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Protecting reasonable conscientious refusals in health care

Jason T. Eberl[1]

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Abstract

Recently, debate over whether health care providers should have a protected right to conscientiously refuse to offer legal health care services—such as abortion, elective sterilization, aid in dying, or treatments for transgender patients—has grown exponentially. I advance a modified compromise view that bases respect for claims of conscientious refusal to provide specific health care services on a publicly defensible rationale. This view requires health care providers who refuse such services to disclose their availability by other providers, as well as to arrange for referrals or facilitate transfers of care. This requirement raises the question of whether providers are being forced to be complicit in the provision of services they deem to be morally objectionable. I conclude by showing how this modified compromise view answers the most significant objections mounted by critics of the right to conscientious refusal and safeguards providers from having to offer services that most directly threaten their moral integrity.

Keywords Conscientious objection · Conscience · Conscientious refusal · Abortion · Aid in dying · Thomas Aquinas · Catholicism

Introduction

In the wake of the United States Supreme Court's decisions in *Roe v. Wade* and *Doe v. Bolton* legalizing abortion [1, 2], the United States Congress passed an amendment to the 1973 Health Programs Extension Act—known eponymously as the "Church Amendment" (after its sponsor, Senator Frank Church)—which protects the right of private health care institutions receiving federal funding, and the individual health care providers employed by such institutions, to refuse to offer abortion or elective sterilization procedures [3]. Recently, debate over whether health care institutions and individual providers should have a legally protected right to

✉ Jason T. Eberl
jason.eberl@slu.edu

[1] Albert Gnaegi Center for Health Care Ethics, Saint Louis University, 3545 Lafayette Ave., Salus 527, Saint Louis, MO 63104, USA

conscientiously refuse to offer legal medical services to patients who request them has grown exponentially,[1] due to the expanded legalization of physician-assisted suicide or physician aid in dying (PAS/PAD) in various states and countries,[2] as well as greater recognition of the rights of transgender persons requesting gender-transforming or gender-confirming hormonal treatments or surgeries.[3] Other cases of conscientious refusals to provide health care services involve pharmacists who refuse to fill prescriptions for what they consider to be abortifacient contraceptives to customers so that they may have them filled elsewhere,[4] sometimes not even returning prescriptions and fertility specialists who refuse to provide assisted reproductive services to LGBT individuals or couples [14].

In this paper, I outline the primary positions defended by scholars in this debate and advance a modified compromise view that bases respect for claims of conscientious refusal to provide specific health care services either on the adjudication of defensible reasons articulated by an individual practitioner or health care institution or on the existence of a general societal consensus that certain services, though legal, are morally contestable on reasonable grounds. I then show how this modified compromise view answers the most significant objections mounted by critics of the right to conscientious refusal,[5] while also safeguarding individual practitioners and health care institutions from having to engage in the routine provision of services that most directly threaten their moral integrity.[6] To start, though, it is first necessary to define what is meant by *conscience* and clarify why it ought to be valued at all in the health care context.

[1] Professional bioethics journals that have published special issues or special sections devoted to this debate include the *American Journal of Bioethics* [4–6], *Theoretical Medicine and Bioethics* [7], *Bioethics* [8], the *Journal of Clinical Ethics* [9], the *Cambridge Quarterly of Healthcare Ethics* [10], and the *Journal of Medical Ethics* [11].

[2] Describing this practice as either *physician-assisted suicide* or *physician aid in dying—medical aid in dying* is another term—automatically betrays one's stance on its ethical legitimacy (the former term signaling opposition, the latter support). Since this paper does not engage the question of whether such practice should be morally or legally endorsed, I will utilize both acronyms together as PAS/PAD.

[3] *Gender transforming* and *gender confirming* represent another pair of terms that demonstrate contrasting stances on the ethical permissibility of a practice, in this case, hormonal or surgical interventions to treat gender dysphoria (the former term signaling opposition, the latter support). This issue is not directly treated in the current paper.

[4] Two recent cases that have received attention from mainstream media and bioethicists alike involve pharmacists who would not fulfill a prescription for mifepristone—a pharmaceutical abortifacient—for patients whose fetuses had already died in utero and needed to be expelled to reduce the risk of further medical complications [12, 13]. These cases involve a misapplication of the pharmacists' legal right to conscientiously refuse to fulfill such a prescription, since the drug was not functioning as an abortifacient insofar as the fetuses had already died.

