1 Introduction

Conscientious objection to military service has a long history.[1] By contrast, conscientious objection in medicine is a relatively recent phenomenon. It became widespread when abortion services were decriminalized. The connection between the legalization or decriminalization of abortion and conscientious objection applies to developed countries – those in the "Global North" – as well to developing countries – those in the "Global South."[2] However, the focus of this discussion of the growth of conscientious objection in medicine will be on two representative countries in the former category – the United States and the United Kingdom.

In the United States, after the 1973 *Roe* v. *Wade* Supreme Court decision established a constitutional right to abortion, many obstetrician–gynecologists (OB–GYNs) who were morally and/or religiously opposed to pregnancy termination conscientiously objected. In the same year, the US Congress passed the Church Amendment (42 U.S.C. § 300a–7[b]), the first health-care "conscience clause" (legislation that protects health-care professionals who refuse to provide a good or service for ethical or religious reasons). The Church Amendment stated that receipt of funds under three federal programs did not authorize any court, public official, or "other public authority" to require individuals or institutions with ethical or religious objections to provide or assist in the provision of abortions or sterilizations (42 U.S.C. § 300a–7[b]).

In the United Kingdom, a legislative act, the Abortion Act of 1967 (1967 c. 87), legalized abortion. Anticipating ethical or religious objections to performing abortions, a conscience clause was incorporated directly into the legislation. It included the following provision: "[N]o person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection." However, objectors were not released from a "duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."

Advances in life-sustaining medical treatment also contributed to an increase in the scope and frequency of conscientious objection. During the second half of the twentieth century, the ability to prolong the lives of patients increased substantially. Some physicians believed that if it is medically possible to prolong a patient's life, they have an ethical and professional obligation to do so, and they conscientiously objected to forgoing life-sustaining treatment – either all measures, or specific measures such as medically provided nutrition and hydration (MPNH).

The scope of conscientious objection has expanded significantly beyond abortion, sterilization, and forgoing life-sustaining treatment. Its scope related to reproductive health includes contraception and fertility treatments. Its scope

related to death and dying includes donation after circulatory determination of death (DCDD), palliative sedation to unconsciousness, and medical assistance in dying (MAID). And its scope is not limited to reproductive health care and death and dying.

Undoubtedly, conscientious objection in medicine – and health care generally – has quickly grown from a relatively limited phenomenon to one that encompasses a broad range of medical services. Corresponding to the increase in its scope and incidence, it has generated a substantial scholarly literature. This Element provides a critical analysis of key positions and debates about ethical and conceptual issues within that scholarly literature.

2 What Is Conscientious Objection?

One obvious answer would be to define conscientious objection as an objection that is conscience-based – that is, based on an individual's conscience. However, since there are several different conceptions of conscience,[3] this is not an unambiguous answer. According to one familiar conception, conscience is a mental faculty that has the dual function of making moral judgments and guiding behavior.[4] This conception maintains that people consult or exercise their conscience to determine whether their past or contemplated future actions or omissions are morally wrong. A religious conception maintains that "conscience may be understood as enabling moral agents to know whether an act conforms to the divine law, that is, to God's standard of right and wrong."[5]

Broader conceptions identify conscience with practical reason, moral agency, or capacity for moral choice. Practical reason is associated with a common conception of conscience during the Middle Ages,[6] and the conception of conscience as moral agency or capacity for moral choice is associated with later followers of Stoicism.[7]

Some conceptions reject the view that a function of conscience is to make moral judgments. A classic example is Kant's conception of conscience as an "inner court."[8] According to Kant, it is not the function of a person's conscience to make moral judgments (e.g., to ascertain their duties). Such ethical judgments are a function of moral reasoning (practical reason). The exercise of conscience involves a process of self-reflection which has the aim of determining whether a person's past or contemplated actions are consistent with duties ascertainable by practical reasoning. Metaphorically, this determination takes place within an inner court, in which the agent acts as prosecutor, defense attorney, and judge. A "guilty" verdict reflects a finding that the agent's past or contemplated actions are not consistent with duties ascertained by practical reasoning. Kant refers to

conscience as an "instinct" and claims that agents cannot escape from their conscience or its inner voice.[9]

A more recent conception that does not attribute to conscience the function of making moral judgments maintains instead that its primary function is as a sort of liaison between a person's ethical convictions and actions.[10] According to this conception, conscience promotes conformity between ethical belief and action. It "follows rather than authorizes moral judgments."[11]

Some contemporary scholars explicitly reject the conception of conscience as a mental faculty with an epistemic function.[12] One conception identifies it with the Freudian "superego," which is a means to protect society from the natural (innate) aggression of its members: "Civilization . . . obtains mastery over the individual's dangerous desire for aggression by weakening and disarming it and by setting up an agency within him to watch over it, like a garrison in a conquered city."[13] A key feature of the superego is the internalization of previously external standards. Freud maintains that prior to the development of the superego, individuals cannot be said to have a conscience or experience feelings of guilt.

