

A Bridge Too Far: Individualised Claims of Conscience

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DOI:

[10.1093/medlaw/fwv011](https://doi.org/10.1093/medlaw/fwv011)

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Peer reviewed version

Citation for published version (Harvard):

Smith, S 2015, 'A Bridge Too Far: Individualised Claims of Conscience', *Medical Law Review*, vol. 23, no. 2, pp. 283-302. <https://doi.org/10.1093/medlaw/fwv011>

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A Bridge Too Far: Individualised Claims of Conscience

Abstract

This article will explore the role of conscience in cases which are not subject to a predictable, generalizable rule-based conscientious objection. These claims arise in cases where doctors, who might have previously provided the treatment at issue, determine that the specific facts of a case mean that they cannot morally provide treatment. In legal cases, the courts have tended to act as if these conscience refusals are part of the best interests analysis. They claim that the treatment, as requested, simply is not in the best interests of the patient. However, the courts have used this analysis even when it appears clear that the refusal of treatment is not in what the patient thinks is his or her best interests. Indeed, in recent cases such as *Aintree v. James*, the court has made it clear that determining what is in the best interests of patients usually relies more on the advice of healthcare professionals than it does the patient. It is not, then, about what patients think they need or want, but what doctors and other medical staff think they can morally provide under the circumstances. This article will explore how re-conceptualizing these sorts of claims as ones about conscience provides a more stable footing for understanding the legal and ethical issues which are of importance to the courts and what this might mean for these sorts of decisions in the future.

Keywords: *Aintree v. James*, best interests, conscience, doctors, medical ethics, medical treatment

I. Introduction

We expect doctors¹ to act according to conscience. Indeed, we not only expect it but mandate it through the use of professional codes of conduct,² ethical statements,³ and international treaties.⁴ General discussions about conscience, though, tend to focus on rule-based expressions of conscience. These are instances in which an individual doctor objects to an entire class of practices. For example, she might not wish to provide abortions and, therefore, expresses a conscientious objection to that practice. Even claims of conscience which express a more limited objection, for example, if a doctor objects to the provision of abortion only in cases where the individual is seeking an abortion on the basis of sex, are often based upon some sort of generalizable rule. As a consequence, there are a number of ways to address these kinds of concerns. We may create a specific statutory grant of conscience, such as the one which exists in section 4 of the Abortion Act 1967. Even if we do not create a specific statutory grant which allows someone to claim a conscientious objection, one may be created by procedures, administrative rules, or other processes.⁵ Moreover, parties within the process can engage in a period of negotiation in order to attempt to resolve disagreements. If doctors have significant objections to particular practices, they may also leave a specialism (e.g., those opposed to abortion could decide to leave obstetrics and gynaecology specialisms) or even medical practice as a whole. This is all possible because these sorts of conscientious objections are predictable *prior* to the event.

¹ Much of what I say here is also applicable to nurses or other healthcare professionals. Due to space limitations, I focus specifically on the conscience claims of doctors.

² General Medical Council (GMC), *Good Medical Practice*, http://www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 21 February 2015). There are important differences between personal ethical codes and professional ones, and my primary focus here is on a doctor's individual conscience.

³ See, e.g. The Hippocratic Oath.

⁴ See, e.g. the Declaration of Helsinki.

⁵ Hospitals might, for example, allow doctors to opt out of providing particular treatments if other medical staff can provide the treatment instead.

Other claims of conscience⁶ are not so predictable. For example, doctors might object to *particular* instances which are not necessarily covered by (predictable) generalizable rules. These cases may involve practices which the doctor does not usually object to but does so in *this* instance on *these* facts. This may well occur in end-of-life cases where doctors have provided a particular treatment, or set of treatments, and then decide that they have reached a ‘bridge too far’, so that that treatment previously provided has now become objectionable. Since these claims involve individualised fact scenarios and practices which are often not objectionable in themselves, it may not be possible to predict when they will arise in advance. Consequently, our strategies for dealing with clashes between patient treatments and claims of conscience are less effective. It is difficult to create a specific statutory grant about such practices if they are otherwise indistinguishable (on a general level) from other cases where claims of conscience would not attach. It may also not be possible for the parties to engage in negotiations beforehand since it might be difficult to specify what conditions will trigger the claims of conscience. Instead, it is more likely that the claim will arise in situations which can only be described in vague language like ‘if it goes too far’ or ‘this far but no further’, but where neither side can predict what ‘this far’ is likely to mean. These type of cases are especially important in discussing conscience because of the link between the claim of conscience and proper medical treatment. Both the provision of treatment in these conditions as well as the withdrawal or withholding of treatment are likely to be considered proper medical treatment. The issue will then centre on what the doctor feels she can do in a moral sense within the bounds of what is proper in a clinical sense.

⁶ Conscience-based claims are often referred to either as conscience-based exemptions or conscientious objections. In order to differentiate between the types of conscience claims I am concerned with here from the generally discussed types, the individualised ones I am discussing will be referred to as claims of conscience with all others called conscientious objections.

A recent example of the type of case I am envisaging is *Aintree v. James*.⁷ Here David James, having contracted an infection, had been in the hospital for several months. While he was not ‘actively dying’, his condition was in decline. In December 2012, he was declared to lack the capacity to make decisions for himself, and the doctors petitioned the court to be allowed to withhold treatment from him in certain situations. In particular, they wished to withhold cardiopulmonary resuscitation, an ‘invasive support for circulatory problems’, and renal replacement therapy (RRT).⁸ The latter might be particularly relevant for the purposes of conscience because while not painful in itself, there can be pain with some of the associated procedures necessary for RRT, inserting a needle for example.⁹ More importantly, in order to ensure that the patient’s blood runs through the renal replacement machine, the patient must be given blood-thinning drugs. One consequence of these drugs is that, because the blood in the patient is thinner, they are more likely to feel cold, often to such a degree that they shiver.¹⁰ The doctors were concerned as they thought it likely that David would require RRT all day every day.¹¹ They believed that there was a good chance that he would be shiveringly cold for the entire time he was on the machine, possibly for the rest of his life. The doctors’ objection was not that the treatment would not work, but that to administer it was something they could not reasonably be asked to do to a patient.¹² The doctors do not explicitly say that they have a problem of conscience, but this is a reasonable presumption from the language they use, and I discuss this further in Section III below.

Notably, there was no evidence that the doctors objected to any of the proposed treatments as practices in and of themselves. Indeed, they had administered some of them to David prior to

⁷ *Aintree University Hospitals NHS Foundation Trust v James*, [2013] UKSC 67.

⁸ *James* (n 7) [8] *per* Lady Hale.

⁹ *Aintree University Hospitals NHS Foundation Trust v James* [2013] EWCA Civ 65, [24] *per* Ward LJ.