[5] I prefer the term *conscientious refusal* to *conscientious objection*, since the latter has historically been utilized in reference to conscripts into military service, which does not present an apt analogue to health care professionals who have freely chosen to enter the profession as well as espouse a specific specialty or subspecialty [15].

[6] My argument is intended to bear on both health care institutions and individual health care providers. For a defense of the former's possessing the right to conscientiously refuse to provide specific health care services, see [16].

Why value conscience?

Definitions of *conscience* range from a sort of moral feeling or intuition to an intellectual faculty by which one arrives at reasoned moral judgments. The first kind of definition figures prominently in arguments by critics of the right to conscientious refusal:

> Doctors must put patients' interests ahead of their own integrity. … If this leads to feelings of guilty remorse or them dropping out of the profession, so be it. As professionals, doctors have to take responsibility for their feelings. [17, p. 164]

On this model of the nature of conscience, the only criterion for putatively valid claims of conscientious refusal is the purported sincerity or genuineness of the refuser's relevant moral feelings or beliefs. As critics rightly note, however, this can lead to a "Pandora's box of idiosyncratic, bigoted, discriminatory medicine" [18, p. 297].

Contrary to the subjective emotivism of the first kind of definition, the second way of defining conscience is rooted in reason and communal practice [19, 20]. This model of conscience can be traced back historically to thinkers such as Thomas Aquinas in the thirteenth century. Aquinas's view on the nature and function of conscience is embedded within his overall account of natural law, in which he understands the human intellect to have natural faculties by which one can understand certain "first principles" of practical reasoning—that is, reasoning about how one ought to act both generally, in terms of the overall aim of one's life or macro-level projects, and within a particular given set of circumstances.[7] It is important to emphasize that on Aquinas's view, persons are not born with their consciences fully formed as some sort of infallible moral database. Rather, their consciences must be cultivated through moral education by others and through their personal histories of practical reasoning. As such, depending on the quality of an individual's moral upbringing or the way in which she has reasoned in past instances, her conscience may become ill-formed. Yet Aquinas affirms that one should adhere to the dictates of even an erring conscience insofar as failing to do so would entail acting contrary to what one believes one ought to do. Conscience thus aims, if fallibly, at moral truth; however, one's rational deliberation, shaped by various external social influences and internal psychological factors, may or may not lead to such truth. In this way, the dictates of one's conscience lie between knowledge—in the sense of certainty—and subjective feeling or intuition. An individual's conscience may err, but the exercise of conscience involves more than a gut feeling of approbation or repugnance; furthermore, each person's conscience ought to be cultivated and exercised within the context of a moral community [21, 2a2ae.33.1–8].

On this model, conscience develops over time out of both individual and collective practical reasoning across various types of circumstances, and thereby fallibly

[7] For further elucidation of Aquinas's account, see [21, 1a.79.11–13; 22, 16.1–3, 17.1–5; 23].

aims at moral truth. One reason, then, for valuing the consciences of health care providers is that doing so protects a robust pluralism of viewpoints on some of the most significant moral debates, impacting on how people define and believe they ought to treat human life at various stages of development or decline. Even when such debates appear to have been settled by law, continued discourse within the health care profession itself—insofar as it arguably constitutes a moral community [24; 25, ch. 3]—is critical for averting moral stagnation that may perpetuate potentially immoral laws. Imagine, for instance, if in the wake of the 1927 *Buck v. Bell* decision [26], medical practice were restricted only to physicians who were willing to perform state-ordered involuntary sterilizations on persons deemed "unfit" to procreate; or imagine if prior to *Roe v. Wade* and *Doe v. Bolton*, medical licenses were issued only to physicians who were morally opposed to abortion.

Of course, the issue at hand is not whether physicians may be morally opposed to a legal medical service *privately*, but whether they may refuse to provide such a service *publicly*. Mark Wicclair provides an additional set of reasons for respecting the consciences of health care providers: (1) the connection between one's moral integrity and one's sense of the good life, (2) the inherent value of one's sense of professional identity and integrity, (3) the psychological harms, including intense feelings of shame or guilt, that may result from the loss of one's moral integrity, (4) the general decline of one's moral character that may follow from damage to one's integrity, and (5) the value of respecting physician autonomy, fostering a diversity of moral perspectives, and maintaining epistemic modesty in light of such diversity [27, pp. 26, 30]. John Lantos and Farr Curlin agree on the importance of conscientious refusal claims within a morally pluralistic profession:

