can develop close, meaningful relationships with those they help), did not choose their profession or moral aversion to some of the treatments it condones, such as abortion and physician assisted suicide. For some, it is a calling towards healing, caring, saving, etc. which led them to a health care profession (Cowley, 2016, pg. 362), and while it is the case that responding to a “call” to heal or participate

in the medical profession may be a choice for some and less of a compulsion, those whose call comes from a religious source do not make a choice. This is because, according to their beliefs there is no choice to make; doing what they have been called to by God is a necessity (Pellegrino 2002, pg. 239). Teachings from the Bible, Torah, Quran, etc. might inspire their vocation to heal. They might see the medical profession, in so far as its objective is to heal and save, as a religious act in itself and their abilities as a gift from God (Pellegrino 2002, pg. 239).

The non-religious conscientious objector also experiences genuine harm when they are compelled to perform abortions or provide physician assisted suicide against their conscience. Their moral principles, while not grounded in religion, can still be felt deeply, and can be understood as a part of one's identity. For example, Pellegrino writes that "to ignore this "inner voice" is to induce guilt, remorse and shame. Only the amoral sociopath escapes the grips of conscience" (Pellegrino 2002, 237). Here, the "inner voice" indicates one's conscience, which does not disappear when we are no longer faced with a moral decision to be made. Feelings of guilt and shame over doing what one feels to be objectively wrong, and remorse for who they believe to be the victim of their actions (an aborted foetus or a sick patient who requested physician assisted suicide) persist long after they provide the procedure or treatment. In addition to feelings of guilt, remorse and shame, practitioners may experience a loss of self-respect, a loss of sense of self, and harm to the partnership between them and their patients (Birchley 2012, 16).

There are many debates surrounding what ought to be the nature of the patient-physician relationship. The territory is decidedly shifting in favour in patients' autonomy. For example, some argue that paternalistic models of this relationship no longer serve patients as well as a model in which patients and physicians collaborate and foster an open dialogue regarding treatment (Raina, Singh, Chaturvedi, Thakur, Parihar 2014, pg. 2). Others, such as Greenblum

and Kasperbauer (2018) focus on social equality between the physician and patient. They argue that, because the patient is in a position of vulnerability while the physician is in a position of power and because the physicians are public employees, it is essential that physicians treat patients as social equals. What kind of authority and guidance should a physician provide to a patient? To what extent can a physician make assumptions about what is best for her patient? Does the patient have any role in the relationship beside being the one who is receiving treatment? One thing that ought to be present in the patient-physician relationship regardless of the answer to these questions is that there should be mutual respect between the two. As Greenblum and Kasperbauer argue “it is not enough, in other words, for the physician to treat the patient. The physician must treat their patients with the respect befitting a social equal.” (Greenblum & Kasperbauer 2018, pg. 316). A physician who does not respect her patient may be less motivated to provide the highest quality healthcare that they can and a patient who doesn't respect their physician may interrupt their medical care and impose burdens on patients and other healthcare practitioners around them. However, a physician might feel that in expecting them to provide a service to which they conscientiously object, the patient is not respecting the physician. This may lead to the physician refusing to see that patient again or not providing the best care they can when they do treat that patient. In this case one of the results is that both the patient and the physician are harmed.

In evaluating the summary of all the ways in which physicians are genuinely harmed by the lack of protection that is afforded to their conscience and integrity by facilitating conscientious objections, it becomes clear that long-term repercussions must develop. A study performed by Gustafsson, Eriksson, Strandberg and Norberg (2010) indicates that, in the medical profession, continually acting against one's conscience contributed to early burnout in healthcare

professionals. This applies specifically to doctors, of which Canada is already experiencing a shortage (Gandhi, 2017).

Although the harm that is experienced by physicians when acting against their conscience is evident and arguably good reason to protect their right to object, some theorists insist that even if physicians made an effort to reject their conscience and operate with value neutrality, this would be impossible. ““For a physician with deep religious commitments, a “value free” stance on certain issues is simply unthinkable”” (Pellegrino 2002, 239). The thought of acting against one’s conscience may be inconceivable to some religious objectors. Moreover, a physician’s values are, intentionally or not, communicated to patients in a variety of verbal or non-verbal ways. Stanley Milgram’s infamous shock experiment illustrates this well (Milgrim 1963, pg. 371-378). Upon putting on the white lab coat, the “experimenter” (person who was administering the “shocks”) displayed almost immediate feelings of authority, power, etc. (Peppin 1997, pg. 46). A physician’s body language, the way they frame information, the way they dress, all of these things can convey their values to a patient, whether the physician intends to or not. And some of what is being communicated is simply the result of their title, or their role (as illustrated in Milgram’s shock experiment), so one can imagine that what is being communicated by those with genuine, deep, religious and moral commitments, having little to do with their profession, will be clearly communicated even without the physician’s intention.

II Value of Physician Integrity

In an essay entitled “On a Certain Blindness in Human Beings”, William James wrote the following: “wherever there is conflict of opinion and difference of vision, we are bound to believe that the truer side is the side that feels the more, and not the side that feels the less.”

(James 2009, pg 6). In debates surrounding conscientious objections in healthcare, whether unconsciously or unintentionally, we tend to gravitate to this way of thinking. Specifically, we tend to survey who is more hurt by policies regarding conscientious objections. Is it the patient, from whom legal medical treatments and procedures are withheld? Or is it the healthcare professional, who may be compelled to provide services to which they conscientiously object? Here, I address the latter. Particularly, I discuss the ways in which a physician's conscience is harmed when they are compelled to act against their conscience and provide medical treatments and procedures to which they morally object. Yet, it may be argued that the medical profession is based in science and that the integrity and conscience of the physician is an irrelevant or potentially obstructing aspect of healthcare that ought to be avoided. However, I don't believe this to be the case. Therefore, I will first establish that it is desirable to foster a medical profession which allows and encourages physicians to act with integrity. Finally, after acknowledging the value of physician integrity, I will unpack an argument inspired by Alberto Giubilini (2014) which illustrates that, while valuable in some ways, physician integrity cannot justify conscientious objections to safe, legal medical treatments and procedures to which patients have a right to access.

Working in healthcare in any role is a stressful, high-stakes career. Everyday decisions must be made which immediately affect the lives of patients. Activities and decisions routinely occur in modern day healthcare that are difficult to navigate. There is an entire academic discipline devoted to exploring healthcare-related questions and considering any ethical, legal, political, economic and environmental interests at stake when answering these questions: bioethics. However, sometimes professional recommendations from healthcare institutions (such as the Hastings Centre) whose main focus is bioethics are unsatisfactory in answering difficult

moral questions. Competing interests including loyalty to colleagues, professional hierarchy, patient wishes, directives from superiors and one's own conscience may factor into a practitioner's decision making. (Birchley 2012, 13) How one ought to weigh the importance and influence of these competing interests is not always clearly laid out in recommendations from professional bodies. Physicians must be able to use their conscience to navigate these competing interests while making these tough decisions. While most of us would intuitively agree that respecting patient wishes is a far more relevant ethical consideration than colleague loyalty, without a conscience, a physician might weigh loyalty to colleagues as equally as important as patient wishes. And while it may be the case that some physician's consciences will mistakenly indicate to them that collegial loyalty is of higher ethical importance than respecting patient wishes, it is reasonable to assume that this would occur in a small percentage of cases. Therefore, it is better to protect physician integrity and foster their ability to make decisions in accordance with that integrity, although a small percentage of those decisions may be flawed, than to prevent physicians from acting with integrity at all.

In addition to its contribution to ethical decision making, another reason that physician integrity and their ability to act according to their conscience ought to be protected is because it will prevent the unethical, illegal and otherwise harmful avoidance of certain medical treatments by objecting physicians (Birchley 2012, 14). One may argue whether or not it is at all useful to discuss physicians' conscientious objections to medical procedures. Having had the dedication and intellect to complete medical school along with competitive internships and residencies and the resiliency to succeed in a profession which can at times seem more draining and thankless than rewarding, physicians are not submissive or compliant people. By not protecting their ability to safely object to a certain treatment, we are not ensuring that physicians will provide

those treatments. One can imagine several ways by which a physician might avoid providing a service to which they object without openly conscientiously objecting to it. They might switch assignments with a colleague if they feel that they might be asked to do something which is contrary to their conscience, for example. It is even conceivable that a physician might neglect to offer, or misrepresent relevant medical information to patients if they feel that to provide that information would lead to the patient requesting a procedure to which they feel they have a moral obligation not to provide.

Some philosophers, such as Edwin Pellegrino, worry that failing to protect a physician's right to conscientiously object and compelling them to provide services which they are morally against will eventually lead to religious physicians, or physicians who are transparent about their ethical objections, being screened out of, or discouraged from applying to medical school (Pellegrino 2002, 234). After all, it is already being recommended that religious applicants to medical school and medical internships do not specialize in gynecology and other reproductive health-related specialties where they would be expected to provide abortions more often than in other areas of medicine (Pellegrino 2002, 234). At the very least, potential medical school applicants may lose interest in the medical profession when they consider that they might have to provide medical treatments which they feel are morally wrong. There is a plethora of online and newspaper articles, such as one published in the Huffington Post titled "More Bad News for Family Medicine and Patients" (Gandhi, 2017), which illustrate that embarrassingly long wait times for treatments and surgeries, over-crowded hospitals and a crisis in access to mental health are the result of an overwhelming shortage of doctors in Canada. By not providing explicit protection to a physician's right to conscientiously object to certain medical treatments, we are contributing to this shortage of doctors.

Fostering a healthcare profession in which physicians are free to act in accordance with their conscience and protect their integrity is not only desirable because it avoids unwanted problems such as doctor shortages and surreptitious avoidance of certain treatments. There are also positive advantages to this sort of protection. For example, Birchley writes that “junior staff, being less accustomed and desensitized to the peculiarities of their environment, may have an outsider’s insight into the ethics and practice that more senior and experienced practitioners have lost.” (Birchley 2012, 16). Once laws are made, debates regarding that law can sometimes be reduced to discussion of the pragmatic and procedural aspects of the law and neglect its ethical components. (Pellegrino 2002, 222). In other words, the morality of the law itself and the moral implications that it has for a society are no longer up for debate. By allowing all physicians with genuine moral objections, but new physicians in particular, to object to medical procedures, we are encouraging and fostering discussions about the ethical content of laws surrounding conscientious objection and any other topic. Perhaps there are aspects of the law which require updating. The medical profession can change rapidly, technological advances specifically may require that health care professionals have meaningful discussions about the ethics of their practice; conscientious objections may incite these meaningful discussions.

Finally, there may be something intuitively wrong about a healthcare profession which would compel physicians to provide abortions or physician-assisted suicide when their conscience won’t allow it. Childress writes that to do so would be “*prima facie* a moral evil” (Childress 1979, 330). Birchley argues that a healthcare institution operating without a conscience would be “troubling” (Birchley 2012, 13). Crowley writes the following:

“Medicine is not a normal job and demands so much more from practitioners than merely fulfilling a contract. The best doctors are those who identify with the role and who are

motivated to go beyond their contractual duties on occasion without carrots and sticks, and who have an understanding of a job well done that is separate from remuneration and promotion” (Crowley 2016, 262).

It is worth exploring why supporting a healthcare institution which would encourage or go as far as to compel physicians to act against their conscience elicits a negative gut response.

Countless thought experiments have been entertained in philosophy classes in which students are asked whether they would hypothetically prefer to be treated by a physician who is human, sometimes makes mistakes, but acts with integrity and according to their conscience one hundred percent of the time or a robot who never makes a medical mistake, but who has no conscience or moral integrity. What is it about conscience and integrity that make someone a better physician or health care professional? This thought experiment illustrates what one might argue is that answer to this question. It does so because it highlights what is difficult to accept about a physician who operates without conscience. Without conscience, and a will to protect one’s integrity, physicians might not be motivated to go above what they are professionally expected to do in order to help a patient. They might not be motivated by empathy for their patient and the need to feel as if they have done all they can do to stay late and work harder in order to find a solution to a problem which someone out of touch with their conscience might have mistakenly conceded doesn’t exist.

