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The “Give and Take” of Medical Morality

By

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ABSTRACT

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Doctors face situations within the medical arena in which their conscience -- as a person and as a professional -- conflicts with patient autonomy. Consider the terminally ill patient who wishes to end all treatment and elect to receive assisted suicide, and his physician who believes that aiding in death is a moral wrong. This creates a conflict of interests between physician and patient.

Historically, a paternalistic model of physician-patient interaction was employed to deal with dilemmas, contributing to infringement of patient's rights and a lack of understanding of ethics on the part of the physician. This manifests as the physician having a limited outlook of treatment.

An increased emphasis on ethics training and implementation of the interpretive model of interaction within medical schools is necessary in order to retain the humanity and compassion of the medical profession. Implementing this revised model will protect the morals of both patient and physician, as it allows conscientious objection: a physician's refusal of providing a certain treatment on the basis of personal morals that conflict with one or more of the values within medicine.

However, these requests for conscientious objection will not always be honored by the hospital if there are serious infringements upon the rights of the patient, causing a give and take of morality. It is necessary for physicians to be competent in the realm of ethics to communicate

with patients on a human level and provide treatment that is in line with many of the conflicting tensions that physicians face.

Key Words: conscientious objection, ethics training, physician, dilemmas, morals, moral conflicts, models of interaction, give and take

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Chapter 1: Introduction

Doctors may face situations within the medical arena in which their conscience, as a person and as a professional and which is guided by their morals and autonomy, conflicts with the patient's autonomy. In these cases, the doctor may refuse treatment and refer or recommend the patient receive treatment elsewhere, or if no alternative help is available, should provide the treatment because of his or her special duties as a physician within the medical community. It is important to respect both the doctor's conscience and autonomy and the patient's autonomy as the doctor takes an oath to uphold the primary principles of medicine. These principles include actively trying to "do no unnecessary harm" to the patient and respect autonomy and notion of 'the good'. Referring the patient to another doctor in these scenarios provides a realistic solution, dissolving the immediate conflict and honoring autonomy of both parties, but does not entirely resolve the conflict, as the physician should still aid the patient in finding a physician willing to perform the treatment that he or she finds inherently wrong. However, when this course of action is not possible, the doctor should provide the desired treatment because the needs of the patient ultimately take priority in the medical arena according to medical principles. These two scenarios exemplify the 'give and take' of medical morality: though respect for autonomy is being honored, a conflict of conscience will always remain. There are several objections to the practice of conscientious objection to be addressed, including accusations of malpractice, loss of integrity for the medical community, and inequity. However, these objections are baseless in that not allowing conscientious objection would be far more detrimental to the profession of medicine than would be forcing physicians to provide treatments that they find deeply morally troubling. The medical community has been founded on

relationships centered on trust and respect for autonomy. If the autonomy of physicians are not equally respected, then the respect within the medical community overall will be tarnished, leading physicians to act in ways that infringe upon patient rights. Physicians who feel they cannot openly and honestly communicate and act in a way that is in accordance with their autonomy may begin to act paternalistically and not provide all available treatment options in fear of being forced to perform a procedure that they find in contrast with their conscience and autonomy. Because of the unique nature of medicine, the autonomy of the patient is ultimately given priority, but the autonomy of the physician should also be honored to uphold the honor and respect within the realm of medicine.

The ethical duties of physicians are diverse yet are closely interrelated and dependent on each value of medicine; caring, also referred to as beneficence, highlights the integral role emotion plays in ethics (Rhodes 2008:76). Doctors should be perceived as compassionate by their patients, and doctors should actually feel compassion for their patients. Related to this value is respect for autonomy, which allows patients to trust their doctors and be confident that their physicians will not violate their basic rights (Rhodes 2008:77). One patient's idea of the good may potentially be very different from another patient's conception of the same goal. In attaining a good end for each patient, different resources may have to be used. For example, two different patients may have two different conceptions of the good — for one, the good may entail exhausting all possible and experimental treatment options until death from a fatal disease, while the other patient may choose to fight until they feel they cannot anymore and then will choose alternative intervention such as assisted suicide. In these two situations, a physician will be required to provide much different treatment or options in order to achieve an end which is good

for the patient. This may cause a conflict of interest for the physician, whose personal autonomy may not exist harmoniously with the patient's conception of the good. For another example, consider a patient who has been diagnosed with a curable form of cancer, who has a 60% chance of survival if he chooses to undergo chemotherapy. The physician, who is abiding by the rules of medicine, allows the patient to choose whether he wants to receive chemotherapy or not. The patient autonomously chooses to not subject himself to chemotherapy, as he feels that at his age, he has experienced a full life and would prefer to not have to experience the pain and suffering associated with chemotherapy and instead live out the rest of his life with palliative assistance. The physician might disagree with this decision, as there is a relatively good chance of survival if the patient decides to pursue chemotherapy, and the physician conceptualizes the good as aiming towards survival at all costs. The physician should then accept that he and his patient consider a good end in different ways but ultimately honor the wishes of his rational patient in order to avoid suffering for the patient. Therefore, there should be adequate resources for these patients and physicians alike to have access to, including a diverse physician population and the ability to refrain from providing or receiving treatment, resulting in justice for those seeking treatment and providing it. A diverse physician population will further the diversity of thought within the medical arena, normalizing differing opinions and beliefs held by the overall population that may not have received much attention historically by medicine. There are many situations in which all possible courses of action will cause at least some suffering. It is a physician's duty to weigh on all levels -- mental, spiritual, religious, and physical -- which action will cause the least amount of suffering for his or her patient. The moral plan of action to take is

the one where the least amount of suffering is experienced by both the patient; however, in this same line of reasoning, respect for physician autonomy should be honored.

Physicians are obligated to take a comprehensive approach to medicine, weighing the potential physical, mental, spiritual, and general effects that a certain treatment may have in order to conform with the patient's conception of the good. Similarly, the physician's autonomy and conception of the good on all levels should be honored. A physician has a right to request to refuse treatment when weighing conflicts if he feels that providing treatment would cause more harm and suffering to himself -- spiritually, emotionally, or mentally -- than finding a different physician to perform the procedure would for the patient, and secondly, that the values he feels will be violated in performing the procedure are in line with the values of medicine. The interests of the physician and patient are closely interrelated, though potentially conflictual, making it difficult to find a balance between them. The patient's perception of the good is concerned with the moral, goal-oriented, and autonomous actions that the patient believes are good, which are in accordance with the overall goals for the good life of rational humans overall (Ivanhoe, et al. 2007:70-71). The spiritual good, which for some is the most important good that can be satisfied by clinical medicine, refers not only to religious belief, but the patient's conception of what the ultimate answers are, such as 'What is it to be human? What meanings should be attached to life?', and so on. In brief, it is the patient's own 'philosophy of life.'" (Ivanhoe, et al. 2007:71). The medical good relates most closely to the objective goals of medicine, that is healing, relieving pain, and carrying out the medical techné (Ivanhoe, et al. 2007:70). However, what is the medical good is not necessarily congruent with other interests; for example, a decision consistent with the medical good might cause psychological suffering or

religious distress to the patient, as well as be at odds with what is defined as the good for rational humans (Ivanhoe, et al. 2007:71). It is the physician's duty to balance these interests and provide treatment that is effective on all levels, for both himself and the patient. All of these interests are interests that are not unique to one who is in the role of a patient; they are very humanistic values which should be balanced in order to retain humanity and morality. It is crucial that physicians have a right to maintain their autonomy just as much as the patient.

It still may not be obvious how a physician's obligations to the medical field may force him to act in a way in which a certain give and take of ethics is necessary. Consider the following: a physician has duties to his patient treat efficiently and effectively, and respect patient autonomy. A physician also has duties to the medical field and the institution to which he belongs to including upholding the honor of the medical community, treating patients in a moral way, and doing no harm through perceived recklessness, endangerment, or ignorance. The physician also has obligations to himself as a rational individual to uphold his moral integrity and abide by his own conception of the good and autonomy. Because a physician may face serious punishment for failure to fulfill these obligations such as being sued by patients, imparting false knowledge, or acting in a negligent way, he may feel that his actions are being scrutinized and that he cannot act in accordance with his personal autonomy and values. This is dangerous because of the suffering that can occur for the physicians, resulting in adequate care not being provided if the physician feels that he should not be providing this treatment. For example, a physician may be forced to provide a certain treatment — such as an abortion — but feel that he is committing an unforgivable religious and moral wrongdoing, therefore experiencing high levels of distress and suffering in attempting to protect the interests of the

patient and of the medical field. Though it is commendable of the physician to do so, it is actually creating a dangerous and negative environment for the physicians and patients. It is necessary that physicians practice medicine with confidence and with honor, and by forcing physicians to provide treatments that seriously conflict with their values in line with the values of medicine, the professionalism and trust within the medical profession is being tarnished. It is necessary that physicians have their autonomy honored with the same weight as the patients, though in a unique way due to the special obligations that physicians have to themselves, the medical community, and their patients.

It is possible to preemptively remedy these potential conflicts by implementing a change in the ethics training of future physicians in medical schools and encouraging an interpretive model of patient-physician interaction to be used. By changing ethics training to emphasize the importance of retaining autonomy, humanity, compassion, and forgiveness, physicians will understand how to better communicate their morals and values as well as practice medicine which is congruent with the values of the medical realm, the values of the patient, and the personal autonomy of the doctor. Additionally, the physician will learn to effectively balance external pressures with the give and take of morals that he is subjected to, while conscientious objection will allow the autonomy of the physician to be respected, yet there will still be an infringement upon the conscience of the physician as he is ultimately required to refer the patient to a different doctor who is willing to perform the treatment he finds conflictual with his values. This infringement occurs because the physician, while acting autonomously in not physically performing the procedure, should still accept that his conscience will be conflicted as he should still acknowledge that the patient will receive the procedure and that the physician should help

the patient receive that procedure in referring her to a different physician. The interpretive model of interaction, which encourages the physician to view the patient as a whole and aid the patient in making an informed decision in line with her conception of the good, will bolster the utility of ethics training as it encourages the importance of the main values which medicine should honor: respect for autonomy, the duty to treat the patient, and act with humanity and compassion.

In order to explain and address the formation of these moral conflicts that arise within medicine, it is necessary to explore how physicians are socialized and in turn, how they learn professional values and how to act in a medical environment when interacting with peers and patients through professional socialization and through ethics training in medical school. This then leads to a discussion of doctor-patient models that have been adhered to throughout history and a recommendation of a new model to adopt. This model will place a larger emphasis on equal collaboration between physician and patient, which will create a more accepting and understanding environment, leading to the possibility of conscientious objection. The specifics of conscientious objection will be discussed and two case studies surrounding conscientious objection of physician-assisted suicide and abortion will be provided, addressing objections to the theory as well. By completing a critical analysis and review of conflicts of conscience that are experienced within medicine, it will be possible to view medicine in a new and reformed way in which the give and take of morals that physicians are subjected to is understood, allowing a suggestion for reform to be made.

Chapter 2: Professional Socialization of Medicine and Learning of Values

The goal of medical school is to shape physicians' identities in accordance with being an effective and professional physician. However, many future physicians enter medical school with preconceived notions of what it means to be a doctor, what medical school is like, and what the profession is overall. These conceptions are often shaped by the media, experiences from the other side of medicine, as a patient, and medical students and medical student hopefuls' sharing of stories (Weaver et al., 2011; 1220). In order to successfully combat these ideas and meet the needs of our medical community by educating future physicians, it is crucial that we understand the aspects of society that shape the physician's identity as a professional.

Professional identity is how one perceives oneself as a competent professional (Weaver et al., 2011:1221). Social identity theory, the most applicable theory to the physician as a professional, explains that an individual has multiple roles and social identities that they take on as they move through different social settings. This theory takes on three groupings: categorization, identification, and comparison. Categorization refers to individuals categorizing others into natural groupings, identification is when people label those in the same group as similar to them and those who are not in the group as dissimilar, and lastly, comparison refers to individuals comparing themselves with others and considering themselves members of a group that has a positive association attached to it (Hogg 1988).

Having a strong professional identity is of utmost importance in effectively carrying out medical treatment; physicians should be able to balance individual autonomy and a strong ethical compass as well as knowledge for practicing medicine in order to be a successful doctor (Weaver et al., 2011;1221). The process of developing a professional identity is one that is long-

term and includes integrating one's personally-held morals with those that are acceptable and in line with the overall profession. Many of the aspects of professionalism may be deemed subjective based on the profession, but in actuality, have been passed down throughout centuries of physicians, most often in a practice known as role-modeling (Weaver et al., 2011:1221). Role models are very influential when it comes to forming professional identity; subordinates mimic the behavior of successful, well-respected physicians, coming to understand what is expected in a clinical setting. Role-modeling builds confidence through interactions with patients, peers, and members of the medical community; having confidence in addition to clinical competence improves the medical community as well as the development of one's professional identity as a physician (Weaver et al. 2011:1221).

