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**What Does the Character of Medicine as a Social Practice Imply for Professional Conscientious Objection?**

**Introduction; the dispute over professional conscientious objection**

 Conflicts of conscience recently in the public eye have involved pharmacists and hospitals rather than physicians. The issue, however, remains acute for the future of the American medical profession. As government becomes more involved in health care, the provision of services deemed critical to the welfare or rights of patients by whoever is in charge in our polity will increasingly be a matter of mandate rather than professional discretion. That has already led to a wave of litigation on behalf of catholic organizations seeking exemption from requirements to provide insurance coverage for contraception. While recent legal conflicts have involved employers and hospitals rather than individual physicians, conflict at the individual physician level is likely to increase, particularly over the issue of referral. Many physicians object to referring patients for services they believe to be immoral, such as abortion.1 Yet much professional and public opinion favors mandatory referral if not more onerous requirements to actually provide services in dispute. The American College of Obstetrics and Gynecology remains on record in favor of its ethics committee’s opinion of 2007 suggesting that physicians both have an obligation to refer for abortion if they themselves opt not to offer that service and to provide abortion themselves if referral is not possible or might “negatively affect a patient’s physical or mental health.”2

 Defenders of robust protection for physician conscience generally frame the issue as one person’s deepest commitments vs. another’s. The commitments of each are important and neither should be compelled to violate her commitments at the other’s expense.3 At the other extreme, some opponents of conscience protection argue that professional membership should imply a willingness to offer all legal and beneficial treatments, with “beneficial” interpreted in terms of patient wishes.4 Such a position leaves no room at all for conscientious objection to any desired legal service. On the one hand, professional obligation is a specification of individual commitments, which may have their source in various forms of non-professional community or affiliation. Professionals are free to interpret their work in the light of broader moral or religious views to which they hold allegiance. And physicians and patients meet on a plane of equality as regards such commitments. On the other, professional obligation is determined by the profession, perhaps in conjunction with society—and those who join the profession must conform to the profession’s direction. Professional obligation is a function of professional specification, not of the varied individual commitments of individual physicians but of a common professional identity specified by the professional collective or by the state; and patients have rights to physician conformity to the common specification.

 Various positions between these two extremes have been taken. Perhaps the most common involves agreement that there are at least some core professional obligations whose binding character is not determined at the level of the individual professional. While professionals enjoy a wide realm of discretion, they must be prepared to defer to at least some standards governing professional work that the profession and society may enforce against them. We may proceed in adjudicating conscientious professional objection by determining what core professional obligations are and then enforcing those on individual physicians.5 Or, alternatively to enforcing them on all physicians, we might decide to permit some conscientious objection even to core professional obligations if these obligations to patients can be fulfilled in ways other than through the objecting physician. That is, conscientious objection may be permitted if another professional is made available to provide the service that a conscientious objector has refused to provide. Those who favor this form of compromise with conscientious objection generally oppose extending it to referral in the circumstances in which they are willing to countenance objection to service provision.6 On this view, physicians may opt not to provide abortion or contraception or whatever service is in dispute; but either they or their employing institutions had better be willing to refer to providers who will. And, if none such are available, the objecting physician may, perhaps, be justly forced to provide the service.7

 Evidently, the two sides in this dispute work from differing positions as to what medical practice is and ought to be. Many defenders of conscience protection view professional practice as a specification of commitments that have their origin in more fundamental aspects of personal life, most notably religion. Individual physicians offer allegiance to religious communities or to ethical principles which are prior to professional membership and commitments. Their professional commitments, it is implied, take their life and reality from religion or other ethical systems that are at the core of human moral identity. On this view, the professional cloak takes its moral coloring, as it were, from the pre-professional person who wears it. Skeptics of conscience protection, on the other hand, contend that the medical profession has its own set of binding commitments that physicians take on when they join the profession, commitments that rightly take precedence over private commitments when physicians wear their professional hat. These binding professional commitments set the limit on permissible professional conscientious objection.

 On either view, professional practice comes close to being whatever some individual or group deems it to be. Either individuals find its specification to follow from their own pre-existing moral commitments; or the profession and society agree on a specification which may then be enforced against dissenters. In approaching the issue of professional conscientious objection I will begin from a differing starting point by considering the nature of medicine as a social practice. I shall contend that skeptics of conscientious objection, in particular, presume a construal of medicine as a rule-driven practice which at best partially captures its reality in the lives of physicians. An opposing way of construing professional practice as primarily a sensibility or “form of life,” in Wittgenstein’s phrase, and only secondarily as rules leads to very different conclusions as to the prudence of permitting or constraining conscientious objection. In what follows I shall not deal with the vexed issue of referral. Even if coercion of the medical profession is not on the immediate horizon in the United States, the thrust of much of the argument from conscientious objection skeptics extends beyond referral to the mandatory provision of contested services by physicians when such services would be otherwise unavailable. It is the likely long term effects of such mandatory provision on physician sensibility and responsiveness to patients in which I am especially interested. I shall argue that a realistic construal of medical practice as form of life rather than as rules implies the prudence of granting a relatively generous space for conscientious objection in regard to the treatments and procedures most at issue (or likely soon to be at issue) in present disputes: contraception, assisted reproduction, abortion, and euthanasia.