III Physicians’ Conscience, Social Integrity and Moral Relativism

Thus far it has been shown that physicians are genuinely harmed when they are compelled to provide services to which they conscientiously object; doing so violates a practitioner’s integrity. It has also been illustrated, for many reasons including fostering good

decision making, preventing the shortage of doctors in Canada and encouraging continual moral evaluation of health care laws, that it is desirable to protect a physician's right to conscientiously object. However, when comparing a physician's right to conscientiously object with a patient's right to act with integrity by insisting on her right to access legal medical treatments, one must be more critical in their scrutiny of physician integrity and its role in conscientious objections. For example, it is not sufficient to ask whether compelling a physician to act against their conscience causes harm and if that harm is undesirable. Some theorists argue that essays which challenge a physician's right to conscientiously object, such as "Doctors Have No Right To Refuse Medical Assistance in Dying, Abortion or Contraception" (Savlescu and Schuklenk, 2016) disvalue the role of conscience and integrity (Birchley 2012, 14). This is notable for two reasons. First, it illustrates why it is important to defend patients' right to access abortion and physician assisted suicide from the perspective of *patient* integrity. In doing so, we avoid devaluing integrity, and we illustrate that healthcare professionals are not the only ones whose integrity is at stake in these situations. Second, by critiquing most challenges to the protection of rights to conscientiously object as neglecting the value of physician integrity, one implies that the only defence that physicians and theorists have in support of conscientious objection is integrity. However, there are many arguments in favour of limiting conscientious objection and supporting a patient's right to services which manage to value physician integrity.

For example, an argument in favour of a physician's right to conscientiously object by Birchley, when considered from the point of view of Calhoun's social understanding of integrity, actually results in the potential limitation of conscientious objections and the defence of patient access to medical procedures. Birchley argues that current laws regarding moral objections to physician assisted suicide and abortion are insufficient (Birchley 2002, 15). The law does not

benefit the patient, from whom legal medical services are withheld or at least made more difficult to access. They also do not benefit physicians; since there is no explicit protection for physician conscientious objection, practitioners may be forced to try to find ways to hide their moral objection or be compelled to act against their conscience. The critics of current laws who argue that they should be improved by limiting conscientious objections by physicians and protecting patients' right to access services fail to acknowledge that doing so will not lead to better access to services, but instead to more extreme methods of avoiding those services by practitioners who morally object to them. Perhaps the only way to improve the law is to go in the other direction – fully protect genuine moral objections to certain services by physicians. In providing them full protection, we can ensure that they are also fully regulated. In legitimizing and regulating the process by which physicians conscientiously refuse to provide services, we can discover and throw out illegitimate objections (Birchley 2002, pg. 14). We can understand “illegitimate” refusals to provide services as refusals which are not religiously or morally grounded. Refusals which are rooted in sexism, racism, and homophobia, for instance, while the physician may call them moral reasons, are immoral and so the refusal should not be accepted. What to do in these instances where a doctor's attempt to refuse providing treatment for an immoral reason, such as racism, is unclear; the quality of care that we can expect from that physician is questionable and the experience of the patient being treated by a doctor who is prejudice towards them will likely be a negative one, however this requires an entirely separate discussion. “[R]equiring practitioners to give accounts of their actions would prompt personal reflection on the ethical appropriateness of their actions, and the impact of their objection upon other staff and patients that might be missing from private avoidance” (Birchley 2002, pg. 15). Not only does an institutionalized system of facilitating conscientious objections allow us to

identify illegitimate objections and deny them, but it may encourage objecting physicians to consider all relevant implications of their actions which might result in their refraining from objecting in the future.

Birchley's argument in favour of protecting a physician's rights to refuse services in order to regulate them and encourage critical discussion regarding conscientious objections is partly compatible with Calhoun's social sense of integrity. By requiring physicians to give accounts of their moral objections, we are requiring them to stand for their moral principles, not, however, in the way that Calhoun requires in her social understanding of integrity (Calhoun 1995, pg. 254). Although it is arguably admirable of physicians to openly refuse to act against their conscience and protect themselves from doing what they believe to be morally wrong, Calhoun's social understanding of integrity requires that moral agents stand *for* their principles by encouraging their peers to act in accordance with their conscience. After all, physicians who object to abortion hold that it is universally wrong to perform every time, not just for themselves. However, Birchely's argument is clearly compatible with Calhoun's social integrity in that it not only encourages, but requires that physicians engage in critical discussion with their co-deliberators regarding the reasoning behind their moral objections. Although Birchley intends for this argument to protect a physician's right to object, the truth is that critical examination of the reasons for their moral objections might prove them all to be illegitimate. As aforementioned, illegitimate reasons for a conscientious refusal include racist, homophobic, sexist and otherwise prejudiced reasons. However, the root of a moral objection can be found illegitimate for additional reasons. What we are evaluating when we hear a physician give an account of their refusal is two things. First is the sincerity of their moral objection; whether or not they genuinely feel that providing an abortion or physician assisted suicide goes against their conscience, and

whether or not their integrity would be seriously harmed if they were compelled to provide these services. Second is the evaluation of *why* they feel that providing these services is immoral (Giubilini 2014, pg.174). Here is where illegitimacy can be found in their objection. Their objection can be illegitimate because it is based in prejudice, as previously shown. It can also be illegitimate because it is factually mistaken. For example, a pharmacist may refuse to provide Plan B because they believe it is abortifacient when, in fact, it is not (Giubilini 2014, pg. 174). Finally, it can be found to be illegitimate because the moral reasoning in which it is grounded cannot be substantiated. In a predominantly secular community, efforts to ground one's conscientious objection in their religious beliefs or their beliefs in God should be labeled illegitimate because there is no substantial evidence to support the existence of a God, and therefore there is no reason to believe that any of the rules of conduct which have supposedly been dictated by God are authoritative. We cannot surrender a patient's right to access safe, legal medical services because their physician insists on living in accordance to the moral dictates of a God, the existence of which cannot be proven and is widely denied by the physician's community.

In a later chapter I say more about religious justifications for conscientious objections to abortions and physician assisted suicide. I argue that arguments based in religion are not sufficient to allow health care professionals to prevent patients from accessing these treatments. There are two reasons for this. The first, which I have already mentioned, is that arguments based in religion are unsound; they cannot be verified. The second is that what is at stake for patients in these circumstances is more important than respect or tolerance for refusals that are based in unverifiable religious beliefs. It is important to note that my conclusion that refusals based in religion should not be permitted depends on *both* of these reasons. My claim is not that

no religious reasons, for any decision or exemption, no matter how deliberate and sincere should ever be accepted. My claim is that, in instances of conscientious objection, arguments supporting a physician's right to refuse must be incredibly strong to justify the harm that patients suffer when they encounter an objection. Religious arguments are not strong arguments. However, religious justification can be accepted for other exemptions. Standardly, religious people are granted time off from work to observe and participate in religious practices. Accommodations are often made for religious people so that they might pray, privately, if required by their religion. Section two of the Canadian Charter of Rights and Freedoms protects individuals' freedom of religion, and their ability to practice their religion in the aforementioned ways by taking time off work, which I argue is a good thing. The reason that it is good thing to afford people these exemptions based on religion (in spite of the fact that their reasons for requiring the exemption is bad) is that doing so fosters integrity and tolerance without creating any significant adverse effects for others. Contrarily, when the same exemptions are granted for conscientious objections to abortion and physician assisted suicide, based on the same religious reasonings, the result is significant harm for the patient. Evaluating the legitimacy and soundness of arguments based in religion is a difficult task because it involves all sorts of presumptions about the thousands of difference religions around the world, about the existence of deities, the reliability of religious texts, the value of religious beliefs and the positive and negative results of organized religion. One could write an entire dissertation on each of these concerns and still not come to an adequate and satisfying answer regarding any one of them. I do not attempt with this project to convince anyone of the merits (or lack-there-of) of any one religion or religion in general. However, according to Calhoun's social theory of integrity, we have a duty to evaluate principles and the justification for principles. Given the importance of policies regarding conscientious

objections for patients, and pregnant women in particular, the reasons one might conscientiously object should be evaluated especially thoroughly. Thorough examination in this case reveals that religious arguments cannot be proven, and that the integrity and tolerance that would be afforded to physicians by supporting their right to conscientiously object, is not enough to justify how this would harm patients.

Chapter Three: Patient Harm, Patient and Institutional Integrity

In nearly all the work I have come across in the areas of conscientious objection and integrity in relation to conscientious objections there is some discussion of the effect that a refusal of treatment has on the requesting patient (Savulescu and Schuklenk, 2016, Brock, 2008) These effects are of particular importance in cases of conscientious refusals to provide reproductive healthcare services such as abortions or end of life care such as active euthanasia or physician assisted suicide. This is because a life is at stake in each case; the life of the patient themselves in the latter two examples, and the potential life of the fetus in the former. I have devoted this chapter, in part, to reviewing the harm that is suffered by patients when they are denied these services for the following reason: surveying the harmful experience of patients when they are denied legal medical services will inform our understanding of why deliberators, in Calhoun's sense, have strong commitments to their principles regarding bodily autonomy, abortion and physician assisted suicide. This understanding will help us to make sense of how the refusal to provide services prevents patients from acting with integrity. While this will be the primary objective of this chapter – to unpack the harm experienced by patients when they are denied service – I will also, in the final section of this chapter, discuss institutional integrity. In this section I defend the position that the notion of institutional integrity is valid, that it is significantly affected by conscience clauses which allow an institution's physicians to conscientiously object to services, and that the resulting effects have an impact on how well hospitals operate and how they care for their patients.

Section I Harm to Patients

I preface my discussion of the harms that patients suffer when they are denied legal medical services (particularly reproductive health services) by making clear something that may

be evident in previous chapters; I classify an unwanted pregnancy as an emergency, and support the rights of women to seek out and access legal treatments to prevent or terminate a pregnancy. And, while I will not spend any much space here discussing the morality of abortion, an argument presented by Elizabeth Fenton and Loren Lomasky (2005, pg. 582), which is also discussed and critiqued by Carolyn McLeod (2010, pg. 13) has persuaded me that a brief overview of why it is essential to argue for the protection of access to reproductive services will further strengthen my argument regarding patient integrity.

Writing in support of the right of pharmacists to refuse to dispense emergency contraception, Fenton and Lomasky say the following: “[whether] averting an unwanted pregnancy can ever count as an emergency is precisely the crux of the parties' dispute. The pharmacist who insists on a right of conscientious refusal maintains that it is the nascent human life that is in dire jeopardy, not the prospective mother” (Fenton and Lomasky 2005, pg. 582). In other words, we can expect health care professionals not to take seriously the direness of the requests of pregnancy prevention or termination services from patients because they do not see the outcome of those services (the prevention of pregnancy and gestation) as something that ought to be desired; in fact according to these views it is something that should be avoided. This likely explains the morally and legally reprehensible actions that some health care professionals have engaged in in order to prevent patients from accessing some reproductive treatments and procedures. According to Christian Fiala and Joyce Arthur (2014) doctors who conscientiously objected to providing abortion services had a history of lying about the services by asserting that patients were further along in their gestation than they were, and/or wrongly informing patients that health care institutions did not provide abortions after eight weeks. In addition to this, some physicians refused to fulfil their legal duty to refer the requesting patient to a doctor willing to

provide abortion services, or intentionally delayed the referral or tests required to make the referral until the patient was no longer eligible for an abortion (Fiala and Arthur 2014, pg. 13) Further, coercion has been used to force patients for whom finding another doctor on their own would be difficult (if not impossible) not to have an abortion at all (whether by the objecting physician or not) ; “In one instance, a physician told his regular patient that he “would no longer provide medical care in the future should she proceed with the abortion” (Fiala and Arthur 2014, pg. 13).