> For situations in which disagreement is consistent with good medical practice, practitioners must be free to follow the dictates of conscience. The risks of disallowing conscientious practice to the profession are greater than that of allowing grounded and well-articulated zones of moral pluralism. [28, p. 266]

The moral dilemma involved in cases of conscientious refusal can be summed up, in most cases, in terms of striking a balance between two competing *prima facie* obligations on the part of health care professionals. On the one hand, health care professionals ought to respect the informed autonomous choices of their patients, as regards both respecting refusal of care by patients who are competent and mindful of the consequences that may befall them and providing care only in response to requests by eligible and competent patients. On the other hand, health care professionals are bound by the duty of nonmaleficence [29, ch. 5], and typical cases of conscientious refusals involve putative harms such as ending the life of a fetus, ending the life of a terminally ill patient, or in the case of gender-transforming/confirming surgeries, causing sterilization. This dilemma can also be construed in virtue-theoretic terms as an apparent conflict between health care professionals' *integrity*, which concerns their inclination toward moral consistency and the wholeness of their value system, and the expectation that health care professionals should be *self-effacing*, meaning that they are to put the interests of patients in front of their own concerns [25, ch. 12]. This conflict is merely apparent, however, since self-effacement typically involves eschewing self-serving interests—such as financial

benefit, avoidance of culpability for malpractice, or career advancement—in favor of patients' interests, and not obviating the moral interests that constitute health care professionals' integrity, which arguably carries "substantial moral weight" [30, p. 176].

Current positions regarding conscientious refusals

There are three main positions on the issue of whether health care professionals should have a legally protected right to conscientiously refuse to provide specific medical services: the absolutist stance, the compromise view, and the incompatibility thesis. An absolutist argues that such a right ought to be protected on whatever grounds an individual practitioner or health care institution justifies their refusal. A typical rationale given in support of this position is that, outside of emergency services, health care professionals have a right to define the scope of their own practice (e.g., a gastroenterologist may refuse to treat Athlete's foot on grounds that such a condition falls outside her area of specialization) and, in some health care systems, they even have a right to refuse care to certain patients (e.g., physicians in the United States may terminate their relationships with patients who are noncompliant, abusive, or nonpaying). Another supportive rationale is that an individual right to, say, reproductive autonomy is merely a negative right that protects one from state interference in the procurement of abortion; it does not entail a positive claim-right against health care professionals, or society in general, to provision of abortion services: "Procreative freedom does not entitle one to the services of providers who profoundly disagree with the means that one is willing to use to achieve procreative goals" [31, p. 172].

The currently dominant position is a compromise view promoted by various professional medical organizations, such as the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG). Recent opinions issued by the AMA Council on Ethical and Judicial Affairs [32] and the ACOG Committee on Ethics [33] both acknowledge health care professionals' liberty to conscientiously refuse to provide medical services so long as certain conditions are met—stipulating, for example, that they communicate accurate and unbiased information about all available services (even those to which they morally object), that they refer patients to other health care professionals willing to provide such services, and that they provide such services in emergency situations when no other willing professional is available.

At the other end of the spectrum from the absolutist stance is the incompatibility thesis promoted by, among others, Julian Savulescu:

> A doctor's conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's good and the patient's informed desires. If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors. Doc-

> tors should not offer partial medical services or partially discharge their obligations to care for their patients. [18, p. 294][8]

In what follows, I will review various supportive rationales for the incompatibility thesis and show how each of them may be accounted for in a modified compromise view that (1) continues legal protections for conscientious refusals to perform certain types of health care services that are persistently morally contested on reasonable grounds, (2) eschews more absolutist protections for conscientious refusals based on reasons that are indefensible, idiosyncratic, or purely faith-based, and (3) provides access to legally permitted services for patients who request them.[9]

Toward a more reasonable compromise

Non-religious foundation for conscientious refusal

A primary complaint among defenders of the incompatibility thesis is that conscientious refusals are typically based on religious grounds:

> I suspect it isn't unfair to note that [conscience] protections in the real world are nothing other than protections for Christian doctors who are unwilling to deliver services they would be obliged to deliver to patients who are legally entitled to receive these services, were it not for their religiously motivated objections. Secular healthcare professionals could arguably avail themselves of conscience clauses, but in a liberal democracy, what reasonable conscience-based cause could they have to refuse the provision of healthcare services to patients? Conscience clauses today are by and large a concession of special rights to Christian healthcare professionals, at least in secular Western democracies. [36, p. ii][10]

