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Conscientious objection in health care

Jason T. Eberl[1]

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The question of whether health care professionals should have a legally protected right to refuse, on the basis of claims of "conscience," to provide patients with legally requested medical procedures first gained prominence in the context of abortion and contraception. In the United States, the Supreme Court's *Roe v. Wade* and *Doe v. Bolton* decisions legalizing access to abortion led promptly to the passage of legislation protecting health care professionals who refuse to perform or participate in abortion procedures from punitive action by their employers. This legislation also covered refusals to provide elective sterilization procedures, such as tubal ligation. Furthermore, prescription pharmaceutical contraceptives may either not be prescribed by an objecting physician or not be dispensed by a pharmacist who refuses to fill such prescriptions—in some cases not even returning the prescription so that the patient can seek fulfillment elsewhere. More recently, this debate has been enhanced by the growing legalization of physician-assisted dying in various countries, such as Canada (2016), and a number of US jurisdictions—including Oregon (1997),[1] Washington (2008), Montana (2008), Vermont (2013), California (2015), Colorado (2016), the District of Columbia (2017), and Hawaii (2018). Additionally, expanding recognition of the health disparities faced by members of the LGBT community, who have a right to nondiscriminatory treatment, has fueled concerns regarding denials of care, whether broadly speaking or with respect to specific services such as gender-related hormonal or surgical interventions for transgender persons.

In 2008, *Theoretical Medicine and Bioethics* [1] published a special issue featuring five articles—two contributed by authors in the present issue [2, 3]—which provided conceptual frameworks for engaging this debate, including the concept of conscience and its value in moral decision-making and the question of whether some sort of accommodation may be ethically provided for conscientious objectors in health care. Since that special issue was published over a decade ago, debate has both widened to encompass new areas of concern—such as LGBT health disparities

[1] Oregon's Death with Dignity Act was originally passed in 1994 but implemented, after legislative challenges and another referendum, starting in 1997.

✉ Jason T. Eberl
jason.eberl@slu.edu

[1] Saint Louis University, 3545 Lafayette Ave., Salus 527, St. Louis, MO 63104, USA

and access to abortion in the developing world—and become more intractable, with arguments having arisen against any accommodation of conscientious refusals to provide legally requested and medically appropriate, as defined by professional standards, health care services (as articulated by two authors in this issue [4, 5]).

This special issue originated with a panel that was organized for the nineteenth annual conference of the American Society for Bioethics and Humanities, which was held October 19–22, 2017, in Kansas City, Missouri. Four of the articles herein were initially presented as part of this panel (Rhodes, Schuklenk, Sulmasy, Eberl), while a fifth contribution was later invited for the purposes of this issue (Wicclair). Each of the articles was initially reviewed by the special issue editor (Eberl), whose own article was initially reviewed by Udo Schuklenk, and then by a blind peer reviewer. The editor and authors are grateful to these reviewers, to Christopher Ostertag and Katelyn MacDougald for editorial assistance, and to Lynn Jansen, who provided overall editorial supervision on behalf of *Theoretical Medicine and Bioethics*.

In her paper, Rosamond Rhodes investigates the nature of conscience and what we mean when we use this term [4]. Whether conceived of as an "inner voice" or "right reason," conscience binds us and limits what we can do. When an individual recognizes that the performance of certain professional responsibilities would conflict with her conscience, she has a moral decision to make: either accept the full responsibilities of the profession or choose another professional role which would be compatible with her personal beliefs. To become a physician is to take on a social role, which is defined by society and not by personal opinions about what the responsibility entails. Therefore, Rhodes argues, individuals who freely pledge their adherence to the medical profession, accepting all of the social trappings that accompany this role, and yet expect to withhold legal and professionally accepted medical procedures from patients—based on their idiosyncratic interpretation of what being a physician entails or for their own sense of inner comfort—violate a fundamental standard of morality by making a promise that they do not intend to keep. For these reasons, she concludes, conscientious objection has no place in the practice of medicine.

Daniel Sulmasy defines *conscience* as a commitment to morality, to having moral precepts and acting in accordance with them [6]. Conscientious action is thus ubiquitous, and as a society, we ought to continue to cultivate and form our consciences—all the more so within the medical profession. A properly formed conscience is necessary to ensure that medical professionals are able to best help patients. One of the difficulties of modern, pluralistic society is the presence of competing definitions of health, treatment, and other fundamental aspects of medicine. Sulmasy thus argues in support of accommodating conscientious objection in medicine on two fronts. First, since the medical profession has an interest in promoting conscientious action, insofar as the general policies and practices of the profession are inherently value-laden, individual physicians ought to be afforded wide latitude to exercise their judgment in particular cases. Second, he argues that requiring physicians to violate their deeply held, personal convictions violates John Locke's classical notion of *tolerance*. He emphasizes, though, that tolerance of deeply held, personal convictions has limits: society need not tolerate intolerant beliefs or accommodate conscientious objections based on discriminatory convictions.