In light of these examples of deplorable actions by physicians who conscientiously object to reproductive health services I would like to provide two excerpts from authors who are proponents of the right of women to access these treatments and procedures which I believe saliently and succinctly communicate the importance of reproductive autonomy. Carolyn MacLeod (2010) writes:

Pregnancy can jeopardize a woman's life, her physical or mental health, or her future as she envisions it. Pregnancy endangers the life of women with certain health conditions (Greenberger and Vogelstein 2005, 1557); for some women, it represents a "period of risk" for physical abuse by husbands or partners (Saltzman et al. 2003); it jeopardizes the mental health of women who are pregnant due to rape and who experience the pregnancy as a nine-month continuation of the rape; it ruins the future plans of many women, who know they could not go through the intimacy of gestation and then give their child up for adoption (Little 1999), and who realize they will be the child's primary caretaker; and for some women it means that they will be dependent on a partner who treats them badly. In brief, what is at stake for many women with unwanted pregnancy is nothing short of life, health, freedom, or respect. Given how essential these goods are, should we not conclude

that a situation in which one or more of them is at risk is an emergency service? (McLeod 2010, pg. 23)

While McLeod's list of harms to women who are forced to follow through with a pregnancy is disturbing and upsetting, they are facts. And therefore, the conclusion that, given these harms, an unwanted pregnancy must be seen as an emergency follows straightforwardly from these facts. Julian Savulescu and Udo Schuklenk, in "Doctors Have No Right To Refuse Medical Assistant in Dying, Abortion, or Contraception" (2017) state the following:

But contraception is legal because the ability to control reproduction is one of the greatest and most valuable of human achievements. Before modern contraception, women died early, suffered from multiparity, were chained to the home, could not work or get an education. When we make contraception legal, we do not do so merely because people ought to be free to choose when and how many children to have. It is because it is good to choose this. (Savulescu and Schuklenk, 2017, pg. 164).

Savulescu and Schuklenk offer something in addition to a reminder of the harm that women suffer in experiencing an unwanted pregnancy. Most arguments in favor of women's rights to access abortion are grounded in the harms that they suffer when they are prevented from doing so *and* in the fact that the right to choose one's reproductive path – their bodily autonomy – is a basic human right. Complimentary to this, Savulescu and Schuklenk argue that it is not just the avoidance of harm and the right to choose that make access to contraceptives and abortion a morally good thing, but it is *the choice itself* (the choice to prevent or terminate unwanted pregnancies), that *also* makes access to contraceptives and abortion a good thing. Pregnancy prevention and termination is a moral good, both personally and socially, because we are better

off individually and as a community when we do not force women to bear children or become mothers when they do not want to, and when we do not allow children to be born to parents who are not prepared or devoted to raising them.

Now, continuing (naturally) under the recognition that reproductive health access is a moral good, I would like to further unpack the harms that women suffer when they are confronted by conscientious objections to abortions and contraceptives by physicians. I carry on under the understanding of harm defined in Chapter II; a "setback to an interest" (Feinberg 1984, pg 32), in which an interest is "something in which we have a stake, meaning that we are better or worse-off depending on the condition of this thing" (McLeod 2010, pg. 17).

Before diving into the harms experienced by women denied emergency contraception, I'd like to distinguish between attentively realized and consciously enabled interests (Sneddon 2019, pg. 135). In this view, attentively realized interests are dependent on our enjoyment in and passion for them. Music, for example, is an attentively realized interest. These are individualizing, meaning that not everyone has the same attentively realized interests, in fact, it's safe to say that most people have attentively realized interests that vary from those around them. Consciously enabled interests, on the other hand, are interests which depend only on "our capacity for conscious enjoyment and suffering" (Sneddon 2019, pg. 135). Our thoughtfulness, enjoyment or passion for them has no part in determining whether or not they are an interest for us. In other words, these are interests that we all have, such as health and financial stability. I argue that a potential explanation for why abortion is not treated as a legal right for women is that legislators and healthcare professionals view what is at stake for these women is their attentively realized interests. Plausible examples include their preference to not endure a pregnancy, their unwillingness to concede certain interests in order to raise a child. However,

there are consciously enabled interests which are at stake for a woman with an unwanted pregnancy. The aforementioned examples of health and financial stability are fairly obvious (although unfortunately not always acknowledged). There are certainly health risks which accompany a pregnancy and labour and delivery as well as health conditions which might result from pregnancy that a woman will experience afterwards, whether a month or the rest of her life. Additionally, raising a child is not cheap and is a setback to the financial stability of a woman, even more so of a woman who was not expecting or preparing for financial undertaking that is parenthood. However, these are not the only consciously enabled interests of women which are set back by the inability to access reproductive healthcare services. Carolyn McLeod argues that the oppressive environment in which conscientious objections occur results in harms to consciously enabled interests such as education, being a part of a community, which respects us, confidence in our moral identity and bodily autonomy.

Consider the previous objectionable actions by health care professionals who conscientiously objected to abortion: the ones who, as Fiala and Arthur (2014) explained, resorted to lying, stalling and coercion to prevent their patients from accessing reproductive healthcare procedures. I think it's fair to assume that these are not the most usual cases. It's simpler to oppose the right to conscientiously object to abortion when the objection is made this way – deceitfully and coercively. Realistically, it is more likely that objections occur when physicians openly communicate to patients that they are not willing to provide the service and, especially given the legal duty in Canada, it is also probable that most objecting physicians do provide a timely referral to a doctor who will provide the service. Let's assume that most conscientious objections to abortions play out this way, which seems to be the most ideal way a conscientious objection can occur – honestly, respectfully, and in keeping with legal dictates

which aim to ensure that the patient is still able to access her requested service. However, even this “ideal” scenario can still be significantly and unjustifiably harmful to patients.

In “Harm or Mere Inconvenience: Denying Women Emergency Contraception” (2010), McLeod discusses the harms that women face when they are confronted by refusals by pharmacists to dispense emergency contraception. While her arguments here focus mainly on emergency contraception (which is not an abortifacient) and pharmacists, the same conclusion can be drawn with regards to abortions and physicians as well as other health care professionals; “although my theory is specific to women who request EC, it has implications for how we understand the effects of conscientious refusals in reproductive healthcare in women more generally” (McLeod 2010, pg. 12)

McLeod begins her discussion of patient harm by briefly outlining and then refuting arguments made by Fenton and Lomasky (2005). The crux of Fenton and Lomasky’s argument is that denying women emergency contraception is not harmful because it is available to them by other means. In other words, patients can go to another pharmacy until they find a pharmacist who will provide them with the prescription. They write that “So long as other sources are willing to step in, the case falls under the category of convenience rather than strategy.” (Fenton and Lomasky 2005, pg.582). However, this is not persuasive. If the only effect of being denied reproductive health services was that the patient would have to seek out the services elsewhere (assuming that the service is available and accessible elsewhere), then perhaps the refusal would be simple by a case of inconvenience. However, this is not the case – and not just because it is not true that abortions are available everywhere and not true that they are reasonably easily accessible to patients. It is also not the case because the results of being refused an abortion are more than having to seek out the service elsewhere. This is best understood by further clarifying

something about the notion of harm; namely the distinction between being harmed and being wronged.

The difference between being wronged and being harmed is the same as the difference between a normative and non-normative harm. A normative harm is harm that is also a wrong. For example, I may lie to a new co-worker and tell them that our boss loves to receive flowers, when she really hates flowers. In this situation I have harmed my co-worker in the normative sense, meaning that I have harmed and wronged her. My co-worker is harmed because our boss is now upset with her and treating her poorly. She is wronged because I have intentionally lied to her with the goal of causing her harm and because I took away from her something to which she is entitled, which is my honesty. Had I genuinely thought that giving my boss flowers was a good idea, then I would have harmed my co-worker, but not wronged her. Demonstrably, not all harms are wrongs. McLeod provides an additional example of being put out of business by someone opening up shop across the street; this is a harm, but not a wrongdoing. (McLeod, 2010, pg. 16).

Fenton and Lomasky do not consider that patients can be non-normatively harmed by their health care professionals' refusal to provide emergency contraception. Their argument rests on the assumption that the only way the patient can be harmed is if she is wronged, and the only way she can be wronged is if the pharmacist intentionally does so by denying her something to which she is entitled. Since, according to Fenton and Lomasky, women do not have a right to emergency contraception, i.e., they are not entitled to it, then preventing them from accessing it does not wrong them, and, therefore, does not harm them. (Fenton and Lomasky 2005, pg. 583). Yet, as shown through my own and McLeod's examples, someone can be significantly harmed

without being wronged. According to McLeod, this is very likely to happen when women face conscientious refusals to requests for reproductive health services.

Diverging slightly from Feinberg's definition of harm as a setback to an interest, an interest being something in which we have a stake, McLeod addresses the following claim from Feinstein. He writes "'For most people, their "psyches are sturdy" enough that they can "take a certain amount of disappointment without their interests being affected, that is, without suffering harm"' (Feinstein 1984, pg. 43). Certainly the stakes we have in some interests will be deeper than others. Additionally, the setbacks that affect our interests will vary in how harmful they are. However, it is important to keep in mind that many harms can be subjective and circumstantial; while there are some things which are considered objectively harmful (such as the loss of a loved one) depending on one's experiences and situation, something may be harmful to them that is not harmful to someone else whose experiences and situation are different. As McLeod writes: "not everyone is so sturdy" (McLeod 2010, pg. 17). Similarly, while there are some things in which everyone has an interest (such as health, healthy relationships, being financially comfortable) each of us has interests that others may not, and how we prioritize those interests is not always the same - the depth of the stake that we have in those interests varies, and the seriousness of setback to an interest which constitutes harm will depend on each individuals' particular situation. Also, multiple setbacks to interests in which we have a minimal, or less important stake, can contribute to our inability to look after and prevent setbacks to the interests in which we have a large, and significant stake, resulting in harm (McLeod 2010, pg. 17).

Therefore, considering this understanding of harm as well as the reminders of why it is essential that women be able to access reproductive healthcare services, are patients harmed when their physician conscientiously objects to providing an abortion? The answer is yes,

because, put simply, allowing physicians to deny women abortions sets back interests which are universally and deeply held, independently of circumstance, and can “easily reinforce sexism as well as racism” (McLeod 2010, pg. 18). Innumerable factors contribute to the sexist and racist effect that conscientious objections to abortion have. First is the relationship between the physician and the patient. While patients and physicians are moral equals, they are not treated as such (McLeod 2010, pg. 15): one is treated as disadvantaged relative to the other. Physicians are the only people who are legally allowed to provide abortions, they have a monopoly on the procedure and are the only option for patients who seek out safe ways to terminate a pregnancy. Additionally, regulating bodies provide physicians with job security, they have financial security and high social status. The patient on the other hand, especially in comparison to the powerful position of the doctor, is vulnerable. They are in a position of weakness, they can do little, if anything to ensure that their request is taken seriously and responded to appropriately. Whether intentional or not, a physician refusing to provide an abortion reads as condemnation from the perspective of the patient. Giubilini reinforces this idea by writing:

It is impossible to know whether the patient has actually been left “no worse off than he would have been had he never met that doctor in the first place.” Even a doctor refusing to perform an abortion and referring the patient to a willing colleague may be imposing a too high level of psychological distress on a woman; for example, it might exacerbate her sense of guilt, especially if she sees the refusal by the first doctor as a form of moral condemnation of her (Giubilini, 166).

Because this condemnation is coming from a physician, a well-respected member of society who we trust to have good judgement not just in matters of medicine, but likely in all kinds of matters (which is something that will be explored further in chapter four), it is made worse. Fenton and Lomasky do not consider the harm that is experienced by patients when, by their

physician, a respected member of society, they are “branded a moral transgressor, this at a time when she is especially vulnerable” (McLeod 2010, pg. 14).