Physicians are constantly seeking to become better professionals by building on the foundation that has been laid throughout their undergraduate and medical school training (Stern, et al. 2006:1794). Becoming a professional does not just include lectures, clinics, and testing, but informal socialization like conversations in the cafeteria (Stern, et al. 2006:1794). The development of humanistic approaches and empathetic attitudes are developed through the professionalization of medical students through rituals such as the white-coat ceremony but also through providing experiences (Stern et al. 2006:1975).

Future physicians are under a great deal of pressure; they are expected to possess certain skills, attributes, and knowledge in order to be considered a good doctor (Lindberg 2009:242). These traits are acquired through the process of professional socialization, both informal and formal. Most medical students learn their professional values through role-modeling, acting in a way which mimics their superiors because they perceive their superiors to

be knowledgeable and respected — traits which these future physicians hope to embody one day. It is important that students learn from their teachers — to a limit. While conformity is definitely a necessary component of professional socialization, there should also be a healthy amount of challenging, questioning, and protesting of their superiors in order to develop a sophisticated and strong sense of autonomy (Lindberg 2009:242). In medicine, these oppositions are rarely made due to the intimidating nature of the medical community.

Six main values were observed to be important to future physicians: wisdom, discipline, humility, empathy, maturity and strength (Lindberg 2009:242). Wisdom refers to a certain set of knowledge a physician has; it is not only knowledge of medicine, but of the overall world, and refers to the ability to use this knowledge to solve problems and make good judgements on behalf of the patient and the entire medical community as a whole (Lindberg 2009:244). A good doctor is also a disciplined one, who is hardworking, well-studied, and adheres to his duties. The disciplined doctor achieves his goals in a fast and efficient way even in high-stress situations (Lindberg 2009:244). Physicians are also expected to have humility and not be overly confident to the point of becoming hubris; being a physician necessitates being able to constantly learn from mistakes and take in new knowledge, participating in life-long learning (Lindberg 2009:245). Physicians should also be able to interact with patients and other physicians in a non-judgmental way. This includes being able to ‘read’ patients and deduce what help they truly need, as opposed to what they state openly (Lindberg 2009:245). Just as important as this is the necessity of maturity, which allows physicians to understand the wants and needs of their patients in a respectful way. Maturity is not a virtue which is expressed solely in the medical context, though — physicians and future physicians are expected to have a certain understanding

of the world outside of medicine. Maturity is a trait which is hard to define, which does not necessarily come with the medical training per se, but with age and experience (Lindberg 2009:246). Lastly, strength has been listed as a necessary virtue that a good physician should exemplify. Strength means standing by difficult decisions and being able to speak your mind with authority (Lindberg 2009:246). All of these virtues are requisite in having a complete understanding of individual autonomy as well as effective physician-patient interactions, and should be present in all theoretical physician-patient models in order to ensure a respectful and well-informed interaction.

For every positive virtue that these future physicians wished to embody, there are traits that are actively avoided during the socialization process. These include lacking credibility, being viewed by the patients as incompetent, not being good enough to be a doctor, being stressed, feeling like an outsider within the medical community, and being humiliated (Pitkala et al. 2003:155). Many students reported feeling inferior to hospital staff and feared that they were incompetent. Medical school has been reported to be a “stressful, anxiety-provoking, and traumatizing experience” (Pitkala et al., 2003;155). It has been said that it is necessary to suppress inner feelings and objectify patients for self-preservation and wellbeing (Pitkala et al., 2003:155). Because of the intense culture of medical school, students sometimes approach it with a kind of superficiality, being more concerned with how they appear in front of their role models and superiors than with how effectively they are treating patients and whether or not they are acting ethically according to their standards, the standards of medicine, and the standards of their patients.

In the first year of medical school, which is arguably the most influential year regarding professional development, medical students have reported feeling that they lack credibility and are concerned with being a good enough doctor, being viewed positively by patients, feeling like an outsider, and living in fear of being humiliated (Pitkala et al., 158). These negative fears and potential experiences contribute significantly to the professional development of medical students. Because these future physicians have so many different forces acting on them, sometimes the underlying understanding of the ethics of medicine will be neglected because physicians are cultivating their professional identity.

It can be argued that a strong professional identity is formed off of superficial grounds, resulting in the negligence of other areas such as ethics education and physician-patient interaction. This also stems from the three groupings of social identity theory being at work: categorization explains the medical students viewing themselves as one unique group with a unique set of skills (McLeod 2008). This categorization can be helpful to physicians, as it allows them to express openly some of the common dilemmas and pressures that they face as well as form a bond with other members of the medical community. However, extreme categorization can be alienating if physicians from certain specialties begin to group together and look down on physicians from a different area, or if the entirety of physicians looks down on the nurses or aids in the hospital. Medicine is a collaborative effort and categorization threatens to become too esoteric and compartmentalized. Identification explains medical students identifying with the entire medical community and viewing those who are not members of that community as ‘other,’ such as considering patients to be subordinate with an entirely different set of morals (McLeod 2008). It is important for physicians to acknowledge the importance and uniqueness of the type

of knowledge they have without acting as if they are inherently superior to their patients. Doing so would escalate the healthy level of paternalism to being unhealthy and arrogant. Lastly, comparison refers to the title of ‘doctor’ and how medical students will attach themselves to that label and think highly of themselves because of it (McLeod 2008). Again, when a physician is too confident in his skills and judgement solely because of his title, there is an imminent threat to the autonomy of his patients; if a physician feels that she is immune to making mistakes or lapses in judgement, then the humanity of medicine disappears because the patient ceases to be recognized as a rational being with values and emotions. All of these factors come into play and contribute to the development of a physician’s professional social identity. However, they can also lead to issues which contribute to having an inadequate understanding of ethics, acting overly paternalistic, and emotionally detaching.

The professional socialization of medicine has emphasized collaboration among physicians, detachment of emotions, callousness in practicing medicine and delivering results, and trust in medicine and medical professionals (Vinson 2006: 1365). However, many students still lack in the areas which require vulnerability: collaboration and trust. An ethnography of American medical schools has explained how medical students are taught to address physician-patient encounters while still adhering to the guidelines of a collaborative relationship (Vinson 2016: 1365). There is an emphasis on paternalism within these encounters, which is concerned with physicians making the important medical decisions regarding treatment options and courses of action and then persuading patients to agree with their decisions throughout the process. This is known as “constrained collaboration,” a technique used by physicians to ideally accomplish the goals of the physician without obviously violating patient autonomy (Vinson 2016: 1364).

Faculty physicians teach medical students in particular to shape a patient's response using certain situational and conversational techniques taught to them in medical school in accordance with constrained collaboration. The students are taught to reinforce a strict patient-physician dichotomy of roles, highlighting that the physician knows best and gives the orders, and the patient consents willingly, knowing as "making the deal" (Vinson 2016: 1372). The physician then "closes the deal" by asking confirmation questions about what the patient has been told and asking him to repeat what he heard and if he understood her instructions. If the patient shows any signs of negative emotion such as fear, anger, or hesitancy, the medical student was instructed to address those concerns and persuade the patient that the plan of action would still be in his best interest and that his concerns were unnecessary (Vinson 2016: 1374).

In U.S. medical healthcare, the needs of the patient should take priority, and the physicians should have remedies to whatever may ail the patient. The physicians should then shape the medical intervention to fit with the desires of the patient, proving that constrained collaboration is incongruent with the principles of medicine such as respect for autonomy. This process, in contrast to its goals, is manipulative and the issues of paternalism and removal of patient autonomy are still present. This method of collaboration is a result of current models of ethics education in medical schools, in which the physician is encouraged to believe she is the most fit to make decisions on behalf of the patient because she is of supreme virtuous character. There is a unique paradox which occurs in uncertain clinical decisions. In these situations, physicians are more likely to abandon paternalism and put all decision-making responsibility on the patient (Diamond-Brown 2016:109). This is dangerous because physicians are professionals and need to exercise a healthy level of superiority over their patient by ensuring the best decision

is being made while still weighing the pros and cons associated with the patient's wishes against the tenet of “do no unnecessary, avoidable harm.” Teaching a revised curriculum of ethics will reduce the effects of these potentially dangerous dilemmas.

Studies of medical students have sought to understand the medical ethics education curriculum, whether the learning outcomes are met, and how the students are dealing with and reflecting upon certain dilemmas. It has been shown that professionalism was the most frequently emphasized solution to the problems presented in these situations, as opposed to communication with the patient (Johnston, Mok 2015:857). This was predominantly observed through study and discussion with individuals who have experienced the healthcare system. The development of professional character in medical students is obviously important and is emphasized in medical education. A professional has a unique set of skills and knowledge in relation to certain responsibilities that he or she has with the public. The components of this definition are parallel to the duties and obligations which a physician has with the public and his or her patients (Stern 2000:26). There exists, however, a difference between an expert and a professional: a professional has a contract negotiated with a specific group of professionals and society, whereas an expert has no such contract and simply has knowledge of certain skills and information.

Professionalism and the values associated with it are heavily influenced by the socialization process that occurs during the clinical portion of medical school. Therefore, the ethics which are taught by medical schools are subjective and dependent on the ethics and values of their teachers and advisors; it is done in a role-modeling type of way, as in “Do whatever you think is right, but if you want to survive in this world you’d better be like me.” (Stern 2000:27).

This is a major problem in current models of ethics education because it causes the physician to potentially make improper decisions regarding ethical dilemmas and make choices which satisfy the autonomy of the attending physician rather than ones which are in the best interest of the patient's autonomy and interest. A physician has been quoted as saying:

I once naively expected values to be taught through simple and single expressions of values: 'Honesty is the best policy,' or 'primum non nocere — above all do no harm.'

But in studying the teaching of professional values, it has been observed that values are more frequently taught as conflicts, as complex dilemmas between two or more sometimes equally worthy values (Stern 2000:28).

The only way to solve these problems presented is to overhaul and revise current ethics education in order to ultimately allow conflicts of conscience to be addressed in a rational way.

Chapter 3: Ethics Training of Medical Students and Consequences

Medical school is a unique experience which comes with many challenges. Students are expected to dedicate their entire lives to learning everything there is to know about the human body, down to minute detail. Most students achieve this, though not without failing to become educated in other crucial aspects of medical training, such as ethics learning, connecting with patients, thinking abstractly, and improving methods of communicating -- a fault at the hands of medical educators. This is not the fault of medical students, though — medical schools seriously neglect to adequately teach ethics to medical students and residents. Medical schools usually adhere to one of two styles of teaching ethics: *ethics-as-virtue*, and *ethics-as-character* (Olufowote 2015:256-257). *Ethics-as-character* encourages physicians to view themselves as virtuous actors which can do no harm if they make the decision which seems best to them, encouraging paternalism within the medical community. *Ethics-as-virtue*, on the other hand, teaches ethics on a case-by-case basis, challenging medical students to consider cases presented to them and make the ethically correct decision, whatever that may be. I argue that neither of these is an entirely acceptable way of teaching ethics in medical schools.

Furthermore, the training of ethics used in medical schools should be changed because of the paternalism it perpetuates. Physicians either take on a high level of paternalism in their decision-making on behalf of the patients, or, in an uncertain situation, they will direct all decision-making to the patient (Olufowote, 2015, 256). Physicians and medical schools should change ethics training of students and adopt a new approach towards medical ethics education and implementation if we wish to solve this problem and allow autonomy to play a greater role in physician-patient interaction.

Teaching detached concern to medical students has been a recurring theme across schools who use the ethics-as-virtue education approach, and the early sociological works emerging in the 1970s have focused largely on emotions, emotional socialization and empathy in medical training and schools (Underman, Hirshfield 2016:94). There have been major shifts within the medical community since the mid-1990s regarding medical education, and the study of emotions since then has been relatively non-existent (Underman, Hirshfield 2016:96). An emphasis on emotion in medical education should be made in order to accommodate the increased diversity of students, with a focus on gender and racial differences in relation to emotion, differences in self-reported empathy among specialties, and loss of empathy during clinical education (Underman, Hirshfield 2016:97). By allowing medical students and physicians to openly express emotion, many of the pressures that are felt during medical school -- feelings of not fitting in, being an outsider, being inadequate, and being perceived as incompetent -- will be alleviated because of the open communication that is allowed, benefitting additionally from the implementation of the interpretive model of physician-patient interaction and in turn a more open expression of autonomy.