This complaint raises significant questions regarding the scope of any putative right to freedom of religious expression, as enshrined, for instance, in the United States Constitution, and there is a long history of contentious legislative and judicial debate concerning the extent to which one's religious beliefs may be publicly exercised and not merely privately held [38]. Schuklenk and other defenders of the incompatibility

[8] Savulescu was a signatory to a "consensus statement" issued at the conclusion of a three-day workshop sponsored by the Brocher Foundation in Geneva, Switzerland [34]. Although the consensus statement does not promote the incompatibility thesis, it does call for greater restrictions on and stronger justifying criteria for granting claims of conscientious refusal than what is required under the current AMA and ACOG opinions.

[9] Julian Savulescu and Udo Schuklenk are open to a compromise view that ensures "no impediment" to patients' ability to access contested services [35]; however, they assess current compromise policies and conclude that they do not adequately guarantee the exclusion of such impediments.

[10] Udo Schuklenk and Ricardo Smalling similarly note that, while non–religiously based morals may also inform a health care provider's conscientious refusal, the majority of litigated cases in Western societies involve refusals that are religiously based [37, p. 234].

thesis presumably have no issue with religious believers' exercising their religious beliefs, but only to the extent that such exercise does not negatively impact on the legally protected interests of others who do not share those beliefs; and this, they charge, is precisely what is happening in the case of conscientious refusal.

Although it may be descriptively true that most claims of conscientious refusal are religiously based, it does not follow that most refusals lack grounding in a defensible rationale, suitable for debate in the public square. What makes a rationale defensible in the public square? Following John Rawls' analysis, a defensible rationale must first incorporate the essential elements common to any form of reasoning: "the concept of judgment, principles of inference, and rules of evidence, and … standards of correctness and criteria of justification" [39, p. 220]. In the case of public reason, Rawls identifies additional requirements that define the nature of rational discourse:

> Public reason further asks of us that the balance of those values we hold to be reasonable in a particular case is a balance we sincerely think can be seen to be reasonable by others. Or failing this, we think the balance can be seen as at least not unreasonable in this sense: that those who oppose it can nevertheless understand how reasonable persons can affirm it. [39, p. 253]

> Public reasoning aims for public justification. … Public justification is not simply valid reasoning, but argument addressed to others: it proceeds correctly from premises we accept and think others could reasonably accept to conclusions we think they could also reasonably accept. [39, p. 465]

Consider objections by Roman Catholic practitioners and institutions to directly intended abortion or PAS/PAD. With respect to abortion, Catholic authorities draw on current scientific data regarding embryological development to affirm the intrinsic genetically based potential of human embryos and fetuses to develop themselves within a supportive environment into more fully actualized persons. The Catholic magisterium even admits that it cannot be demonstrably proven that a human person's existence begins at conception.[11] Yet Catholic authorities rely on a combination of reasonable arguments that a human person does begin her existence at conception, in conjunction with a precautionary principle stipulating that one ought not to risk harming entities which may in fact be persons.[12]

[11] The term "magisterium" refers to the formal teaching authority of the Roman Catholic hierarchy concerning matters of faith and morals. As noted below, there is not necessarily a monolithic Catholic view on all bioethical issues, and some Catholic bioethicists disagree about how to interpret and apply certain magisterial teachings, or outright disagree with some teachings.

[12] The relevant assertion, articulated by Pope John Paul II, is as follows: "Even if the presence of a spiritual soul cannot be ascertained by empirical data, the results themselves of scientific research on the human embryo provide 'a valuable indication for discerning by the use of reason a personal presence at the moment of the first appearance of a human life: how could a human individual not be a human person?' Furthermore, what is at stake is so important that, from the standpoint of moral obligation, the mere probability that a human person is involved would suffice to justify an absolutely clear prohibition of any intervention aimed at killing a human embryo" [40, no. 60]. For non–theologically based, scientifically informed arguments that human personhood begins at conception, such that the moral duties of nonmaleficence and justice are applicable to human embryos and fetuses, see, *inter alia*, [41–45]. Rawls