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² *Ibid* [22], [24], [25] *per* Ward LJ..

the time period in question. This, therefore, was different from a case where a doctor objects to the provision of RRT in all instances. They instead argued that they could not provide these treatments in this particular case under these particular facts. None of the treatments were morally objectionable in general, but they were *here* and, as a consequence, the doctors argued that they should not be forced to provide them.

The case was not decided by any reference to conscience. Neither party appears to have mentioned claims of conscience, nor did the judges rely on them in making their decisions. Instead, they relied on the standard ‘best interests’ analysis.¹³ Nevertheless I argue that doing so disguised rather than illuminated the important issues in the case. The main issue to be decided was not the best interests of David James but the extent to which the doctors should have been *required* to provide treatment they objected to. A more direct analysis of claims of conscience would have provided a more accurate resolution to the case at hand. To do this, however, would require that courts have a better understanding of how to address claims of conscience like the one in *James*. They do not currently have any effective method for doing so, and thus rely on distorted analysis under the best interests test. My purpose here is to provide a means of analysis that courts could use in these types of case. In order to do this, some preliminary work must be done on what we mean when we discuss conscience, before developing a conceptual model for exploring these kinds of conscience claims. I will then return to a discussion of *James* in order to test the usefulness of this conceptual model. Finally, I will explore the model’s normative implications.

II. Concept of conscience

¹³ *Ibid.* [15], [45]; *James* (n 7) [35]-[45].

Before attempting to create a conceptual model of claims of conscience in medical treatment, we need an understanding what conscience is. We often talk about doing something ‘in good conscience’,¹⁴ or we might refer to being able to do something with a ‘clear conscience’.¹⁵ What do we normally mean when we talk about conscience in these sorts of ways? Conscience involves reasons which are both moral (at least partially)¹⁶ as well as intentional. They must also be inward-facing. Conscience claims are about my moral choices and decisions, not what I necessarily think others are required to do.¹⁷ More specifically, conscience, in the way we generally use it, is a feeling, attitude, or belief, which is frequently but not necessarily based upon religion, about whether doing something is right or wrong.¹⁸ Feelings, beliefs, or emotions can provide reasons for action,¹⁹ and conscience is no different in that regard.²⁰ It provides an impetus for acting in a certain way, but that does not necessarily require any complex thought pattern or rationale. Instead, we often use conscience as a ‘moral nose.’²¹ Because of conscience, we shy away from various actions or activities and are drawn towards others, but it may not be especially clear why this is the case. Conscience also does not have to be correct.²² Merely because one is acting from a clear conscience does not necessarily make it right. It only means the individual in question

¹⁴ JF Childress, ‘Conscience and Conscientious Actions in the Context of MCOs’ (1997) 7 *Kennedy Institute of Ethics Journal* 403, 403; FA Curlin, ‘Conscience and clinical practice: Medical ethics in the face of moral controversy’ (2008) 29 *Theoretical Medicine and Bioethics* 129, 129.

¹⁵ C. Fitzgerald, ‘A Neglected Aspect of Conscience: Awareness of Implicit Attitudes’ (2014) 28 *Bioethics* 2, 25.

¹⁶ EJ Sutton and REG Upshur, ‘Are there different spheres of conscience? (2010) 16 *Journal of Evaluation in Clinical Practice* 338, 339.

¹⁷ E Sepper, ‘Taking Conscience Seriously’ (2012) 98 *Virginia Law Review* 1501, 1526-1531.

¹⁸ Childress (n 14) 403; Sepper (n 17) 1527-1528. W. Kinghorn, ‘Conscience as Clinical Judgment: Medical Education and the Virtue of Prudence’ (2013) 3 *American Medical Association Journal of Ethics* 202.

¹⁹ Martha Nussbaum, *Upheavals of Thought: the Intelligence of Emotions* (Cambridge: Cambridge University Press 2001).

²⁰ Childress (n 14) 403-404. Childress highlights, however, that it not just a belief but a consistency between our beliefs and our actions. Also, FA Curlin, ‘Caution: Conscience is the Limb on Which Medical Ethics Sits’ (2007) 7 *The American Journal of Bioethics* 30, 31; Sutton and Upshur (n 16) 339.

²¹ J Glover, ‘On Moral Nose’ in John Coggon, Sarah Chan, Soren Holm, Thomasine, Kushner (eds), *From Reason to Practice in Bioethics: An Anthology Dedicated to the Works of John Harris*, (Manchester: Manchester University Press, 2015).

²² Curlin (n 14) 31; Sepper (n 17) 1530.

believes it to be. Moreover, one does not have to perform a morally beneficial action in order to be able to do so with a clear conscience. Instead, we have a clear conscience when we have not done something morally wrong. This may include actions which we think are morally neutral in addition to those we think are morally bad.

Conscience, then, is the doing or failing to do something on the basis of our beliefs about the rightness or wrongness of the conduct in question.²³ Notice, however, that conscience claims do not necessarily require that one act according to a moral rule. A claim of conscience requires that the reason in question be a moral one, but it need not be a rule-based reason. One can have a moral qualm about performing a particular action in one case without it necessitating that the individual be able to articulate a rule as to why. This may be because the claim is based upon a moral hunch, but it might also be because there are a number of ethical rules at play in a particular case. It might, therefore, not be possible to articulate a single rule behind the claim of conscience. Nor is it necessarily a claim which must be predictable, especially if we consider conscience in the context of a moral ‘nose’ or hunch. The beliefs, feelings, and emotions which create feelings of conscience may only arise when the issue becomes an impending one and not previously. This again might be especially true when there are a number of ethical rules which combine in a particular instance to create the claim. The set of circumstances might not be predictable or may only be predictable in very general terms.

Defining conscience does not end the inquiry. In fact, the use of conscience creates particular problems in moral decision-making that need to be addressed. Conscience claims are frequently, if not always, controversial. Not everyone will agree with what individuals

²³ Childress (n 14) 403; Fitzgerald (n 15).

believe to be matters of conscience. Indeed, one of the purposes of conscience is to provide a way in which individuals can act upon their moral beliefs or attitudes without having to agree to a consensus view as to what those moral beliefs and attitudes are. Furthermore, conscience is likely to affect others, particularly in a healthcare setting. It is important that claims of conscience are evaluated in terms of the impact upon others. A claim which provided an unacceptable adverse effect upon other individuals need not be allowed merely because it is one of conscience.

For these reasons, we can question the benefits of privileging conscience at all. There are some initial reasons why we might believe conscience deserves a special place. First, conscience claims are usually based on strong feelings. We rarely make a serious claim in a situation where we do not find it important, even if all we are doing is negating the strong feelings of someone else. Invoking conscience, then, is at least partially a claim that the feelings involved are considerable ones. This strength of feeling provides an initial reason to accept an individual's claim of conscience, especially in cases which do not involve a direct harm to anyone else. Requiring someone to do something they may not want in a case they care little about is a minor inconvenience; doing so in a case where they have strong feelings is much more onerous.

