Anscombe Bioethics Centre

Friends' Newsletter

Autumn 2022 | Issue 50

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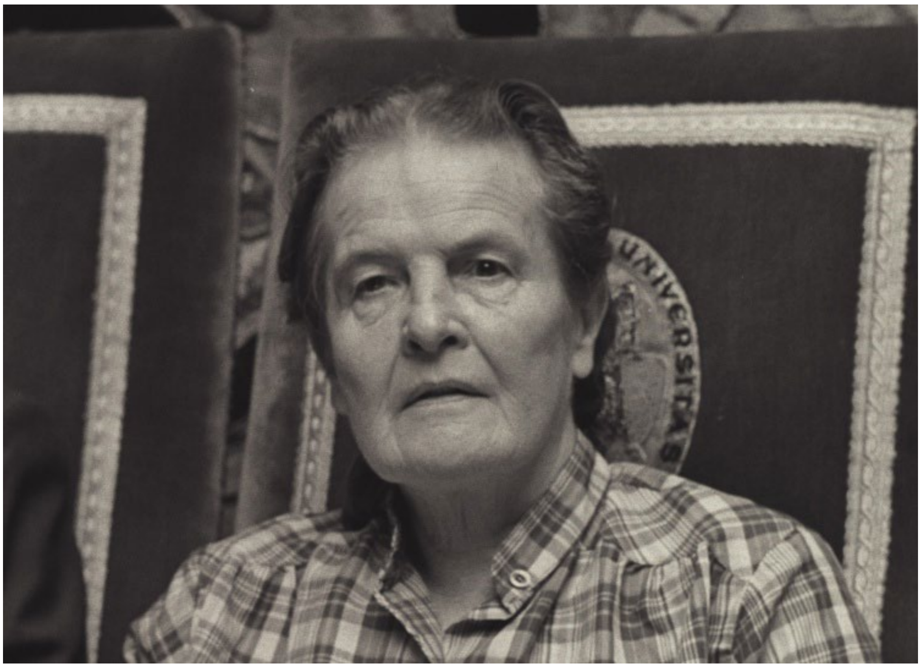
Welcome to the fiftieth edition of our Friends' Newsletter! A regular newsletter for friends of the Centre was established in the summer of 1996, just under twenty years after the founding of the Centre in 1977. The present Newsletter reproduces the introduction to the very first edition written by the then director, Luke Gormally.



The philosopher Elizabeth Anscombe once remarked that the decision when not to save a life that could be saved 'is a deep and important question of medical ethics.' There remains a need to study such deep and important questions.

Looking back

What is striking is how the situation facing Catholic healthcare professionals in Britain in 2022 presents many of the same challenges it did in 1996. There are new issues, of course: taking organs on the basis of 'deemed' consent; the use of puberty blockers to treat gender dysphoria in minors; the restrictions on commercial, social and even religious interaction imposed during the pandemic; the novel and sometimes monstrous proposals for experimentation on human embryos, from cloning embryos, to production of human-nonhuman hybrids, to three-parent embryos, to synthetic embryos. However, many issues are the same or are expansions of practice already well-established in 1996: the enacting of permissive abortion legislation in Ireland similar to that in England, Wales and Scotland; the routine withdrawal of clinical nutrition and hydration from people with persistent disorders of consciousness, not only those in a 'persistent vegetative state' and no longer with a requirement to go to court; the institutional discrimination against healthcare workers of faith on the basis on non-discrimination in the delivery of services; the withdrawal of treatment from severely ill children against the wishes of parents. The words of Luke Gormally are ever more relevant, Catholic healthcare professionals increasingly have to work 'in environments strongly influenced by secularised (often utilitarian) understandings of human life'.

On the other hand there are areas where Britain and Ireland have maintained the Hippocratic understanding of the meaning of medicine and a Judeo-Christian commitment to the caring for those who are sick. Despite multiple attempts, neither euthanasia nor physician-assisted suicide have been legalised anywhere in the British Isles. Palliative care has continued to flourish and is an area where spiritual care continues to be recognised. Hospitals maintain their chaplaincies and, paradoxically, the presence of religious diversity can make it easier to defend access for Catholics to spiritual care. Internationally, the overturning of *Roe v. Wade* in the United States this year and new restrictions on abortion in parts of Europe in recent years, show that change for the worse is not inevitable and change for the better is possible. Nevertheless, maintaining a vision of healthcare that respects human dignity is a continual struggle.

The Centre was first named after Thomas Linacre, physician to Henry VIII, doctor and priest, who was principal founder and first president of the Royal College of Physicians of London. He represents the aspiration to ethical standards in medicine and a vision that is at once scientific and theological, medical and ethical.

The contribution of the Anscombe Bioethics Centre is 'first of all to study, in the light of Catholic teaching, the pressing ethical questions which are raised by developments in clinical practice or by changed social expectations, and then to make available the fruits of that study'. This was true when those words were written in 1996, it was true when the Centre was established in 1977, and remains true today. The philosopher Elizabeth Anscombe once remarked that the decision when not to save a life that could be saved 'is a deep and important question of medical ethics.' There remains a need to study such deep and important questions. This is true of new developments in practice but it is equally true of some of the perennial questions raised by human health, sickness, life and death.