With respect to PAS/PAD, the magisterial Catholic perspective is largely informed by a triple-indictment of suicide argued by Aquinas vis-à-vis the duties one owes to oneself (anteceding Immanuel Kant's later similar argument against suicide [46]), to one's community (echoing Aristotle [47, 5.11.1138a10–12]), and to God [21, 2a2ae.64.5; 48]. While each of these duties is contestable, only the third is theologically based. Moreover, arguments against PAS/PAD have been mounted by secular bioethicists. Daniel Callahan, for instance, argues that euthanasia and PAS/PAD do not fall within the proper scope of medical practice, which is essentially the healing of broken bodies [49]. Daniel Sulmasy and colleagues also mount a series of non-faith-based arguments against PAS/PAD and euthanasia [50]. For one, such practices obviate the distinction between valuing persons, who have incalculable moral value (dignity), and valuing interests, which may be comparatively valued and thereby lead to utilitarian outcomes that have a long history of critics [51, 52]. Specifically, euthanasia and PAS/PAD "require us to accept that it is morally permissible to act with the specific intention-in-acting of making a somebody into a nobody, i.e., to make them dead" [50, p. 248]. Instead, "the terminally ill, especially, need to be reminded of their value, their intrinsic dignity, at a time of fierce doubt. They need to know that their ultimate value does not depend upon their appearance, productivity, or independence" [50, p. 249]. Finally, concerns about the legalization of PAS/PAD have been voiced by advocates for people with disabilities [53].[13]

I share the concern that conscientious refusals based purely on religious beliefs may lead to problematic outcomes, particularly when claimants are not even fully aware of the rational foundations, if any, for the religious proscriptions to which they are adhering or, worse, when they misunderstand or misapply what their religion teaches.[14] For instance, there is nothing in the authoritative teachings of the Church that would exhort Irish Catholic physicians not to utilize Caesarean section for obstructed pregnancies out of concern that the procedure would inhibit women from having "the maximum number of children possible in the future" [17, p. 162]. First of all, the Catholic magisterium does not teach that women ought to have the maximum number of children possible and, in fact, encourages the practice of "responsible parenthood," which may require limiting one's procreative activity "with regard to physical, economic, psychological and social conditions" [56, no. 10]. Second,

Footnote 12 (continued)
himself cites an argument against the moral permissibility of abortion by a Catholic leader, Cardinal Joseph Bernardin, as one that "is clearly cast in some form of public reason" [39, p. 480, n. 82].

[13] Rawls notes that certain Catholic social justice principles—namely, the *common good* and *solidarity*—fall within the scope of defensible conceptions of justice within the sphere of public reason [39, pp. 451–452]. That these Catholic principles of social justice encompass unborn, dying, and disabled human beings has been affirmed consistently by the Catholic magisterium, most recently by Pope Francis [54, no. 117; 55, no. 101].

[14] Although, on the Thomistic conception of conscience described above, individuals must adhere to even an erring conscience, they still bear a measure of responsibility for ensuring that their consciences are well-formed—in this case, through an accurate understanding and application of relevant religious teachings and their supportive rationales. Furthermore, an individual's moral requirement to adhere to the dictates of an erring conscience does not entail that her appeal to conscience must be respected by the wider society.

even though the Catholic magisterium condemns elective sterilization as a means of intentionally avoiding conception, if an otherwise legitimate medical procedure risks, or even reliably promises to cause, a sterilizing side effect, the procedure may still be justified by appeal to the principle of double effect [57, dir. 53].[15] Finally, religious traditions are not necessarily monolithic with respect to the various proscriptions that could impact on the provision of health care services. For instance, Catholic bioethicists are currently contesting such issues as whether administering emergency contraception to rape victims could be permissible based on whether the primary mechanism of action is merely contraceptive or potentially abortifacient [60, 61], whether conjoined twins may be surgically separated when it is foreseen that one of them will die upon separation [62, 63], and whether medically provided nutrition and hydration may be licitly withdrawn from a patient in a persistent vegetative state [64, 65], among others (see [66]).