Strong feelings alone do not provide a sufficient reason to privilege conscience. The strength of our feelings or belief is not a good indicator of whether they are reasonable. Allowing someone to exercise their conscience does not provide a necessarily greater chance of getting the decisions they make correct. Correctness, though, is not the fundamental reason to respect an individual's decision of conscience. Instead, respecting conscience is important

because it is an essential element of respecting the autonomy of others.²⁴ If we wish to allow others to exercise their own decision-making capabilities and to respect their worth as persons, then we must also respect the precursors to those autonomous decisions.²⁵ One of those precursors is conscience. It is the exercise of conscience which allows us to determine if our actions or inactions are morally acceptable or not and act accordingly. Respecting other individuals' conscience is a crucial part of respecting their autonomy.²⁶

This is important in medical law because we must take account of the autonomy of various parties. Much of medical law seeks to ensure that patients are able to act according to their autonomous wishes,²⁷ but we do a disservice to the idea of autonomy if we focus only on patients.²⁸ Autonomy is an attribute that is shared by all persons. It is this universality which is considered important to its use as an ethical foundation for medical law.²⁹ We must remember that doctors as well as patients have autonomy.³⁰ We can do as much harm if we require doctors to engage in practices they find abhorrent as we do when we force patients to accept treatment they do not want.

III. Legal conceptions of conscience

In legal decisions, individualised claims of conscience by doctors tend not to feature in the

²⁴ A Gold, 'Physician's "Right of Conscience" – Beyond Politics' (2010) 38 *Journal of Law, Medicine and Ethics* 134, 139.

²⁵ Sepper (n 17) 1526-1531.; RD Orr, 'Autonomy, Conscience and Professional Obligation' (2013) 3 *American Medical Association Journal of Ethics* 244.

²⁶ MR Wicclair 'Conscience-Based Exemptions for Medical Students' (2010) 19 *Cambridge Quarterly of Healthcare Ethics* 38, 39.

²⁷ See, e.g., any of the cases on consent such as *Re C (adult: refusal of medical treatment)* [1994] 1 All ER 819; *Re B (adult: refusal of treatment)* sub nom *Ms B v. An NHS Hospital Trust* [2002] 2 All ER 449. See also J Montgomery, 'Law and the Demoralisation of Medicine' (2006) 26 *Legal Studies* 185, 187.

²⁸ M Brazier, 'Do No Harm – Do Patients have Responsibilities too?' (2006) 65 *Cambridge L.J.* 397; J. Coggon, 'Would Responsible Medical Lawyers Lose Their Patients?' (2012) 20 *Medical Law Review* 130.

²⁹ T. Beauchamp and J. Childress, *Principles of Biomedical Ethics* (7th Ed.) (New York: OUP 2013), 101-149.

³⁰ Orr (n 25).

equation. They are rarely, if ever, discussed in general terms, nor is it made explicit when they are a ground for a legal decision. Statutes, normally, only discuss conscience when it is based on predictable rule-based behaviour. Cases, with the possible exception of *Burke*,³¹ do not mention claims of conscience as a reason to allow particular practices. If claims of conscience provide a reason, it is usually not explicit. Instead, in cases in which claims of conscience are in issue, we focus almost exclusively on the patient. If the patient has capacity, then the focus is on their autonomous decision. The clearest example of this is in the case of *Ms. B*.³² Ms. B was tetraplegic and attached to a ventilator to help her breathing. Considering this intolerable, she asked for the ventilator to be withdrawn.³³ Her doctors and health care team refused, primarily on the basis that they liked her and did not want to see her die.³⁴ The hospital argued that they should not be made to remove the ventilator from Ms B because she was not making a truly informed choice since she had not attempted the suggested weaning process.³⁵ They, therefore, presented a technical argument, but the doctors' concern was apparently that they could not in good conscience withdraw the ventilator from her.³⁶ Dame Elizabeth Butler-Sloss P, in deciding the case, focused on whether Ms B has the capacity to make a decision. Since all of the evidence presented to the court was that she had capacity, Dame Butler-Sloss determined that Ms. B's autonomous decision controlled the case, and that if she wanted the ventilator withdrawn the hospital would have to find some way to oblige that wish.³⁷ That included transferring her to another

³¹ *R (on the application of Burke) v. General Medical Council* [2005] EWCA Civ 1003, [2005] 3 FCR 169.

³² *Ms B* (n 27).

³³ *Ibid* [47].

³⁴ *Ibid* [56]-[58].

³⁵ *Ibid* [63].

³⁶ Dame Butler-Sloss P refers to the doctor's feelings about Ms B: 'The clinicians had clearly become emotionally involved. That situation was entirely understandable. They had with the nursing staff kept Ms B alive and looked after her in every respect including her most intimate requirements. Obviously, a relationship had built up', *ibid* [98].

³⁷ *Ibid* [95].

institution willing to withdraw the ventilator if the hospital would not do so.³⁸ The medical team's feelings about the rightness or wrongfulness of doing this were not discussed in any depth, even though Dame Butler-Sloss agreed with the medical team that Ms B should not die.³⁹

If the patient is not determined to have capacity, then decisions will be made in her 'best interests' under the Mental Capacity Act 2005 (MCA).⁴⁰ The MCA specifies that best interests entail a holistic judgement about the patient's beliefs and wishes as well as their welfare.⁴¹ Furthermore, the views of carers, including doctors, family and friends should be taken into account, although only to the extent of helping to determine what the patient is likely to believe is in their best interests.⁴² There is, however, no indication that the doctor's personal, as opposed to professional, views ought to be taken into account. This implies that doctors should not consider their own conscience in determining what constitutes best interests in the specific case, even in situations where this might be appropriate. Instead, the best interests test focuses on the patient and what might be relevant to her.

Even if best interests do include claims of conscience by medical professionals, their inclusion distorts the actual issue. Since the best interests are those of *the patient*, any claims of conscience by doctors must be in that context. In other words, claims of conscience within the realm of best interests analysis do not focus on conscience as an attitude or belief of

³⁸ *Ibid* [100 (viii)]. Another hospital had already been found. A doctor unrelated to the Trust in the case had offered to give Ms B a bed at their hospital and abide by her wishes regarding treatment. *Ibid* [85].

³⁹ Dame Butler-Sloss P had considerable respect for Ms B, 'I would like to add how impressed I am with her as a person ... I hope she will forgive me for saying, diffidently, that if she did reconsider her decision, she would have a lot to offer the community at large', *ibid* [95]. She also makes it clear that while she is deciding that Ms B is capable of making the decision to have the ventilator withdrawn, Ms B can reconsider that decision. *Ibid*. [95].

⁴⁰ MCA, s 1(5).

⁴¹ MCA, s 4(6). Also *James* (n 7) [39].