The utility of ethics education will also increase if there is free communication between physician and patient because it will result in a deeper understanding of the obligations the patient feels to herself, her family, and other factors, as well as the obligations that the physician holds to the patient and the medical community. Allowing for emotional expression will increase bonds between physicians and patients because it brings the doctor down to a more human level. The clinical environment is currently cold and detached, as medical students are taught to not form close personal bonds with their patients, emotional or otherwise. This has negative

repercussions because patients might feel that they are inferior to their physicians or feel that they cannot engage in a non-judgemental conversation with their doctors. By encouraging physicians to adopt a humanistic approach to medicine and their interactions, these consequences can be avoided. Unfortunately, because physicians should become accustomed to delivering negative diagnoses and information, they have become even more detached. Since young, inexperienced physicians learn behavioral norms through observing more experienced physicians -- ethics-as-virtue education --, they adopt this behavior and the detachedness associated with it, resulting in physicians treating their patients in a callous and detached way. This may have implications such as physicians acting unsympathetically and making personal decisions on the behalf of the patient (Ratzen 2014). For example, a physician who has become accustomed to delivering bad news might tell a patient's family that their loved one has been diagnosed with a terminal illness in a way that the physician perceives as professional and detached, but that the patient perceives as heartless and uncaring. If physicians are encouraged to take an interpretive approach to models of interaction, then the patient will be considered as a whole sum of their parts, and the physician will accordingly deliver news to the patient and their family in a way that they feel will be accepted.

Furthermore, the demographics of medical students coupled with patient health movements such as desire for involvement in medical decision-making and institutional factors such as training and educational structure have changed, resulting in a need of revival of ethics education in medical schools in order to accommodate the diversity of medicine as a whole -- not just of the patients. Demographics of students have changed, with women and whites each making up almost half, Asians making almost a quarter, black students making about 6%,

Latinos making 4%, and multiethnic people making almost a tenth of all medical school enrollees as of 2014 -- a major difference from the demographics of this population observed in the 70s (Underman, Hirshfield 2016:96). The diversity implies that ethics-as-character education, which teaches ethics on a case-by-case basis, is too limited and might not give physicians a diverse view of different scenarios and thus should not be used to teach ethics.

Additionally, using ethics-as-virtue, while helpful in encouraging physician self-awareness, will encourage unreasonable levels of paternalism in the medical community as it causes doctors to only consider their conception of themselves as a virtuous physician in relation to their actions and medical decisions. Physicians can become callous because of the paternal nature of clinical education in addition to the pressures of the medical realm. These norms and their impacts add to the theme of ever-increasing detachment which can be broken through by using an interpretive model of interaction bolstered by an obligation-based framework of medical ethical decision-making that respects patient and physician autonomy.

The current methods of teaching ethics neglect to provide resources and skills which are necessary to deal with systemic issues which cause conflicting interests among physicians and residents (Olufowote 2015:259). Medical students in their residency are usually the primary caretakers within the hospital, as they provide around-the-clock care and often make treatment decisions by themselves despite their constant supervision. This paradox arises out of insecurities held by residents; they are stretched incredibly thin and feel a pressure to have all of the knowledge of the attending physician without any of the same experience. In an attempt to not seem inferior or uneducated, residents might make uninformed decisions or choices that they are not entirely confident in. Therefore, when certain circumstances regarding controversial care

arise, residents are put into a position in which they do not have sufficient experience due to either ethics-as-character or ethics-as-virtue education models, potentially leading to misunderstandings and an inability to ensure autonomous decision-making on the part of the patient (Olufowote 2015:263). For example, because of the inherently unique and demanding nature of residency combined with lack of training and supervision, residents sometimes fail to meet the needs of patients in need of care because they misunderstand their wants, disagree with patient wishes and make decisions that are in their own best interest, and feel unable to rid themselves of other pressures which arise as systemic issues in the healthcare system including the threat of malpractice lawsuits, administrative burdens, and need to retain autonomy -- which should take priority.

The need for autonomy takes precedence over other needs because it allows for a novel approach of ethics to be assumed; the duty for a physician to do good for her patient, ultimately achieving patient autonomy, is her primary duty, which should be aimed at through all action and use of an interpretive model of interaction. The physician community is required to balance all of these tensions, plus other, external forces, potentially causing them to make decisions which ultimately belong to the patient as a part of their autonomy. These external forces can come in the form of legal repercussions and financial burdens. It is no secret that malpractice litigation is a lucrative business, and physicians are subject to the threat of lawsuits everyday. This puts huge amounts of pressure and stress on the practicing physician who should be confident that his decisions and treatments provided for the patient are approved by the patient herself.

Additionally, there are administrative forces that are at work in the medical community: providing certain treatments cost more and are more time-consuming to others, and physicians

might feel pressured to offer one service over the other in order to satisfy these pressures, although there might be a more effective treatment available to the patient. Ultimately, these conflicts can lead to the neglect of a physician to honor the patient's wishes. An interpretive approach to patient-physician interaction allows physicians to achieve these goals by taking the patient's background and morals into consideration. An individual's conception of the good is of utmost importance, and a physician who values these ideas is doing the community a favor by fighting back against these institutional pressures which makes providing adequate, reasonably paternalistic care for the fully autonomous patient so difficult to do. In order for a physician to fully understand her patient's conception of the good, it is crucial that the two parties be able to interact effectively and communicate openly, necessitating a critical review of doctor-patient models.

Chapter 4: Doctor-Patient Models

The doctor-patient relationship is the one which underlies all of this discussion surrounding the education of ethics in medical schools; this is the relationship which faces the highest risk of being damaged if an ethical dilemma is handled incorrectly (Wilk, Platt 2016:76). As has been stated before, historically, physicians have acted in very paternalistic ways: physicians did not inform patients and arrogated all decision-making authority unto themselves (McCullough 2011:67). This paternalism deprofessionalizes medical ethics and the institution of medicine, tarnishing the mutual relationship of trust and respect for autonomy. The foundation of bioethics, one which is founded in paternalism, is one which we should abandon because it denies the fiduciary relationship -- providing the highest standard of care -- between physician and patient and lacks trust by emphasizing paternalism (McCullough 2011:74). In studies which addressed physician and patient autonomy in decision-making and setting healthcare boundaries amongst competing values through interviews and surveys that questioned how to ideally handle hypothetical medical situations, most patient participants believed that the patient and the physician should have collaborative autonomy and control over the decisions made in a medical environment regarding intervention and treatment plans (Maurer et al 2017: 591). Additionally, patients expressed desire to have their wants and desires acknowledged, but still gave ultimate decision-making power to the physicians after collaboration -- showing that a physician is expected to exercise a moderate level of paternalism.

There is a social contract which exists between physicians and society that requires these physicians to perform services for the members of society. Knowing that the patients would, firstly, be able to trust that their physicians were making the best decisions while still taking into

account the patients' autonomy and, secondly, be held morally and, perhaps more concretely, legally accountable for these decisions, improved interactions and overall faith in this social contract. These factors fostered the essential sense of trust and respect for physicians and the medical community as a whole. It was of utmost importance to many patients that there was fair collaboration -- with all professional duties being fulfilled -- and problem-solving between physician and patient, leading to many of these participants agreeing that policies should protect the medical, autonomous, and conscientious wellbeing of the public through improved models of doctor-patient interaction and better understanding of possible courses of action and policies.

While it has been proven that patients are willing to give physicians a moderate level of control in the form of paternalistic actions, is imperative that patients be more involved in the medical decision-making process. There are currently four models of patient-physician interaction that have been posited: the paternalistic model, the interpretive model, the informative model, and the deliberative model. (Emanuel et al., 1992:2221). Recently, there has been a shift towards the informative model, which does not restrict patient independence and autonomy to the degree of the other three models (Emanuel et al., 1992:2221). There is a unique relationship that exists between patients and physicians; it is true that the patient should retain his autonomy and be able to make decisions about treatment that he feels are acceptable, but it is also important to still respect the judgmental capacities and knowledge of the physician. There has been much discussion recently about whether there should be a greater amount of patient control, and if so, if it would cause an imbalance in judgement of wants due to the sick patient's desire for security without regard for correct interpretation and understanding of medical

information (Emanuel et al., 1992:2222)? In order to make an informed recommendation for future physician-patient models, it is important to discuss those that have been used in the past.

First, the paternalistic model, also referred to as the parental model or the priestly model, refers to the interaction between patient and physician in which the patient is given care that best promotes his health, according to the judgements of the physician (Emanuel et al., 1992:2222). In this model, there is the assumption that there are shared beliefs between physician and patient about what is the best end for the patient, and the physicians can then diagnose, provide treatment options, and encourage the patient to agree to the treatment that the physician deems most useful (Emanuel et al., 1992:2222). This model has been encouraged historically within the medical realm. Physicians have been viewed as the ultimate decision-makers in practice as they were regarded as more knowledgeable in practical medicine and also in the best interests of the patient. The paternalistic model allows the physician to act as the patient's guardian and obtains consent through guiding and convincing the patient to accept the intervention of the physician -- a relationship which has been actively moved away from in recent years due to the complete lack of patient autonomy that this model perpetuates.

Second, the informative model is also known as the scientific, engineering, or consumer model, and refers to the relationship between a physician and patient in which the physician diagnosis the patient, provides all possible treatment options and relevant information, and then allows the patient to choose the option that best realizes her values and goals (Emanuel et al., 1992:2223). This model assumes that the patient has a clear conception and understanding of their values but is lacking the facts necessary to make a well-informed decision. The physician's role is to provide the facts so the patient can express autonomy through complete

control over medical decision making (Emanuel et al., 1992:2223). This model moves closer to the ideal patient-physician relationship, but gives too much responsibility to the patient. The medical realm is unique in that there is a necessary but moderate level of paternalism that should be exercised by the physician in order to ensure the physical well-being of the patient. If the patient is given entire decision-making capability, then there might be certain potential medical outcomes that are neglected because of the patient's lack of medical understanding and training.

The interpretive model is slightly similar to the informative model, but instead aims at bringing the patient's values to light and helping the patient decide which medical intervention is in keeping with his actual wishes (Emanuel et al., 1992:2222). The physician adhering to the interpretive model goes beyond that of the informative model because she helps the patient to articulate his assumedly unknown and unfixed values. In this model, the physician is analogous to a counselor who does not impart judgement or personal biases, but instead refers to the patient's life as an entire narrative and then helps the patient come to recognize and understand his morals and goals in order to make the decision which is best for the patient himself (Emanuel et al., 1992:2222). The physician will then provide treatment options that are in line with the patient's morals and aid the patient in choosing his preferred treatment plan without the use of persuasion, resulting in an ideal combination of paternalism on behalf of the physician with respect for patient autonomy.

The last model is known as the deliberative model, which aims to help the patient realize the best health-related values that can be achieved in the medical situation (Emanuel et al., 1992:2222). The physician, differing from that of the interpretive model, only discusses that which is directly health-related and relevant, purposefully neglecting to consider any other non-

health-related factors. The physician can persuade the patient to make a certain decision, but should avoid coercion (Emanuel et al., 1992:2222). For example, the physician may tell his patient that in his professional opinion, he advises that his patient takes Action A, but should not tell his patient that he should or should take Action A, or say that if he, himself, were in the same position as his patient, that he would take Action A. This model seriously lacks in that it does not consider the patient a rational, whole being; it neglects to consider the entire narrative of a patient's life and potential non-medical factors that could affect the patient. Instead, the deliberative model takes a narrow approach and only considers elements which are directly related to the medical aspects of the situation.

While each of these four models have useful and relevant justifications and intentions behind potential use, it is obvious that in allowing for greater patient autonomy, it is imperative to adopt the interpretive model as the norm for most patient-physician interactions. The patient should not be viewed as an end in himself as strictly a medical problem that should be taken care of with no other consideration of autonomy or personal identity, and should instead be allowed to make decisions that keep with his entire life narrative, taking into consideration morals held outside of the realm of medicine, including personal, spiritual, or otherwise. The interpretive model allows for true consent and expression of autonomy, as the patient can “evaluate knowledgeably the options available and the risks attendant upon each” in relation to their values (Emanuel et al., 1992:2222). Furthermore, moving away from the paternalistic model and shifting towards the interpretive model allows for more open and honest communication of these values and opinions for both parties, allowing for conscientious objection to be discussed openly, objectively, and without judgement.

Chapter 5: Conscientious Objection

The Church amendment is a legal provision which has set up conscientious objection in healthcare and has laid the framework for future discussions of conscientious objection. The Church amendment allows healthcare providers to object to providing treatments “on the basis of moral beliefs or religious convictions.” The specific language used in this amendment directly allows providers to object to providing services such as sterilization and abortion based on moral convictions. The amendment is as follows:

The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act [42 U.S.C.A. § 201 et seq.], the Community Mental Health Centers Act [42 U.S.C.A. § 2689 et seq.], or the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C.A. § 6000 et seq.] by any individual or entity does not authorize any court or any public official or other public authority to require--

(1) such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or

(2) such entity to--

(A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or

(B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedures or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

This is a legal document which makes it legal for healthcare providers to object to performing services such as abortions and sterilizations based on personal or religious morals. The amendment also prohibits employers from discriminating against individuals who refuse to

provide certain treatments “on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions” (Church amendment). This amendment has importance and implications in the legality and acceptability of conscientious objection in healthcare today.