Something that works in tandem with the nature of the doctor-patient relationship to contribute to the characterization of refusals to provide abortions as sexist is the current prevailing views on women’s sexuality and social role in general. Physicians’ conscientious objections to abortion, because they are made in the context of the unequal doctor-patient relationship, reinforce sexist views regarding what ought to be the role of women in society and women’s sexuality. McLeod rightly asserts that “Actions or statements have meaning against a certain social background (e.g., of myths about women’s sexuality); their meaning does not necessarily come from what one intends.” (McLeod 2010, pg. 18). One might argue that a suitable solution to avoid unintended sexist condemnation would be for the physician to clearly explain the reasoning behind their objection, which is grounded in something other than sexist views (religious views, for example). However, this is an unacceptable solution for at least two reasons. First, although it might (I would argue, however, it likely will not) remove any worries about sexist condemnation from the mind of the patient, it replaces it with moral condescension. Explanation of a physicians’ negative moral judgement regarding the decisions that a patient has made about her body and her health result in a condescending, paternalistic “I know better than you”. Whether the reasoning for the negative moral judgement is grounded in sexist ideals, religion, or some other moral consideration, it is still harmful, and it can lead to reinforcement of different stereotypes i.e. “baby killer” instead of “promiscuous”. Second, a doctor’s denial that their objection to providing abortion is grounded in sexism is not guaranteed to be taken as honest or genuine; it could easily be seen as deceitful or as an excuse.

Having established that conscientious objections to abortion do indeed enforce sexist stereotypes about women and women's sexuality, we can take stock of how experiencing this sexism constitutes harm in Feinberg's sense. First, the upsetting revelation experienced when requesting a service to which one had a right and learning that it is in the right of the physician to refuse to provide that service, may be off-putting enough to prevent patients from looking elsewhere for reproductive health services. I think it's reasonable to accept that the unexpected refusal of service combined with the implied sexist condemnation of one's hugely significant life choices is even more likely to be harmful and influential enough to make patients reluctant to make the same request to another physician, even if they are referred to them. Even a patient who was aware of a physician's right to conscientiously object, and who braced herself for the possibility that her request for an abortion may be denied, may find the experience of the refusal so uncomfortable and upsetting that they would not want to risk making the same request to another physician and facing the same denial. Therefore, it is possible that experiencing a physician's refusal to provide an abortion, even if they offer a referral to another physician, may influence the patient in such a way that she reluctantly follows through with the pregnancy. Given that this woman initially requested an abortion, we can assume that she had a stake in not being pregnant, and not becoming a mother, and many other interests that are made possible through not being a mother (potentially getting an education, pursuing a particular career, avoiding a painful pregnancy). These interests are either set back or completely disregarded when she is prevented from terminating the pregnancy.

More still, while these (education, career) are indirect harms that may result from being forced to carry out an unwanted pregnancy, the denial of a woman's right to exercise bodily autonomy is a harm to her consciously enabled interest of bodily autonomy that is the direct

result of being refused an abortion. We all have a deep stake in bodily autonomy – in the right to determine what happens to our bodies. This is an interest to everyone regardless of whether or not we think about or enjoy it. Yet, refusal to provide an abortion violates a woman’s right to bodily autonomy and the unlikeliness that she will seek an abortion elsewhere (even if by referral), which results in carrying and delivering a baby, is an assault on her bodily autonomy as well.

Another interest in which women have a stake is the “sense of security that goes along with living in a society that respects them” (McLeod 2010, pg. 19). Doctors are the gatekeepers to abortion, there is no safe and legal way to terminate a pregnancy outside of regulated reproductive health services administered by a physician. Yet women are often prevented from accessing this necessary service by those who own the monopoly on it. This is made worse when coupled with the realization that women are inadequately protected from sexual assault in Canada (McLeod 2010, 19). Many of these preventable sexual assaults undoubtedly result in unwanted pregnancies, and the inability of women to access timely abortions and without fear of judgement result in these women being forced to carry out the pregnancy. An additional discouraging consideration is that sexual assaults which are committed by one’s partner may cause women to stay in abusive relations for several reasons including perceived necessity due to inadequate support for new mothers and children. Therefore, failure to ensure that women can access abortion services coupled with the facts that prevention of sexual assault and support for new mothers is seriously lacking communicates to women, not only that we as a community do not agree that she should have the ability to terminate an unwanted pregnancy, but also that we are not interested in preventing her pregnancy nor are we interested in giving her the tools she needs to raise the child she has been forced to have to the best of her ability. Women have a

stake in being seen as persons worthy of respect because when this respect is absent, they suffer unwanted pregnancies, abuse and poverty, among other things.

One's moral identity is also at stake when discussing the harm that women experience when their request for reproductive health procedures or treatments is denied (McLeod 2010, pg. 19). The aforementioned condemnation that is felt by women when a physician conscientiously objects to providing an abortion can result in her being unable to access abortion at all, even through a referral. However, it can also result in her questioning whether or not she is making the right decision in seeking to terminate her pregnancy and whether or not she makes good decisions in general. If a well-educated, respected member of society such as a physician disagrees with her reproductive choices to such a degree that they must exercise their right to conscientiously object and recuse themselves from participating in it, then surely there must be something wrong with their choice? And, if there is something wrong with this choice, which is regarding something as significant as whether or not to terminate a pregnancy and prevent having a child, why should she be confident in her other choices, regarding less important matters which she may have given less decision-making effort into making. While one's moral identity or taking oneself to be a good person is not necessarily a consciously enabled interest, it is definitely an attentively realized interest for many. It's reasonable to accept that most people take whether or not a decision is moral to be a highly relevant consideration in their every day decision making. Not only because we want the moral thing to be done, but because we want to be the kind of person who does the moral thing.

McLeod lists bodily autonomy, living in a society in which women are respected and moral identity as interests which are at stake in the debate surrounding a physician's right to conscientiously object. I take the first two of these to be consciously enabled interests and the

last one to be an attentively realized interest. However, McLeod acknowledges that the persuasiveness of her arguments regarding the harm done to these interests heavily depends on the recognition that we live in a society which is oppressive to women. Without an accurate understanding of the sexist social landscape in which conscientious objections to reproductive health services occur, the stakes that women have in these interests seem less deep and the setbacks that are applied to those same interests seem less harmful. For example, the feeling of condemnation that results from a denial of an abortion may seem like less of a big deal. The problem of sexual assault may seem less pervasive when one does not consider the sexiest structures which contribute to these assaults and allow them to go unacknowledged or unpunished. And bodily autonomy, as well as the threat to bodily autonomy that conscientious objections create, may seem like it is respected equally among all persons considering we are all prevented, in some degree, from doing certain things to or with our body in ways that are similar to how women are prevented from accessing abortions. For example, men may request medical treatments or procedures, even cosmetic treatments, which doctors, for a number of reasons (including that they do not believe the treatment is necessary) might refuse to provide. However, cognizance of sexist and discriminatory laws, practices and treatment of women allows one to understand that women's bodily autonomy is limited in more ways and in different and more harmful ways than men's bodily autonomy is limited.

Yet, even if one does recognize the sexist social landscape in which conscientious objections to abortion exist, there are still doubts about whether or not this is a relevant distinction in determining whether physicians have a right to refuse to provide treatment. After all, the condemnation that patients feel when faced with a refusal of service is potentially only *perceived* condemnation. It may be the case that the physician engages in no judgement of the

patient's choice, respects her wishes and aims to politely communicate their objection with consideration for how the patient might interpret it. Pellegrino, who supports the right of physicians to conscientiously object, writes: "Respectfully, courteously, but definitively the religious physician must inform the patient of her objection while promising to care for the patient until transfer or referral can be arranged by the patient, family, or social services" (Pellegrino, pg. 240). Further, the objecting healthcare professional may be considerate of the oppressive structures affecting their patient because she is a woman. They might do what they can to mitigate the effects of this oppression combined with the physician's objection. All of this is ideal, and may well happen some, if not most of the time. In fact, as McLeod writes, "these professionals have a duty to do what they can to counteract harmful effects that stereotypes can have on patient autonomy" (McLeod 2010, pg. 21). Unfortunately, what physicians can do to mitigate these effects while still refusing to participate in the abortion is not sufficient to actually address the harm that women experience as a result of the objection. Referrals, for example, may be a means by which a physician aims to mitigate harm to patients, but even this may be useless if the experience of the initial objection prevents the patient from seeking out an abortion elsewhere. Also, as previously discussed, an explanation from the physician to the patient about their views and reasons for their objection will likely come off as condescending rather than helpful or considerate. But the real problem with this objection is that it does not matter if the patient has been wronged by the physician i.e., whether or not the physician is the source of the harm or whether or not they endorse the things that make the objection harmful (such as sexist oppression). As Schuklenk and Savulescu write, "the multiplicity of causal factors does not alleviate moral responsibility" (Schuklenk and Savulescu, pg. 166). While physicians may not be the *only* contributor to the harm that patients experience, they do contribute, nonetheless. Even if

the physician is not the main source of the harm or wrongdoing, even if they do not believe the sexist stereotypes that their actions contribute to, “we fail to deal with the conflict between the objecting pharmacist [physician] and the woman as it actually exists; that is, as a conflict between two people who are [treated as] morally unequal..” (McLeod 2010, pg. 21). Regardless of the physician’s view on women’s issues like bodily autonomy, prevention of sexual assault, childcare support, etc., these things do significantly affect the experience of a woman when confronted by a conscientious objection to abortion and while the physician themselves might not endorse sexist views on these issues, their actions do.

Finally, another harm that women experience which is not taken into account by McLeod, and which I consider a threat to an attentively realized interest as opposed to a consciously enabled one, is the violation of privacy that can result from being denied an abortion. In Christian Fiala and Joyce H. Arthur’s “Dishonorable Disobedience” (2014) they name privacy as something that is in danger of being harmfully compromised when women are refused abortion services (Fiala and Arthur 2014, pg. 15-16). The most obvious case of this is when a conscientious objection results in a public confrontation which indicates to those around the patient, not necessarily that they have requested an abortion, but at least that they have done or requested something that is morally reprehensible. But there are other ways that being denied access to abortion can contribute to the violation of a woman’s privacy. Symptoms such as morning sickness “and psychological distress from a developing pregnancy they want to terminate” (Fiala and Arthur 2014, pg. 16) can increase over the duration of a pregnancy. As can (and often does) the size of a pregnant woman’s stomach. Therefore, delaying a woman’s access to an abortion puts her at risk of being forced to admit to those around her, including her employer, friends, family and partner, that she is pregnant. Depending on the woman’s

circumstance, this could be significantly harmful. What's worse is that the women who are most vulnerable to harm as a result of this violation of privacy are the ones who are most likely to experience it. Fiala and Arthur write "Low-income and rural women are hurt the most by the exercise of CO, because such women may not have the resources to seek services elsewhere. It also disproportionately affects women from ethnic minorities, and women who experience intimate partner violence or sexual violation, who are twice as likely to need abortion services than women who don't experience such violence" (Fiala and Arthur 2014, pg. 16). Women who are most likely to be significantly harmed by being forced to reveal their pregnancy to others include women whose partners may react violently and women who live in rural and low-income communities and households who would be disastrously disadvantaged by the loss of a job. Yet, these women, because they lack resources due to their rural, low-income environment, are the most likely to experience the violation of privacy which causes these significant harms.

So far, I have claimed to address both abortion and physician assisted suicide in arguments. However, in this most recent discussion of harms to patients, I have focused exclusively on harms to patients who are prevented from accessing abortion as a result of a conscientious objection. I argue that the majority of my arguments regarding Calhoun's social understanding of integrity and abortion apply straightforwardly to physician assisted suicide as well. However, I recognize that my discussion of harm to female patients seeking abortion does not translate to patients seeking physician assisted suicide, most notably my discussion of harms that are dependent on a sexist social landscape which oppresses women. In this regard, a brief supplementary treatment of harms that are particular to patients who are prevented from accessing physician assisted suicide as a result of conscientious objections is required. Some harms are common to patients seeking both procedures. For example, we all have a deep stake in

bodily autonomy, and being prevented from choosing how and one's life ends jeopardizes bodily autonomy in the same way that being prevented from terminating a pregnancy does. The sense of security that follows from living in a society which respects us is also something that we all have a stake in. This translates in a similar way from abortion patients to patients seeking physician assisted suicide. It is distressing for individuals to consider that if they were to become terminally ill, whether at a young age or later in life, that they might not have the ability to make decisions about the end of their life, including their treatment and how and when they die. The patient's moral character is also at stake in situations when physician assisted suicide is requested and refused in the same way that it is when abortions are requested and refused. Implicit in a physician's refusal to provide medical assistance in dying are judgements about capacities for suffering, definitions of suffering, the value of life and the need to avoid death. Conscientious objections to physician assisted suicide can communicate to a patient that their choice is wrong, that they're failing to properly value and respect life and reasons for living, and that they're too weak or unwilling to suffer through an illness to experience a natural death, which is implied to be morally superior to a medically assisted death.