**Practices as rule-guided activities**

 There is a divide in the way we construe the relationship between social practices and the rules and principles associated with them. Are practices governed by rules? Or are practices somehow the primary reality to which rules relate as more or less adequate description rather than as a directing influence? The first view is championed by John Rawls, according to whom a practice is “any form of activity specified by a system of rules which defines offices, roles, moves, penalties, defenses, and so on, and which gives the activity its structure.”8 The second view is favored by many interpreters of Wittgenstein, who famously argued that practitioners cannot look to rules to guide action in a practice as rules cannot keep us “on the rails” of the practice;9 it is custom or use (the practice itself) that somehow does that.10

 Rawls’s conception of social practices offers a plausible understanding of the landscape of professional practice, including disagreements over what elements of practice are essential and what are dispensable (and, hence, fair game for conscientious objection).11 Consider Rawls’s discussion of the practice of promising, or, as he would have it, our practices of promising. Given his definition of a practice mentioned above, practices (or institutions) such as promising exist when actions are “regularly carried out in accordance with a public understanding that the system of rules defining the institution is to be followed.”12 The rules of promising tell us how the practice of promising is conducted. They tell us how promises are made, when promises are binding, and when promises may permissibly be broken. Morality does not inhere in the rules of particular promising practices, which are “constitutive conventions”13 rather than moral principles. The morals of a promising practice reside rather in the practice’s measuring up to fundamental moral principles or failing to do so. In looking to justify particular acts of promising or promise breaking, we ought not to look to those acts in isolation but to the justifiability of the practice of promising instantiated in the promising act. Rawls suggests that there may be many variations of the practice of promising, as understood by different groups of persons.14 He suggests a procedure for the assessment of given acts or practices of promising. Promising practices are just when they accord with the principle of fairness. That is, social practices are just when they are fair (accord with Rawls’s two principles of justice) and when participation in them is voluntary.15 In the case of promises, promises made in accord with fair promising practices are “bona fide promises.” Such promises are governed by a moral principle, the “principle of fidelity.” The principle of fidelity is that bona fide promises are to be kept.

 So, in Rawls’s scheme, social practices are specified by publicly understood systems of rules, which are primary, and by acts falling under the practices (because they conform to the practice’s rules), which issue from actors following the rules. Practices may be identified from without, by picking out people who are acting according to the rules in question self-consciously and voluntarily.16 Acts such as promising connect not to a single practice but to one of a family of practices, as different people may have different rules for when promises must be kept and when they may be broken, hence differing promising practices. It is the practices rather than individual acts falling under them which are subject to moral assessment. And the bar to which practices must appeal for moral approval are foundational principles: for Rawls, the principles of justice.

 Now if we proceed as Rawls would recommend, we can assess divergent forms of medical practice according to whether the rules instantiated in the practice meet a broader test of morality or rationality. In Rawls’s case the appeal is to the principles of justice. In the case of medicine it might be to other principles deemed fundamental or foundational such as autonomy or beneficence. The greater the degree to which patient autonomy is taken to be a foundational principle of medical practice, and the less one is inclined to grant the status of a patient to the fetus, the more likely one will be to find a permissive stance toward abortion to be mandatory for physicians. Whereas the converse of these positions and a view of medicine as aimed primarily at health and healing will lead to highly restrictive stances toward abortion. The battle over conscientious objection is fought at the level of fundamental moral principles that justify particular professional practices.

**The contemporary debate over conscientious objection: what ought to be the rules of medical practice?**

 The dispute over conscientious objection in medicine generally proceeds from recognizably Rawlsian premises. Given variant medical practices as regards the services at issue in conscientious objection disputes, conscientious objection skeptics begin by seeking the fundamental principles that underpin ideal medical practice—that is, the form of medical practice among those extant that is justifiable. Once one identifies these principles, one may proceed to consider what kinds of deviation from meeting professional obligations might be tolerable (or not). The work here is done in the specification of professional obligations, in particular those judged to be essential or at the heart of what physicians do. Once core professional obligations have been articulated, it is a straightforward step to conclude that conscientious objections placing the objector outside the space of fulfilling these core professional obligations cannot be tolerated.