While the national context may vary, these perennial questions reflect our common humanity and 'bioethics', as it has come to be known, is by its nature international in scope. This is in part because one country influences another, but also because we need to learn from the achievements and mistakes of other nations, as they do from ours. In relation to euthanasia and assisted suicide, for example, the experience of those jurisdictions, such as the Netherlands or the state of Oregon, that have legalised euthanasia or assisted suicide acts as a warning to others. At the same time, human solidarity in the face of common concerns has expanded the work of the Centre so that it contributes not only to those in Britain and Ireland but also to those in other countries.

This Newsletter includes a letter from Cardinal Ratzinger written in 1993 in reply to a request by Professor John Finnis, writing at the time as a Governor of the Centre. This request concerned the plans of the Centre not only to draw upon international knowledge and experience but also to contribute to ethics education in other countries, especially in Eastern Europe. Cardinal Ratzinger was happy to write, in a personal capacity, a recommendation of the work of the Centre, praising the ’great value’ of the service it provided, acknowledging the ‘well-deserved respect’ in which it was held by professionals and academics, and endorsing its work as ‘deserving of every support’. The particular plans and projects undertaken by the Centre have varied but the need for, and international significance of, its work has remained.

The Centre was first named after Thomas Linacre, physician to Henry VIII, doctor and priest, who was principal founder and first president of the Royal College of Physicians of London. He represents the aspiration to ethical standards in medicine and a vision that is at once scientific and theological, medical and ethical. He was a fitting patron for the Centre but when the Centre moved to Oxford in 2010 there was already a Linacre College, and to avoid confusion a new name was required.

The new patron chosen was Elizabeth Anscombe, a great thinker whose work *Intention* remains foundational in moral philosophy. She converted to Catholicism while an undergraduate in Oxford in the late 1930s. She became a Fellow of Somerville College, Oxford and later Professor of Philosophy at the University of Cambridge. She was neither a medic nor a cleric but she wrote on the deep ethical questions of human life, including euthanasia, abortion and contraception. She was also personally involved in the work of the Centre contributing a key section to its first major publication in 1982 on *Euthanasia and Clinical Practice*. This work provided the basis for a later submission to the House of Lords Select Committee of Medical Ethics that in 1994 advised against legalisation of euthanasia. She died in 2001.

Looking forward

The Centre continues to be inspired by the work and example of Thomas Linacre and Elizabeth Anscombe. In the past six months the Centre has been active in particular on the issues of assisted suicide, abortion and conscientious objection.

In relation to assisted suicide, the Centre has continued to publish a set of briefing papers on euthanasia and assisted suicide and has also updated its online guide to the evidence in this area. Over the past year, staff and others connected with the Centre have published three peer review studies on the relationship between the legalisation of euthanasia or assisted suicide and rates of suicide. This work formed the basis of a conference in Oxford on 10 September, which is World Suicide Prevention Day, and is summarised in a briefing paper written by the director. The Centre’s work has also informed the Parliamentary Office of Science and Technology *POSTBrief* on ‘Assisted dying’ which, while understating the dangers, was rightly critical of the unevidenced assurances of those advocating for a change in the law.

On abortion, the overturning of the *Roe v. Wade* decision this year has energized the debate in the United States. There has been a backlash fanned by fears that legal restrictions on abortion will endanger the health and even the lives of pregnant women. In this context, some medical bodies have urged that abortion be regarded as an essential element of maternal healthcare. In response to such statements, the director wrote an article that was published in the *New York Times*, and is also included in this Newsletter. Consideration of the evidence shows that there is no clear relationship between abortion and maternal mortality. It is possible to restrict access to abortion while improving health outcomes for women. The relationship between empirical investigation and in-principle ethical analysis is subtle, but if arguments can be framed in empirical terms then they can speak to a wider audience, as has been seen in the debate over euthanasia and assisted suicide. This article provides the theme for a possible strand of future research for the Centre, if funding for this can be found.

On conscientious objection, the Anscombe Bioethics Centre drafted an open letter to the World Medical Association which was signed by nearly four hundred professors, senior academics and healthcare professionals. This letter (also reproduced in the present Newsletter) urged the WMA to uphold respect for conscientious practice and, in particular, to resist proposals that doctors with a conscientious objection be required to refer patients to a doctor who would carry out the procedure. Imposing this kind of duty to refer would effectively undermine conscience, as it would require doctors to facilitate procedures that they consider harmful, unjust or otherwise unethical. Happily, in October this year, the General Assembly of the WMA agreed wording for its International Code of Practice that did not include a duty to refer.

The Centre thus continues the mission for which it was established, engaging in serious scholarship in order to support doctors, nurses and biomedical scientists – those 'working at the coalface' – and also those, such as bishops and hospital chaplains, who may be called upon to offer guidance on such questions, and finally those charged with determining law and public policy on bioethical issues. The Centre does this on limited resources, through collaboration with academics and clinicians and with the ongoing spiritual, practical, and financial support of many benefactors.