Section II Harm to Institutional Integrity

So far I have focused on physician integrity and alluded to the notion of patient integrity, which will be the topic of my next and last chapter. Right now I want to briefly turn my attention to institutional integrity for two reasons. First, there are minimal laws surrounding abortions in Canada. While there does exist a legal obligation to refer patients to a physician who will provide the abortion, there is nothing else to govern or protect a woman's right to an abortion. This ambiguity means that it is possible for several physicians working within the same public healthcare institution to have varying beliefs regarding the morality of abortion. Therefore, some

of those doctors may provide abortions and some may refuse to do so. It follows that patients and the general public have no way of accurately informing themselves or others about whether or not they can expect to access abortion if they visit that healthcare institution, even if they know others who have been successful in accessing one and that there are physicians there who willingly provide them. This creates unnecessary opportunities for conscientious refusals; for women to be denied access to reproductive treatments and procedures, which I have already established is detrimentally harmful. Therefore the first reason that a discussion of institutional integrity is necessary is that it will illustrate how institutions having an available, coherent and consistently enforced ethical code or set of values will minimize the instances in which patients are denied services by a healthcare professional who conscientiously objects to their request.

The second reason that it's important to talk about institutional integrity is that it's valuable to an institution's employees, patients and community, not just because it prevents conflict and unnecessary harm by minimizing conscientious objections, but also because it's beneficial to work in and be treated in a healthcare institution which endorses the same values that one does oneself. This is of even more significance under Calhoun's social understanding of integrity, in which it is essential that we endorse our views and subject them to criticism from our fellow-deliberators. One effective way in which healthcare professionals can do this is by developing a mission statement and set of values for the institution for which they work and standing for those values individually.

Many theorists speak about institutional integrity without mentioning it by name. Edwin Pellegrino, for instance, in arguing that Catholic healthcare institutions are in jeopardy of losing funding as a result refusing to provide certain services, writes "The ethical 'code' or commitment of a specific institution is now customarily expressed in its mission statement. This is in a way

the ‘conscience’ of the institution” (Pellegrino, pg. 235). His argument is that, in lieu of closing Catholic hospitals by cutting their funding, regulators discreetly pressure these hospitals to merge with secular, public institutions by not granting them religious exemptions because they treat all people, regardless of religious affiliation, and provide more than just religious services. However, Pellegrino adds that there are very specific moral and religious dictates which govern how Catholic hospitals can merge or cooperate with non-religious or non-Catholic hospitals (Pellegrino 2002, pg. 237). When Pellegrino talks about the ethical code, mission statement, conscience, and moral and religious dictates of an institution, what he is referring to is that institution’s integrity.

This is clear when we consider the definition of institutional integrity provided by A.S Iltis in “Institutional Integrity in Roman Catholic Healthcare Institutions” (2001). He writes that “Institutional integrity can be understood as the coherence between what an institution claims to value (its stated moral character), what an institution does (its manifest moral character), and an institution's fundamental moral commitments (its deep moral character)” (Iltis 2001, 98). For our purposes it will be helpful to fully understand what Iltis calls stated, manifest and deep moral character. Stated moral character includes an institution’s mission statement and values. These must be clearly articulated and made available to the institution’s employees, patients and the general public. Kevin Wildes seconds Iltis’ notion of stated moral character when he writes “an institution can have a moral identity and conscience. A necessary condition for talking about institutional conscience is the moral identity of an institution. One way to explore this moral identity is to look at the mission of an institution” (Wildes 1997, pg. 416). Manifest moral character is constituted by how an institution’s mission statement and values are acted upon in practice. It includes the actions and judgements of the institution and the healthcare professionals

who work there and *how* these actions and judgements are carried out. Finally, deep moral character is the fundamental moral commitments and internalized values of an institution. These are what make a hospital, for instance, a “certain kind” of institution. Many institutions and physicians can object to and refuse to provide abortions; these refusals are a part of stated and manifest moral character. However, what determines a Catholic hospital as a “certain kind” of institution – a religious institution – are the fundamental principles which inform their values. In this case the deep moral character could include the belief in God, for example. In keeping with Iltis’ conception of deep moral character, Mark Wicclair writes that Catholic hospitals are a good example of institutional integrity, because they have more than mission statements, they have genuine missions (Wicclair 2011, pg. 130). There is an interesting connection here between Iltis’ definition of deep moral character and its requirement for institutional integrity, and a requirement of integrity that both Calhoun and Taylor accept (Taylor, pg. 146). Individual integrity requires that we are sincere about our commitments. We must not shallowly endorse certain principles simply because we want to be seen as the kind of person who endorses such principles. Integrity requires that our values are held genuinely and deeply.

Iltis also provides a salient example which illustrates why consideration for institutional integrity is essential to proper patient care and to respect for doctor’s moral commitments. When a terminal patient, admitted to St. Clare’s Catholic Hospital, requested that nutrition and hydration be withheld from her, she was told that she would have to be transferred to another hospital because St. Clare’s conscientiously objecting to participating in practices which would contribute to or hasten the death of one of their patients. However, the patient contested the objection and “The court determined that St. Clare's was obligated to grant Requena's request to withhold nutrition and hydration because she was not given prior notice of the fact that the

hospital's moral commitments were in conflict with requests to terminate life-sustaining interventions involving basic nutrition and hydration.” (Iltis 2001, pg. 96). Because the hospital had an inaccurate or incomplete stated moral character, an unnecessary conflict occurred between a patient seeking to access legal medical procedures to which she has a right, and physicians who object to those medical procedures.

While some physicians, such as Pellegrino, indirectly endorse institutional integrity and others, like Iltis, explicitly argue in favour of institutional integrity and its value, others deny its existence or validity all together. In “The Case Against Institutional Conscience” (2011), Spencer Durland argues that acknowledging institutional integrity, particularly of religious hospitals and healthcare institutions, often leads to that integrity being prioritized over the integrity of patients and physicians. This is unacceptable because the integrity of hospitals and other healthcare institutions is much different and less valuable than the integrity of healthcare professionals, patients and people in general. In reference to the “Ethical and Religious Directives for Catholic Health Care Services”, Durland writes “”The Directives were written by the USCCB and are interpreted by local bishops, neither of which is a "healthcare provider" under federal conscience legislation. But a grant of institutional conscience gives this group not simply a right of conscience equal to direct providers (despite their very unequal participation), but a superior claim to conscience protection, since employees at Catholic hospitals must abide by the Directives, regardless of their religious persuasion or clinical morality”” (Durland 2011, pg. 1680). The criticism here is that institutional integrity in the case of Catholic hospitals is essentially nothing more than the collective integrity of the hospital’s directors (bishops) and, given that these directors are not healthcare practitioners or direct participants in the provision of

any medical service, the fact that their integrity is prioritized over the integrity of the physicians and their patients is not right.

I argue that Durland misses the mark in his criticism of institutional integrity. This is, actually, not a criticism of institutional integrity itself, but of how Catholic healthcare institutions abuse institutional integrity to force doctors and patients to act in accordance with religious dictates, even when they are in direct opposition to best care practices and physician beneficence. Durland provides three sad examples of physicians in Catholic hospitals being forced to act against their own best judgement and refuse to provide reproductive healthcare services (for context, one of these examples involved the hospital forcing a physician to turn away a patient who had the hand of a fetus sticking out of her cervix because a fetal heart beat was still detected) (Durland 2011, pg. 1657). Some of Durland's concerns are valid. As Wicclair writes, "hospitals are not living, conscious organisms. They lack awareness and do not have the capacity to think, form intentions, or feel good or bad. Moreover, in contrast to healthcare professionals, hospitals cannot experience the effects of a loss of moral integrity, and they cannot experience guilt or suffer from injury to their identity" (Wicclair, pg. 130). Institutional and personal integrity are different, partly in the sense that a loss of personal integrity is bad for the person whose integrity has been lost – it is direct. The loss of institutional integrity is not harmful to the institution itself. As Wicclair points out, institutions cannot experience guilt or suffering. It is the employees and patients of hospital who are indirectly affected, in various ways, by the loss of institutional integrity.

However, if we evaluate the institutional integrity of secular institutions with the same criticisms that Durland has applied to Catholic institutions, we might find that prioritizing institutional integrity over personal integrity is not necessarily wrong. Public hospitals and

secular hospitals and other healthcare institutions, associations and governing bodies which determine the legality of certain treatments and procedures may be most qualified, well-equipped or better suited to make and enforce the decisions regarding divisive topics such as physician assisted suicide and abortion. In fact, due to a precedent set by the decision in *Burwell v. Hobby Lobby et al.* (in which Hobby Lobby won the right to not cover the cost of their employees' contraceptives through insurance out of conscientious objection), although it used to be only religious institutions which were granted conscience exemptions, secular and for-profit institutions in the United States may be afforded the right to conscientiously object more often in the future. While personal bias is not completely avoided in this case, at least multiple perspectives and opinions are taken into account. In support of this, Vischer writes that institutional integrity "is not simply the sum of its parts; the corporation [institution] needs discretion to shape its own identity. Under some circumstances, this will limit the conscience-driven conduct of individual employees, but that is the price of the corporation's [institution's] mediating role" (Vischer, pg. 857). In order to properly function with institutional integrity, hospitals must make and enforce decisions, which will unavoidably result in instances in which the institution's integrity overrides the personal integrity of physicians. This is okay. Given the value of institutional integrity for a large number of people, overriding physician integrity is a reasonable cost.

I have briefly discussed the value of institutional integrity here, which includes avoidance of instances of conscientious objection. However, Mark Wicclair summarizes some of the other values well in the following passage:

"First, it can be important to physicians, nurses, pharmacists, and other personnel to be able to practice and work in a community that shares a commitment to a core set of goals,

values, and principles. Practicing or working in an institution that permits actions that violate a healthcare professional's core values might compromise her moral integrity. At the very least, it can contribute to considerable moral distress. Second, it can be important to patients to receive care in a facility that is committed to their fundamental values. Even if a patient's moral integrity is not at stake, it can be a considerable source of distress to be cared for in a facility that engages in practices that are inconsistent with one's fundamental ethical or religious values" (Wicclair, pg. 131).

I would like to note here that it is not only working or being cared for in an institution which *engages* in practices one does not agree with which causes distress, but also working or being cared for in an institution which *conscientiously objects* to practices one may have received themselves before and to which one believes patients ought to have a right. For women working and being treated in a hospital, simply knowing that if they were to request certain reproductive healthcare services, their request would be refused in that institution can be damaging. It may lead to the conclusion that receiving proper care in that hospital is dependent upon our agreement and compliance with certain moral standards which may directly contradict the moral principles and values of the patient.

Chapter Four: Addressing Conscientious Objections

So far, we have surveyed the following morally relevant aspects of conscientious objections to abortions and physician assisted suicide:

1. how we define integrity, not only in the sphere of conscientious objections, but more generally as well - this has resulted in the endorsement of Calhoun's social understanding of integrity.
2. how being compelled to provide services to which one conscientiously objects negatively affects physicians.
3. how being denied access to legal medical treatments to which one has a right harms patients, specifically female patients who are prevented from accessing reproductive healthcare services.
4. how allowing conscientious objections is detrimental to the integrity of healthcare institutions and contributes to unacceptably low levels of patient care.

Now, I turn to how the legislation and policies regulating conscientious objections ought to be changed in light of these findings.