A contemporary, expansive conception of conscience identifies it as "the faculty in human beings with which they search for life's ultimate meaning."[14] According to this conception, conscience is "that seat of imagination, emotion, thought, and will through which each person seeks meaning in his or her own way."[15]

To define conscientious objection in medicine, one need not specify and justify a conception of conscience. Conscientious objections can be understood as objections that are based on a physician's *moral convictions*. This is a common understanding of the concept. Physicians can object to a medical service for a variety of reasons. Objections can be characterized as conscientious objections if and only if they are based on a physician's moral convictions. The crucial question is whether the reason for objecting is the belief that an act (or omission) is morally wrong. It does not matter whether the objection is *conscience*-based in any sense other than whether it is based on the physician's *moral convictions*.

Physicians' moral convictions can be based on their religious beliefs; or they can have a nonreligious basis. The relevant moral convictions can be about the obligations of the individual *as a moral agent*, and they can involve beliefs about the obligations of the individual *as a member of the medical profession*. In the latter case, the objection is based on the *physician's conception* of the goals of medicine and the professional obligations of physicians. For example, an OB–GYN refuses to perform abortions unless they are required to prevent the imminent death of pregnant women because – contrary to the established view within the profession – the OB–GY believes that unless this condition is satisfied, terminating pregnancies is incompatible with a physician's obligation to promote health.

2.1 Moral Complicity

When physicians conscientiously object to a medical service, they sometimes object only to providing the service. For example, an OB–GYN who conscientiously objects to abortion refuses to perform pregnancy terminations but is willing to refer patients to abortion providers. However, conscientious objections can go beyond refusing to provide medical services. Physicians can also conscientiously object to informing patients about a medical service or referring patients to a health professional who is willing to provide the service. For example, an emergency room physician who conscientiously objects to emergency contraception (EC) might refuse to provide it to rape victims who request it and also refuse to inform them of the availability of medication that can prevent pregnancy even several days after intercourse. More broadly, physicians can conscientiously object to *any perceived participation* in a medical service that is contrary to their moral convictions. For example, a physician who conscientiously objects to gender reassignment surgery might refuse to treat a patient who experiences post–gender reassignment surgery complications. Claims of conscientious objection that go beyond objections to providing a medical service are generally based on the provider's interest in avoiding moral complicity and the belief that direct or indirect participation in an immoral practice can involve moral complicity.

Michael Bayles offers a complicity-based reason for OB–GYNs who conscientiously object to abortion to refuse to refer to willing providers:

> If a physician sincerely believes abortion in a particular case is morally wrong, he cannot consistently advise a patient where she may obtain one. To do so would be to assist someone in immoral conduct by knowingly providing a means to it. The physician would bear some responsibility for the wrongful deed. Believing the abortion to be morally wrong, he believes that it is wrong for anyone to perform it and for the woman to obtain it. If he directs her to a physician who will perform it, then he assists both of them in acting wrongfully.[16]

In response, some bioethicists distinguish between direct and indirect referral and maintain that complicity is absent when referral is indirect. According to Frank Chervenak and Laurence McCullough, direct referral is said to involve communication between physicians – one who refers and one who receives the referral.[17] The former contacts the latter and takes steps to assure that the patient will receive a medically indicated service that the former is unable or unwilling to provide. By contrast, indirect referrals are limited to providing patients with information (e.g., the names and contact information of providers from whom they can receive the service at issue).