Conscientious objection has historically been associated with refusal to comply with mandatory military enlistment. More recently, in the 1960s and 70s, conscientious objection has been seen in the healthcare field with doctors beginning to refuse to administer abortions or aid in patient death (Wester 2015:427). This has led to the commonly accepted definition of ‘conscientious objection’ in healthcare to refer to the ability of health care professionals to refuse the administration of certain drugs, procedures, and other services within his or her skill set and competence level on the basis of violating his or her set of moral or religious guidelines (Wicclair 2011:1). The major question that arises out of this issue is whether or not we should allow for these objections, and if so, how? Conscientious objection creates a conflict of interest between those of the health care provider as an autonomous, moral agent, and those of the patient who has a right to receive care free of judgement.

Wicclair defines conscientious objection as

In the context of health care, physicians, nurses and pharmacists engage in acts of conscientious objection when they: (1) refuse to provide legal and professionally accepted goods or services that fall within the scope of their professional competence, and (2) justify their refusal by claiming that it is an act of conscience or it is conscience-based (Wicclair 2011:1).

Conscientious objection involves one’s beliefs — either secular or religious — about what is right or wrong. In refusing certain services based on these grounds, the health care professional

should then provide an explanation for his or her reasoning behind refusing the good or service.

Objections made on the basis of moral and ethical beliefs are distinct from those made on the basis of self-interest, safety, or financial gains. Refusals of the latter type do not fall under conscientious objection, as these types of objections are based on beliefs which are central to our identity.

There have been multiple different definitions of conscientious objection provided. The permissibility of conscientious objection in the world of medicine is a more encompassing issue that is related to many different types of dilemmas that occur between physicians and patients, explaining these differences in definitions. Similarly to issues regarding providing physician assisted suicide or voluntary euthanasia, physicians sometimes struggle with whether or not it is moral to refuse providing certain treatments that are within their capabilities on a personal ethical basis (Rasinski 2011:11). Conscientious objection is permissible in situations in which there is no general consensus about the morality of performing a certain action, such as abortion or physician assisted suicide (Wicclair 2000:206). In these scenarios, the controversy that arises suggests that tolerance and allowance for conscientious objection are necessary (Wicclair 2000:207). Wicclair restricts his definition of conscientious objection by narrowing acceptable objections to be based off of personal moral beliefs, not including professional values (Wester 2015:428). This means that concerns about the necessity of the procedure, the risks involved, or what is best for the patient, should not be involved in decisions regarding conscientious objection. Lynch, on the other hand, provides a different notion of conscientious objection. She identifies her definition, which allows strictly professional medical norms such as do no unnecessary harm and respect autonomy to be the foundation of conscience-based refusals, as a

type of ethical orientation (Wester 2015:428). As the healthcare profession is so unique in its characteristics, it should allow for the professional's personal values to be included in their practice, to a point.

Past arguments have stated that conscientious objection is most strongly supported by the rationale of moral integrity. Most individuals believe holding fundamental beliefs about what is right and wrong is important, and some might even argue that violating one's deeply-held personal beliefs is wrong, leading to deep feelings of shame, regret, and guilt; there is quite a difference between producing physicians who are walking robots with no moral compass and producing physicians who are autonomous, moral agents who uphold the responsibility of medical professionals who have a duty to provide goods and services to their patients. An additional argument in support of honoring appeals to conscientious objection is formed off of the basis of the principle state of neutrality; individual's ideas of what the "good life" is should all be equally respected, therefore allowing for conscientious objection (Wicclair 2011:2). Mark Wicclair, a philosopher who supports conscientious objection, argues that there are many reasons for supporting conscientious objection, but the most compelling centers on maintaining moral integrity. Wicclair considers moral integrity to be a prima facie duty, as other factors such as patient wellbeing can override this interest (Wicclair 2017:7). What is so important in Wicclair's argument for conscientious objection is that he upholds practicing medicine as a human and moral enterprise which seeks to protect human values and reduce suffering. Moral dilemmas do not have a perfect solution that will dissolve all conflict and alleviate all feelings of wrongdoing, and Wicclair addresses this:

My objective, however, is not to offer the best philosophical account of moral integrity. My aim is considerably more limited and practical. I simply want to argue that one conception of moral integrity...is sound and suitable in the specific context of responding to health professionals' conscientious objections and requests for accommodation (Wicclair 2017:7-8).

Maintaining moral integrity is important because of the direct effect it has on personal integrity and one's conception of oneself as a moral character and actor. This in turn will effect one's conception as being a virtuous and moral professional, which will allow medicine to be practiced more effectively by protecting humanistic values.

What is important to remember in all of these scenarios is that the patient most likely does not *want* to die or does not *want* to abort the fetus that could become their child. However, it is the best choice that they have; it is in their best self-interest. These are not easy decisions to make and should not be taken lightly, but should be dealt with with respect, compassion, and knowledge. The same can be said about physicians in their role in these situations. There are a few reasons suggested for recognizing the permissibility of conscious-based objections: ethical relativism and toleration of moral diversity. (Wicclair 2000:210-221). These reasons are weak ones, though, and do not get to the true root of the issue, necessitating other reasonings to be considered.

Ethical relativism posits that ethical statements have truth only in relation to moral guidelines and that there are a few different moral guidelines that may clash, but none of which are superior (Wicclair 2000:210). Using ethical relativism as a reason to support conscientious objection is a weak one, as it would allow physicians to refuse to provide further treatment or palliative care for the patient who is terminally ill and refuses life-sustaining therapy based on

personal morals that contradict with providing treatments, either curative or palliative, for those who are terminally ill. However, according to guidelines of the British Medical Association, the American Thoracic Society, and The Hastings Center, there is a valid standard of treatment which requires physicians to continue to participate in the treatment and palliative process of the patient even when life-sustaining treatment is refused (Wicclair 2000:210). These guidelines give a framework which should be consulted when providing care. The main principles of medicine are respecting patient autonomy, doing no harm, and respect the patient's conception of the good, which are laid out in these guidelines. These principles take precedence in medicine, ultimately destroying the argument of the ethical relativist. Therefore, listing ethical relativism as a reason to allow conscientious objection is a weak argument.

A second suggestion of reasoning behind conscientious objection is tolerance of moral diversity; "according to the principle of toleration of moral diversity, we should tolerate the moral views of others and not attempt to impose our ethical beliefs on them" (Wicclair 2000:211). If this is true, then any physician for any reason would be able to refuse to provide any treatment to her patient. Additionally, accepting this line of reasoning would require any and all appeals to morals to be tolerated if we are to respect diversity. This is troubling because there are obviously standards for providing treatment which are present in the medical culture that take priority over other morals. These standards include protecting patient autonomy and doing no harm. While toleration for moral reasoning can be listed as a reason for more contentious actions such as abortion or physician assisted suicide, it is a weak justification for established norms such as refusing to honor a patient's wishes of halting treatment and thus should not be listed as the reason to allow conscientious objection (Wicclair 2000:211).

Moral integrity is also cited as a reason to support conscience-based objections. This line of reasoning requires the acceptance of the following implications about the physician:

“(1) She has core ethical values. (2) These core ethical values are part of her understanding of who she is...they are integral to her self-conception or identity. (3) It would be incompatible with those core ethical values to participate in...care” (Wicclair 2000:214).

This reasoning seems to have some merit, as it applies to the physician’s conception of herself as a moral actor, which is imperative in providing ethical treatment that respects patient autonomy and conception of the good while doing no harm. This reasoning is still very broad: loss of self-respect is a rational basis for refusing to treat, but this line of thought can be similarly applied to other professions such as marketing or advertising (Wicclair 2000:214). It is true that independent advertisement agencies are generally not allowed to refuse to represent a certain client that goes against their morals, such as tobacco companies, because of professional standards and business norms that encourage these agencies to earn revenue and not discriminate between clients (Wicclair 2000:214). Therefore, there should be a difference between the medical profession and other professions regarding the permissibility of conscience-based objections.

The answer to this difference is that medicine is a ‘moral enterprise’:

(1) Physician decision-making should be guided by a consideration of obligations to patients rather than the physician’s self-interest. (2) Physician decision-making should be informed by ethical values and professional standards..., and physicians should not act as mere ‘technicians’ who will perform requested services on demand” (Wicclair 2000:215).

This definition of medicine as a moral enterprise seeks to explain what medicine is about, which is something that is humanly valuable. Medicine aims at protecting these values, such as autonomy and wellbeing, ultimately relieving suffering of all forms: mental, physical, spiritual,

etc. To say that medicine is a moral enterprise is not to say that physicians should be guided solely by personal values and ethics, but rather that they should adhere to the goals and values of medicine (Wicclair 2000:216). Because medicine is so unique in nature, goals, and guidelines, there should be adequate reasoning for recognizing and honoring objections which have significant moral weight, which is found in medicine being a moral enterprise. Therefore, as stated by Wicclair, “an appeal to conscience has significant moral weight only if the core ethical values on which it is based correspond to one or more are values in medicine” (2000:217). These values include compassion, moral integrity, altruism, trustworthiness, and respect for autonomy (Wicclair 2000:217). Retaining moral integrity is a rational basis for allowing physicians to conscientiously object, but it should be used as reasoning in addition to another, underlying principle in order to explain why moral integrity is crucial.

Autonomy is a necessary function of medicine that allows patients — and physicians — to play an active role in medical decision making, and is often listed as a reason to allow conscientious objection. Proponents of this line of thought state that respect for autonomy applies to patients just as it does to physicians, allowing physicians to refuse providing treatment if they have objections to it. But there is a limited spectrum of reasoning that physicians can use to object, and the main principles of medicine should still take priority. Because, ultimately, the patient has priority over the morals of the physician because of these medical principles, allowing conscientious objection based on autonomy is a solid reasoning. Because medicine is a reciprocal institution based on a relationship of respect and trust of both patient and physician, it is necessary to respect physician autonomy just as we would respect patient autonomy. Because patients, as stated earlier, always take top priority, then the principles of medicine will be upheld.

However, in situations where it is possible for a physician to refuse a certain treatment without infringing upon the rights of the patient, it is permissible to honor these requests. It is important to remember, though, that there is a difference between respecting autonomy and respecting conscience (Wicclair 2000:213). It is possible for a physician's conscience to be respected — if the physician withdraws from caring for her patient and refers him to another physician — but not have her autonomy respected — as when she withdraws from care, she will not have her moral preferences or autonomy respected in the future treatment of the patient (Wicclair 2000:213). This is where the physician should be comfortable with experiencing a give and take of morals. Now that it has been shown that conscientious objection may be allowed on the basis of respect for autonomy, it is important to determine when conscientious objection may occur.

Wicclair has put forth five guidelines for identifying relevant consideration of conscientious objection. The first states that (1) conscience-based objections have more moral value and are a more serious consideration when they are based off the physician's central moral values (Wicclair 2000:221). Therefore, when performing a certain treatment will cause great distress to the physician's core values, the request to object should be considered. This is a crucial distinction, as it sets a standard for objections. Physicians may not object to performing services that they simply find controversial or contentious. A physician's request for objection will carry much more weight when the values listed as reasoning for objection are core values to the physician that pose risk to be greatly harmed if the physician is forced to perform a certain service. In this case, the physician may experience severe and undue suffering, similarly to the patient who is being denied treatment or forced to receive treatment against his wishes such as in

the earlier example of the patient being forced to receive a blood transfusion, prioritizing the need for mutual respect of core values for both patient and physician (Wicclair 2000:221).

The second guideline states that (2) when there are significant differing moral appeals to conscience from professional norms, there are similar differences in moral weight (Wicclair 2000:222). If there is no largely agreed-upon consensus about the morality or permissibility of the action, such as with physician assisted suicide, then there should be different moral weight assigned to each individual's morals. Acknowledging the subjectivity of morals experienced by different individuals as a result of external influences such as upbringing, religion, and education allows these differences to be taken into consideration individually on a case-by-case basis. Approaching conscience-based objections on the individual level will be incredibly useful as it will allow only serious, relevant objections to be honored and will take into consideration the physician's entire narrative to gauge the values which are most central to their being. However, there should be caution taken when applying this guideline. If we are to only allow physicians to object when there is no agreed upon consensus regarding the necessity of providing the treatment, then it will be difficult for progress and change to be achieved within the medical community. For example, historically, it was perceived to be permissible to perform exploratory and experimental surgeries on non-consensual, non-anesthetized members of minority groups. Consider the case of James Marion Sims, who is known as the Father of Modern Gynecology (Vedantam, et al. 2016). Sims famously performed experiments on slaves and this practice was widely accepted. If it had not been for conscientious objectors, this moral evil which had become a norm would have never been changed. It is important to consider objections on an

individual basis to not allow norms and consensus to play such a large role in these considerations in order to allow for progress in medicine (Wicclair 2000:222).