However, while I have already unpacked the necessity for an investigation of how we address conscientious objections in Canada, it would be useful to briefly address a possible objection to my project which questions the effectiveness of philosophers theorizing about medical practices. The objection, which seems reasonable and discouraging at the outset, goes like this: physicians are intelligent and determined people. They not only completed but excelled in undergraduate education, medical school, internships, specializations, residencies. They are not likely to accept legal changes to medical policies which guide and regulate their practice;

especially changes which affect how they are required to respond to requests for treatments which have life or death implications, about which physicians may have genuine and strong religious or otherwise moral convictions. It may be the case that even the best possible outcome to physicians' unacceptance of these policy changes may translate to healthcare professionals using the proper channels to protest and try to reverse the changes but, in the interim, refusing to abide by their new legal obligation, or simply refusing to provide any service at all. Therefore, the objection to my project is that it may be pointless to argue for re-evaluation and changes in conscientious objection policies because the success of these changes (i.e., ensuring that patients can access services), depends on the co-operation of health care professionals, who are not likely to co-operate. In other words, we cannot force doctors to provide abortions, or physician assisted suicide. Even if we were to try, we may only make it more difficult for patients to access reproductive health, or end of life care. We also risk deterring potential doctors from settling on this profession, making access to other services more difficult for all patients.

In answer to this objection, I turn to the examples set by Sweden, Finland and Iceland (Fiala 2016, pg. 201-206). In 1975, 1970 and 1997 respectively, governing bodies in Sweden, Finland and Iceland all removed conscience clauses to abortion in reproductive healthcare policy or definitively stated their opinion on the matter. While each country retains some requirements for eligibility for abortion, these requirements are general, take into account most if not all relevant factors which might influence a woman's decision to seek an abortion, and are open to interpretation. For example, in Finland:

For pregnancies up to 12 weeks where the woman is between 17 and 39 years, two physicians are required to approve the abortion – the primary care doctor who refers, and the hospital physician who performs the abortion. About 92% of abortions are performed

in the first trimester, mostly for social reasons, such as a stressful life situation. All abortions after 12 weeks require approval from the National Supervisory Authority for Welfare and Health. Between 12 and 20 weeks, abortions are similarly allowed for social, age, parity, or sexual violence indications, foetal indications, and in cases of ‘disease or physical defect’ in the woman. Abortion is also allowed up to 24 weeks (Fiala, 2016, pg. 201-202).

These requirements take into account more than just the physical health of the mother and the health and viability of the fetus. They not only recognize that considerations such as employment, housing, financial security, and potential abusive relationships can be the most important contributors to a woman’s decision to terminate a pregnancy, but they assert that these are valid reasons for terminating a pregnancy.

The removal of conscientious objections as a valid reason to refuse to provide an abortion in these countries’ reproductive health policies has been successful. This success is measured, not just in terms of the facts that women are having an easier time accessing abortions and abortion rates are lower in these countries compared to western countries, but also in terms of the response from the medical community in these communities. Beginning in 2014, there was over a year-long discussion in the Finnish parliament brought about by a petition signed by 50,000 Finnish citizens regarding whether or not Finnish health care professionals had the right to refuse to perform or participate in abortions because of a personal or religious conscientious objection. Ultimately the petition was rejected, and conscientious objections continue to be invalid reasons for recusing oneself from providing abortions. What is particularly significant here though, is that throughout this debate, “the Finnish Society of Obstetrics and Gynaecology and the Finnish Medical Society opposed the initiative” (Fiala 2016, pg. 203). Given their demonstrated support

for a woman's right to access abortion and restriction of a health care professional's ability to refuse to provide on based on conscience, I think it is reasonable to infer a couple of things about the Finish Society of Obstetrics and Gynaecology and the Finish Medical Society. First, that they were either not concerned about the prospect of refusals from physicians and other healthcare professionals to comply with their new legal obligation to provide abortion, or they forecasted that such refusals were unlikely to occur. Second, that they were not worried about the possibility that refusing physicians the right to conscientious objection might deter potential health care professional from settling on a career in health care and create barriers for everyone to all types of services. There are additional reasons to believe this is the case.

Sweden, Finland and Iceland do not shy away from clearly expressing to potential healthcare professionals that the legal requirement to provide abortions is expected of them and will be enforced. In Sweden:

“Medical authorities have stated that those who object to performing abortions (or inserting intrauterine contraception) cannot become obstetricians/gynaecologists (Ob/Gyns) or midwives. Abortion care is included in the curricula for all medical students, and those who wish to become an Ob/Gyn or midwife must have mandatory training in abortion care. There is no way to opt-out AND Most anti-choice medical and nursing students are dissuaded from entering the specialties of obstetrics/gynaecology or midwifery, since they may not be able to obtain certification or employment without the ability and willingness to perform abortions” (Fiala 2016, pg. 202).

Finland and Iceland enforce similar requirements of potential health care professionals. In Finland, medical students who plan on specializing in obstetrics and gynaecology or as general

practitioners must go through mandatory training in providing abortions (Fiala 2016, pg. 203). In Iceland, mandatory training and providing abortions is required for all students specializing in Ob/Gyn (Fiala 2016, pg. 204). In addition, requiring that medical students participate in abortion training and ensuring that they are informed that they have no right to refuse to provide abortions on the grounds of conscience seems to have had no negative affect on general patient care, the ability of women to access abortions, or the safety of those abortions. For instance, women seeking an abortion do not have to travel far (Fiala 2016, pg. 202) All hospitals and some private clinics provide abortions and they are spread throughout Sweden, Finland and Iceland. This means that patients do not have to postpone their abortion until they can arrange to travel far distances to reach an abortion provider, and the fact that their abortion will be provided earlier rather than later means that there is less likelihood of complications. Additionally, and thanks to physicians' inability to object to abortions in Finland, over 90% of abortions are administered medically as a single-visit outpatient procedure, rather than surgically (Fiala 2016, pg. 203). This means that abortions are happening quicker, earlier in pregnancies and are requiring less time and resources. Further, Fiala writes that "Access to abortion ranges from good to excellent and services are high-quality and well-organised, at least in part because abortion care is recognised as basic medical care for women. It is a funded part of the public service in all three countries" (Fiala 2016, pg. 204) Schuklenk and Savulescu also assert that, although the objection which I am challenging now might lead some to believe that there are risks in requiring objecting physicians to provide abortions (risks that they might not perform safe abortions), there has been no indication from Sweden, Finland or Iceland that this is a likely result (Schuklenk and Savulescu 2016, pg. 163) In summary, the limitation and/or outlaw of conscientious objections to abortion in Sweden, Finland and Iceland illustrates that requiring physicians to provide abortion

can be done successfully, and without harmful consequences such as poor patient care, or interruption to access to services.

Referrals

Physicians who conscientiously object to carrying out abortions have a legal obligation in Canada to provide their patients with effective referrals to a healthcare professional who will. The debate surrounding conscientious objections and the role of integrity often approaches referrals with a focus on complicity. For example, Peppin argues that by requiring objecting physicians to refer patients to other physicians who will provide physician assisted suicide and abortions, we are requiring them to be complicit in these treatments. He argues that this is a very short step from requiring that they provide the treatment themselves. (Peppin 1997 pg. 44). However, Calhoun's definition of integrity allows us to recognize another issue with the concept of referrals. The purpose of referrals is to allow physicians to avoid providing a service to which they conscientiously object, in order to maintain their integrity, while ensuring that patients can still access the service to which they have a right; it is a compromise. However, in recognizing that an essential component of integrity is one's willingness to stand for, as opposed to stand by, their principles, we recognize that referrals in no way preserve the integrity of physicians who conscientiously object. Not only because by referring their patient to another healthcare professional the physician becomes complicit in the service to which they object, but because in refusing to provide a service but allowing their peers to provide it, they are not standing up for their beliefs. When Edmund Pellegrino writes "Obviously the patient cannot be abandoned, legally or morally, and must be cared for until a transfer has been effected" (Pellegrino, pg. 240), he is in direct opposition with his own principles. When we argue that an action is morally wrong, we mean that it is morally wrong for everyone, not just ourselves.

Therefore, when Pellegrino argues that objecting physicians must provide referrals for their patients requesting abortion, he suggests that objecting physicians have an obligation to ensure that the service to which they object is accessed. While referring the patient to an abortion as opposed to providing the service oneself may have implications for the degree of negative feelings the physician feels as a result (e.g., guilt), there is no difference between providing an abortion and referring one's patient to a physician who will provide an abortion when it comes to the preservation of integrity.

Working within Calhoun's social understanding of integrity as something that requires standing for, as opposed to by, our principles allows us to better address theorists who argue that referrals provide no moral problem for conscientious objectors. For example, Crowley argues that referrals do not provide as difficult a complicity problem as we might assume, writing that the objecting physician is not responsible for their colleague's free actions, and that they are merely describing an available fact regarding what services their colleague willingly provides (Crowley 2016, pg. 362). Blustein writes

On the other hand, and here I come to the view alluded to at the start of this paragraph, it might be countered that this argument is defective precisely because it does not consider the action in relation to the agent, that is, the action-as-performed-by this particular physician. As performed by him, it would violate his inner harmony or integrity, and (we may suppose) it would not have this effect on the second physician. Looking at action in this agent-relative way, it now does seem to make a moral difference who honors the patient's request" (Blustein 1993. pg. 298).

However, as shown in my first chapter, when Calhoun supports her claim that integrity is a personal *and* social virtue, and when she introduces the significance of standing for, as opposed to by, our principles, she writes the following: “Moreover, not standing up for one’s best judgment about what would be just or what lives are acceptable forms of the good suggests that it does not really matter what we as a community of reasoners endorse. The person of integrity, one might plausibly think, is precisely the person who thinks this does matter. Integrity here seems tightly connected to viewing oneself as a member of an evaluating community and to caring about what that community endorses. That is, it seems to be a social virtue.” (Calhoun 1995, pg. 254). In other words: if their goal is to maintain their integrity, it is not enough for physicians to conduct only themselves in accordance with their principles (i.e., to avoid providing abortion), they must also defend and endorse their principles to their peers because their views are not just right for them, but for everyone. Further, as persons of integrity, they ought to have a stake in the morality of the principles that their community endorses; therefore, it should matter to objecting physicians that their medical community supports the principles that they believe to be right.

For a long list of reasons outlined in chapter three, we must ensure that patients seeking abortions are able to access them. In an effort to preserve physician integrity while securing access to abortion, a compromise in the form of physician referrals has been adopted. However, not only do referrals not provide effective and reasonable access to abortions (as aforementioned, they necessitate additional doctors’ appointments and abortion requests, can lead to longer waits for the procedure and may have infeasible travel requirements), but they also do not sufficiently preserve physician integrity. This is because they require that physicians not only allow a service to which they conscientiously object to be provided, but they require that physicians facilitate the

service. Since abortion referrals inadequately foster abortion access and do not sufficiently protect physician integrity, this compromise ought to be done away with. Additionally, since abortion access is a right and a necessity, the outcome of all this ought to be that physicians should not have the option to conscientiously object.