Chervenak and McCullough maintain that although it might be plausible to ascribe moral complicity in cases of direct referral, a physician who provides an indirect referral "cannot reasonably be understood to be a party to, or complicit in, a subsequent decision that is the sole province of the patient's subsequent exercise of autonomy in consultation with a referral physician."[18]

Karen Brauer, a past president of Pharmacists for Life, challenges the claim that indirect referrals do not establish complicity: "That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.' What's that saying? 'I will not off your husband, but I know a buddy who will?' It's the same thing."[19] Giving the wife information that will enable her to enlist the services of a willing killer satisfies the criteria of "indirect referral." Arguably, if the "referral" results in the spouse's murder, the person who provided the information cannot avoid complicity by claiming that the decision to kill "is the sole province of the . . . [wife's] subsequent exercise of autonomy in consultation with a referral [killer]." Accordingly, characterizing a referral as indirect may not suffice to establish a lack of moral complicity, and additional factors may need to be considered.

Drawing on the natural law tradition, Daniel Sulmasy offers a complex multifactor account of moral complicity.[20] He identifies several conditions. One, "formal cooperation," is a sufficient condition of moral complicity. According to this condition, if *x* shares in the intent (i.e., goal or purpose) of a wrongdoer *y*, *x* is morally complicit in *y*'s wrongdoing. Accordingly, if a physician who has a conscience-based objection to palliative sedation to unconsciousness refers a patient who requests it to another physician with the intent of helping the patient achieve their goal, the physician is morally complicit in a perceived wrongdoing. However, a physician who has a conscience-based objection to providing a requested good or service can provide a referral without sharing the patient's purpose. The physician can intend only to respect the patient's autonomy and/or to fulfill a perceived professional obligation to refer. A similar point applies to disclosing options, including those that a physician is unwilling to provide due to conscience-based objections.

According to Sulmasy, if formal cooperation is absent, it is necessary to assess "material cooperation," and he provides seven questions to guide an assessment of moral complicity:

> (1) How necessary is one's cooperation to the carrying out of the act? Could it occur without one's cooperation? The more likely that it could occur without one's cooperation, the more justified is one's cooperation. (2) How proximate is one to the act, in space and time and in the causal chain? The further removed one is, the more justified is one's cooperation. (3) Is one under any degree of duress to perform the act? Is someone compelling the act at

> gunpoint? Does failure to cooperate mean loss of livelihood and ability to provide for a family? The more duress one is under, the more justifiable is one's cooperation. (4) How likely is one's cooperation to become habitual? The less likely, the more justifiable. (5) Is there a significant potential for scandal? I am using scandal here in the technical sense of leading others to believe that the one who is providing the material cooperation actually approves of the act so that observers might thereby be led to think it morally permissible. The less the potential for scandal, the more permissible the cooperation. (6) Does one have a special role that would be violated by this action? The less one has special role responsibilities that potentially would be contravened by the act, the more justifiable it is. (7) Does one have a proportionately important reason for the cooperation? That is, is there some morally important good that will come about because of one's indirect cooperation? If so, one has a better justification for cooperation.[21]

According to these criteria, moral complicity is a matter of degree.

There are other conceptions of moral complicity, and there is ongoing controversy among their defenders and detractors. It is beyond the scope of this Element to engage further in the debate, much less to identify and defend a justifiable conception. Fortunately, that is unnecessary. If, as maintained in Section 3, a key aim of accommodation is to give physicians moral space in which to practice medicine in accordance with their moral beliefs, considerable deference should be given to a physician's conception of moral complicity. Granted, beliefs about complicity are second-order metaethical beliefs, but they can shape first-order normative ethical beliefs.

2.2 Some Important Distinctions

It may be understandable that physicians who believe that a medical service is morally wrong would want to prevent patients from acting immorally. However, conscientious objection should not be confused with obstruction. The aim of conscientious objection is for physicians to avoid providing – or participation in the provision of – medical services that violate their moral convictions. Metaphorically, it is to keep their hands "morally clean." In this respect, conscientious objection is "inner-directed." By contrast, obstruction is "outer-directed." The aim is to prevent others from actions that the physician believes are morally wrong.