In 1993, Cardinal Ratzinger wrote, in a personal capacity, a recommendation of the work of the Centre, praising the 'great value' of the service it provided, acknowledging the 'well-deserved respect' in which it was held by professionals and academics, and endorsing its work as 'deserving of every support'. A copy of this recommendation is reproduced on page 8.

A theme that is present in the recommendation from Cardinal Ratzinger and in Luke Gormally's introduction to the first Friends' Newsletter, and is more relevant than ever, is the need to attract funds in order to ensure the future of the Centre. The work of the Centre has relied from its inception on support from the Catholic community, through individual donations and through parishes, religious orders, and dioceses. It has also relied on funding from Trusts and from individual benefactors to support specific projects. If the Centre is to continue to address the need for Catholic reflection on bioethics, then we will need to increase both regular giving and the funding of specific projects.

The Centre continues to trust in Providence and to depend on the generosity of benefactors. Please consider how you might be able to support the Centre, by your prayers, in practical ways and, if you are able, financially. The words of the first Newsletter remain true today 'Whether we have the resources to give [these issues] the attention they require will depend to an important degree on the Friends who continue to support us.'

‘After Twenty Years’: The first Friends’ Newsletter[1]

This newsletter makes its first appearance in the year in which the Linacre Centre begins to celebrate the 20th anniversary of its foundation in the summer of 1977. Readers must think that we have been oddly reticent over publicising our existence and our work. The reticence has, I think, been due to three factors.

First, staff have always been few in numbers (down to two during one fourteen month period), so that the demands on our time have left little opportunity for self-advertisement.

Fr Anthony Fisher OP (now Arcbishop of Sydney) speaking with Luke Gormally at the Centre’s international conference organised to celebrate the twentieth anniversary of our foundation. Cambridge, July 1997.

Professor John Finnis speaking at the 1997 conference.

Second, we have for the most part seen our role as requiring in-depth reflection on the ethical issues raised by contemporary practices in the field of health care; if that is one’s role it can seem inopportune to have the sort of public profile which attracts regular intrusions by the media demanding instant wisdom encapsulated in snappy soundbites.

The third factor is connected with the second: we have been strongly influenced by the spirit of the Centre’s first Director, the late David Williams CBE. David undertook to establish the Centre after a career of some distinction in the civil service. And he impressed upon his colleagues at the Centre (the present writer, in at the beginning as the Centre’s first Research officer, together with the late Sister Janey Milne Home SHCJ, the Centre’s first Administrative Secretary) that we had a job

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[1] This was the introduction for the first edition of the Friends’ Newsletter (Summer 1996), written by Luke Gormally.

Elizabeth Anscombe with Cardinal Cahal Day at the Centre's international conference in Cambridge, July 1997.

to do not unlike that of civil servants. Like good civil servants we should be in a position to offer well thought-out advice to those who had to make decisions – in our case, doctors, nurses, scientists, pro-life activists, and bishops – and that we should do so without attracting attention to ourselves. Concern for anonymity in our early days even extended to publications!