Thirdly, (3) when objections are made based on values that are central to the physician's identity as an ethical professional rather than personal ethical conceptions they are given more weight because medicine has such unique characteristics, requirements, and boundaries that require physicians to act in accordance with guidelines and norms that are different from any other community (Wicclair 2000:224). If an objection is made because the physician feels that providing the treatment would tarnish her reputation as an ethical professional rather than her reputation as an ethical person, then the objection will carry more weight because it is considering the entire medical profession and technique overall. An example of this scenario might be the physician who refuses to provide an abortion for a woman who is carrying a fetus which is healthy and is progressing normally according to medical guidelines. The physician refuses to provide the treatment because she feels that she is causing harm to a being by terminating their life. The physician feels that doing so would tarnish her reputation as an ethical physician because she feels that providing an abortion is doing harm, thus violating one of the primary principles of medicine she is required to adhere to. This request for objection would be given more weight than a similar request by a physician who refuses to provide an abortion based on personal morals, such as the physician who believes that providing an abortion would personally tarnish his reputation as a good Christian. This is arguably the most important guideline, as it directly relates to the professionalism that is so crucial to the medical community. When a physician feels that her identity as a physician who is upholding the core values and principles of medicine is being tarnished by performing a certain action, then there is a unique importance to

that request of objection; it is not simply a personal, small-scale, and potentially subjective request to abstain, as it has large-scale implications for the reputation of medicine. Giving serious weight to objections that lie in the individual's conception of himself as a virtuous, competent, and effective physician who is upholding the core principles of medicine will allow medicine to progress and improve over time. This guideline as well as the second guideline should be combined and refer to each other in order to ensure that the concerns associated with the second objection are avoided and that medical moral advancements are made.

The fourth guideline put forth by Wicclair states (4) the rights and values of the patient should avoid being compromised at all costs (2000:225). Therefore, it is best for patients to lay out their wishes in advance, but regardless, physicians should honor these requests in a respectful, non-judgmental manner, such as referring the patient to another doctor. Because of the primary principles of medicine it is crucial that physicians honor these and ultimately act in the best interest of the patient. Being a physician carries unique professional obligations, and while equally honoring physician morals would happen in an ideal medical setting, it is important, as a professional, to primarily respect the patient's wishes.

Lastly, (5) different individuals assign different moral weight to certain virtues, making it necessary for recognized rights to guide the deliberation process of whether to honor a request to object from providing treatment (Wicclair 2000:226). Because there is no way to assign worth to these values, it is a subjective process, but should be considered on a case-by-case basis referring to recognized professional norms (Wicclair 2000:227). In these considerations, though, it is important to allow medical principles such as the principles to guide subjectivity and assignment of weight to individual morals. There is a need for refinement in the consideration of

conscience-based objections in medicine, which takes a more nuanced approach on a case-by-case basis.

I accept this argument and these guidelines, but also suggest a sixth clause which works in tandem with Wicclair's fourth guideline: a requested accommodation will only be honored if it will not inflict extreme physical, mental, or spiritual pain on the patient. One might question why mental and spiritual pain are of such importance in the practicing of medicine. It is because some individuals give great weight to the religious and spiritual forces in their life. The mental and spiritual suffering brought on by being forced to abstain from, or even receive, a certain treatment may be far worse than the pain experienced by the physician who does not wish to provide it. Consider the patient who is opposed to receiving a blood transfusion for religious reasons who is being cared for by a physician who requests to refuse to honor the patient's abstaining from receiving this transfusion. If the physician ignores the patient's request, does not listen to his reasoning, and administers the transfusion anyway, then the patient may experience intense spiritual or religious suffering. This suffering may be brought on in that the patient feels that he will be going to hell and have committed an unforgivable sin in receiving this transfusion. This experience of religious suffering may be worse than that experienced by the physician who feels that it would be irrational to not provide the blood transfusion. This is a necessary stipulation that should be made because of the importance of the patient's and the physician's conception of the good and their autonomy. If this factor is not considered, then the levels of paternalism within the medical community will reach astronomical and dangerous levels.

There is a thin line between respecting the physician's morals in conjunction with the patient's morals and the duties that the physician holds, and with inciting high levels of

paternalism to the detriment of the medical field (Wicclair 2014:269). It has been said that within the medical field it is the morals of the physician versus the morals of the patient (Huddle 2017:429). While this may be true to a point, there is a way to mediate this in a rule-based and obligation-centered environment which is reinforced through ethics training within medical school. These five requirements allow physicians to maintain moral integrity while still remaining responsible for their duties that they hold to their patients. There will still be situations, though, in which physicians will not have their conscience fully honored. This discussion of scenarios in which conscientious objection would be permissible and certain specific scenarios in which there might be a conflict of morals or conscience has led up to this ultimate concluding point which is important to make. It is important to not list these scenarios as problems which should be given a concrete solution to, but rather as moral dilemmas we should provide a comprehensive exposition of. Again, medicine is a moral enterprise which aims at protecting human values and reducing suffering. There is no one correct, fool-proof action to take in these situations, but it is imperative that we consider what is at stake: the suffering of a patient and the infringement upon physician conscience and autonomy. Because a primary principle of medicine is to act for the good of the patient, the alleviation and prevention of patient suffering should take utmost priority. In these specific examples of conflicts of conscience that have been provided, there has been no one way to deal with them. Therefore, each case should be considered on an individual basis in relation to Wicclair's guidelines, alleviation of suffering, and protection of humanistic values.

Chapter 6: 'Give and Take': Two Case Studies

There is a certain give and take regarding conscience which physicians should subject themselves to as a necessary part of being a medical professional. Even when a physician's request for conscientious objection is honored, her autonomy is retained but her conscience is still subject to conflicts. There are some morals one holds as a result of upbringing, including, but not limited to family and religious influences, which can be explained by culture and surroundings. There are also morals imposed onto physicians by the medical community, as seen within the universal medical principles regarding respecting patient autonomy and doing no harm. These morals may come into conflict with the duties that the physician holds to his patients. In certain scenarios, the conflicting morals of the physician may also conflict with the patient's wishes. Take for example a patient who is rapidly hemorrhaging and requires a blood transfusion, but who refuses the blood transfusion on the basis of religious principles. The patient feels an imperative obligation to refuse the blood transfusion because it goes against his morals, although the consequence of doing so may be death. The wish of the patient most likely conflicts with the physician's moral duty, which is to heal and treat the patient and to always do good for the patient.

This is where current medical ethics fails to resolve the issue at hand, necessitating the need to refer back to patient autonomy and consider which medical principle takes precedence in this situation. In being a moral physician, a doctor should respect patient autonomy, do good by the patient, and to heal. However, because of one's own personally-held beliefs or moral obligations, the physician may have a unique idea of what those concepts -- such as 'doing good' and 'doing no harm' -- entail. For example, one physician may believe that doing good for the

patient is providing palliative care when a patient is given a terminal diagnosis, while another physician may conceptualize the good as providing curative treatments until death for a patient with a terminal diagnosis. However, the physician should refrain from wholly imparting his own beliefs about what is good or moral onto his patients and understand what the core of those medical principles is. Referring back to the case when the physician's conception of the good differs from that of the patient regarding a blood transfusion, the physician should acknowledge that the patient is a rational being, and respect her autonomous wishes to abstain from receiving a blood transfusion. The physician may ask the patient if other interventions are acceptable, but should ultimately respect the patient's wishes and not administer a blood transfusion. This decision should be made because of the patient's status as a rational, consenting, and well-informed adult who is aware of all of the risks and benefits associated with receiving or abstaining from a medical intervention.

The physician used considerations of differing personal virtues and weighing the importance of certain morals in this conflictual dilemma to revisit his core duties and obligations which he has to his patient as a doctor, and then correctly made a decision referring back to humanitarian principles in order to effectively practice medicine. It is important to acknowledge that in honoring the patient's wishes and conception of the good that the physician was forced to act in a way which violated his morals. The physician, whose conception of the good includes administering a blood transfusion to rational adults in order to sustain life, acted in accordance with the wishes of the patient in order to uphold the principles of the medical community. Ultimately, the physician experienced 'give and take' of morals, as he was required to sacrifice some of his morals for the good and autonomy of the patient.

This discussion of ethics and morality has led up to identifying the central issue underlying many medical dilemmas, and is especially useful in today's political climate and dealing with the ramifications that it has caused in the medical arena. In every situation where there is a conflict of interests, it is the physician's duty to ultimately, at the base of all ethics, consider the harm and suffering that their patient will experience depending on which course of action is taken, as it is a core principle of ethics to treat the patient. Doing harm can include malpractice in the technical sense, but also by acting overly paternalistically and by making decisions on the behalf of the patient that conflict with his or her conception of the good and autonomy. Unfortunately, there are many situations in which all possible courses of action will cause at least some suffering, such as in the case of the terminal patient who wishes to sustain curative treatment until death despite the physician's idea that palliative care should be administered to ensure the most comfortable, yet inevitable, death. The suffering here is felt by the physician who is forced to sustain life at all costs despite the potential physical toll it might take on the patient, and is felt by the patient who is ultimately dying and who has a small chance of survival despite the interventions she is being subjected to. It is a physician's duty to weigh on all levels -- mental, spiritual, religious, and physical -- which action will cause the least infringement of patient's rights. The moral plan of action to take is the one where the least amount of suffering is experienced by the patient.

As has been discussed earlier, there is a healthy and necessary level of paternalism in the medical community. Physicians, as social actors, are required to make decisions in the best interest of their patients, for their patients. This entails respecting physical, mental, emotional, and spiritual manifestations of the patient's conception of the good -- a narrow-minded approach

cannot be taken when effectively practicing medicine. While this is an idyllic view of how medicine should be practiced, physicians are under pressure from institutional and personal moral forces, leading to other factors influencing decision-making such as finances, administration, and potential legal action. Because physicians are expected to act as morally virtuous, responsible persons and be aware of the unique set of skills and knowledge they have been imparted, they begin to allow paternalism to infiltrate their practice.

Paternalism is a term used to address one's acting in strict accordance with one's own wishes, best interests, and notions of the good on the behalf of another (Debeljak et al., 2008:217). This definition is uniquely related to this discussion of ethics because of the risk of a physician unknowingly making treatment decisions on behalf of his patients that are in accordance with the physician's morals but conflict with those of the patient, or to provide a certain treatment only to avoid negative repercussions associated with external factors such as cost and legal action. For example, a physician may neglect to make a patient aware of a certain treatment option available to them because the physician perceives the treatment not to be cost efficient, or because the physician is hesitant to provide a treatment based on the riskiness of the procedure and the physician's caution in avoiding malpractice lawsuits. To say that physicians, on average, act with paternalistic tendencies is not an attack on the character of those who become physicians; in fact, it is an attack on the institution and culture of the healthcare and medical fields over all. Physicians should not live in constant trepidation that their actions may be the wrong one, thus causing them to face legal and moral repercussions. Additionally, this paternalism is not entirely selfish, which is defined as self-interest, which excludes the consideration of others. The physician considers himself, his patients, and other factors, though

he may not give enough moral weight to the wants and needs of the patient, as discussed before (Debeljak et al., 2008:218). Rather, physicians participate in a type of “enlightened” paternalism, which considers the patient and other factors. This approach is still morally wrong because the physician uses these other actors (patients) as a mere means to the physician’s end, which is avoidance of moral and legal repercussions, ultimately neglecting to fully honor the patient’s autonomy (Debeljak et al., 2008:218). In this case, the physician is only honoring his needs and morals and neglects to honor those of the patient, resulting in disproportionate value being placed on the autonomy of the physicians within the medical realm.

It still may not be obvious how a physician’s obligations to the medical field may force them to act in a paternalistic way. Consider the following: a physician has duties to his patient to treat efficiently and effectively, and respect patient autonomy. A physician also has duties to the medical field and the institution to which she belongs to including upholding the honor of the medical community, treating in a moral way, and doing no harm through perceived recklessness, endangerment, or ignorance. Because a physician may face serious punishment inflicted by the medical field for failure to fulfill these obligations such as being sued by patients, imparting false knowledge, or acting in a negligent way, she feels that her actions are being scrutinized and so act in a way which protects herself and keeps her best interests at heart. For example, a physician may make decisions on the behalf of her patients that are not congruent with the patient’s wishes, but protect the self-interests of the physician. By doing so, the physicians are acting in accordance with paternalism. In these scenarios, the physician is allowing factors that are extraneous to the goals of humanistic medicine to infiltrate the practice of medicine. While these pressures are still important in the avoidance of lawsuits and in using resources adequately,

they should not enter the doctor's judgements of what treatments to provide to his patients in order to prevent suffering.