Civil disobedience is another type of outer-directed action that should be distinguished from conscientious objection. Whereas conscientious objection typically is inner-directed with the aim of avoiding acting against one's conscience, civil disobedience is public and outer-directed.[22] An aim of civil disobedience is to promote change – typically through unlawful but peaceful protests – by calling attention to unjust laws and policies and increasing

pressure for change. Whereas individuals who engage in acts of civil disobedience can expect penalties for unlawful acts, conscientious objectors seek exemptions that will protect them from penalties for refusing to provide specific medical services.[23]

Conscientious *objection* involves a *refusal* to provide legally and institutionally permitted medical services that are contrary to a physician's moral convictions. By contrast, what some call conscientious *provision*[24] and others call conscientious *commitment*[25] occurs when physicians (conscientious providers) offer legally or institutionally prohibited medical services because they believe that they have a moral and/or professional obligation to offer them. In the United States, several states have enacted legislation that prohibits gender-affirming care for adolescents.[26] These laws have triggered instances of conscientious provision. Some pediatricians who practice in states that prohibit gender-affirming care for adolescents have continued to offer it when they believe it is necessary to protect and promote the health and well-being of their patients. Restrictions on abortion have also triggered conscientious provision. In the United States, occasions for abortion-related conscientious provision are likely to increase in the aftermath of *Dobbs* v. *Jackson Women's Health Organization* (142 S. Ct. 2228) – the US Supreme Court decision that overturned *Roe* v. *Wade*. As result of *Dobbs*, states are now legally permitted to prohibit or substantially restrict abortion, and several have done so.[27] Ironically, overturning the decision that contributed to the extension of conscientious *objection* into the domain of health care may well act as a catalyst for conscientious *provision*.

Most of the focus of this Element will be on conscientious objection and conscientious objectors. However, asymmetry in accommodating conscientious objectors and conscientious providers will be examined in Section 5.

3 Should Conscientious Objectors Be Accommodated?

A general aim of accommodation is to give objecting physicians moral space in which to practice medicine consistent with their moral convictions. To ask whether physicians who conscientiously object should be accommodated is to ask whether they should be able to refuse to offer or provide medical services that are contrary to their moral convictions without facing sanctions or penalties, such as suspension, dismissal, loss of hospital privileges, censure, loss of medical license, or legal liability. It is generally agreed that physicians are free to refuse to offer or provide medical services that are illegal, contrary to standard of care, or outside the scope of their clinical competence. Consequently, the issue of accommodation generally does not arise for such refusals. However, with respect to medical services that are legal, standard of care, and within the scope of

a physician's clinical competency, there is considerable controversy about whether or when to accommodate conscientious objectors.

3.1 Reasons to Accommodate

Defenders of conscientious objection offer one or more reasons to accommodate. They are *pro tanto* reasons for accommodation. That is, depending on the circumstances, there might be overriding reasons, such as the impact on patients and nonobjecting physicians, that justify not accommodating.

Moral integrity is among the most frequently cited reasons for accommodation – both by its defenders and its critics. Accommodation is said to provide objectors with moral space in which to practice medicine without compromising their moral integrity.[28]

3.1.1 Moral Integrity

There are several conceptions of moral integrity.[29] They include identity,[30] self-integration,[31] social,[32] objective,[33] reasonableness,[34] and intellectual virtue[35] conceptions. The identity conception will be used to explain what it means to maintain or undermine one's moral integrity and why maintaining it can matter to physicians.

According to the identity conception, persons have moral integrity only if they have a coherent set of core, self-defining moral beliefs. They are self-defining insofar as individuals associate them with their sense of who, or the kind of person, they are. Core moral beliefs are standards by which individuals judge themselves. Lynne McFall draws a useful distinction between *defeasible* and *identity-conferring* commitments.[36] The former can be "sacrificed without remorse" and without undermining one's integrity.[37] By contrast, the latter "reflect what we take to be the most important and so determine, to a large extent, our identities."[38] Core moral beliefs are identity-conferring commitments. Maintaining moral integrity requires consistently acting in accordance with one's core moral beliefs; and one's moral integrity is undermined or compromised if one acts contrary to them.

Defenders of conscientious objection have identified two respects in which maintaining moral integrity can matter to physicians.[39] First, it is claimed that moral integrity can be an essential component of their conception of a good or meaningful life. In this respect, moral integrity is said to have intrinsic worth or value to them. Second, it is claimed that a loss of moral integrity can be devastating because it can result in strong feelings of guilt, remorse, and shame as well as loss of self-respect.