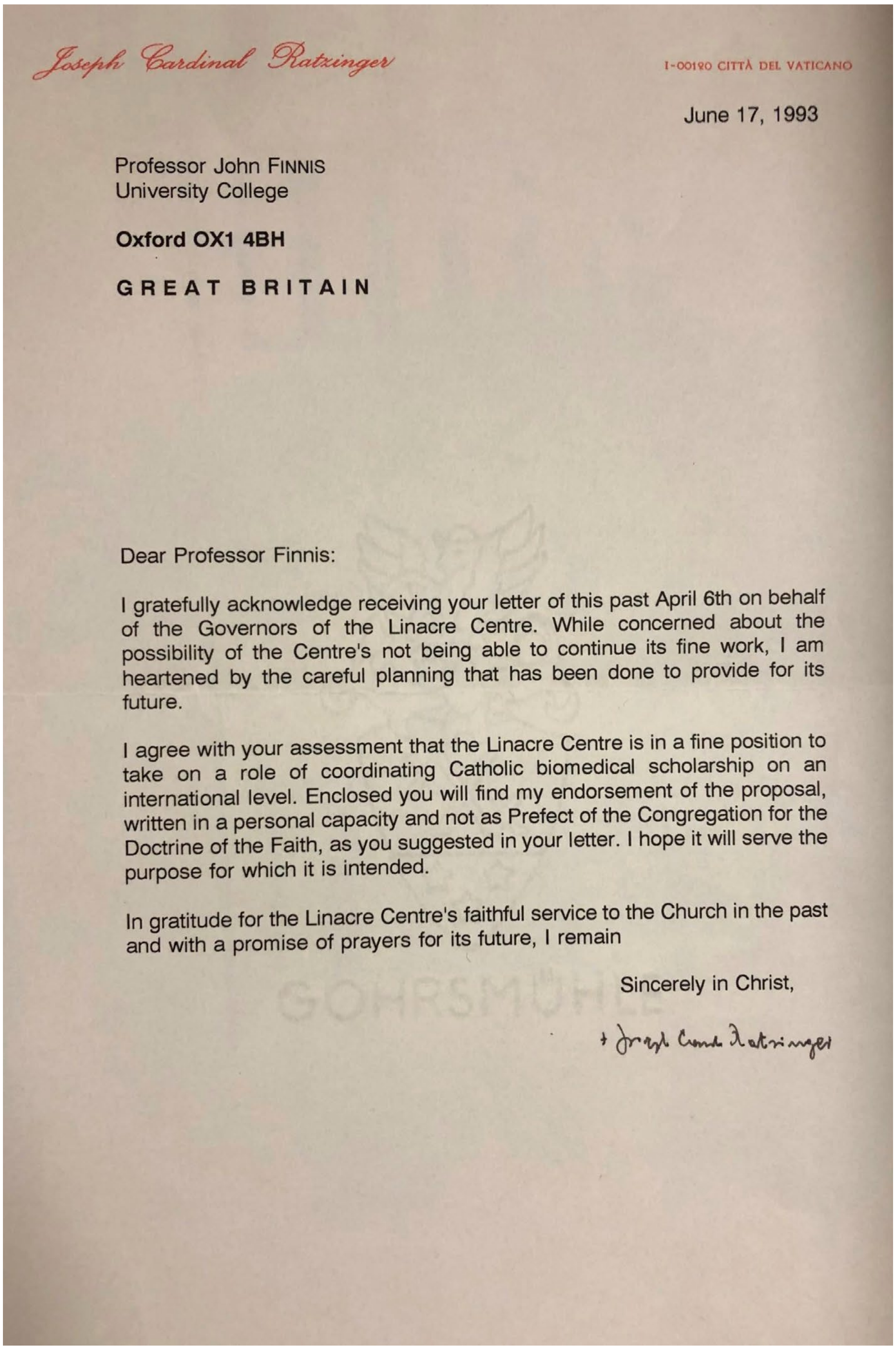
A concern for in-depth reflection on contemporary bioethical issues in order to be well-placed to offer sound advice is important to the character of the Linacre Centre. The Centre was established first of all to study, in the light of Catholic teaching, the pressing ethical questions which are raised by developments in clinical practice or by changed social expectations, and then to make available the fruits of that study; in the first place to fellow Catholics, who are working at the coalface of clinical practice and to those, such as bishops, who may need to offer guidance on such questions in the exercise of their pastoral ministry. But our task has not merely been to offer (directly and indirectly) some help to doctors, nurses and others to live their professional lives in ways consistent with what we know as Catholics to be the truth about human life and human dignity. Since many have to work in environments strongly influenced by secularised (often utilitarian) understandings of human life there is an urgent need to bring what influence we can to bear on the formation of public policy. The Centre has sought to address this kind of task also.

The indispensable basis of the Centre's work is, as I have remarked, serious study of the pressing issues which face us. The fruits of that study have been communicated in three distinct areas of activity: through publications; through courses, seminars and study days we have organised; and through our work as consultants to other bodies.

The Centre's reputation for sound Catholic scholarship in the field of bioethics rests to a large extent on the series of publications we have brought out over the years. During the 1980's we also had a demanding commitment to providing intensive courses in different parts of the country (for hospital chaplains and nurses in particular) and a programme of seminars, study days and residential conferences for junior doctors and nurses and for medical and nursing students in London.

This programme was possible particularly in the mid '80s when we had more numerous staff than we have since had; in the two years 1984-1985, Dr Teresa Iglesias and Dr Fred Fitzpatrick overlapped in the periods each served as full-time Fellow of the Centre. Since the late 1980s we have had fewer staff and today have only on full-time Research Fellow (Dr Helen Watt).

Increasingly through the 1980s we found our role as consultants to other bodies growing. In particular, we have had a substantial commitment to the Catholic Bishops' Joint Committee on Bioethical Issues, a committee unique in bringing together on a regular basis bishop from England and Wales, from Scotland, and from Ireland. As Director of the Centre, I have served on this Committee for some 13 years, as well as on its Standing Committee. Through this link the Bishops have been able to secure the services of staff in chairing and convening working parties and in drafting a number of reports and statements.



Joseph Cardinal Ratzinger
I-00120 CITTÀ DEL VATICANO

June 17, 1993

Professor John FINNIS
University College

Oxford OX1 4BH

GREAT BRITAIN

Dear Professor Finnis:

I gratefully acknowledge receiving your letter of this past April 6th on behalf of the Governors of the Linacre Centre. While concerned about the possibility of the Centre's not being able to continue its fine work, I am heartened by the careful planning that has been done to provide for its future.

I agree with your assessment that the Linacre Centre is in a fine position to take on a role of coordinating Catholic biomedical scholarship on an international level. Enclosed you will find my endorsement of the proposal, written in a personal capacity and not as Prefect of the Congregation for the Doctrine of the Faith, as you suggested in your letter. I hope it will serve the purpose for which it is intended.