Paternalism also refers to a physician subordinating the patient because he thinks that it is in the best interest of the patient. Paternalism, in moderation, is a necessary function of medicine; physicians should be able to assess whether a patient is a rational agent with rational wishes, and if he is irrational, be able to make decisions that are in his best interest. However, because of the idea that physicians are always virtuous, all-knowing agents, doctors can sometimes exercise high levels of paternalism. Physicians may subordinate their patients to the point of neglecting the patient's wishes and conception of a good end and give options and provide treatments that the doctors themselves believe to be the best option, disregarding the beliefs of the patient. This may be done unconsciously, as is the case with egoism within the medical community. It is not rational to say that physicians intentionally act in an egoistic or paternalistic way; it is, however, quite reasonable to attribute the high prevalence of these actions to the inadequacy of medical training and professional ideals of physicians that is a consequence of being an actor within the medical field.

There are serious ramifications that exist as a result of these actions; physicians are ill-equipped to ethically deal with medical dilemmas that arise. During the limited medical training that physicians receive, they are provided with the same cases over and over again to learn what to do in a uniquely challenging situation. Medical students, at the end of this training, know how to deal with a patient who refuses a blood transfusion on a religious basis, or a patient who wishes to end his own life before a terminal illness takes it from them -- both of which we will further analyze -- but rarely understand the ethical principles that lay at the core of these

problems. I argue that there is a unique ethical evaluative process that should occur in order for physicians to be able to solve these problems and allow physicians to interact with their patients, ultimately experiencing a give and take of morals in the medical setting. Two small-scale case studies will be completed in order to critically analyze objectors of specific procedures: physician assisted suicide/euthanasia and abortion.

Physician-Assisted Suicide and Voluntary Euthanasia

Guidelines have been put in place by Oregon to allow physicians to assist patients in committing suicide. These guidelines are known as the Oregon Death with Dignity Act. The components of the act set limitations for those who wish to initiate a request for life-ending medication and for the physician who is fulfilling the request. One may request this medication if one is:

- (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

An adult is defined, within this context, as an individual who is 18 years or older, and the attending physician is the physician who is primarily responsible for the adult's care and treatment of his disease. The physician also has duties to his patient during this period:

- (1) The attending physician shall:
 - (a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;
 - (b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860; (c) To ensure that the patient is making an informed decision, inform the patient of: (A) His

- or her medical diagnosis;
- (B) His or her prognosis;
 - (C) The potential risks associated with taking the medication to be prescribed; (D) The probable result of taking the medication to be prescribed; and
 - (E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;
 - (d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;
 - (e) Refer the patient for counseling if appropriate pursuant to ORS 127.825; (f) Recommend that the patient notify next of kin;
 - (g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;
 - (h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;
 - (i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
 - (j) Fulfill the medical record documentation requirements of ORS 127.855;
 - (k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
 - (L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or
 - (B) With the patient's written consent:
 - (i) Contact a pharmacist and inform the pharmacist of the prescription; and
 - (ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.
 - (2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 §3.01; 1999 c.423 §3]

These limitations provide reasonable guidelines in order to protect the patient from external sources of coercion, as well as to make sure the patient is aware of all other treatment options, his prognosis, and the steps which the patient must take in order to receive assisted suicide. The patient must make an oral request to his physician for this service as well as submit a written request. The patient then is required to make a second oral request to his physician no less than fifteen days after making the initial oral request (127.840 §3.06). The form of the written request is also subject to certain criteria:

(1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule. [1995 c.3 §2.02]

In section (1), a capable patient refers to one which has been deemed by a court, the attending physician, or the patient's psychiatrist to be fully rational, understanding, and able to effectively communicate health care decisions (127.800 §1.01. Definitions). It is also important to highlight that one of the witnesses must not be a relative to the patient in any way or in the person's will in order to ensure that there is no coercion on behalf of the family in order to acquire a percentage

of the patient's estate after death, or for other external, non-medical reasons (127.800 §1.01. Definitions). Some healthcare providers argue that PAS and VE are inherently wrong moral acts as they are essentially killing, and posit that it is not the duty of a physician to perform either of these actions (Varelius 2013:229). Others argue that these actions are reasonable treatments that fall within the umbrella of duties and obligations a physician holds to his or her patients. As always, it is imperative to acknowledge the importance of respect for patient autonomy and the patient's conception and active pursuit of a good end. First, though, the specifics of killing should be expanded upon.

This process in Oregon allows the physician to take a less active role in the patient's death. In Canada, however, patients have access to assisted suicide from physicians who take a moral active role. Individuals have access to physician assisted suicide in Canada only if the following criteria are met:

- (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
- (b) they are at least 18 years of age and capable of making decisions with respect to their health;
- (c) they have *a grievous and irremediable medical condition*;
- (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
- (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. (Canada Bill C-14).

Eligibility refers to the patient being a rational adult and having a previous and irremediable medical condition. The patient who meets these eligibility requirements then must have at least two physicians and/or nurse practitioners who are independent from each other

confirm that he has a grievous and irremediable medical condition. To be categorized as having this type of medical condition, the patient must be categorized as the following:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- (d) **their natural death has become reasonably foreseeable**, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining (Canada Bill C-14).

There have also been legal safeguards put into place to protect vulnerable persons from being coerced into committing suicide or from acting without full understanding of all options. These safeguards are similar to those which are in place in the United States, and include having two independent medical opinions and two independent non-medical witnesses who are not beneficiary's under the patient's will, owners of the healthcare facility that the patient is being cared for at, or are direct carers of the patient. There is also a ten day waiting period for a patient to sign and date a written request to die which must be completed ten days from the date the patient will die. The patient must also be made aware of other options such as palliative care, express consent before death, and be able to decide to not follow through with the assisted suicide.

Within both — Canada and the United States — practices of physician assisted suicide, there are risks of strains on moral integrity. Physicians take a more passive, external role in patient suicide in the United States, as they fill a prescription for a patient who will ingest the prescription, fall asleep, and die without pain or suffering. In Canada, though, a physician might take a more active role in assisting her patient's suicide, as she may have to bring about death by

lowering the power of a ventilator, essentially suffocating the patient in order to bring about death. This act may strain the moral integrity of the physician who feels that physicians are meant to be healers, not killers, and who perceives aiding in suicide to not be a beneficial act of unorthodox healing, but rather as murder or killing.

People have different opinions regarding the physician's role in assisted suicide. Some believe that the procedure should only be carried out by a consenting physician, while others believe that physicians have a duty to aid their patients in assisted suicide. Kamm addresses this by providing a 4-step argument:

1. Doctors have a duty to treat pain, even if treatment will bring death sooner, when death is a lesser evil and pain relief is a greater good, or when death is imminent and only morphine can aid the patient.
2. Doctors then have a duty to intentionally cause evils and do harm when the evils to be committed are lesser than the goods to be achieved.
3. All assuming that death is a lesser or imminent evil because it is not different from other lesser evils.
4. Therefore, doctors have a duty to cause their patient's death when death is a lesser evil than the suffering that the patient would suffer in the future (Kamm 2008:147).

Kamm refers to this argument as the Doctor's Duty Argument. This argument is founded, first, on the premise that physicians have a duty to treat pain in some situations even if it will hasten death when the relief they are providing reduces suffering. The next premise of the argument states that physicians may be required to commit some evils when the evil is committed to achieve some greater good, such as over-prescribing morphine to a dying patient in order to hasten death and ultimately relief. Lastly, Kamm states that death is a lesser evil because it will end suffering that the patient is currently experiencing. Kamm concludes that doctors have an obligation to bring on patient death when death will cause less suffering than the patient would experience in the future. Some may argue that because of the professional ethic

physicians are bound to, performing physician assisted suicide is forbidden. A doctor should avoid unnecessary harm, and by keeping patients alive when their pain outweighs the potential for good, the doctor is directly harming his patient. But while it may fall within a physician's duties to assist in suicide or perform euthanasia in certain scenarios, this does not require physicians who feel deeply morally opposed to performing these actions to do so. This is because physicians may potentially object to performing PAS or VE on the basis that they feel that it conflicts with one of the core principles of medicine, to do no unnecessary harm. This objection is founded in the belief that physicians should be healers and not killers and in intentionally bringing on patient death, a physician is going against the goals of medicine. Because this objection is founded in a core principle of medicine, it is reasonable, and thus an objection that may be honored. Medicine is a moral enterprise which aims at protecting humanity and human values and in turn prevents suffering. While preventing suffering of a patient is of primary importance, there should still be respect for physician autonomy because of the protection of human values that medicine seeks to provide. Therefore, physicians may elect to aid in patient suicide or abstain altogether from providing this type of intervention.

In the medical world, PAS and VE are only provided to patients that are gravely ill with a terminal diagnosis and a prognosis of less than six months to live, confirmed by more than one physician (Death with Dignity). In order to determine what to do for a rational patient who requests PAS or VE to be provided to them, a principle-based framework should be initially consulted. A physician's obligations include the following principles: respecting patient autonomy, acting in accordance with the patient's personal, physical, mental, and spiritual conceptions of a good end, and doing no harm. If a patient is terminally ill with a short

prognosis and feels on all levels that a good end would be one that includes PAS or VE, then it is the duty of the physician to provide those treatments. A physician might experience a conflict of interests in this scenario; personally, they feel that killing a patient is wrong, but they also feel that the patient has a right to elect himself for PAS or VE if the above guidelines are met and the patient feels it is a good end for himself (Sjöstrand et al., 2011:207). The physician should, in this case, question how to act in accordance with being a responsible, autonomous, respected doctor who upholds the principles of the medical community. A virtuous doctor is respectful, knowledgeable, effective in treatment, and is trustworthy, and would acknowledge that a person has a right to his or her own body, and that the patient will likely experience unnecessary mental and spiritual suffering that could potentially be far worse than any physical pain that could be brought on by disease or death if PAS or VE is not provided to the patient that desires it. Therefore, the physician may elect to aid the patient or refer them to a different physician in order to aid the patient in dying.

This is not to say that the autonomy and personal morals of the physician do not matter; it is true that the physician may experience distress by performing certain treatments including PAS and VE. This is why it is necessary to allow physicians to conscientiously object to performing these interventions. However, the physician should act virtuously and in accordance with duty, weighing her duties and obligations from an ethical standpoint in relation to the primary principles of medicine. Therefore, the physician who is wholly opposed to the practice of physician assisted suicide will experience a give and take of morals: she should accept that this practice she finds deplorable is still being performed by those who perceive it to be a patient right, but will also be able to retain some of her morals and autonomy by not being forced to

perform this intervention. As directly stated before, though, the physician's autonomy will be respected but her conscience will still be conflicted. Ultimately, the physician will retain her morality to a point and be able to provide treatments or refer and make decisions in the best interest of his patients while respecting physician and patient autonomy and notion of the good.

Abortion

As has been stated earlier, the Church amendment is a legal provision which allows physicians and other healthcare providers to object to performing certain services, such as abortions, because doing so is "contrary to his religious beliefs or moral convictions" (Church amendment). Abortion is a unique dilemma that physicians should deal with because it can be argued that instead of dealing with only two parties (physician and patient), you are dealing with three (physician, patient, and fetus). Claims of conscience in abortive services have famously been debated throughout the years. Physicians, as has been discussed earlier, are sometimes opposed to providing physician assisted suicide to a terminally ill patient who requests it. Abortion adds yet another layer to this already morally difficult situation; we are now not only dealing with a conflict of interests between a physician and a patient, but we are also dealing with potentially terminating a fetus, which could be considered a human life with their own rights.