Supporters of conscientious objection offer two additional reasons for enabling conscientious objectors to practice medicine without undermining their

moral integrity. First, it is claimed that when withholding an exemption leads to a loss of moral integrity, the result can be a general decline in a person's moral character, which is particularly undesirable for physicians and other health-care professionals. Charles Hepler asserts a claim along these lines in relation to members of his profession (pharmacy): "We would be naive to expect a pharmacist to forsake his or her ethics in one area (e.g. abortion) while applying them for the patient's welfare in every other area."[40] Douglas White and Baruch Brody maintain that "if physicians do not have loyalty and fidelity to their own core moral beliefs, it is unrealistic to expect them to have loyalty and fidelity to their professional responsibilities."[41]

Second, it is claimed that moral integrity has intrinsic worth or value. Jeffrey Blustein maintains that integrity is "an important virtue of a certain sort, one that, when combined with other valuable traits, provides an additional ground for admiration of the individual."[42] The claim that moral integrity has intrinsic value has been challenged.[43] To be sure, it requires qualification. Insofar as moral integrity can involve a commitment to any ethical or religious belief, it does not guarantee ethically acceptable behavior. Depending on the content of a person's core moral beliefs, maintaining moral integrity can require invidious discrimination, genocide, cruelty, and so forth. Arguably, however, admiration and respect for moral integrity, like courage and honesty, is at least partially independent of an assessment of ends and consequences. That is, although we might justifiably withhold our admiration and respect if we judge the ends and consequences to be excessively bad, our admiration and respect is not always contingent on a favorable assessment of ends and consequences. Arguably, all other things being equal, the world is a better place if it includes people who are committed to principles and whose actions are not exclusively opportunistic or transactional.

Notably, to justify accommodation, objectors can appeal to an interest in maintaining their moral integrity – understood as the identity conception – only if providing the medical service to which they object is incompatible with their core moral convictions. Incompatibility with defeasible moral beliefs that do not implicate core moral beliefs is insufficient. Incompatibility with defeasible, noncore moral beliefs may cause moral distress, but not a loss of moral integrity. Although other conceptions of moral integrity do not have this specific requirement, they have some requirement(s) beyond incompatibility with one or more of an agent's moral beliefs. For example, Cheshire Calhoun's social conception requires interacting with others and engaging in a process of community deliberation;[44] Elizabeth Ashford's objective conception includes a constraint against the agent "being seriously deceived either about empirical facts or about the moral obligations she actually has";[45] and McFall's reasonableness

conception limits beliefs to "ones a reasonable person might take to be of great importance and ones that a reasonable person might be tempted to sacrifice to some lesser yet still recognizable goods."[46] For many conceptions, requirements such as these are in addition to the identity conception's core moral belief condition.

Alberto Giubilini challenges the moral integrity justification. He claims that arguments in support of conscientious objection based on respect for the moral integrity of objectors are "extremely weak."[47] His critique is based on two claims: (1) Respect for moral integrity is not absolute – there are situations in which it cannot justify refusing to provide medical services. (2) There is no acceptable criterion for determining when it is justified to fail to respect the moral integrity of conscientious objectors. The second claim will be considered in Section 3.2. At this point, it suffices to note that Giubilini's critique is not inconsistent with the view that respect for moral integrity provides a *pro tanto* reason to accommodate. Indeed, his critique assumes that this is the case. If respecting moral integrity did not provide a *pro tanto* reason for accommodation, there would be no need to identify justified limitations.

Jeffrey Byrnes offers a challenge to the moral integrity justification that focuses on alleged insurmountable epistemological problems associated with core moral beliefs.[48] He claims that agents lack the "authentic self-knowledge" needed to reliably identify their core moral beliefs. In this respect, an agent's core moral beliefs are epistemically opaque to the agent; and, insofar as observers rely on the agent's self-knowledge, the agent's core moral beliefs are also epistemically opaque to them. As a result of this alleged epistemic opacity, Byrnes claims, "even if conscientious objection is permitted in health care, appeals to 'core moral beliefs' should not be the basis for such an objection."[49]

In response, it can be claimed that Byrnes assumes an unreasonably stringent standard of "authentic self-knowledge."[50] To be sure, moral agents do not have infallible self-knowledge. However, infallibility is an implausible requirement. It is sufficient that moral agents generally have a capacity to correctly identify their core moral beliefs. Moreover, the fact that moral agents sometimes can be mistaken about their core moral beliefs does not warrant a default assumption that it is more likely than not that moral agents cannot correctly identify them. Without relevant empirical data, a blanket policy of not recognizing conscientious objection based on core moral beliefs risks throwing out the baby with the bath water in two respects. First, a blanket refusal to consider objectors' core moral beliefs would inappropriately include health professionals who have legitimate grounds for accommodation. Second, even if agents are confused about whether some moral beliefs fall within the core or the periphery, there are likely to be actions that are so central to the core that their status is