 So how do skeptics of conscientious objection identify core professional obligations? In general, they look either to what members of the profession have said as to professional obligations, or to considerations outside of a narrowly professional ambit that bear on what physicians do or ought to do. Mark Wicclair appeals to professional codes of ethics to identify 3 core professional obligations for medicine: 1) respect for human dignity, 2) an obligation to promote patient health and wellbeing, and 3) respect for patient autonomy.17 These are the foundations of professional life that conscientious objection must not be allowed to subvert. Dan Brock construes core professional obligations capaciously; he contends that the profession of medicine is obligated to provide “all legal and beneficial medical interventions sought by patients.”18 Robert Card proposes to subject conscientious objections to tests of rationality. And the tests lead to a destination similar to Wicclair’s. Card demands that conscientious objection “not cause needless or unjustified harm to patients”; that it “respect the power inequality between physicians and patients”; that it “not be based upon discriminatory beliefs”; and that it “must not violate the duty of care by failing to assist patients in an emergency situation or time-sensitive circumstances.”19 Holly Fernandez Lynch and Rebecca Dresser suggest that professional obligations of physicians are determined by the needs of patients and go on to specify particular needs that physicians must be willing to meet on pain of failing to fulfill professional requirements. And the profession, collectively if not necessarily at the individual level, has an obligation to make sure that patient needs are met.

 The difficulty in which we are left by the specification of essential professional duties through an appeal to fundamental principle is that disagreement over principles is not resolvable. We do not agree about the relative importance of patient self-determination for medical practice nor about the moral status of the fetus; and there is no satisfactory way of resolving the disagreement absent a single perspective granted authority, such as that of God.20 A wide scope for conscientious objection in medicine is premised upon the desirability of permitting de facto disagreement and moral pluralism among physicians, that is, on the desirability of what would be in Rawls’s terms a diversity of medical practices rather than a single canonical practice. While moral diversity among physicians has hitherto been an unremarkable aspect of the American medical profession, it is increasingly called into question as healthcare moves from being a private matter between individual doctors and their patients to becoming a public matter of rights and entitlements. As recent court battles over mandatory employer provision of contraception suggest, the stipulation of given health care services owed to citizens as a matter of right tends to subvert conscientious objection to those services on the part of providers, whether those actually providing the service or those merely paying for them. To the degree that health care becomes a political right, the state will find itself stipulating a particular form of professional practice as the norm. And in the absence of binding reasoned warrant for that form or many other existing forms of professional practice, the state’s preferred form will be imposed on the profession as a matter of power. Unresolvable disagreement at the level of principle upon which political power imposes practical uniformity—such is the depressing upshot of a Rawlsian view of professional practice allied to the transfer of health care from the private to the public realm.

**Practice as form of life rather than as representational scheme**

While a Rawlsian view of practices as rule-governed activities poses a bleak prospect for resolution of disputes over professional conscientious objection, an opposing view of practices associated with Wittgenstein (and others), “practical holism,” offers a differing perspective. In Rawls’s view of social practices, rules determine practice. One begins at the level of abstract principles; from these follow rules in the form of a representational scheme that allows specification of what to do in the range of circumstances that fall under a practice. The rules, that is, the web of if-then conditional statements governing a given practice, guide practitioner action. The unity of a practice on this view is that of the grammatical and logical coherence of the representational scheme comprising the practice’s rules. We may alter the practice by altering the representational scheme. Thus Rawls infers differing promising practices among promisers holding differing specific rules of promise keeping. Some might view keeping a lunch appointment with a lesser friend as imperative even if one is interrupted by a greater friend’s emergency need for one’s time. Others might see the greater friend’s need as an occasion for promise-breaking rather than keeping. Two differing rules of promising practice indicate promising practices so far different from one another—as the practice is what it is as a product of its rules.

Practical holism suggests that instead of rules determining practices, practice is primary and rules are derivative.21 This sort of account of rules and practices had its genesis in the work of Wittgenstein and Ryle in the 1940s and 50s. In the *Philosophical Investigations* (1953), Wittgenstein made the critical observation that successful rule following could not be underwritten by representations alone.22 The proper bearing of a rule in any given context can be discerned by a skilled rule follower. A representational account of the rule follower’s situational discernment might be called an “interpretation” of the rule. On the representational account, the interpretation might be said to guide the rule’s application in the given situation. But if so, the interpretation is itself another rule—a rule guiding the use of the more general rule in the specific situation. And the interpretive rule itself requires correct use—use which, if representationally guided, must be by way of yet a further interpretation rule; and so on into an interminable regress of rules.

The rule following regress problem suggests that something additional to representations is necessary for skilled rule following in practices, something that enables correct use of rules. Philosophers concerned with social practices have sought to elucidate this something under various names, from “know how” (Ryle23) to “the background” (Searle24) to “embodied coping” (Dreyfus25) to “habitus” (Bourdieu26) to Wittgenstein’s cryptic remarks concerning “form of life”.27 For these and other philosophers and practice theorists, the contention of “practical holism” about complex practices is that underpinning the representational scheme of practice language are natural ways of acting—norms of practical action felt as such by seasoned practitioners that keep them on the track of right action in practical contexts as practice representations alone cannot do. It is these norms, the practice as a form of life, that inform practice representations and enable their correct use by practitioners.