Udo Schuklenk begins by looking at the effect of conscientious objection on access to certain procedures and the larger implications of enshrining conscience protections in legislation [5]. His primary concern is that conscientious objectors can effectively bar patients' access to certain medical services due to their monopoly on such services, especially in rural areas and countries where access to health care is generally tenuous. Schuklenk argues that the actions of conscientious objectors not only harm their professional relationships with their patients, but also engender mistrust in the medical profession writ large. He concludes that conscience claims by medical professionals should not be accommodated for several reasons, foremost of which is that private, idiosyncratic views held by professionals do not belong at the bedside as patients are foreseeably harmed. Like Rhodes, Schuklenk underscores that physicians willingly take up the medical profession, which entails the moral obligation to uphold the profession's standards, but his primary criticism is the implications for access to health care services.

Mark Wicclair approaches the debate by looking at the incompatibilist argument against tolerating conscientious objection in medicine—promoted by Rhodes and Schuklenk, among others—concluding that it falls short [7]. Rather, he argues, legitimate concerns about the implications of accommodating conscientious objection can be mitigated by imposing certain constraints. For Wicclair, the incompatibilist argument rests on two assumptions that fail to explicitly rule out conscientious objection: first, that physicians have an obligation to put patients' interests or well-being above their own self-interest and, second, that physicians are obligated to provide all services within the scope of professional practice. After arguing that these assumptions are too general to prohibit specific instances of conscientious objection, Wicclair rehearses other concerns surrounding conscience accommodations, such as discrimination, unfairness, lack of access, and slippery-slope implications. He concludes that while there are legitimate misgivings about the potential consequences of accommodating conscientious objection in medicine, the absolutist non-toleration arguments against accommodation fall short—hence a compromise view is most reasonable.

In the final contribution to this special issue, I (Jason Eberl) defend a modified compromise view [8] by first elucidating the understanding of conscience formulated by Thomas Aquinas. For Aquinas, conscience is situated within the larger framework of natural law, which is accessible to all human beings through the use of reason. One must cultivate the faculty of conscience through education, and in so doing, one is better able to pursue moral truth. Protecting conscientious refusals allows individuals and communities to continuously grapple with life's fundamental questions; without such engagement, we risk permitting the perpetuation of immoral laws and practices. I argue that conscientious refusals to provide specific health care services should not be based upon idiosyncratic religious tenets, but rather ought to be rationally defensible. I further affirm requirements that health care professionals disclose all relevant medical information to patients, including information about morally objectionable services, and provide referrals or transfers of care to professionals willing to provide such services. I conclude that health care professionals may not licitly refuse to provide legal, but morally objectionable, services in emergency situations on account of epistemic humility, given that there is reasonable disagreement among conscientious individuals representing contrary sides of the intractable debates at issue.

Debate over conscientious objection in health care has grown more popular and more nuanced in the decade since the last special issue on this topic was published in this journal. As evidence of the debate's continued growth, two of the contributors (Schuklenk and Eberl) have recently organized panels at other international conferences with diverse sets of panelists; furthermore, at least five other special issues on this topic have been published in various bioethics journals since 2014. This controversy among bioethicists and health care professionals will surely inform continued changes in public policy—whether conscientious objection ceases to be accommodated, as is the case in Sweden, Finland, and Iceland, or legal protections for objectors are reinforced, as through the Trump Administration's establishment of a new Conscience and Religious Freedom Division in the Office for Civil Rights within the US Department of Health and Human Services [9]. While some sort of compromise view may be the way forward, the parameters of such an agreement still need to be articulated and discussed vis-à-vis, for example, protecting patients from unjust discrimination, ensuring access to contested services, and determining standards for adjudicating conscience claims. Recognizing that the debate is far from settled, the authors featured in this special issue advance arguments and analyses that work to clarify the conceptual frameworks involved, affirm relevant ethical positions across the spectrum of controversy, and highlight the practical outcomes of whatever future policies may be adopted.

References

1. Curlin, Farr A. (ed.). 2008. Conscience and clinical practice: Medical ethics in the face of moral controversy. Special issue, *Theoretical Medicine and Bioethics* 29(3): 129–212.
2. Sulmasy, Daniel P. 2008. What is conscience and why is respect for it so important? *Theoretical Medicine and Bioethics* 29: 135–149.
3. Wicclair, Mark R. 2008. Is conscientious objection incompatible with a physician's professional obligations? *Theoretical Medicine and Bioethics* 29: 171–185.
4. Rhodes, Rosamond. 2019. Conscience, conscientious objection, and medicine. *Theoretical Medicine and Bioethics*. https://doi.org/10.1007/s11017-019-09513-9.
5. Schuklenk, Udo. 2019. Conscience-based refusal of patient care in medicine: A consequentialist analysis. *Theoretical Medicine and Bioethics*. https://doi.org/10.1007/s11017-019-09510-y.
6. Sulmasy, Daniel P. 2019. Conscience, tolerance, and pluralism in health care. *Theoretical Medicine and Bioethics*. https://doi.org/10.1007/s11017-019-09509-5.
7. Wicclair, Mark R. 2019. Preventing conscientious objection in medicine from running amok: A defense of reasonable accommodation. *Theoretical Medicine and Bioethics*. https://doi.org/10.1007/s11017-019-09514-8.
8. Eberl, Jason T. 2019. Protecting reasonable conscientious refusals in health care. *Theoretical Medicine and Bioethics*. https://doi.org/10.1007/s11017-019-09512-w.
9. United States Department of Health and Human Services. 2018. HHS announces new Conscience and Religious Freedom Division. Office for Civil Rights press release, January 18, 2018. https://go.usa.gov/xnvfJ.