⁴² MCA, s 4(7).

doctors about their own conduct, but on a way to assess whether a particular treatment is best for the patient. *James* provides an example of this in practice. The objection of the doctors was not that the treatment, including RRT, would not work, but that to administer it was something they could not reasonably be asked to do to a patient.⁴³ In the Court of Appeal this objection was used by the court to conclude that the treatment would not be in David's best interests, despite admitting that he was happy and would probably want to continue to live.⁴⁴ The Court used the objection of the medical team to the proposed treatment to determine what constituted best interests. However, this approach was not supported by Lady Hale in the Supreme Court. She instead stated that in identifying best interests it was necessary to focus on the individual patient.⁴⁵ Both the Court of Appeal and the Supreme Court thus focused their attention on David's best interests instead of conscience.

Even so, there is evidence that claims of conscience played at least some part in the doctors' views about the case. First, there is considerable focus on the painful, discomforting, and distressing nature of the treatment, particularly in relation to RRT. It also plays a role in the doctors' views about the other treatments that David might receive. In the case of RRT, Dr G referred to the shivering effect of the blood-thinning medication as the thing he is 'personally really concerned about'.⁴⁶ This concern is separated from the clinical concerns about RRT which Dr G expressed as the possibility of bleeding or strokes. These are hardly minor concerns; nevertheless, shivering was Dr G's primary concern specifically the 'distress' and 'very unpleasant experience' it would cause.⁴⁷ This focus on the distressing rather than medical effects of the treatment suggests that Dr G's primary concern was more moral than

⁴³ *James* (n 9) [22], [24], [25] *per* Ward LJ.

⁴⁴ *Ibid* [46]-[47] *per* Ward LJ.

⁴⁵ *James* (n 7) [39] *per* Lady Hale.

⁴⁶ *James* (n 9) [24] *per* Ward LJ.

⁴⁷ *Ibid per* Ward LJ.

clinical.

Moreover, the doctors repeatedly stated that they held this opinion despite the evidence of potential benefits to David, benefits they did not dispute.⁴⁸ Additionally, neither the doctors nor the Court of Appeal argued that David would not have wanted treatment to continue had he been able to decide for himself.⁴⁹ They also did not dispute the fact that he seemed to get significant benefit from the presence of his family and friends or the other interests that he had. Similarly, they did not dispute that David's family wished him to continue to receive treatment, at least partially on the basis that they believed it corresponded with his most likely wishes. There are, consequently, significant benefits to David James if he received treatment like RRT. Despite this, the doctors made it clear that they objected to the provision of these treatments. When answering a hypothetical question, Dr G indicated that even if David had specifically communicated a request for these treatments, he would 'explain[] why I thought that it would be deeply inappropriate for me as the attending clinician and the rest of my colleagues to *offer* these treatments'.⁵⁰ While this claim is couched later in terms of 'the right course of medical action', the use of the phrase 'deeply inappropriate' indicates a moral rather than a clinical objection to providing treatment. If the claim is more moral than clinical, it is likely to include at least an aspect of conscience.

Neither of these two facts, individually or together, provides enough evidence to argue that claims of conscience were clearly at play in the *James* decision. Instead, they highlight that

⁴⁸ This is not specifically stated in the sections replicated in the Court of Appeal judgment. However, the doctors talked about the treatment options as being 'distressing', 'discomforting' or 'painful', *ibid* [22], [24], [25] *per* Ward LJ. They do not indicate that RRT would not help David's renal functioning. This can be contrasted with the provision of antibiotics which the doctors clearly indicated would not be useful. *Ibid* [8] *per* Ward LJ.

⁴⁹ *Ibid* [46]-[47] *per* Ward LJ.

⁵⁰ *Ibid* [19] *per* Ward LJ, emphasis added.

there are claims which sound like claims of conscience and can be interpreted in that manner. The focus on the pain, distress, and discomfort that the doctors would be causing David should they use these treatments, along with the claim that it would be inappropriate to offer them irrespective of David's views, seem to shift the case towards a focus on what the doctors were prepared to offer as opposed to what he might have wanted to receive. Dr G's comments confirm this. The question, as a consequence, has shifted from a patient-focused model (such as best interests) to one which is doctor-focused, and one which would have involved, at least partially, claims of conscience. Consequently, there is a plausible case that claims of conscience were part of the doctor's opinions in *James*. Those claims, however, are never explicitly addressed by the courts.

None of this means that judges do not consider the doctor's conscience in cases which come before the court, it just means that these claims of conscience are often hidden by other legal concepts or rules. If a judge uses conscience to decide a particular case, they may talk instead of different legal rules such as best interests to justify the decision, as they did in *James*.⁵¹ This is problematic because these claims of conscience are then not subject to any analysis by the judges. Neither Ward LJ nor Arden LJ, for example, provided any meaningful analysis of the claims of conscience by the doctors in *James*. There was no attempt to examine whether these claims of conscience were true; that is, that the doctor actually had the particular claims of conscience in question, nor to consider the effect of such a claim. This does not necessarily provide protection for either patients or doctors, because these claims of conscience are not subject to any scrutiny, and even if a doctor has a legitimate claim of conscience, there is no guarantee that it will be considered in any meaningful way by the courts. As a consequence, a legitimate claim of conscience may not

⁵¹ *Ibid* [45] *per* Ward LJ.

be approved even in cases where it might be appropriate to do so.

Moreover, hiding these sorts of claims within something like a best interests analysis distorts the use of that test. Best interests, as Lady Hale makes clear in *James*, is a patient-centred approach.⁵² But the purpose of the test gets changed to include claims about what the doctor believes it is appropriate to provide, instead of focusing primarily on the patient. This creates problems because what is best for the patient need not necessarily include things that the doctor feels able to provide. *James* provides an example of this since the best interests of David would have meant that the treatment was continued. The problem with providing the suggested treatments did not come from *his* perspective. There is no reason to believe that, had it been possible to ask him, David would not have wanted the treatments in question. Indeed, the doctors appeared to accept this.⁵³ However, forcing the best interests test to account for the *doctors'* views changes the test to include aspects which are not only hidden, but need not be consistent with the factors which are the supposed reason for examining the best interests of the patient in the first place.

IV. A conceptual model of decision-making in ethically troubling cases

If claims of conscience are a necessary part of any decision in an ethically controversial case, then it behoves our legal mechanisms to find a way for the law to make them a factor. This will provide a more accurate assessment of what has happened in a particular case and allow us to include the claims of conscience of the doctor in our legal understanding of the case at hand. In developing a conceptual model of claims of conscience, there are several places we

⁵² *James* (n 7) [39] *per* Lady Hale.