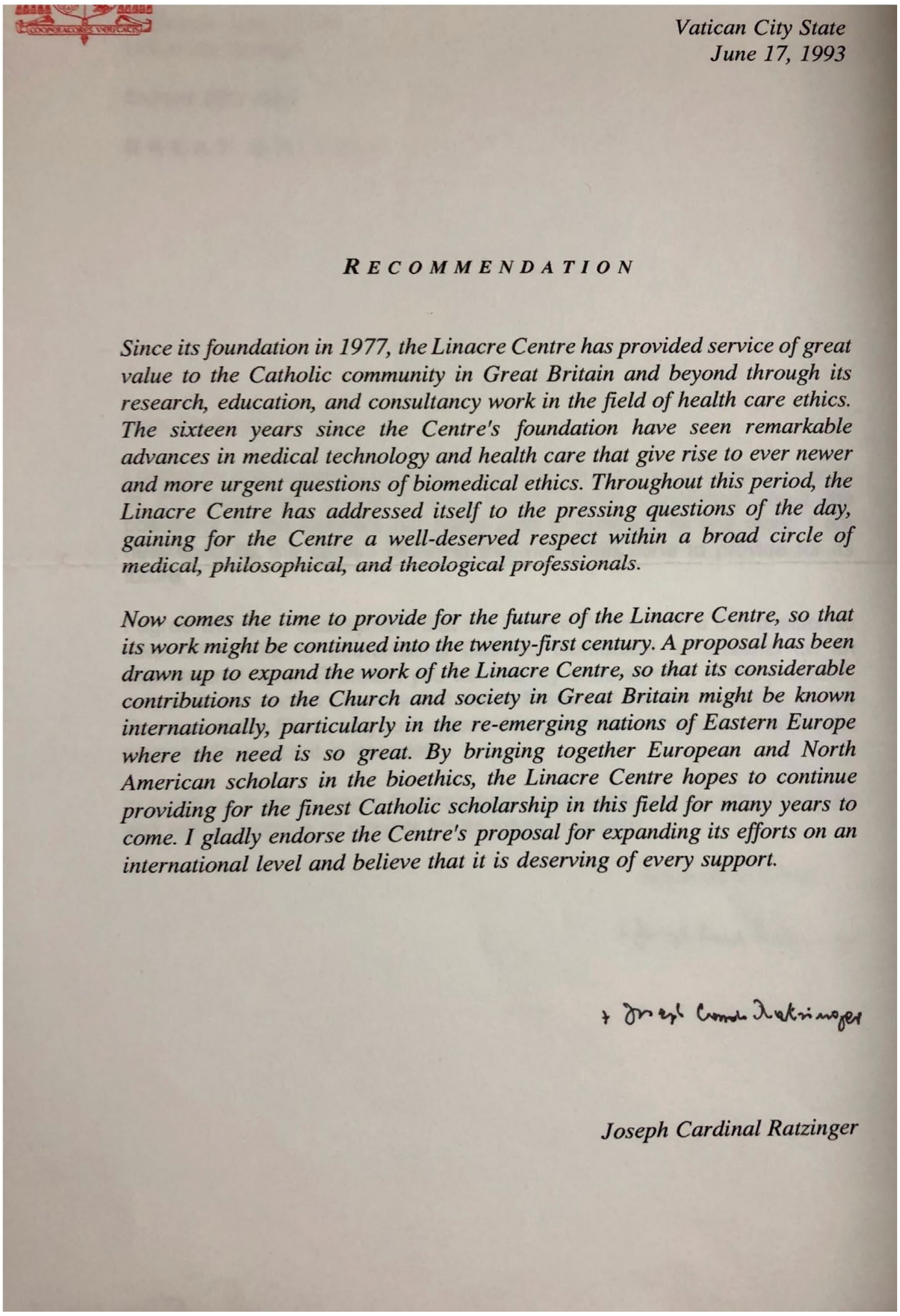
In gratitude for the Linacre Centre's faithful service to the Church in the past and with a promise of prayers for its future, I remain

Sincerely in Christ,

+ Joseph Card. Ratzinger

Letter from Cardinal Ratzinger to Professor John Finnis

Our services have not been confined to Church bodies within these islands. On the one hand we have found Church authorities from beyond these shores consulting us, and on the other we have found ourselves increasingly contributing to general public policy debates in our society. Perhaps the best known of those contributions was the thorough submission we made in 1993 to the House of Lords' Select Committee on Medical Ethics, a contribution widely recognised as having substantially influenced the important Report of the Committee published in 1994. (Readers will recall that contrary to the initial expectations, the Committee unanimously recommended



Vatican City State
June 17, 1993

RECOMMENDATION

Since its foundation in 1977, the Linacre Centre has provided service of great value to the Catholic community in Great Britain and beyond through its research, education, and consultancy work in the field of health care ethics. The sixteen years since the Centre's foundation have seen remarkable advances in medical technology and health care that give rise to ever newer and more urgent questions of biomedical ethics. Throughout this period, the Linacre Centre has addressed itself to the pressing questions of the day, gaining for the Centre a well-deserved respect within a broad circle of medical, philosophical, and theological professionals.