Among the implications of this view is that the unity of a practice is not that of the merely grammatical and logical coherence of the representational scheme comprising the practice’s rules. If coherence at the level of representations were primary, then Rawls’s view of varying practices of promising as signifying adherence to varying sets of rules among promisers would be plausible. The opposing suggestion of practical holism is that the form of life of a practice has the unity of a metaphorical organism; particular practical responses to practice situations hang together in the practical responsiveness possessed by the skilled practitioner just as parts of an organism form a whole.28 Variations in important practice rules among practitioners are best seen not as multiple varying practices but instead as varying approximations to a single practice. It is not a matter of contingency that important practice rules are what they are, any more than it is a matter of contingency that a given cat has four legs rather than five. Change a rule in a representational scheme and you simply have a (so far) altered scheme; alter a practice form of life and, if the change is sufficiently momentous, the practice may turn into something its former bearers might find unrecognizable.

I contend that the practice of medicine is best understood not as a Rawlsian scheme of principles and rules directing practical action but instead as a form of life—an ensemble of natural ways of acting in regard to patients that practice representations describe (imperfectly to all but seasoned practitioners) rather than direct. Such a view of practice follows readily from the experience of medical educators. It is a truism among clinical teachers that the norms of medical practice cannot be learned by novices simply by mastering practice representations.29 Novice physicians learn the practices of diagnosis and of conducting professional relationships not by studying texts (or insufficiently by that alone) but by imitating practitioners more skilled than they. If they do study texts, they may know the practice rules qua prescriptions or formulae. But knowing rules of diagnosis or professional conduct in this way does not convey the rule knowledge of the skilled practitioner. A novice in medicine may know that if fever, productive cough, and a pulmonary infiltrate are present, a diagnosis of pneumonia is likely correct. Yet she may not be able to reliably diagnose pneumonia absent practice and clinical experience. The rules of professional conduct are similar; knowing rule expressions such as “do no harm” or “protect patient confidentiality” need not be accompanied by the knowledge of what a skilled rule follower would do in a given situation in which either rule bears and is properly brought to bear by the skilled rule follower. For both of these kinds of rules, “knowing that” (the rule as information) comes apart from “knowing how” (knowing how to follow the rule).30 The practice as a representational scheme is parasitic upon the practice as a form of life which novices “get the hang of” as they work their way into the clinical milieu.

**The demands of contemporary conscientious objection skepticism in light of medical practice as form of life**

 While consideration of practice as a form of life offers no means of resolving the principled disagreements involved in conscientious objection, it does clarify what is being asked of a practice when certain kinds of changes in what the practice requires are demanded. From the perspective of practical holism about medicine, *requiring* the services at issue in conscientious objection disputes is momentous in a special way—as requiring (in the long run) a shift in how practitioners see and respond to clinical reality. Why this should be is not obvious if we begin from discussions of medical ethics or from declarations of professional commitment. Assertions that honoring patient requests for services such as abortion, assisted reproduction, contraception, or physician-assisted suicide is obligatory for physicians rest upon appeals to patient autonomy. And patient autonomy, after all, has a very high place in contemporary codes of medical ethics. If such documents still prohibit physician killing, those prohibitions are vigorously challenged in current discussion. At the level of principle, requiring a willingness to perform these services of physicians would be major step, but such a step would have plenty of backing among many physicians at the level of principle.

 Contemporary medical practice as a form of life, however, differs in important respects from articulations of medical norms as enumerated in codes of ethics or discussed in contemporary literature. The case for a requiring physicians to provide currently contested services turns in part on the contention that the autonomy aimed at by medicine should include an expansive degree of patient self-determination. Yet patient autonomy, while prominent in academic discussion, is honored in practice in highly qualified ways in comparison with the less qualified recommendations of, for instance, the Physician’s Charter.31 The form of patient autonomy honored without reservation by physicians is negative autonomy—the right to refuse treatment. The necessity of honoring patient decisions against treatment is indeed part of the second nature acquired by physicians during their training. Positive patient autonomy to have the medical services they choose is not. Indeed, what physicians learn and practice is a disposition to limit treatments offered to patients to those which medical norms recommend according to the demands of the patient’s illness. Patients are often interested in tests or procedures which, by the lights of medical practice, are unnecessary or harmful. Physicians learn to firmly discourage choices to have such services and do not provide them (unless they are very inexpensive and relatively innocuous).

 As regards autonomy, what physicians seek for patients is not so much the fulfillment of patient positive choices as the state of wellbeing from which patients can make such choices unconstrained by illness. Physicians seek health and healing. They do not see themselves as charged with furthering any of the myriad visions of the good which patients may pursue from that state. They often find themselves opposed to the modes of life which patients choose insofar as such modes tend to subvert future health. And they do not scruple to express that opposition in the course of patient care, advising against smoking, overeating, driving without seatbelts and the use of illicit drugs. Such advice issues from a more or less aggressive stance favoring health and a relative impartiality (from the standpoint of medical norms) as regards what patients may choose to do (not directly subversive of health) in and with their healthy state. In contrast to the level of abstract principle, patient autonomy figures in the lived responsiveness of medical practice only in a highly qualified way; and patient self-determination construed as patient choices of particular given life plans when healthy figures little if at all. Physicians in their professional role value the capacity for self-determination but not its exercise in any particular direction compatible with health once health is achieved.