⁵³ *James* (n 9)[46]-[47] *per* Ward LJ.

might begin. The first is the guidance provided by the General Medical Council (GMC) and British Medical Association (BMA). The GMC's guidance is contained in paragraph 52 of *Good Medical Practice*,⁵⁴ but it does not provide a detailed model for determining when and how doctors are entitled to object on the basis of conscience.⁵⁵ Instead, it indicates merely that if a doctor has a conscientious objection they must express that objection to the patient and direct them to a 'suitably qualified colleague' or other doctor depending on the circumstances. It thus only talks in general terms and provides little advice about how to handle a particular situation. Additional advice is provided in *Personal Belief and Medical Practice*,⁵⁶ but while it provides more information, than the *Good Medical Practice* guidance, it is designed to deal with more generalizable, predictable, rule-based conscientious objections. It talks in terms of 'particular services or procedures' but also specifies that doctors must notify patients in advance of their conscientious objection to providing such.⁵⁷ This may be possible in terms of generalizable, rule-based objections, such as not wishing to provide abortion services, but it is less possible in cases where the objection is based upon individual circumstances as it was in *James*. Moreover, the same paragraph indicates that one way to notify patients is to ensure that any conscientious objections are disclosed within 'any printed material about [the] practice and the services' provided.⁵⁸ Again, this is possible where a doctor is clear about their conscientious objection to a practice or service beforehand, but it would not provide any significant advice to a doctor who has provided treatment in a specific case previously but now believes that things have reached 'a bridge too far.'

⁵⁴ GMC (n 2).

⁵⁵ S Fovargue and M Neal, "'In good conscience': Conscience-based exemptions and proper medical treatment' in this issue.

⁵⁶ GMC, *Personal Beliefs and Medical Practice* (2013) http://www.gmc-uk.org/static/documents/content/Personal_beliefs_and_medical_practice.pdf (accessed 21 February 2015).

⁵⁷ GMC (n 2) [10].

⁵⁸ *Ibid.*

The BMA's guidance also provides little that would aid the resolution of claims of conscience. Its official policy indicates that doctors should have a *right* to conscientious objection in cases of abortion, fertility treatment, *and* the withdrawal of life-sustaining treatment from a patient who lacks capacity.⁵⁹ Like the GMC, then, the BMA focuses on generalizable and rule-based objections which can be predicted. One of the reasons for its preference for largely statutory-based objections is that the BMA believes that the claims relate to 'specific acts, not to specific individuals or groups of individuals'.⁶⁰ Nevertheless, it indicates that other requests for conscientious objection could be considered provided that individual patients are not disadvantaged, but suggests no more than that these requests 'should be considered on their merits'.⁶¹ At best, then, the GMC's and BMA's guidance would allow a claims of conscience in a situation like *James* to be considered, but provides no mechanism or advice regarding how to do so.

Academic literature also tends to focus on generalizable, predictable rule-based conscientious objections. For example, Savulescu has argued that doctors should not be entitled to make a conscientious objection at all since their professional duties ought to override their personal ones.⁶² He does not see this as onerous as those with particularly strong objections could merely seek out a different specialism or, indeed, profession. However, it is unclear how such a rule would work in the types of 'this far, but no further' cases we have been considering. It would only appear to work in the case of an objection which was stable and based upon rule-based criteria such that an individual doctor could decide far enough in advance about such an objection to do something about it.

⁵⁹ BMA, 'Expressions of doctors' beliefs' <http://bma.org.uk/practical-support-at-work/ethics/expressions-of-doctors-beliefs> (accessed 21 February 2015).

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

⁶² J Savulescu, 'Conscientious objection in medicine' (2006) 332 *British Medical Journal* 294

More nuanced models of conscientious objections also seem to presume a focus on rule-based ones. For example, Meyers and Woods have proposed a system for dealing with conscientious objection claims in abortion cases.⁶³ They provide a list of six criteria which they (at least tentatively) believe provide a sufficient basis to judge objections on.⁶⁴ These objections require that the ‘scruple-based objection’ be sincere, consistent with other beliefs and actions, fit within an otherwise coherent set of beliefs, and be a key component of the ‘petitioner’s moral or religious framework’.⁶⁵ Additionally, reasonable alternatives must be explored such as finding another doctor to provide treatment and the substitution of services. These criteria are to be determined by a review board at an ‘informal’ level, with possible appeals to a formal hearing of the board and then a court of competent jurisdiction. In cases where the doctor in question has a generalizable, rule-based objection to a practice, such as abortion, Meyers and Woods model makes some sense. A doctor could determine well in advance that they have an objection to a particular practice, articulate that decision in the subsequent manner, and have it adjudicated both informally and formally well before any adverse effect upon patients actually happened. In a *James*-type situation, this may be less likely. In addition, it is unclear how the criteria Meyers and Woods develop would operate in such a case. Requiring, for example, that the case be consistent with other beliefs and actions might be difficult in a situation where the doctor involved has provided the treatment in question to the patient before but now believes that, in the current situation, things have reached ‘a bridge too far.’ Moreover, the need to articulate a full-formed belief system might be likewise problematic in cases in which the issue involves a specific patient in specific

⁶³ C Meyers and R Woods, ‘An obligation to provide abortion services: What happens when physicians refuse?’ (1996) 22 *Journal of Medical Ethics* 115.

⁶⁴ For comment on this and alternative criteria see S Fovargue and M Neal, “‘In good conscience’: Conscience-based exemptions and proper medical treatment’ in this issue.

⁶⁵ Meyers and Woods (n 63) 119.

circumstances.

None of this is surprising considering the fact that academics such as Meyers and Woods are primarily concerned with cases such as abortion ones. In other words, the reason that their system would pose particular problems in a *James*-type claim of conscience case is that they were not considering this type of claim when they created their model. Nor does it appear to have been one in the minds of those articulating the official positions of the BMA and GMC as they were presumably focusing on the statutory conscience clauses. It is thus worth considering what a model might look like which focuses primarily on *James*-type cases. For the purposes of this model, we will consider a judicial decision-maker although there is no specific reason why one ought to be required. This is merely because such cases are likely to end up in the courts for resolution if they cannot be decided by less formal means. It, therefore, seems preferable to consider a model which could be used by judges in the determination of these sorts of cases.

Since these sorts of cases are individualised and based upon a specific set of facts, it is first necessary to outline those facts for analysis. This is likely to involve a relatively detailed history, diagnosis and prognosis of the patient. The judge, like the doctor making the claim, will need to have a solid understanding of what has led to the current situation as well as how that situation might be different from previous points in time in the treatment of the patient. In addition to the clinical understanding of the condition, it will be necessary for the purposes of evaluation to have an understanding of what the patient wants. This will depend on whether the patient has capacity. If she does, then further questions arise as to whether they have been provided with sufficient information to be able to make an informed choice, and whether they have made that choice independently of controlling influences. If the patient

has capacity, has received sufficient information and made the choice free from controlling influences, then the decision made by the patient is autonomous,⁶⁶ and thus worthy of respect, even if that decision is neither rational or wise.