Many factors should be considered when determining the permissibility of an abortion of a healthy fetus, both from the view of the physician and of the patient. The patient might experience unnecessary suffering both physically and mentally if forced to carry a fetus to full term. However, there might be moral suffering experienced by the physician if he or she is

deeply morally opposed to performing an abortion. Additionally, because — depending on one’s beliefs and moral orientation — it could be argued that the fetus is a third party, the potential pain and suffering that the fetus might experience should be taken into consideration. It can be argued, then, that an abortion does not benefit ‘both’ patients — the fetus and the woman — or any patient. Since the fetus is being terminated, it can be argued that the patient is killing and causing harm. Additionally, because the woman might experience physical or emotional distress from receiving an abortion or might be subject to social judgement or stigmatization, it can be argued that she is experiencing suffering. If this is true, then what is the justification of physicians providing abortions? *Roe v. Wade*, a landmark legal decision, determined that women have a right to their body and thus a right to decide to receive an abortion, ultimately providing a justification. Feminists have historically argued that women have a right to choose whether or not to give birth and that it is not the decision of the government to deem whether a woman must bear the pain and suffering of carrying a fetus to full term and then giving birth to that fetus when she does not want to. Though some argue that providing an abortion causes harm to a patient, it is also reasonable to argue that the harm caused by aborting a fetus is outweighed by the alleviation of suffering that the woman will experience as a result of receiving a wanted or needed abortion. *Roe v. Wade* has set laws and guidelines in order to determine a timeframe in which it is acceptable to perform an abortion as well as provided protections for women’s privacy (410 U.S. 113). This timeframe has been created in accordance with scientific research and guidelines that have determined when the point of viability is, which is around 20-24 weeks after conception (505 U.S. 833). Many physicians refuse to provide abortions beyond this point, which is morally reasonable, as some argue it is the duty of physicians to be healers and by

providing abortion, physicians are actively violating this duty. Some physicians still refuse to provide early-term abortions on the basis that it is still a killing, which is inherently wrong and immoral.

To come to a conclusion regarding this dilemma, it is important for the physician again to reflect on his or her duties to the patient which have been formed to act in accordance with medical principles. The emotional pain that a patient experiences from carrying a child full-term may outweigh that of going through an abortion (Buchbinder et al. 2016:23). The same may be said about a fetus which has no chance of survival once they are born at full-term because of painful developmental impairments. As it is a physician's duty to provide effective, rational, and respectful treatment to their patients with a limited amount of pain, it is reasonable to argue that it is within the obligations of a physician to provide abortions for their patients. This being said, it is important to retain respect for the physician's autonomy as well, allowing physicians to object to performing abortions for both healthy and terminal fetuses if referrals are made to a second physician who is willing to perform the procedure. What is unique about moral dilemmas in medicine is that often, no matter which action is taking, there is still a sort of 'remainder,' morally; not everything gets perfectly squared away. In cases of PAS and abortion in which either physician or patient feels a moral dilemma, there will be no entirely right answer or entirely wrong answer. There are multiple actions that can be made such as providing the abortion against one's morals, or referring the patient to a different physician, or the patient just opting out of having an abortion. None of these will always be the right answer, and this is the nature of all moral predicaments, not just of medical moral dilemmas. However, what is unique about medicine is the fact that it is a moral and a human enterprise, aiming at protecting

humanistic values and alleviating suffering. Therefore, it is necessary for physicians to consider which course of action will cause the least amount of suffering for their patient.

In this discussion of moral compromise, it is important to explore the notion of forgiveness in the medical context. It is not just patients who feel moral obligations in spiritual, medical, and personal contexts; physicians also deal with this conflict, as has been explored previously. Physicians have a unique responsibility to their patients in that the rational wishes of the patients should come before the physician's personal conception of the good, necessitating self-forgiveness in situations which physicians feel they are violating their morals or even religion. In situations in which the physician objects to performing a certain procedure, such as an abortion, but there are no other physicians willing and available to perform the procedure, then that physician should perform the procedure because of the primary duty of the physician to treat his patients and act in their best interest. While the physician, in this case, should bear suffering of conscience, it is imperative that this suffering is weighed against the suffering experienced by the patient who might also suffer consciously, mentally, and physically. The patient who is refused treatment with no alternative way to receive it may be left with a physical stigma or deformity that the patient should bear along with her suffering. Because the patient ultimately takes priority in the medical realm, the physician is required to provide these services in this limited scenario. Self-forgiveness is "of particular relevance to the practice of doctoring, given the culture of the medical profession as it currently exists" (Ivanhoe, et al. 2007: 88).

Because of the professionalism of medicine which requires physicians to adhere to a set of high standards as ultimate healers who avoid mistakes and imperfections, there is a deep sense of guilt felt when this reputation is not upheld, even in the personal, internal sense which arises in the

discussion of the give and take of moral values (Ivanhoe et al, 2007:89). Physicians may feel this guilt when there is a conflict between their interests and the interests which are best for the patient.

A common scenario in which this specific type of conflict arises is when a physician is caring for someone who is incurable; that is, someone who has a fatal disease or illness with no realistic chance of recovery or survival. Physicians often feel a type of invulnerability and need to control natural consequences such as death or disease (Ivanhoe, et al. 2007:104). When a physician is faced with a terminal patient, there might be anxiety about how to treat this patient when no treatment is available. Patient abandonment is morally reprehensible as it violates multiple obligations held by the physician in addition to many core values of medicine, and some treatment options may not be enough to assuage the pain experienced by these terminal diseases. Some physicians might be content with simply providing palliative pain management to their patients until death. If this plan is in accordance with the patient's wishes and conception of the good, then there is no conflict of interest. However, a different patient may wish to have physician-assisted suicide provided to him. In this case, the rational patient's conception of the good on all levels — personal, medical, spiritual, and at large — have caused them to come to the conclusion for various reasons that an assisted euthanasia is the most dignified death. The doctor has a duty to his patient to provide medical assistance which is congruous with the patient's active pursuit of the good, thus necessitating the physician's obligation to aid in the patient's suicide — but this might be at odds with the physician's own morals. Therefore, self-forgiveness is necessary; the truly virtuous physician is one who, when confronted with a conflict which he knows will cause some moral distress to himself, chooses the plan of action

which best benefits his patient and her conception of the good, whether that is providing the treatment himself or referring the patient to a different willing and capable physician. It is imperative that the physician fully understands the notion of 'give and take' in the morality of clinical medicine and that the decisions that have been made in the best interest of the patient are morally best, and that self-forgiveness functions as "a corrective to erroneous or unreasonable beliefs about one's fault and hence unreasonable self-blame" (Ivanhoe, et al. 2007:105). There are still opponents to these suggestions of how to deal with conflicts of conscience and autonomy, though, and it is important that they are addressed.

Chapter 7: Objections to Theory and Application to Cases

We allow physicians to elect to conscientiously object because we live in a country where it is permissible to refuse services to individuals based on personal beliefs and autonomy that conflicts with the core values of medicine, though there are opponents to this reasoning. Julian Savulescu, a rejector of conscientious objection, argues that refusing medical treatment because it is not in line with your personal beliefs is wrong and prejudiced (2006:294). He argues that a doctor's personal values and conscience should not interfere with providing treatment, all doctors and medical students should be aware of the duties and obligations associated with being a doctor, and physicians who object to providing care and thus compromise the care of their patients should be disciplined (Savulescu 2006:296). While it is true that patient autonomy takes priority, it is damaging to the medical field to say that physician autonomy carries no weight. It is important that physicians are considered to be autonomous moral agents by themselves and by their patients as open communication between physician and patient will be fostered allowing medicine to be practiced as a moral enterprise. Savulescu specifically concludes the following:

Values are important parts of our lives. But values and conscience have different roles in public and private life. They should influence discussion on what kind of health system to deliver. But they should not influence the care an individual doctor offers to his or her patient. The door to "value-driven medicine" is a door to a Pandora's box of idiosyncratic, bigoted, discriminatory medicine. Public servants should act in the public interest, not their own (Savulescu 2006:297).

In a medical situation, Savulescu calls doctors indispensable instruments in carrying out a medical treatment and states that individuals "should not be doctors" if not prepared to

provide legally permitted treatment (Savulescu 2006:294). In essence, Savulescu's argument against conscientious objection is founded in the reasoning that it will weaken the medical profession overall, infringing upon patient autonomy and respect for physicians.

There have been several additional narrowed arguments against conscientious objection that have also been suggested, the first of which revolves around inefficiency and inequity associated with conscientiously objecting to providing treatments (Savulescu 2006:295). A study cited by Savulescu has shown that less than half of clinical geneticists and obstetricians were prepared and willing to perform an abortion at or before the pregnancy reached 13 weeks (Savulescu 2006:295). Savulescu says that these findings are troubling because it is the job of these specialists to provide this service to patients. If the population of physicians willing to perform this service minimizes, there is a risk of patients being inconvenienced and potentially left uninformed (Wicclair 2006:295).

The issue of inconsistency is also cited as a reason to reject conscientious objection; Savulescu references the hypothetical situation in which a physician refuses to provide treatment for patients over the age of 70 because he believes that these people have already lived a good life and thus are not deserving of receiving care, as it is a wasteful use of limited medical resources and time (Savulescu 2006:295). It is not acceptable for physicians to refuse providing treatment on the sole basis of self-interest or opinions such as the one in this scenario because acting in the best interest of the patient is one of the primary principles that guide medical action. This principle entails providing treatment for those at any age, regardless of an individual's conception of how many years it takes to complete a full life.

It is also true that doctors have special commitments to their patients that they should accept in order to become a doctor (Savulescu 2006:295). Savulescu states “[t]o be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system” (Savulescu 2006:295). This is all entirely true, but what is part of a just healthcare system is in line with the a priori principles of medicine: treat the patient, respect autonomy, and act in accordance with the patient’s conception of the good. Treatments which are regarded as entirely beneficial and rational by the majority of recognized and respected physicians fall within the realm of a just healthcare system and its principles, and treatments which are required and are thus not usually the focus of conscience-based objections. However, more contentious acts of care such as abortion and physician assisted suicide do not necessarily fall perfectly within the guidelines associated with these principles depending on physician morals and conception of ‘doing no harm’; physicians may elect to perform these, and other physicians may decide to decline to provide these treatments and refer the patient to a different, willing doctor when objections are founded in conflicts of value relating to the core values of medicine and the physician’s identity as a moral doctor. Both decisions are morally permissible when in line with the guidelines of reasonable conscientious objection as both respect the autonomy of the patient and the physician.

What Savulescu so crucially neglects to consider in all of his arguments is the fact that medicine aims at protecting humanistic values. By enforcing a strict, detached culture of medicine, there will be high levels of suffering experienced by patient and physician because of the lack of humanistic protection of values. Savulescu’s argument against conscientious

objection is weak because medicine is founded on the basis of trust and respect between physician and patient. This means respecting the autonomy of both patient and physician.

While I agree with Savulescu on the premise that physicians have a duty to their patients to provide adequate medical treatment as a primary principle of medicine, there should be a mutual respect of personal and professional morals and autonomy between both parties, as medicine is a humanistic and moral enterprise. A patient may object to receiving treatment if the request is rational, and the physician should honor that. Similarly, the physician should be allowed to object to providing certain services if those objections are founded in the doctor's conception of herself as a moral physician. Doctors are moral agents — similarly to how we all are agents capable of making moral decisions, and thus should honor all of their values, both person and professional. Conscientious objection allows these morals to be upheld in a procedural, rational, and fair way. Savulescu's argument is in fact contradictory, as allowing for conscientious objection will increase trust in the medical community as physicians and patients will be able to have open, honest communication and practice medicine in an earnest, effective manner.

In regard to Savulescu's argument on inefficiency and inequity appealing to OB-GYNs unwilling to provide abortions, there are many responsibilities other than providing abortions that obstetricians have, such as providing birth control, women's health screenings, and treatment for other conditions. Despite the fact that a significant proportion of OB-GYNs are not willing to provide an abortion, adequate treatment can still be provided to patients outside of that specific procedure. This fact still does not minimize the effects of having OB-GYNs who are unwilling to provide abortions. While physicians may elect to not perform these types of procedures, it is imperative that physicians refer their patient to a physician who is trained and

willing to perform such procedures. While the physician may feel that his morals are still being conflicted because of his referral to a different physician to still carry out the procedure he finds morally wrong, it is the duty of the objecting physician to aid his patient in finding care. This is where the give and take of morality takes place again, as the physician should acknowledge that the procedure will ultimately happen, though at the hands of the other doctor. Ultimately, autonomy of both parties continues to be respected, as the physician is not forced to perform a treatment he finds morally abhorrent, and the patient will receive the procedure she desires.

Savulescu neglects to consider the nuanced approach which gives importance to autonomy and morals of physicians and patients, and instead argues for a narrow and deficient view of conscientious objection that does not consider these required aspects of adequate medicine. Refusing to provide treatment can be seen as prejudiced because some argue that it looks down upon or shames the values of patients and may make the patient being refused treatment feel that they are being judged for their medical wants. Savulescu goes so far as to say denying a treatment to an eligible, autonomous candidate is malpractice, as the physician is not providing treatment and could be perceived as acting negligently (2006:294). He argues that denying treatment directly results in a loss of integrity of the profession and reflects lack of morality of the professional and of the profession overall.