Now comes the time to provide for the future of the Linacre Centre, so that its work might be continued into the twenty-first century. A proposal has been drawn up to expand the work of the Linacre Centre, so that its considerable contributions to the Church and society in Great Britain might be known internationally, particularly in the re-emerging nations of Eastern Europe where the need is so great. By bringing together European and North American scholars in the bioethics, the Linacre Centre hopes to continue providing for the finest Catholic scholarship in this field for many years to come. I gladly endorse the Centre's proposal for expanding its efforts on an international level and believe that it is deserving of every support.

+ Joseph Card. Ratzinger

Joseph Cardinal Ratzinger

Recommendation from Cardinal Ratzinger

that active euthanasia should not be legalised.)

The above account of the kinds of commitment which have engaged us for close on twenty years will perhaps go some way towards explaining why we have hitherto failed to produce a regular newsletter. We are launching one at this juncture as part of our new 'Friends of the Linacre Centre' Scheme. We need a formal body of Friends because we need a regular commitment of financial support if we are to achieve certain objectives, in particular the appointment of an education officer at the Centre. There is a great demand for the services of such a person which we are not well-placed to meet with present resources. The Newsletter gives individuals, schools, communities and parishes, who have become friends of the Centre, a point of contact with our ongoing work, and short articles which we hope many prove useful.

It would be good if some of our new-found Friends (as well as some old friends) find themselves able to take part in the international Conference we have organised to celebrate the twentieth anniversary of our foundation. Initial publicity for the Conference is enclosed with this Newsletter. As you will see, we have assembled an outstanding group of speakers, and the themes and issues to be addressed are among fundamental themes and issues which have engaged us over twenty years in the effort to present and develop a Catholic Bioethic[2] adequate to the challenge of our times. Doubtless many of the issues will continue to require attention for years to come. Whether we have the resources to give them the attention they require will depend to an important degree on the Friends who continue to support us.

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[2] This conference was held at Queen's College Cambridge in July 1997 and the papers were subsequently published as Luke Gormally (ed.) *Issues for a Catholic Bioethic* (London: Linacre Centre, 1999). Elizabeth Anscombe participated in the conference, though she did not contribute a paper. Among those who contributed papers was the current director: David Albert Jones, 'The Encounter with Suffering in the Practice of Medicine in the Light of Christian Revelation'.

The End of Roe Doesn't Need to Bring an Increase in Maternal Mortality[3]

It has been argued repeatedly that without access to abortion, the health of women will suffer and women will die. This fear is expressed overtly by the three dissenting justices in *Dobbs v. Jackson Women's Health Organization*, the decision that overturned *Roe v. Wade* last month. They cite experts who say that 'a ban on abortions increases maternal mortality by 21 percent.'

These concerns are real. But comparison with Europe shows that such dire outcomes are not preordained. Many of Europe's abortion laws are stricter than many Americans may realize, and the issue is less of a political fixation, but maternal health outcomes in Europe are much better.

While most European countries allow abortion on request, the median time limit for this is only 12 weeks into pregnancy. Many also impose other conditions such as mandatory waiting periods, mandatory counseling or third-party authorization by parents, doctors or committees. It is true that in some European countries, abortion remains accessible well beyond the time limit for elective abortion. Nevertheless, an overwhelming majority of these laws would be incompatible with *Roe v. Wade* and Planned Parenthood v. Casey, which until recently protected abortion up to the point of fetal viability (around 24 weeks). Furthermore, several European states (Andorra, Liechtenstein, Malta, Monaco and Poland) ban abortion at every stage of pregnancy in all or almost all circumstances.

After almost 50 years of U.S. law and policy shaped by *Roe v. Wade*, how does maternal mortality in America compare with that in Europe? The answer is stark. The United States has a much higher rate of maternal death per capita than the European Union. Indeed, one has to go to Moldova — one of the poorest countries in Europe — before finding a European country where maternal mortality is as bad. In 2017, both the United States and Moldova recorded 19 maternal deaths per 100,000 live births. That year, while the United States spent $10,103 per person on health care, Moldova spent the equivalent of $244. This rate of death is the average across America, with many states having a far higher rate of maternal mortality than Moldova.

Worse still, across the country, the rate of death for women of color is even higher. In 2020, the U.S. maternal mortality rate for Black women was 55.3 per 100,000 births, compared with 19.1 for white women and 18.2 for Hispanic women. This figure is without parallel in the developed world.

What about European countries with the most restrictive abortion laws? How does maternal mortality in these countries compare with maternal mortality in countries with more permissive laws? The answer again is clear. There is no significant difference in maternal mortality among countries in Europe on the basis of how restrictive their abortion laws are. Indeed, if anything, more restrictive states seem to be safer for women. Poland, which has one of the most restrictive abortion laws in Europe, has the lowest rate of maternal mortality in Europe: only two deaths per 100,000 births.