 From the standpoint of medical practice as the sensibility experienced by practitioners, this is so much the worse for contentions that facilitating the reproductive choices of healthy patients are core commitments for the medical profession. One may argue that they ought to be core commitments; but it is difficult to argue that for the practice of medicine in its present form they are so or that such commitments connect in essential ways to the commitments to patient autonomy that physicians actually experience. Medicine is neither taught nor practiced in such a way that solicitude for the fulfillment of positive patient choices, reproductive or otherwise, is de rigeur as a matter of professional identity. Physicians of course do engage in activities aimed at furthering patient choices in matters not directly connected with health. In addition to assisted reproduction and contraception they engage in cosmetic surgery, the training of athletes, psychological coaching, and, doubtless, other activities aimed at enabling people to achieve particular aims connected to adapting bodily functions or appearance to particular ends. Such activities are far from the heart of medical practice as that practice is transmitted from teachers to trainees in academic medical centers.

 The form of life of medical practice as it is thus offers no clear reception in the name of autonomy to assisted reproduction and contraception as core physician activities. Abortion and active euthanasia face that obstacle but also an additional one. The sensibility of medicine as practitioners experience it is deeply bound up with the preservation and extension of life and with an unwillingness to be actively involved in taking it. That norm of course has its particular configuration in contemporary medical practice. In the case of physician involvement in patient death, contemporary practice countenances withdrawal of support but not active involvement in assisting death. In the case of abortion, while societal attitudes underwent a sea change in the course of the 20th century, the medical profession has been notably less receptive to abortion than the general public and remains less so. From the standpoint of principled debate, requiring physician willingness to offer the services presently contested in disputes over conscientious objection would be to award victory to one side of a dispute contested in roughly equal numbers of physicians favoring and opposing availability of the services in question.32 From the standpoint of what services physicians are presently willing to offer, however, such a requirement would turn the profession upside down, requiring participation in services that at present relatively few physicians are actually willing to perform.

**Is medical practice as form of life actually opposed to abortion or active euthanasia?**

 Those disposed to grant the plausibility of considering medical practice as a form of life rather than merely as rules may nevertheless be inclined to dispute the above picture of physician sensibility as regards patient self-determination in general and determinations favoring death in particular. After all, the profession is not a monolith. On what grounds do I posit a physician form of life that is widely shared and antipathetic to these procedures? Medical trainees and physicians themselves exhibit a wide diversity of opinion on these topics. And, of course, many physicians are willing to perform contested procedures. Is that not evidence that the Rawlsian picture of multiple medical practices issuing from conflicting principles is a better fit to reality than my suggestion of a single medical practice from which physicians may or may not diverge? The objection is formidable as a sensibility of practice, if it exists, is much more difficult to assay than more tangible aspects of practice. Available survey data do, however, offer some support to the hypothesis of a practice-based sensibility as regards contested services that affects medical trainees as they progress through training and become practitioners.

 If practice in regard to contested procedures were determined mostly by principles embodied in attitudes brought to the medical context from elsewhere, we might expect to see trainees translating their principles into the medical context and, as they progressed through training, acting on those principles as they made the transition from observers to actors in the clinical milieu. What actually happens appears to be a good deal more complex. The general story in available survey data is one of students entering medical school with attitudes toward abortion and physician assisted suicide as or more permissive than those of the general public—but as training progresses, becoming less willing to consider actually offering these services in their own practices. And even those who approve in theory of these services find themselves less willing to participate than their approval would indicate. In the case of elective abortion, a combination of economics and a tradition of professional avoidance drove service provision away from usual institutions of health care (including academic hospitals) and toward free standing clinics by the mid-1980s.33 By the early 1990s, only 12% of obstetrics gynecology training programs offered routine training in abortion.34 A movement to increase the availability of that training in the mid-1990s likely helped to increase the number, but as of 2004 routine training was still offered in only 51% of training programs.35 While medical students start school at least as supportive of abortion rights as the general population,36 and remain so as obstetrics gynecology residents,37 after they complete their training a much smaller proportion actually offer abortion services in practice. As of 2009, only 14% of practicing obstetrician gynecologists offered abortion services.38 And of those physicians who perform abortions, most perform a small number while relatively few physicians perform most abortions.39

 There is of course more than one possible explanation as to why medical trainees undergo an evolution from looking like the general population in attitudes to abortion to an eventual stance much less likely to include abortion provision in practice than those initial attitudes would suggest. Abortion is so controversial and its provision sufficiently stigmatized that physicians who might otherwise wish to provide it are deterred from doing so.40 But that is unlikely to be the whole story. Much reluctance among obstetricians gynecologists to perform abortions stems from discomfort with the procedure. In the case of second trimester abortions, it is likely that an important number of those who perform them during training recoil from their experience doing so and subsequently avoid doing these procedures in practice.41