If the patient lacks the capacity to make an autonomous decision, then the analysis turns to her best interests. But the lack of an autonomous decision does not mean that the analysis automatically moves to best interests. If, for example, a patient has not made an autonomous decision because of a lack of information, then the issue is how best to inform the patient so that they could make one.⁶⁷ The best interests test is only appropriate if the patient is incapable of making an autonomous decision, an issue which would be based on their capacity under the MCA. As Lady Hale indicated in *James*, the best interests test is not an objective one,⁶⁸ and, therefore, not based on some hypothetical idea about a reasonable patient. Instead, the patient's own interests, wishes and desires are the touchstone.⁶⁹ It is a question as to what is best for *this* particular patient in *this* particular case. Moreover, best interests are not limited simply to medical best interests;⁷⁰ the test is what holistically is best for the patient. This does not mean that the medical interests of the patient are not important, as the welfare of the patient is a crucial aspect of the decision about best interests. That decision, however, is one made by the judge, and welfare interests are only part of the larger whole. All of this information about the surrounding factual circumstances and the patient's known or supposed wishes forms the background for the evaluation of the claim of conscience. If a claim of conscience, as articulated earlier, is about what a doctor is willing to provide, it is a preliminary requirement to understand what the patient might be asking to

⁶⁶ Beauchamp and Childress (n 29) 104-105.

⁶⁷ *Ibid* 107.

⁶⁸ *James* (n 7) [39], [45] *per* Lady Hale.

⁶⁹ *Ibid* [39] *per* Lady Hale.

⁷⁰ *Ibid* [39] *per* Lady Hale.

receive. Only once this is done should the analysis turn to what it is that the doctor might feel willing to provide.

The claim of conscience itself should be subject to evaluation. This will require, first, that the doctor is able to articulate the claim as a conscience-based one, as opposed to some other type of claim.⁷¹ Is this something which is against the conscience of the doctor to provide? It is also necessary for it to be an actual claim rather than a plausible claim. The claim of conscience must be based on what the doctor actually believes, not what she might have believed. Furthermore, the doctor must be able to articulate reasons as to why they have this particular belief. This does not require a substantial, thought-out coherent set of beliefs based upon a comprehensive ethical or religious view. Instead, the doctor must be able to articulate why it is that the treatment in this case is subject to a claim of conscience. What is it about *this* case and *these* circumstances that means the doctor is unable to provide the requested treatment? What differentiates this case from other cases where the doctor has provided the treatment, or would do so? The doctor is not required to articulate a firm set of beliefs in the way Meyers and Woods suggest, but they must be able to provide some reason which explains why this case is different from other cases. These cannot be any reasons but must be limited to the treatment in question and its effect upon the patient. And it is not acceptable for a doctor to object to provide treatment for a patient for a reason which would otherwise count as discriminatory. For example, a doctor could not object to providing treatment to a patient merely because it would leave a patient physically disabled.

The final aspect of the analysis which must be examined are the costs of accepting claims of

⁷¹ See S Fovargue and M Neal, "In good conscience": Conscience-based exemptions and proper medical treatment' in this issue for a similar requirement in rule-based cases

conscience. If the claim of conscience was accepted, what is the likely result? This includes not only looking at the physical result that will most likely occur for the patient, but also whether there are any alternatives available. For example, is it possible to transfer the patient to another doctor, medical team, or hospital which is willing to provide the treatment that the patient seeks? Is it possible to provide alternative treatments which might be effective in the situation which fit the claim of conscience of the doctor? If providing alternative treatment options is not possible, are there options which are at least available which will provide, for example, palliation to the patient? These concerns are important because even a reasonable claim of conscience might be overridden in a case where the effects on the patient are too severe under the circumstances.

V. A Test Case

We can test this model using *James* as an example, and then explain where the real fault lines in the case lie, and what role conscience played in the case. Under the model, we start with information about the patient's condition, history, and prognosis. From the evidence available in the decisions, David was in significant decline which seemed to require ever increasing levels of treatment. We know that he was a permanent fixture in the Intensive Care Unit of the hospital, and there was little to no chance that he would leave it. The treatments included RRT, CPR, and 'invasive support for circulatory problems'.⁷² These are significant treatments with associated problems, including, at least as far as RRT was concerned, the likelihood of 24-hour care which would make David shiveringly cold.

With regards to what, if anything, David wanted to receive in terms of treatment, it does not

⁷² *James* (n 7) [8] *per* Lady Hale.

appear that the doctors discussed with him what he might want in a situation he now found himself in before he was determined to lack the capacity to decide for himself. So, it was not possible to rely on his autonomous decisions in determining how to treat him. Instead, the court had to determine what his best interests were, and it is here that the dispute between the courts emerged. The Court of Appeal argued that the best interests test was objective and that David's medical best interests, as determined objectively, controlled the determination of his best interests overall.⁷³ The Supreme Court disagreed. Lady Hale decided that best interests were an individual decision. It did not matter what a reasonable patient would have wanted. What mattered was what was best for David, which included what he would have wanted under the circumstances.⁷⁴ Taking that as the appropriate test, the provision of these treatments *would* have been in David's best interests at the time of the original trial court decision since, as noted above all of the indications show that he was happy despite his medical condition.⁷⁵ According to Lady Hale, it did not matter whether the proposed treatment could return him to a life of significant function, or whether he would ever be able to return home.⁷⁶ What mattered was what *he* would have considered best under the circumstances, and the trial judge was justified in saying that meant that treatment ought to continue.⁷⁷

The remaining issues surround the doctor's claims of conscience. As noted in Section III above, there was evidence to believe that the doctors' objections to continuing to treat David relied, at least in part, on matters of conscience. They were concerned about the distress, pain, and discomfort that he would experience if the treatment had to be provided. More

⁷³ *James* (n 9) [47] *per* Ward LJ.

⁷⁴ *James* (n 7) [39] *per* Lady Hale.

⁷⁵ *Ibid* [40]-[42], [48] *per* Lady Hale. Lady Hale indicates that significant information available to the Court of Appeal changes the decision and it was no longer in his best interests at that point, *ibid* [46].

⁷⁶ *Ibid* [44] *per* Lady Hale.

⁷⁷ *Ibid* [40]-[42] *per* Lady Hale.

importantly, their objections were framed in terms of what *they* thought they ought to provide to him, rather than what he would have wanted to receive. The doctors expressed the view that, even if David had capacity and requested the treatment at issue, they still would have refused to provide it. Moreover, since they did not dispute the family's claim that David would have wanted to continue treatment and that it provided important benefits to him, the doctors' concern involved a belief about what they could be asked to provide and not what was necessarily 'best' for David. We can, therefore, presume, under the model, that the doctors did have claims of conscience in the case.