Faced with this evidence, someone might doubt that the data are reliable or are being collected in the same way. This doubt can be addressed by looking specifically at the United Kingdom and Ireland. Until 2018 the British Isles included one of the most permissive legal regimes in Europe and one of the strictest. In England, Wales and Scotland abortion is legal for mental health reasons, effectively on request, up to 24 weeks and is provided free on the National Health Service. In the Republic of Ireland, before 2018, abortion was legal only to save the mother's life. (It remained illegal in Northern Ireland until 2019, and even now it is difficult to obtain an abortion there.)

In 2009, the Republic of Ireland joined the United Kingdom in its Confidential Maternal Death Enquiry. This allowed direct and robust comparison between the two countries. The most recent report, published in December 2020, found that the

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[3] By the director, published in the New York Times on 9 July 2022.

maternal mortality rate was lower in Ireland and statistically was no different, at a time when there were around 30 abortions a year in Ireland and more than 200,000 abortions a year in England and Wales. Again, for comparison, the maternal mortality rate in the United States during this period was roughly twice that of the United Kingdom and more than three times that of the Republic of Ireland.

The evidence from Europe demonstrates that it is not necessary or inevitable that restricting abortion will lead to adverse health outcomes for women. Still, in the United States the uncomfortable truth for Republicans is that, according to a 2019 analysis by America's Health Rankings, eight out of the 10 states with the lowest maternal mortality are blue states, whereas eight out of the 10 states with the highest are red states. Mississippi, whose proposed law was at the center of the *Dobbs* case, is in the bottom half of the table for maternal mortality. It was also given the lowest ranking of any state for overall health of women and children. The dissenting minority in *Dobbs* notes that Mississippi 'neither bans pregnancy discrimination nor requires provision of paid parental leave,' has 'strict eligibility requirements for Medicaid and nutrition assistance' and has 'rejected federal funding to provide a year's worth of Medicaid coverage to women after giving birth.'

If Mississippi and other red states wish to demonstrate that they are truly 'pro-life,' then they must address their shameful levels of maternal mortality. The first priority is to address 'concentrated disadvantage' among their poorest citizens, and especially among women of color. This measure has been shown to be an important determinant of maternal health. Second, it is essential to ensure that women have access to health care not only before and during but also in the weeks after giving birth. Third, according to the World Health Organization, midwife-led maternity services provide an evidence-based approach to reducing maternal mortality. Currently there are only four midwives per 1,000 births in the United States, in comparison with 43 per 1,000 births in the United Kingdom. There is much that could be done, but it is not being done and maternal mortality in the United States is not falling but rising.

The right to abortion granted by *Roe v. Wade* did not prevent this ongoing scandal, and restricting access to abortion will not inevitably make things any worse. The situation is perpetuated, in part, by a national debate that remains hyper-focused on abortion access (whether against or in favor) rather than on the causes and remedies of maternal mortality. While this remains the case, hundreds of women and disproportionately women of color will continue to die needlessly every year in the richest country in the world.

David Albert Jones is the director of the Anscombe Bioethics Centre in Oxford, England, a fellow of Blackfriars Hall, Oxford University, and a professor of bioethics at St. Mary's University, Twickenham.

This article was published by the New York Times on 9 July 2022.

Press Release: Anscombe Bioethics Centre Welcomes International Recognition of Right to Conscientious Objection in Healthcare[4]

The Anscombe Bioethics Centre welcomes the decision of the World Medical Association (WMA) to uphold the right of conscientious objection in healthcare.

The final text of the International Code of Medical Ethics was agreed last week. It is a rejection of earlier proposals that doctors with a conscientious objection be required to make 'effective referral' for such procedures. Instead, the WMA recognises that both patients and physicians 'may hold deeply considered but conflicting conscientious beliefs'. Both need to be respected.

The final text of the Code is in line with the open letter to the WMA which was co-ordinated by the Anscombe Centre and was finally signed by almost four hundred professors and clinicians from across the globe: No doctor should be obliged to provide or facilitate a procedure that, reasonably and in good conscience, they judge to be harmful, discriminatory, unjust or otherwise unethical.

The open letter helped inform a key meeting between delegates of the WMA and the American Medical Association in Washington on 11-12 August 2022. It was at this occasion that the text was finalised before being presented to the general assembly for approval. The International Code of Medical Ethics is a reference point for national medical associations throughout the world and is potentially of enormous influence.

The WMA also maintains its opposition to euthanasia and assisted suicide and to doctors being forced to refer patients for these procedures. This is in contrast to government policies in countries such as Canada where doctors are now required to refer people for 'medical assistance in dying' even if the patients are not dying, and where some doctors are encouraging patients to consider euthanasia even when the patients have not raised the issue themselves. What is at first framed as a right to die can become a perceived duty to die. Where euthanasia or assisted suicide are legal the protection of patients may depend on the courage of conscientious healthcare professionals to resist such insidious pressures.