 In the case of physician assisted suicide (PAS), polling data over the years has revealed a similar pattern. The public favors PAS more than does the medical profession. Of physicians in favor of making PAS available, a far smaller proportion are actually willing to participate. And those physicians who work most closely with the dying are the least open to PAS. Medical students beginning medical training are generally more permissive about PAS and abortion than the general public. During their training, something happens to them. While theoretical approval of both PAS and abortion remain relatively high, many of the same physicians who approve of the availability of these services are unwilling to perform them. And in the case of PAS, experience working with the dying appears to lessen both approval and willingness to participate.42 For both abortion and physician assisted suicide, then, there appears to be something about the milieu of medical training that turns trainees away from these procedures. And, notably, the turning away is not necessarily a matter of deliberation and decision but instead, likely the result of an effect on sensibility that is to some extent independent of deliberation. It seems plausible to understand this effect by adopting Jonathan Imber’s suggestion that human form is “a basic element in an aesthetics of medical practice.”43 That is, the sensibility of medical practice forms trainees to regard both later term fetuses and dying patients as patients indeed by default—worthy of life and comfort if not always, in the case of dying patients, of life support. That some practitioners overcome this practice sensibility and practice in spite of it is not counterevidence to its existence—only to its inevitability.

 The character of physician evolution from trainee to practitioner as regards participation in abortion, particularly abortion beyond the 1st trimester; and that character as regards participation in physician-assisted suicide—in each case a pattern of practice asserts itself against much theoretical argument. And in each case, the pattern is consistent with what I am positing as a sensibility or form of life opposed to shrinking the realm of patients whose lives physicians regard as not to be taken by them. That sensibility looms large for practitioners and it so far shows no sign of withering away in the face of an onslaught of critical scrutiny from academic bioethicists.44 How if it were to be simply overridden by legislation prohibiting conscientious objection to presently contested procedures?

**Overriding professional conscientious objection to services contested in the United States is unjustified and imprudent; other means of achieving access are preferable**

 If I am correct in suggesting that the view of medicine as a Rawlsian rule-driven practice must be supplemented by a different picture of medical practice as a form of life—imbibed during medical training and passed on to succeeding generations of medical trainees, the contemporary dispute over conscientious objection takes on a different complexion. In the Rawlsian framework, the dispute is about contending sets of principles said to be “core” or essential to the commitments of the medical profession. Disagreement about essential principles has led to variant medical practices expressive of contending principles. If principles supporting obligatory physician provision of contested services have not clearly undermined opposing principles they are at least making a strong showing in the ongoing conflict. We can foresee their eventual victory by force of argument or, if not quite that, then by the vote. Such new principles can then be imposed upon the medical profession and medical practitioners can simply learn to follow the new rules. That is, after all, what practitioners do in the Rawlsian scheme.

 Medical practice conceived less as rule driven and more as a form of life leads to a different picture. Dispute over contending principles looms large but it occurs in the air; on the ground is the practice of medicine as it is taught and learned and carried on by practitioners. That practice sensibility is shared, distinctive, and very much an organic unity. Dispute over medical practice as regards presently contested services became important at the level of principle in the 2nd half of the last century and is, at present, intense. But medical practice as the sensibility of practitioners has remained remarkably resilient and resistant to change. That sensibility is unfriendly to the kind of deference to positive patient autonomy demanded by a stance favoring the mandatory provision of presently contested services. And it is opposed to active physician participation in the taking of human life.

 Of course the shared form of life underpinning a social practice is not vindicated by the mere fact of its existence. It is perfectly plausible that in any given case, a practice sensibility may need to change. And of course changes in a practice’s sensibility have often been initiated not as a result of endogenous evolution but through forceful measures taken from outside the ambit of practitioners. Skeptics of conscientious objection would likely argue that some measure of change from without needs to be imposed upon the medical profession to ensure a sufficient availability of contested services. A sensibility may stubbornly resist changes in behavior even if the changes are theoretically approved of. What harm might there be in prodding recalcitrant physicians, many of whom approve of contested services in principle, to actually provide them? Physicians will get used to doing what is initially uncomfortable and, eventually, will come to see contested services as they see other medical services as simply demanded by the clinical context in which those other services appear to be necessary. Sensibility will follow action taken in opposition to it.