The Physician-Patient Relationship

When comparing physician and patient integrity, or physician integrity and patients' rights, it is essential to have a clear understanding of the nature of the physician-patient relationship and the roles of each party. Our understanding of this relationship can inform our views on the value of physician and patient integrity and the rights that each party ought to be afforded. The charge of paternalism is often laid against physicians who conscientiously object – especially when the objection is to abortion and other reproductive health services such as conception treatments because this objection reinforces sexist social structures and contributes to the oppression of women. For example, Kara W. Swanson writes that many factors including feminist movements and women's health movements have ““emphasized the dark underbelly of unfettered medical discretion, and the damaging choices made by doctors in deciding who was “deserving” of treatment”” (Swanson 2015, pg. 320). An example of this “dark underbelly” is the women who have died seeking illegal and unsafe abortions as a means to terminate their pregnancy when their requests to health care professionals for a safe abortion were denied. Unnecessary deaths as a result of illegal abortions have occurred before and after abortion was decriminalized. In discussing Ob/Gyn Alan Guttmacher's work to improve access to abortion under paternalistic abortion laws which criminalized the procedure, Swanson writes “the poor and less well-connected risked their lives and health at the hands of less skilled practitioners, and

Guttmacher treated dying girls and women in the aftermath of such illegal abortions.” (Swanson 2015, pg. 315). Fiala writes:

‘CO’ tries to turn back the clock to the days when women died from unsafe, illegal abortion. A woman in Poland died in 2010 after being refused a legal abortion by objectors. But women have also died or were seriously injured after being refused an abortion because it was against the law, as per recent reports from Ireland, Nicaragua, and El Salvador. Abortion is still illegal in large parts of Africa, Asia, and Latin America, and a few countries in Europe. An estimated 47,000 women die every year and almost 7 million are injured from unsafe, usually illegal abortion” (Fiala 2015, pg. 204).

It's clear that criminalizing abortions does not result in less women seeking and accessing abortions. It only renders the abortions than women have less safe.

Yet, some theorists still argue that physicians’ conscientious objections, even conscientious objections to abortions understood in the context of a society in which women’s bodily autonomy is limited, are not necessarily paternalistic. Blustein is one such theorist. He argues that, unless a physician’s intent is to impose their beliefs regarding their patients’ objective best interests onto the patient for their own good, then an objection cannot constitute paternalism (Blustein 1993, pg. 291). However, this is not the only requirement of medical paternalism. In “A Normatively Neutral Definition of Paternalism”, Emma C. Bullock suggests that paternalism is demonstrated when at least one of the following three requirements is met:

1. The physician causes the patient’s choice to be denied or diminished, or their ability to choose to be discouraged.

2. At least one of the reasons for (1) is that the physician believes that it is in the best interest of the patient.
3. The physician does not consider the fact, or acts regardless of the fact, that the patient would not make the same choice if they were informed of the interference with her choices (Bullock 2015, pg. 19).

What is advantageous about Bullock's definition of paternalism, and what is missing from Blustein's understanding, is that more than just the intent of the physician is taken into account. There might be physicians who conscientiously object to providing abortions whose sole intent may be to just recuse themselves from participating in the procedure in order to preserve their integrity. However, besides the facts that this does not succeed in preserving one's integrity and this is likely not the case for most objecting physicians (I argue that it is reasonable to accept that physicians who object to abortions are likely motivated in at least some part by a desire to prevent their patient from accessing an abortion on the grounds that they believe it is in the patients best interest), the physician's intentions are not the only indicator of paternalism. Cases such as these (as rare as I think they are), in which the physician's only motivation is to avoid participation in abortion, are still instances of paternalism. In refusing to provide abortions, physicians clearly deny or diminish their patients' choice to terminate their pregnancy. The multitude of issues with referrals and barriers to accessing referral treatments which have already been discussed also show that, even when physicians do provide referrals to abortions, they still discourage the patient from being able to make their own choice regarding their pregnancy.

Some theorists, arguably in an effort to thwart the charge of paternalism or at least to justify paternalism, have tried to validate conscientious objections by their adherence to some definition of health, or core values of medicine. There are two lines of thought here. First,

objections to providing abortions, reproductive health services or physician assisted suicide are not paternalistic because they do not stem from physician's own principles, but from pre-established definitions of what good health and good medicine are. It is not a case of physicians imposing their own beliefs upon a patient. It is a case of a physician applying pre-established, generally agreed upon medical principles and standards of care to treat a patient. The second line of thought is that, even if one were to concede the fact that this is still paternalism in that it imposes someone else's values onto the patient, in this case the values of regulating bodies of medical practice, the imposition, and therefore the paternalism, is justified in so far as it supports or is adherent to pre-established, generally agreed upon good principles of medicine and definitions of health. Wicclair takes this stance when he writes that physicians may conscientiously object when their objection is in keeping with the core values of the medical profession (Wicclair 2011, pg. 223).

Yet, how these principles are prioritized, especially when they contradict one another means that "adherence" to these principles in medical practice is not as straightforward as Wicclair suggests. For example, Alberto Giubilini brings up the core value of autonomy (Giubilini 2014, pg. 172). Patient autonomy is often accepted as a core value of medicine. Patient autonomy also seems to be in direct contradiction with the right of physicians to conscientiously object. Therefore, there is a problem with justifying conscientious objections by their adherence to core values of medicine because those same core values indicate that it is essential that a patient have the right to choose what happens to her body. In addition to this, what are and what *ought to be* the pre-established, generally agreed upon principles of medicine and health are two different things. Lamb quotes the World Health Organization and the Minnesota Nursing Association in defining health as a "state of complete physical, mental and social well-being and

not merely the absence of disease or infirmity. Well-being consists of being ‘healthy’ in mind, body, and morality (that which is right or wrong), which is a precursor to ethics: to do that which is good or right” (Lamb 2016, pg. 34). This definition of health, and its inclusion of being healthy in morality, will be discussed at a later point in relation to integrity and conscientious objections. For the present purpose, this definition of health further illustrates the difficulty with grounding conscientious objections in their adherence to the core values of medicine. The way we define mental and social well-being is partly subjective. What looks like social well-being to one person may seem unhealthy to someone else. Therefore, as Schuklenk and Savulescu write, we need to “give up the idea that medicine is only about promoting objective best interests” because “interests should be subjectively defined” (Schuklenk and Savulescu 2016, pg. 170). This does not mean that the promotion of interests is not a function or purpose of medicine. I also think it is important to point out that some, not all interests, are subjectively defined. As aforementioned, Sneddon distinguishes between attentively realized interests, which are individualizing and depend on our enjoyment in them, and consciously enabled interests, which are common to everyone and depend only on our abilities to feel enjoyment and suffering. Medicine is certainly meant to promote some “objective best interests”, such as good health and quality of life. However, it should also promote attentively realized interests. One’s hobbies, passions and goals should be taken into account when determining medical treatments. If, as Sneddon suggests and I agree, our well-being is predicated on the promotion of our interests, and many of our interests are subjectively-defined, we cannot determine the morality of conscientious objections by their adherence to core values of medicine. This is because, in practice, core values of medicine require subjective interpretation.

So, it seems that these attempts to avoid the charge of paternalism fail. They fail first, because beliefs and principles about what is good and right are still imposed upon the patient; whether the imposition stems originally from the physician or the medical institution is irrelevant. It is the physician who chooses to interpret medical principles in such a way that results in a conscientious objection and their view being imposed onto the patient. They also fail because the “core values of medicine” which Wicclair suggests validate paternalism have not been pre-established, are not generally agreed upon, and can be interpreted and prioritized differently by each individual, which becomes an especially difficult problem when some values contradict one another (e.g., autonomy and physician beneficence). In addition to this, the core values of medicine ought to be adaptive to the society in which that medical profession operates. Schuklenk and Savulesu write:

A career in medicine might span 40 years and the field a doctor leaves might be almost unrecognizable from the field she enters. It is clear that the scope of professional practice is ultimately determined by society, and that it is bound to evolve over time. That is true not only for the question of what kinds of services must be provided, it is also true for conscientious objection itself, as the mentioned examples of the two Scandinavian countries [Sweden, Finland and Iceland] show. If a professional norm is no longer fit for purpose, it should be changed (Schuklenk and Savulescu 2016, pg. 163).

The core values of medicine must properly address the moral questions that arise from actual medical practice. However, actual medical practice and the moral questions that arise from it are constantly changing as a result of evolving social landscapes and scientific and technological advances. We cannot justify paternalism as an acceptable form of the physician-patient

relationship, which ultimately contributes to the justification of conscientious objections, in something so fluid and dependent on our ever-evolving society.

Some, such as Blustein, argue that refusing to accept paternalism leads to another worry; that when we limit or altogether take away a physician's ability to make certain medical decisions on behalf of their patient, for their patient's best interest, we reduce them to an "engineer", someone going through the motions, simply fulfilling patient requests (Blustein 1993, pg. 291). We do not give proper respect to the physician's medical expertise, or even their prior experience navigating similar moral questions that have arisen through their medical practice. Blustein worries that barring physicians from practicing paternalistic medicine will require "self-deception, or a misunderstanding of the nature of agency, for one cannot block moral responsibility for one's professional activities merely by selectively focusing on the technical proficiency with which they are carried out" (Blustein 1993, pg. 291). However, it's not true that limiting paternalistic practices necessitates that physicians deceive themselves, delude themselves about their culpability, or try to separate their practice from moral responsibility. What is true is that preventing physicians from being able to practice paternalism and impose their beliefs on their patients means that those physicians must either accept that they will be providing medical services and procedures to which they are morally averse, or they must re-evaluate their beliefs. This second option, the reevaluation and assessment of beliefs, is what I turn to now.

Evaluating Reasons

By understanding integrity as a social virtue, one that properly prepares us to be members of a community, we require that individuals submit their principles to evaluation by their fellow

deliberators – their peers in the community. I now focus on what would result from evaluating physicians’ reasons for refusing to provide legal medical services and how this evaluation ought to shape laws guiding conscientious objections in Canada. To start, it needs to be established that the views of physicians who conscientiously object to abortion are not in line with the majority of Canadians’ views. An Ipsos Pole conducted in 2017 indicated that 77% of Canadian believe that abortion should be legalized, 53% of Canadians believe that abortion should be permitted under any circumstances and whenever a patient requests it. A little under one quarter of Canadians said that it should be legalized but with certain limitations determined by considerations such as the stage of the pregnancy and if the pregnant woman was the victim of sexual assault (Simpson, 2017). Opinions on the morality of abortion are changing in Canada, and they are shifting towards legality and a woman’s right to choose. Compared to the same survey conducted by Ipsos almost twenty years ago, in 2017 significantly less Canadians answered that abortion should not be permitted. Canada is one of the most progressive countries in the world when it comes to recognizing and endorsing abortion rights and a woman’s right to choose. However, laws governing health care in Canada do not reflect this. Instead, our laws support physicians’ right to refuse to provide services which are contrary to their conscience and principles. However, as Fiala writes, “conscientious objection in reproductive healthcare amounts to a capitulation to anti-choice views without any benefit to women or society. It can be seen as an objection to the legality of abortion, and a backdoor attempt to limit the accessibility of safe abortion.” (Fiala 2016, pg. 206). When we allow conscientious objections to occur and protect physician’s ability to conscientiously object, we suggest that they have good reasons for doing so. We acknowledge their views, their reasons for those views, as well as the consequences of those views (i.e., that abortion becomes far less accessible, if accessible at all, to

women), and we accept them. Despite the facts that 77% of Canadians argue that abortion should be legalized, and most Canadians believe that abortion should be accessible regardless of circumstance, health care policies continue to foster practices which support the notion that there is something morally wrong with abortion.

It is intuitive to reason that the laws which govern our society ought to properly reflect the views of that society. Calhoun argues that our duties as social beings and members of a community, and part of what renders integrity valuable and a virtue, include the responsibility to endorse and submit our views to our peers for critique and evaluation. This is because, in doing so, we contribute to the advancement of a common project; which is determining what we, as a community, think is worth doing. Therefore, when members of a community notice that laws which govern it no longer represent the values and principles of the majority, but still align with the views of a few, how do we go about illustrating that those laws should change? I believe the first step is to determine that the majority of individuals do, in fact, disagree with the current views being endorsed, which I have already shown. The second step is to engage in what Calhoun suggests is necessary for people of integrity to do, that is, evaluation of the views in question (Calhoun 1995, pg. 256). It is important to clarify that the distinction between the views of the majority versus those of the minority, while arguably necessary in order to initiate a discussion regarding the differing views, is not an indicator of what view should ultimately be endorsed by the community. While most Canadians believe that abortion is a moral good, after critical debate between co-deliberators who submit their honest and best judgements and reasons for their beliefs to one another for evaluation, it could conceivably be agreed that the majority were mistaken in their views, and that abortion should not be legalized. However, I believe that this is not a likely outcome of honest, critical debate regarding abortion in Canada. This is for

two reasons. I will be blunt about these reasons because I believe my previous discussion allows for it. First, the views of the majority (i.e. the view that abortion should be legalized) are supported by good reasons which I have outlined in chapter three. Second, the views for the minority – those (including physicians) who believe that abortion is morally wrong – which I addressed in chapter two, are bad and do not sufficiently support the right of physicians to conscientiously object.