The WMA International Code of Medical Ethics is not perfect. For example, it requires doctors to tell patients whenever they have a conscientious objection. However, in the United Kingdom, the General Medical Council has rightly observed that it is not 'always necessary or helpful for a patient to be aware of the professional's personal beliefs'. What is important is that the patient is informed in a timely manner if a doctor will not provide what the patient is asking for, and that the patient is informed that they have the right to seek alternative medical care.

Commenting on the revised International Code of Medical Ethics, Professor David Albert Jones, Director of the Anscombe Bioethics Centre, said:

> *'It is heartening to see conscience upheld by a medical body representing so many doctors in so many countries. At the same time, in the United Kingdom, there is certainly a need to strengthen legal and professional protection of conscience rights. With so many pressures on health and social care, what we need is not the imposition of uncritical adherence to state or institutional control but more support for conscientious professionals. They are the last line of defence for ethical patient care'.*

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[4] This press statement was released on 10 October 2022 immediately after the World Medical Association General Assembly which approved the revised International Code of Medical Ethics.

Open Letter to the World Medical Association on Conscientious Objection[5]

We the undersigned hold that to fulfil their professional duties to patients, to uphold the integrity of the medical profession, and to avoid harm to society as a whole, physicians must commit themselves to acting ethically in the practice of medicine and must always refrain from actions that they judge to be unethical. The duty of a physician to practise with conscience includes the duty not to act contrary to conscience.

A physician who, in good conscience, and in line with a reasonable body of medical opinion, judges a procedure to be harmful, discriminatory, unjust or otherwise unethical must not be placed under a professional, contractual or legal obligation to identify and refer to another healthcare professional who would provide the procedure. This stance is articulated and embodied in the WMA policy on euthanasia and assisted suicide which states that:

> *No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.*

There are wider implications of making effective referral compulsory in the context of conscientious objection. For example, if a physician who objects in conscience to a legally-sanctioned medical procedure is obliged to identify and make effective referral to another physician who does not object, then in some jurisdictions a physician who objected to participation in 'enhanced interrogation', or to capital punishment, or to force feeding of a prisoner who is on hunger strike, or to 'conversion therapy', could be forced to facilitate these procedures by effective referral. However, to require a conscientious objector to facilitate delivery of a procedure to which they have a serious ethical objection is a direct attack on their conscience and moral integrity.

A principled conscientious objection is always to a procedure and not to a person. Physicians must not refuse to treat a particular patient or group of patients because of beliefs about them unconnected with the medical propriety of the procedure. In particular, physicians must not refuse to treat criminals or enemy combatants or refuse to treat the health consequences of the patient's way of life, choices, or beliefs.

A physician must ensure that conscientious objection is exercised in a way that takes full account of their duty of care for the life and health of the patient. The physician should also seek to minimise any disruption of patient care. If a clinician cannot in good conscience provide what the patient requests, the physician should, where appropriate, respectfully explain the reasons for the decision and should, where appropriate, inform the patient of other options that are available to them, including the option to seek a transfer of care to some other healthcare professional. However, the physician is not ethically obliged to provide, and must not be coerced into providing, effective referral of a patient for procedures that the physician sincerely and reasonably considers unethical.

Professor David Albert Jones, MA MA MSt DPhil. Director, Anscombe Bioethics Centre, Oxford, UK; Professor of Bioethics, St Mary's University, Twickenham, UK; Research Fellow, Blackfriars Hall, Oxford, UK.[6]

Professor Lani Ackerman, MD, FAAFP. Professor of Medical Education and Family Medicine, Director of Clinical Skills, Diplomat ABFM, CAQ Geriatrics, CTropMed, Diplomat ABQIURP, TCU School of Medicine, Fort Worth, TX, USA.

Professor Emmanuel Agius, SThB STh MA SThD. Professor of Religious and Philosophical Ethics, University of Malta, Malta.

The Right Honourable Professor the Lord Alton of Liverpool, KCSG, KCMCO. Visiting Professor, Liverpool Hope University; Honorary Fellow and Former Professor of Citizenship, Liverpool John Moores University, Liverpool, UK.

Professor Paul S Appelbaum, MD. Dollard Professor of Psychiatry, Medicine, and Law, Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York, NY, USA.

….and 388 other signatories including many of the most prominent living bioethicists and Christian medics worldwide.

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[5] This letter was drafted by the director and revised in the light of feedback from other academics and clinicians. It was posted on the Anscombe Bioethics Centre website on 10 August 2022 and simultaneously sent to participants at a joint World Medical Association / American Medical Association meeting held in Washington DC. It remained open for new signatories until the WMA General Assembly in October and attracted a total of 393 signatories of which the first five are listed below. A full list of signatories is given on the Centre website at www.bioethics.org.uk/news-events/news-from-the-centre/open-letter-to-the-world-medical-association-on-conscientious-objection/ .

[6] All institutional affiliations listed here are for identification purposes only and not to represent the position of the institution named.