 That a change in practice form of life would (eventually) follow legislated change in practice is plausible. The difficulty for practitioners living in the present sensibility is in the supposed justification of the forced change. The Rawlsian position suggests that superior principles are sufficient warrant for changing practice, as practice flows from principle. The opposing Wittgensteinian position would, however, deny that principles underpin social practices in any important way. What justifies a social practice is, in the final analysis, the practice itself as experienced by its bearers. Ethical argument can serve to recommend one or another of contending practices; but its success in doing so rests upon connecting successfully to what is basic or fundamental in our moral phenomenology; that is, to what is most important in our moral responsiveness as that responsiveness is elicited by our coping with the world. And it is of immense moral importance to physicians who inhabit the traditional medical sensibility that they not kill patients.44

 The Wittgensteinian will, of course, be accused of committing the naturalistic fallacy. That we happen to take a moral stance cannot justify that stance. Attitudes insufficiently vindicated by theory amount to no more or less than prejudice. Yet it is unclear that the Wittgensteinian need be troubled by this accusation; as it is unclear that the empirical and the normative can be as neatly separated as the accusation implies. The moral stances fundamental to given social practices are empirical data but they bear normative authority for practitioners. While given moral attitudes may be revealed as prejudicial, what achieves the revelation is not theory per se but theory bringing to bear other moral attitudes seen to be fundamental in light of which those at issue are revealed to be prejudicial. The Wittgensteinian will go on to suggest that the proper role of theory is not to generate a morality independent of our basic moral phenomenology but instead to confront the morality we presently acknowledge and to seek to rationalize it, expose its blind spots, reconcile its inconsistencies (when that is possible) and to extend it in unfamiliar situations. If theory threatens to up end fundamental moral attitudes, perhaps such implications, far from being signposts to be followed, in fact constitute fatal objections to theory.

 The differing metaethical commitments of the Rawlsian and his/her Wittgensteinian opponent thus lead to an impasse. Yet beyond the Wittgensteinian resistance to overturning the sensibility of practice on grounds of principle that are at best inconclusive as to the practice matters at issue, there is a further objection to forcing physicians to offer presently contested services. What is at stake may be far more than an incremental adjustment affecting a limited set of practice activities. To the degree that a practice such as medicine is best conceived as form of life, the worry would concern the potentially broader change in practice sensibility that might result from what might otherwise seem a limited change in what activities physicians regarded as routine. Would the physician’s general regard for people as patients—the nurturing, protective regard that physicians presently learn and exhibit—remain unchanged when the taking of life in the form of abortion or active euthanasia became not merely conceivable but part of a physician’s second nature? How might that regard be affected when being a living human being was no longer sufficient to include one in the circle of potential patients to whom the physician saw herself bound to provide healing and relief of suffering so long as they lived? When being a living human being of a certain sort was instead tantamount to requiring death at the physician’s hand? What would it be like for an internist to confront a patient in a particular state and not merely conclude that she merited active euthanasia or assistance in suicide because of calculation that she met a set of conditions, but instead to perceive the patient, prior to any thought or calculation, as meriting those services? Could the physician’s attitude to all patients remain unchanged when certain patients elicited such a response? I do not mean this worry to come across as a slippery slope argument. The concern is not so much that a new practice sensibility might be the first step toward an undesirable destination and that taking that step would somehow begin a trajectory that could not be interrupted. It is that the new sensibility would itself be a destination far indeed from the present world of most practitioners, virtually a different planet. From the vantage point of the present planet, the physician sensibility in which deferring to patient positive autonomy is optional at best and in which killing a patient is either unthinkable or, if thinkable, not doable for most physicians, what life would be like on the new planet is not easily conceivable.

 To the extent that the picture of medicine as a form of life is an accurate one, the overturning of contemporary conscientious objection to contested procedures portends the transformation of the present medical practice sensibility. When the profession takes on the perspective demanded by conscientious objection skeptics it will not be merely an adjustment of principle but also a revolution in how practitioners think and feel. That such a revolution should happen not through the natural evolution of practitioner norms as these interact with broader streams of social change but instead through legislative fiat seems, at best, a dangerous mode of proceeding. If it be granted that forcible interference with the present sensibility of medical practice is potentially dangerous and likely imprudent, how can we proceed if we collectively make the judgment that services presently contested in medical conscientious objection disputes will be made available to citizens as a matter of right? Rather than coercing the medical profession into providing them (when they are not forthcoming spontaneously from the profession), I conclude that the prudent course would be for the state to take upon itself the provision of these services. This could be achieved independently of the medical profession for some services. Technicians could be trained to perform early abortions and the simpler forms of contraception could be over-the –counter or become the province of specially trained non-medical personnel. Technicians could also be trained to provide what is now physician-assisted suicide. There would likely be a need for interface between such non-medical providers and the medical profession. And in the rural areas in which the profession itself is most likely to be unavailable to provide contested services, there might be a need for state provided transportation to assure that such interface was adequate.

 In the case of second trimester abortions and more complex forms of contraception and assisted reproduction, involvement of the medical profession would appear to be necessary. For these services, the state could incentivize professionals willing to provide them to move to areas where they are presently unavailable, or take upon itself the responsibility to transport citizens desiring these services to the medical professionals. Any solution to the problem along these lines is of course rife with logistical difficulties. Facing these difficulties, I would contend, is preferable to coercing the medical profession to become something it is now not and shows no signs of turning into of its own accord. The present “homo medicus” may have its disadvantages; it seems at best rash to suppose that these would be fewer than would appear after the creation of what might be an entirely new practitioner sensibility that would be the end result of coerced provision of presently contested services. This new physician species would not appear immediately, of course; the old sensibility would exist in tension with new practice activities for some time to come. When those activities were no longer felt as alien, when they were naturalized into the sensibility of practice—it is then that the overriding of conscientious objection would bear its mature fruit and we would know where we stood. Better, given the uncertainties involved, to achieve certain ends by circumventing a social practice that has served us well and continues to do so rather than by forcibly transforming that practice into something sufficiently different as to be unrecognizable to (many of) its present bearers.