It then becomes necessary to determine whether the doctors could have provided a set of reasons to explain why *this particular* claim of conscience ought to be accepted. Considering the importance of non-maleficence as a bioethical principle,⁷⁸ in addition to the fact that RRT does not normally continue as long as they thought it might have to in this case,⁷⁹ there is evidence that the position of the doctors was based upon acceptable reasons. Treating a patient who is shiveringly cold because of something you have done must be troubling, especially if there is nothing the doctors can do to alleviate the situation. They would have been required to treat David continuously despite the difficulties they were causing him, which means the treatment would be significantly harder for the doctors to accept providing. Providing a bad side effect for a limited time for treatment which will ultimately provide a benefit is one thing, doing so for a considerably longer period of time without an ultimate goal is another. This would be ethically problematic, and there is, therefore, no reason to believe that the doctors' claims of conscience in the case were anything other than based upon these reasons. There is no evidence in the case, for example, that there was any

⁷⁸ Beauchamp and Childress (n 29)150-201.

⁷⁹ James (n 9) [23]*per* Ward LJ.

discriminatory basis for their reasons for not providing the treatment.

The effects of this claim of conscience, however, are substantial for David. The reason these treatments were at issue is because they were the only ones thought to have a prospect of improving his condition. Otherwise, the doctors appear to have been limited to more palliative options. This is why the family objected so strongly to not providing the treatment, because they believed this course of action would lead to his death. There might, however, have been alternatives, although the case does not make this clear. For example, it might have been possible to transfer David to another treatment team, either within the same hospital or to a different one. This would have meant that he would have still been able to receive the treatment everyone thought he wanted, while allowing his doctors to make their claims of conscience. This might have been a particularly useful resolution in the light of the fact that David did not, at the time of the initial case, require any of the specified treatments.⁸⁰ It was not a case where the doctors were being required to do anything at the time nor, more to the point, anything which might have been against their claims of conscience. Transferring David to another team (within or without the hospital) was not explored by the court, and it is, therefore, unclear whether it was available. It is possible that all medical teams and hospitals, or at least all medical teams and hospitals to which he could feasibly have been moved, shared the opinions of the doctors in this case. If that were so, the effects of claims of conscience become weightier and, despite their objections, it might have been necessary to force them to continue unless, of course, this fell outside the normal bounds of proper medical treatment. Furthermore, the options the doctors would have accepted are not clear nor is there any indication how effective they might have been. We do not know, for example, how much David could have been benefited from palliative methods,

⁸⁰ *Ibid* [39] *per* Ward LJ.

or whether those methods would have allowed him to enjoy some of the benefits of continued existence. Thus, if the only way to successfully deal with David's pain was to put him in a state which meant that he did not recognise his family, this might present problems for the doctors' claims of conscience since family seems to have been so important to him.

Without full information about the effects of claims of conscience, it is not possible to reach a firm result in our test case. Nevertheless, it provides us with important questions to be considered. For example, if evidence at court had shown that an alternative treatment team could have been arranged for David, then the claims of conscience ought to have been accepted. If it could not, then the issue becomes more difficult, and requires further questions about the options acceptable to the doctors and the anticipated effects of those treatments.

VI. Benefits of the new model

From this example we can see that my model accurately reflects the issues involved in ethically troubling cases, and identifies the relevant questions. These are important aspects of a conceptual model for ethically difficult cases which includes claims of conscience, but they are not the only benefits which might accrue from using such a model. The model is beneficial to the doctor because it recognises the importance of the doctor's autonomy in medical law. As noted above, if we truly wish to respect autonomy we need to respect the autonomy of *all* of the parties involved in medical cases.⁸¹ This includes, at a minimum, the autonomy of the doctor as well as that of the patient. My model accomplishes this by providing a justification for doctors to make honest claims of conscience. Doctors can make these claims directly as opposed to having to hide them behind other principles. There is no

⁸¹ Beauchamp and Childress (n 29) 101-149

need for a doctor to force a claim of conscience into a connection with the patient's best interests, as they appear to have done in *James*. This ability to make direct claims of conscience will allow doctors to assert an autonomy interest in the actions that they perform. It will help to separate these autonomy claims from the best interests and welfare concerns that doctors might have about the patient, as I have shown in Section V above.

In addition, this model of decision-making exposes the conscience of doctors to more regular scrutiny. Since the claim of conscience is not hidden behind other principles, judges can more effectively examine whether those claims are reasonable because they can be addressed directly. Judges will then be less likely to be misled that a claim of conscience is something else, and can analyse these claims more appropriately. A claim of conscience *is* different to a claim about the patient's best interests and should be evaluated on different grounds. Allowing a general space for these claims to be made provides a mechanism which allows for that evaluation. Additionally, if claims of conscience become a more regular part of these sorts of cases, judges will be better able to determine when one exists, even if it is hidden behind other values. The more experience the court has with evaluating claims of conscience, the more likely the court is to recognise these claims and act accordingly.

We can see this through an examination of what could have happened in *Ms. B* if claims of conscience had been a regular aspect of the analysis. As stated in Section III above, the doctors did not want to remove the ventilator from Ms B because they did not think that it was the right thing to do. However, without further analysis, that particular claim is unclear. We do not have an understanding about why the doctors thought the removal of artificial ventilation was unacceptable. We can speculate about two possible answers. First, the doctors were worried about causing the death of Ms B. Alternatively, they were concerned

primarily with a potential violation of the law. The first possibility is one that the court is likely to consider reasonable, the second is not because the court has informed doctors that these actions do not violate the law.⁸² More importantly, being able to subject these claims of conscience to scrutiny provides the court with an effective way to regulate the doctor's behaviour. If the claim was the first one, then a judge's best response is probably to do what Dame Butler-Sloss did in the actual case, move the patient to a doctor willing to perform the specified action. If it is the second, then a more effective answer would have been to re-emphasise to the doctors that removing the ventilator was not a crime. But it is only when these claims of conscience receive proper scrutiny that these answers become clear.

A new model of medical decision-making, which allows space to consider a doctor's claim of conscience, would also result in returning the concept of best interests to a focus on the patient and her interests. At the moment, best interests includes a hidden element of the doctor's conscience, as an action is considered to be in the best interests of the patient only if the doctor is willing to do it. This is especially true in the cases that we have been considering. However, this conflates questions of what the doctor is willing to do, what the patient wants, and what may be best for them. Distinguishing between these provides the opportunity to focus on them individually in order to better understand what really matters for patients and doctors so these sometimes competing claims can be properly balanced.

The *James* decision again provides a good example of this benefit. As noted in Section IV, the decisions of the Court of Appeal and the Supreme Court talk in terms of David's best interests but there is evidence that the case was primarily about the doctors' claims of conscience. This is what causes problems, particularly in the Court of Appeal. The Court

⁸² *Airedale NHS Trust v Bland* [1993] All ER 821.

cannot justify forcing the doctors to act in a way they find abhorrent but can only avoid it by making statements about what is best for David which miscast his interests, beliefs and welfare. Limiting the court's ability to use claims of conscience in appropriate cases means that concepts such as best interests have to be forced to fit situations where they are not appropriate.