Savulescu and Schuklenk, a philosopher who takes a stance similar to Savulescu, have responded to criticisms regarding the lack of success their arguments in opposition to conscientious objection have had in influencing any type of legislative change, explaining that the prominence of organized religion in our society is to blame (Savulescu et al. 2017:162). They argue that though our society is not entirely religious, that many of the protections written

into the constitutions of our institutions — medical, governmental, educational — were implemented during times that were heavily influenced by religious forces (Savulescu et al. 2017:162). This point is true, though only to a point. While guidelines were implemented due to the heavy influence of religion during earlier times, there are still many people who identify with the morals that religion has imposed. The religiosity of past societies has also influenced today's institutions, shaping our morals and even our professional behavior. Today, there is more diversity of religions that are practiced in society, but many of these religions have the same core values: do no avoidable harm, forgive, give more than you receive, respect others, etc. Many religions also consider human intervention in death such as in abortions or assisted suicide to be immoral and a sin, while some other individuals -- potentially religious -- view performing these services to those in need a moral good. Because of the diversity of influences on morals and the diversity of religious interpretation, differing conceptions of professionalism, and ultimately individual autonomy, should be respected. Religion has played a role in the formation of our society today, and though we should not allow religion to heavily dictate medicine, it is reasonable to acknowledge religious influences on autonomy that an individual, whether she is a physician or a patient, may hold. These facts necessitate the availability of conscientious objection in order to respect the autonomy of the diverse physician population.

There is not a general agreement about religious, spiritual, or personal morals that a physician should have outside of those listed in the Hippocratic Oath — a consideration Savulescu fails to take. Therefore, physicians are allowed to object on the behalf of other personal values and autonomy, if they are in line with medical values, as there is a difference between those and the interest of self. Referring back to the trust and respect-based relationship

between physician and patient and the emphasis on humanity that should be made, the issue of inconsistency is realized not to be an issue. As stated earlier, different individuals may have different conceptions of a good end in accordance with their autonomy. The physician is expected to respect these differing opinions of his patients and not refer to them as ‘inconsistencies.’ This same respect should be given to physicians as well, who are entitled to having differing morals, and thus are allowed to object to performing certain services that conflict with their conception of themselves as a moral, virtuous physician and autonomous actor.

It may be true that we are allowing religion to infiltrate medicine to a high degree, but this is a reflection of our society. Medicine should be equipped to deal with the population at hand, and physicians are members of that larger population. All members of society have had past experiences and influences that have shaped their morals and views on autonomy. These factors then ultimately consciously, or subconsciously, dictate an individual’s professional behaviors, as well. Earning the title of ‘doctor’ does not exempt someone from having morals that have been acquired through religious influences; a physician has still been brought up in a society that has external influences that shape morals. Because medicine is for the people, there should be an acceptance of religious diversity for the patients as well as for the physicians. One rational physician may conceive doing no harm differently than a second rational physician due to religious, spiritual, or other personal experiences and influences. To not honor reasonable requests of conscientious objection would be to use physicians as a mere means, which is immoral in itself. It is imperative that the morals and the autonomy of physicians are respected within the moral enterprise that is the institution of medicine.

To support conscientious objection is not to allow every request of conscientious objection to be honored, as has been suggested by opponents of conscientious objection. Only those requests that meet the five guidelines created by Wicclair in addition to the extra guideline that has been put forth earlier should be honored: (1) conscience-based objections have more weight when they are based on the central values of the physician (Wicclair 2000:221). (2) When there are notable differences from respected professionals regarding requests of conscientious objection in respect to medical norms, there are also differences in the moral weight of these values, (Wicclair 2000:222). (3) Conscience-based objections are more morally significant when central to the physician's conception of herself as an ethical physician rather than an ethical individual or member of any other group (Wicclair 2000:224). (4) Whenever possible, the patients' rights and interests should not be compromised (Wicclair 2000:225). (5) The competing values that an individual experiences can have more or less moral weight and it is advisable to allow norms to guide a comparison of these interests (Wicclair 2000:226). The sixth clause I suggest states that (6) a requested accommodation will only be honored if it does not inflict high levels of physical, mental, or spiritual pain on the patient. The physician who makes such ridiculous requests akin to the ones that Savulescu has mentioned — such as the gynecologist who refuses to perform internal exams — would never have his requests honored because the value that the objection is based off of is not in line with any of the values of medicine. The problem with Savulescu's argument is that he neglects to consider that conscientious objection is only permissible in situations where there is a conflict of professional morals and medical norms that threaten a physician's identity as a moral physician, and lack of consensus surrounding the morality of the issue among the respected medical community.

What we must respond to this argument against conscientious objection, above all else, is this: it is not permissible to allow requests for conscientious objection founded solely in religious or personal values. These requests must be founded in or seen to potentially effect the physician's ability to be perceived as and act as a moral, virtuous physician. An example of an unacceptable religious request for exemption would be a physician who refuses to provide an abortion because, as a Catholic, the physician is prohibited from performing such an act. According to the physician, doing so would result in the physician being a bad Catholic. This differs from the acceptable request, in which a Catholic physician refuses to provide an abortion because he feels, because of his religiously influenced values, that doing so is killing, not healing, which goes against the goals of medicine and thus causes the physician to act without professionalism and not act as a moral physician. The crucial distinction lies in that the adequate request for conscientious objection is based in the physician's conception of himself as a moral physician, rather than a moral individual. The abstaining physician should provide reasons for objecting that are founded in his conception of professionalism, which may or may not be affected by religiously inherited values. Wicclair has provided a realistic and useful set of guidelines that should be referred to in order to deem the acceptability of requests for conscience-based objections.

Chapter 8: Conclusion

Physicians are subject to a certain ‘give and take’ of morals in the medical arena, as they are required to potentially sacrifice their own conscience in order to provide reasonable, safe, effective, and desired treatment to their patients. Fortunately, there are guidelines set up within the American healthcare system to ensure the protection of morals of both patients and physicians. When physicians have moral objections to providing a certain service that are in line with one or more of the core values of medicine, a request for conscientious objection may be made. Wicclair has created five guidelines that should be adhered to in order to honor the objection once it has been determined to be in line with the core values of medicine: (1) the objection will have more moral weight if based on beliefs that are central to the physician’s identity, (2) -- which should be adhered to cautiously -- the objection is given more weight if the consensus about the action’s morality varies greatly among respected professionals within the field, (3) there is more weight given to the objection when it is concerned with the doctor’s conception of herself as an ethical *physician*, not just an ethical individual, (4) the accommodation of objection should always aim, when honored, to be completed without infringing upon the patient’s rights and interests, and lastly, (5) each proposal of objection should be considered individually, as certain values can carry more weight than others (Wicclair 2000:221-227). I argue that a sixth clause should also be implemented into the deciding process, which is built off of the fourth clause that Wicclair provides. A request to conscientiously object to performing a certain treatment should only be honored when it does not inflict serious pain on the patient — physical, mental, or spiritual. It is not up to the medical community to judge those whose religion or personal experiences have shaped their morals, no matter how different from

their own morals they may be. The United States is a diverse country which is home to many individuals from different backgrounds. Religion has played a major role in the development of this country and all of its different institutions, and so its effects on the moral foundations of the people of this nation should also be respected. Fortunately, the option of conscientious objection based on the six guidelines set out before allows the morals of patients and physicians to be retained and medicine to be practiced as a moral enterprise.

Conscientious objection, though, should be a last resort and not a first choice when physicians are confronted with a challenging medical dilemma. Current models of ethics education in medical schools — ethics-as-character and ethics-as-virtue — are lacking in teaching physicians to make medical decisions regarding patient treatment in accordance with their duties and their humanity in an attached and compassionate way. The pressures of medical school and the medical field as a whole often cause young medical professionals to have to balance conflicting obligations. By employing the use of ethics concerned with duty as well as encouraging an interpretive model of doctor-patient interaction, the negative effects brought on in high-stakes medical dilemmas can be mediated. This new ethics curriculum required physicians to consider themselves as first and foremost a physician and to weigh their duties and obligations that they have to their patient over any other obligations. The physicians should consider the patient's conception of the good on all levels — physical, mental, emotional and spiritual — and provide treatment in accordance with that. This is related to the interpretive model of physician-patient interaction, as this model creates guidelines that guide the physician in helping the patient realize their core values and morals. The physician refers to the patient not just as a medical problem that needs to be treated, but as an individual with a past and a future.

The interpretive model allows the physician to view the patient as an entire narrative, providing treatment options that are in line with the patient's conception of the good and aiding the patient in making the best, most well-informed decisions. This model, combined with a deep understanding of duty, will allow future physicians to be adequately trained in ethics in order to create an environment where medical dilemmas can be handled more efficiently.

Admittedly, bioethical and medical ethical recommendations are usually very attractive on paper though still face occasional complications and limitations when put into practice. This is because ethical theories of medicine attempt to combine the abstract — theories — with the concrete — the application of these theories in medical treatment. Medicine is a complicated institution because of its direct impact on the health and wellbeing of humans, and so no bioethical theory will be entirely foolproof. However, the ethical theory and ethics training I have argued for — one which is based on humanity and the use of an interpretive model of interaction — is most useful in today's society. This is because it considers the patient as an autonomous, rational agent, which is something that past models of medicine have failed to do because of the high level of paternalism that physicians were expected to exercise. This model of 'give and take' allows physicians to exercise a reasonable level of paternalism over their patients, allowing for medicine to still be practiced effectively and properly while introducing humanism and compassion. These traits will allow medicine to be practiced as a moral enterprise while acknowledging the influence that external factors such as family, upbringing, experiences, and religion have had on the formation of morality of patients and physicians alike. Furthermore, physicians will be allowed to make conscience-based objections in order to preserve their own morals as well. This theory has limitations, though, in that ethics is a

subjective discipline. It is difficult to assign a definitive weight or worth to an individual's morals, because different beings value certain morals more than others. Therefore, there might be dissimilarities between the values between patient and doctor that the guidelines for reasonable conscientious objection cannot address. Despite these limitations, this theory should be adopted when we consider what is at stake; if these changes are not implemented, then the institution of medicine will fail to operate successfully as a moral enterprise.

It is crucial that ethics education for physicians is improved upon because it is unrealistic to rely entirely on ethics review boards -- an objection cited by those who are opposed to putting ethical responsibility on the physicians. There would be serious practical and professional implications if referring to an ethics committee is a first option. It is blasphemous to say that external review boards are to be consulted whenever there is an ethical dilemma at hand; doing so would result in wasted time and resources and would result in physicians who are unaware of the moral implications of practicing medicine -- a discouraging consideration given that medicine is a moral enterprise. There would also be a loss of respect and trust experienced by the physician whose patient's perceive her as a treatment-providing agent who is ignorant to the moral and ethical implications that are associated with medicine. The patient might feel she is at risk of receiving care that is not in her best interest or that her interests are not even being considered during a dilemma, as the physician might only consider his best interest in order to preserve medical integrity. It is necessary for physicians to be aware and well-practiced in the realm of ethics relating to medicine in order to effectively communicate with patients on a human level and provide treatment that is in line with many of the numerous conflicting tensions that physicians are subjected to.

Future research on this issue should center around recurring moral themes within high-stake medical dilemmas. Studies should focus on the most common morals and factors which are considered important to patients and physicians when there are conflicting opinions regarding the morality of a certain medical intervention. For example, consider an interaction between a patient, a senior physician, and a young medical intern. The patient is requesting a certain treatment, such as a bariatric surgery for weight loss, and the medical intern has considered all available options, the patient's history -- which includes struggling to lose weight because of pre-existing conditions--, and the available resources and deems the bariatric surgery an acceptable line of action. The patient values her autonomy and being considered a rational agent who is capable of making decisions. The intern has been trained in a time where patient autonomy is given much value and the physician has a duty to his patient to provide the best treatment available that is in line with the patient's wishes. However, the senior physician disagrees, and believes that the patient does not require the surgery and should thus lose the weight by 'traditional' means, including diet and exercise.

This recommendation by the senior physician is not meant to be dismissive of the patient and her wishes, but is rather a reflection of his training, in which paternalism was encouraged and the physician was deemed as an agent incapable of doing wrong if the correct considerations were made (available resources, other options, necessity of treatment, etc.). In this scenario, the intern might have a more modern outlook on medicine and give more value to the wants of the patient, while the attending physician's suggestions might solely be a reflection of the time in which he was trained when the norm was for medicine to be practiced entirely paternalistically with no real consideration given to the patient's desires. The two physicians will

then give more weight to different values and environmental pressures considering the generation they are from, their upbringing, the type of ethics training they have received, and the culture of medicine that they were exposed to when undergoing this medical training.

By making ethics training a more universal and objective practice, guidelines regarding moral weight assigned to certain personal values based on the prevalence that they are cited as being important by affected individuals can be integrated into existing professional documentation. This will result in physicians across the nation and from different generations applying ethics in medical situations using the same standards, making it a less subjective practice. Future research can be narrowed and focused in order to build upon and strengthen this theory, increasing its effectiveness in achieving much-needed change within the education of ethics of our medical community.

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