Thomas Nagel writes "for if by committing murder one sacrifices one's moral purity or integrity, that can only be because there is already something wrong with murder. The general reason against committing murder cannot therefore be merely that it makes one an immoral person" (Nagle 1972, pg. 132). In relation to this, Crowley asserts that "by itself, however, the threat of guilt or any other merely psychological harm is not enough reason to grant an exemption. After all, people could feel guilty about lots of things, just as integrity can involve loyalty to bad things as well as good" and that "the mere threat of feeling guilty is not enough of a reason for an exemption, because so much of feeling guilty is a matter of choice" (Crowley 2016, pg. 360-361). All of this is to say that I will not consider the guilt or emotional distress that a physician might feel as a result of performing an abortion to which they conscientiously object as a valid reason for supporting conscientious objection. It is clear than in these cases the guilt and emotional distress is not predicated on abortion itself, but on the physician's view of abortion. It is also clear that the views that the physician endorses which indicate to them that abortion is wrong are the product of their own thinking and reasoning and therefore to act in accordance with these principles is the intentional choice of the physician. The physician's disposition to experience distress from performing an abortion is not the result of some particular circumstances that are out of their control, such as gender, race, age, orientation, etc. This

disposition is the result of views that have been purposefully endorsed. So, instead of focusing on the emotional harm that physicians may experience, which is the result of the views they choose to endorse, I will address the reasons that they might choose to endorse those views.

Giubilini distinguishes between two reasons we may want to protect the rights of physicians to conscientiously object. The first is that we should foster tolerance and respect towards others regardless of the justifiability of their beliefs (Giubilini 2014, pg. 161). There are several problems with this justification other than the fact that it fails to recognize the essential aspect of integrity that is standing by one's principles. The first, which illustrates another distinction made by Giubilini, is the difference between giving respect and impartiality to conflicting parties (i.e., patient and physician) and giving respect and impartiality to the conflicting moral stances (i.e., pro access to abortion or PAS and pro-life views). In order to achieve the former, it is not immediately clear that we need to do the latter. Also, a society can foster tolerance and respect between its members while insisting that unjustifiable beliefs not necessarily be accepted or allowed to influence how that society is governed. The open, honest discussion between co-deliberators which occurs in order to determine what is worth doing in a society is exactly the sort of model which fosters tolerance and respect while still working to determine the truth about what is worth endorsing. Perhaps, although it would not (On Calhoun's account) achieve integrity, there are situations in which the morally good method of fostering tolerance and respect is to allow others to act in accordance with principles that we believe are wrong and are in stark contrast with our own. For example, consider that your co-worker prints much more than you, and prints things that don't necessarily require a hard-copy, and only prints one-sided instead of double-sided. You, an advocate for the environment, consider this to be wrong as it wastes paper which requires energy to recycle. It may be the case that the right thing

to do here is to avoid conflict and ensure a tolerable and respectful relationship between you and your co-worker by not challenging her actions. However, addressing conscientious objections to abortion is not one of these situations. In my example, the actual effect that your co-worker is having on the environment, and the degree to which she is acting contrary to your views may not be very big (maybe your co-worker makes up for her environmental toll at work by living incredibly green at home.) But the effect that results from conceding to the views of physicians who object to abortions is significant. It might mean that a woman who does not want and/or is not prepared to experience pregnancy, childbirth or motherhood, is forced to do so anyway. The desire to foster tolerance and respect between those who do and do not think that abortion is morally acceptable is not enough to justify this sort of result. The second reason we may want to protect the rights of physicians to conscientiously object is because their objection is morally justifiable, in which case those with mistaken views or objections should not be allowed to object. Which means that, in order to support the right of physicians to continue to conscientiously object, they must demonstrate that their reasons for wanting to do so are sound.

Christopher Crowley addresses comparisons between conscientious objections to abortion and racist and homophobic refusals of treatments and services (Crowley 2016, pg. 360) He begins by insisting that racism and homophobia have been completely discredited in the public sphere and that they do not ground any public policies or laws. While I believe Crowley is wrong in this regard, it is his following claim that is most relevant to the matter at hand. He writes that “in contrast, a doctor can refer to the wrongness of abortion as an intelligible reason for refusing a patient, without thereby losing moral and intellectual credibility. There is a real debate to be had about abortion, whereas there is no debate about racism” (Crowley 2016, pg 360). Crowley is right to say that there is absolutely nothing that justifies racism. However, he

over-inflates the contrast between the impossibility of justifying racism and “intelligible reasons” one might have for their conscientious objection to abortion. It is not obviously clear that there is a real debate to be had about abortion. To determine the truth of this, we must evaluate what Crowley calls the “intelligible reasons” for a physician’s conscientious objection.

The first set of reasons I address are those which stem from religion. Schuklenk and Savulescu write that “individual moral judgments about the rights and wrongs of particular medical practices are by necessity partly arbitrary. They are arbitrary in the sense that their moral basis cannot be conclusively evaluated for soundness (an impossibility when it comes to religious convictions, for instance)” (Schuklenk and Savulescu 2016, pg. 167). While I will address the first part of this quote later, it is the last section, which indicates that it is impossible to verify the soundness of views that are based in religion, which is relevant now. While I have yet to come across a survey or any inquiry which shows the different reasons that physicians have for conscientiously objecting to abortion (and I wonder if such a thing could ever be accurately accomplished), it is certain that many physicians object on religious grounds. Pellegrino, whose argument for the need to protect the conscience of religious doctors who conscientiously object to certain medical procedures was discussed in chapter two, is an example of a doctor and theorist whose objection to abortion is the result of religious beliefs. He writes that “nominal “Catholics,” who firmly believe that fidelity to conscience dictates opposition to church teachings on the issues of human life and sexuality, are arguably examples of wrongly formed conscience. Their “consciences” compel them to oppose official (Magisterial) teaching, which, for Catholics, is a source of authoritative guidance for conscience formation” (Pellegrino 2002, pg. 227). Here, Pellegrino insists that Catholic physicians, and perhaps even all religious physicians (regardless of which religion) must oppose that which the church and their religious

texts oppose. This would mean that, at least for Catholic physicians, they must conscientiously object to procedures such as abortion and physician assisted suicide. Further, Pellegrino argues that concerning topics such as these (abortion and physician assisted suicide), physicians absolutely cannot compromise. This is because such significant issues which concern life and death effect one's "spiritual destiny" and determine whether or not they will go to heaven (Pellegrino 2002, pg. 231). When these sorts of beliefs are the basis for one's arguments against the morality of procedures such as abortion, it is impossible to determine the soundness of the argument. It is true that if God existed and was omniscient and the religious texts that we read accurately conveyed God's knowledge and will and that these texts indicated that abortion is wrong that we could conclude that abortion is, in fact immoral. However, each of Pellegrino's arguments depend on the existence of god and the reliability of religious texts, and both of these things depend on speculation and cannot be reasonably supported. The result is that religious physicians cannot possibly demonstrate that their reasons for conscientiously objecting are sound, and therefore they will not hold up to evaluation by the physicians' community and co-deliberators.

Robert K Vischer writes "A person may be culpable for improperly forming her conscience, but not for following the dictates of that improperly formed conscience" (Vischer 2010, pg 857). All sorts of things can influence the views that someone adopts and that ultimately constitute one's conscience. While many of these things may be out of one's control (such as the media and one's upbringing), ours views and consciences are also influenced by deliberate choices that we make independently of outside forces; choices such as remaining uneducated about certain topics and discounting the views of our peers with differently-formed consciences. Vischer suggests that while we are responsible and should be held accountable for

the deliberate choices we make that help form our conscience, we cannot be at fault for acting in accordance with our wrongly-formed conscience. Vischer's concern helps illustrate an important aspect of Calhoun's social understanding of integrity. Compelling physicians to perform abortion, physician assisted suicide and any other procedure to which they conscientiously object is not about retribution or penalty for their wrongly-formed views, or their past of acting in accordance with those views and harming others as a result. Vischer is right, we cannot blame physicians for refusing to provide abortions when they had deeply held, genuine convictions which they believed determined their spiritual fate, which indicated to them that abortions were morally wrong. Calhoun agrees too, writing "acknowledging others are deliberators who must themselves abide by their best judgement seems part of, not exterior to, acting with integrity" (Calhoun 1995, pg. 260). However, we can, and should, submit those convictions to critical examination by a community of one's peers. If the reasons for one's convictions are shown to be unsound or invalid, then the conviction cannot be accepted or allowed to impact the functioning of that community. If the reason for refusing to provide abortion is that one's religion deems it immoral, we cannot accept their refusal because their reasons are not good. As Schuklenk and Savulescu write: "as professionals, doctors have to take responsibility for their feelings." (Schuklenk and Savulescu 2016 pg. 164). We cannot allow a community to suffer because of the decision of a few of its members to support mistaken views.

According to Calhoun though, integrity also requires that we are careful about how we go about rejecting the decidedly wrong views of our peers. She argues that integrity requires that we avoid "arrogance, pomposity, bullying, haranguing, defensiveness, incivility, close-mindedness, deafness to criticism" because they "all reflect a basic unwillingness or inability to acknowledge the singularity of one's own best judgment and to accept the burden of standing for it in the face

of conflict” (Calhoun 1995, pg. 259-260). This requirement echoes Giubilini’s concern that the best way of addressing conscientious objections must foster tolerance and respect in a community. There may be some principles or issues which a community wrestles with which are difficult, complicated and require significant moral deliberation. In cases such as these where right and wrong are not so clear and there may be a near equal amount of deliberators on each side of the debate, it is easier to avoid arrogance and close-mindedness and to recognize the singularity of our own views and respect the views of our peers. However, in cases where what is truly worth doing is clearly evident (which, I argue it is in respect to abortions), it may be more difficult to exercise tolerance and respect, especially when there is a significant difference between the numbers of the majority and the minority. Still, “if we are not pulled as far as uncertainty or compromise, integrity would at least demand exercising due care in how we go about dissenting” (Calhoun 1995, pg. 260). What does “exercising due care” look like in the case of compelling physicians to perform abortions against their judgement by disallowing conscientious objections? Given the weight that issues such as abortion have for many physicians who oppose it, especially for religious doctors as Pellegrino has argued, it is unlikely that these physicians will be satisfied with any attempt at exercising due care, no matter how earnest and sincere. However, integrity requires that we try anyway. In the context of conscientious objections to abortion in Canada, this might look like following the proper legal channels to develop and update laws pertaining to abortion and conscientious objection and refraining from protesting or picketing at the practices or physicians who conscientiously object. It could also include an “adjustment time”, for physicians who may decide to stop practicing medicine (such as those who are near retirement, or those whose convictions against abortion are so strong that they would rather stop practicing medicine than be a part of an institution that

provides them), to change aspects of their practice, or to relocate to a place where they are less likely to receive requests for abortion. Even more, it might also require more individualized and intimate kindnesses. Keeping in mind Vischer's concern that we not hold physicians accountable for following their conscience (even if it wasn't formed correctly), we should exercise understanding and discretion and show gratitude when interacting with a physician who is fulfilling their obligation to provide an abortion when doing so violates their moral principles.

Pellegrino argues that the discussion of issues such as conscientious objection is "significant because once the ethical issues are expressed in law, the debate may be reduced to instrumental and procedural details that cannot resolve underlying moral sources of controversy" Pellegrino 2002, pg. 221-222). As Fiala writes (Fiala 2016, pg. 205), an essential step in preventing this from happening in the case of abortion is to foster and support acceptance and awareness of women's rights, including their right to reproductive healthcare and bodily autonomy, and to ensure that those rights are reflected in Canadian laws.

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