Another benefit of this new model is that it allows for conscience-based claims which are not based upon predictive, generalizable rules. While this has been the dominant model for conscientious objections, not all conscience-based claims take this form. Many are objections to specific instances of a practice which the doctor might generally agree with. The reasons why a particular case might be objectionable could also rely on a number of individual factors which make it difficult to predict them in advance or provide a coherent set of rules which would apply in all situations. A decision-making model such as this, which provides a way to analyse individual claims of conscience, offers a way to explore these types of claims without requiring an individual to fit into a classification which might not be accurate. A final benefit is that it provides a way to fully explore issues that arise between individual doctors and the profession. Doctors do not need to necessarily agree with the view of the profession as a whole. Actions which they think inappropriate may be accepted by the profession and vice-versa. Conscience provides a way to evaluate these differences and the model provides a mechanism to do that. Since claims of conscience are evaluated by an objective third party, the court, it becomes possible to explore situations where an individual doctor differs from the rest of the profession.

VII. Problems with the new decision-making model

While there are benefits to this new model, there are, of course, problems too. The first problem concerns the power of doctors. Allowing a doctor to refuse to provide a particular treatment because it is against her conscience could be another way for doctors to reassert power over patients. The disparity in power between the two is already considerable, and we need to guard against exacerbating this. There are several possible responses. We could claim that doctors are already using claims of conscience in practice, and, therefore, this new model changes very little. That would not be accurate, however. Doctors *do* use conscience in determining which treatments they will provide, but giving them a more open way to utilise claims of conscience is not likely to lead to fewer instances of its use. Instead, the benefit of the model lies in exposing these claims to scrutiny. Doctors will first have to show that they have a claim of conscience, instead of merely showing that a claim of conscience is possible, and then that claim is based on justifiable reasons and does not have an unacceptable adverse effect upon the patient. The new model might thus better constrain a doctor's power over her patient. Since claims of conscience are subject to a more searching scrutiny, suspect claims are less likely to be allowed. This should, therefore, provide less power to doctors.

For this model to work it will be crucial that courts actually exercise their authority in this area. This, however, leads to the unfortunate second problem, the use of *Bolam*⁸³ in medical law cases. While there might have been a historical claim that courts will defer to doctor's judgment on cases which fall outside of their specific expertise, the most recent statement of the Supreme Court indicates less willingness to do so, at least outside specifically clinical matters.⁸⁴ As a consequence, the problems of *Bolam* are less likely to be an issue, at least if

⁸³ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

⁸⁴ See *Montgomery v. Lanackshire Health Board* [2015] UKSC 11.

Montgomery is an indication.

Even if the new model does not provide greater power to doctors, we may wish to avoid it on the ground that it lessens the power of patients. As a result, patients might be considered to have less right to make autonomous decisions than they do now. That concern, though, overestimates the power that patients currently have. As case law makes clear, patients do not have a right to require that doctors provide particular treatment.⁸⁵ All they have is a right to request that treatment.⁸⁶ If the requested procedure would not fulfil the duty that the doctor has to the patient – if it is not considered proper medical treatment - then there is no requirement that a doctor provide it, even if the patient sincerely desires it.⁸⁷ Thus, the new model would not take away from patients something that they currently have. Moreover, there is the possibility it will provide an additional benefit to patients because it will allow them to contest these claims of conscience to determine whether they are reasonable. At the moment doctors, by hiding claims of conscience behind other values, prevent patients from contesting and evaluating those claims. Pushing them out into the open will allow them to be analysed and explored just like the other claims involved in medical cases benefitting patients and providing them with additional resources in medical decision-making.

The final potential problem is not about the power of either doctors or patients but of the courts. If we use this new model of decision-making to explore decisions in ethically difficult medical cases, the final authority for the decision will rest with the courts. It will, therefore, ultimately be out of the hands of both doctors and patients. It would instead lie with a third party, a judge, who may not understand the views of either party. Judges may

⁸⁵ *Burke* (n 31) [31], [50].

⁸⁶ *Ibid* [50].

⁸⁷ *Ibid*.

come to these cases with their own biases and prejudices which might influence their decisions. For example, a judge may have a particular view about treatment at the end of life which influences the way she views the claim of conscience by a doctor in a case involving that treatment. If that view is no more advanced than that of the patient or the doctor, there is no reason why it should prevail, especially since the judge will not have to face the consequences of that decision. Furthermore, there is the additional problem raised by Montgomery that the legalisation of medicine has resulted in the de-moralisation of medicine.⁸⁸ Claims which were initially based on moral ideas become legalistic and substantive moral claims are consequently lost in the discussion. He is also sceptical of the distinction between medical and moral decisions, and argues in favour of the creation of a 'legitimate common moral community' which accepts that medical and moral decision-making are interlinked and not separate.⁸⁹

While I share Montgomery's concerns about the de-moralisation of medicine and am sympathetic to the creation of a 'legitimate common moral community', I am probably more cynical about the ability of doctors to effectively do so without significant oversight. Unless and until medical education changes to put an increasing emphasis on medical ethics, the training doctors receive on that front can be largely haphazard. Indeed, Montgomery notes that most medical ethics training happens 'from their experience of practice'.⁹⁰ The real life application of ethics is to be respected, but ethical training also requires reflection, discussion, and interaction with others about the moral principles which underlie a decision. Not all of these might be present in the sorts of practice experiences Montgomery notes. As a consequence, there is a need for oversight of the ethical decisions that doctors make. Judges

⁸⁸ Montgomery (n 27).

⁸⁹ *Ibid.*

⁹⁰ *Ibid* 201.

can provide that kind of oversight, not because they have any particular privileged position in relation to ethics but because they have experience in setting boundaries about decision-making processes. They can, therefore, play the role of gatekeeper and set limits on what constitutes the kinds of decisions which qualify as reasonable in these types of cases. They can thus set a basic framework from which Montgomery's common moral community can grow and develop.

VIII. Conclusion

In this article I have explored claims of conscience which are not predictable and generalizable rule-based conscientious objections, but are based on individualised, specific facts and have arisen in situations where doctors might previously have provided the requested treatment but now decide that things have reached a 'bridge too far.' These claims of conscience are different from what we consider standard conscientious objection claims, and have not been specifically addressed by the courts. Instead, they are hidden behind legal tests such as best interests. This causes problems because the best interests test does not provide an effective method for analysing these types of claims. Instead, it distorts the use of that test. However, these types of conscience claims should be subject to direct analysis instead of being subsumed under other legal and ethical tests. The model proposed in Section IV not only allows for a direct analysis of claims of conscience by doctors in these sorts of cases but does so in a way which protects the interests of patients. Courts would be better suited if they examined cases like *James* using such a model than the method currently employed because it provides a clear explanation of the actual problem in these sorts of cases. This is not only better from an analytical perspective but might also provide a way for doctors

and patients to discuss more openly and honestly *how* conscience affects the difficult and often terrible choices that must be made at the end of life.