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7 Fernandez Lynch, *Conflicts of Conscience*, Ch. 8.

8 J. Rawls, “Two Concepts of Rules,” *Philosophical Review* (1955): 64:3-32. footnote #1.

9 L. Wittgenstein, *Philosophical Investigations* (London: Basil Blackwell, 1953) §217-19.

10 Wittgenstein, *Philosophical Investigations*, §199.

11 The following discussion, as will be evident, is deeply indebted to Michael Thompson’s explication of Rawls in M. Thompson *Life and Action* (Cambridge, Harvard University Press, 2008), Ch. 10.

12 J. Rawls *A Theory of Justice*, (Cambridge: Harvard University Press, 1971), p. 55.

13 Rawls, *Theory of Justice*, p. 344.

14 Rawls, *Theory of Justice*, 345-6.

15 Rawls, *Theory of Justice*, 111-12.

16 Rawls, *Theory of Justice*, 55-6.

17 Wicclair, *Conscientious Objection in Health Care*, p. 88.

18 D. Brock, “Conscientious refusal by physicians and pharmacists; who is obligated to do what, and why?” *Theoretical Medicine and Bioethics* 29 (2008): 187-200, at 192.

19 Card, “Reasonability and Conscientious Objection”, 323-24.

20 As has been pointed out by, among others, H. T. Engelhardt, Jr., “Moral Obligation after the Death of God: Critical Reflections on Concerns From Immanuel Kant, G.W.F. Hegel, and Elizabeth Anscombe,” *Social Philosophy and Policy* 27, no. 2 (2010) 317-40, at 320-25.

21 “Practical holism is the view that while understanding “involves explicit beliefs and hypotheses, these can only be meaningful in specific contexts and against a background of shared practices.”” D. Stern, quoting Hubert Dreyfus in Ch 8 “The Practical Turn” in *The Blackwell Guide to the Philosophy of the Social Sciences* (London: Blackwell Publishing Ltd, 2003), 185-206 at 188-192.

22 Wittgenstein, *Philosophical Investigations* §185-219. The central rule following passages in the *Philosophical Investigations* are §185-242. See also J. McDowell, “Noncognitivism and Rule Following” §3, Ch. 10 in J. McDowell, *Mind, Value and Reality* (Cambridge: Harvard University Press, 1998).

23 G. Ryle, *The Concept of Mind* (London: Hutchinson, 1949) Ch 2.

24 J. Searle, *Intentionality* (Cambridge: Cambridge University Press, 1983) Ch 5.

25 H. Dreyfus, “Overcoming the Myth of the Mental: How Philosophers can Profit from the Phenomenology of Everyday Expertise” *Proceedings and Addresses of the American Philosophical Association* 79(2005): 47-65.

26 P. Bourdieu, *Outline of a Theory of Practice* (Cambridge: Cambridge University Press, 1977), Ch 2.

27 Wittgenstein, *Philosophical Investigations*, §19, 23, 241.

28 See M. Thompson, *Life and Action: Elementary Structures of Practice and Practical Thought* (Cambridge: Harvard University Press, 2008), Ch 11 for a defense of the suggestion that the unity of practices is analogous to that of a life form.

29 As per William Osler: “To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all” in W. Osler, *Aequanimitas* (London: Forgotten Books, 2013) p. 220.

30 For contemporary defenses of the distinctiveness of knowing how from knowing that and of the indispensability of knowing how for practical action, see P.M.S. Hacker, *The Intellectual Powers: A Study of Human Nature* (London: John Wiley & Sons, 2013) Ch. 4 and David Wiggins, “Practical Knowledge: Knowing How To and Knowing That” *Mind*  121 (2012) 481: 97-130.

31 Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine. Medical Professionalism in the New Millennium: A Physician’s Charter, *Annals of Internal Medicine* 136, no. 3, (2002): 243-6. The ensuing discussion is indebted to my more extensive treatment of these issues in “Putting patient autonomy in its Proper Place: Professional Norm-Guided Medical Decision Making” (In Press, *Kennedy Institute of Ethics Journal*).

32 That is, In the case of the two most controversial services, abortion and physician assisted death.

33 J. Dellapenna, *Dispelling the Myths of Abortion History* (Durham: Carolina Academic Press, 2005), p. 822.

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44 For reasons of space and focus, the constraint against killing patients professed by American medical organizations and the majority of American physicians, which I contend is often experienced as a deontological constraint, an aspect of the sensibility of medical practice, cannot be defended here. It is enough for my purposes to note that its validity is an open question.

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