I thus do not advocate for religiously based claims to protection of conscientious refusals because such claims are religiously based; rather, such claims must be backed up by a supportive rationale that, while contestable, is defensible in the public square. However, this position raises the important question of who adjudicates the reasonability of a claimant's basis for conscientious refusal. Many who advocate some form of a compromise view contend that, as with conscientious objectors in the military, a tribunal should be appointed to review claims and grant protection of refusals on a case-by-case basis [67–70]. Such a procedure raises more questions concerning who would compose such a tribunal, how members would be appointed, and what safeguards there might be against bias among tribunal members toward certain viewpoints [71]. As such, I do not believe that tribunals would be the optimal means of adjudication, except perhaps in unusual cases involving claims to refuse provision of widely accepted health care services. When it comes to services that are widely contested, however, adjudicating individual claims may not be necessary so long as there is a generally recognized, defensible, rational foundation for specific types of claims. Abortion and PAS/PAD would be clear candidates for a blanket allowance of conscientious refusal, particularly as they involve intentionally ending human lives [72], which accords with the current compromise view espoused by the AMA. Slippery-slope concerns that more idiosyncratic claims may also end up meriting protection can be alleviated by recourse to a formal system of review.

Avoiding discrimination

Another key provision of the proposed modified compromise view is that justifiable refusal may be based only on a reasonable moral objection to performing a specific type of action. That is, a health care professional may licitly refuse to perform an action when she objects to the action itself, and not on the basis of discriminatory judgments about the patient requesting the action. This distinction is most evident in

[15] For elucidation of the principle of double effect, see [58, 59].

the provision of various types of services for LGBT patients. Consider two different cases:

> **Case 1:** A surgeon refuses to perform a genitourinary operation as a means of gender transformation/confirmation for a patient experiencing gender dysphoria because she believes that healthy tissues and organs should not be irreversibly damaged to treat dysphoria and that the treatment may not even be successful.
> **Case 2:** A fertility specialist refuses to provide assisted reproductive services to a lesbian couple (e.g., artificially inseminating one of them with donor sperm) because he believes that homosexual couples cannot be as effective parents as heterosexual couples.

In the first case, the surgeon objects to performing a specific action against which she has defensible, though defeasible, arguments based on her understanding of the nature of good medical practice—namely, not causing irreversible physical damage in order to treat a psychological condition. She is not targeting her refusal solely at transgender patients—presumably, she would, for similar reasons, object to amputating a patient's healthy limb in order to treat body dysmorphic disorder. Additionally, even if this surgeon were to accept causing irreversible bodily damage as proportionate to ameliorating dysphoria, data on the efficacy of gender transformation/confirmation surgeries in alleviating gender dysphoria are contested.[16] To be clear, I am asserting here not that the hypothetical surgeon's reasons for refusal are sound, but rather that there is a defensible, non–religiously based rationale undergirding her refusal to perform a specific type of action, such that she would refuse on the same grounds to perform a similar surgery for a non-transgender patient. Now compare this surgeon to the fertility specialist in the second case. The latter is discriminating against a particular type of patient, not objecting to a specific type of action, as it is clear that he has no moral objection to providing the requested assisted reproductive service to heterosexual couples. No matter whether the fertility specialist's objection has a religious or non-religious foundation, the modified compromise view promoted here legitimates only conscientious refusals to perform specific types of actions, regardless of who is requesting them.

Disclosure, referral, and complicity

I concur with the standard requirements of the compromise view that physicians should disclose all medically appropriate and legal treatment options to their patients, including options which the physician herself conscientiously refuses to provide. I also agree that physicians who refuse to perform certain services should

[16] For example, Lawrence Mayer and Paul McHugh report, based on a study conducted in Sweden: "Compared to the general population, adults who have undergone sex-reassignment surgery continue to have a higher risk of experiencing poor mental health outcomes. One study found that, compared to controls, sex-reassigned individuals were about 5 times more likely to attempt suicide and about 19 times more likely to die by suicide" [73, p. 9] (in reference to [74]).

disclose that fact to their patients early on in the therapeutic relationship: a woman who requests an elective termination of her pregnancy should not be surprised when her obstetrician refuses to comply, the same goes for a terminally ill patient who requests PAS/PAD—the time of request is not the appropriate moment for physicians to inform patients of their conscientious refusal to perform a service. This requirement is even more stringent for health care institutions—such as Catholic hospitals—the mission identity of which precludes offering specific health care services.

Upon refusal to provide a requested service, health care professionals and institutions should offer a referral that allows the patient to find a willing practitioner or facilitate the patient's transfer to another hospital or clinic. They should also assure the patient of their willingness to provide continued care outside of such morally objectionable practices, emphasizing that it is merely the requested service that is being refused, not the patient him- or herself as a person.[17] Again, I reject discriminatory practices which would involve health care professionals or institutions' refusing to treat certain patients at all because of features such as their gender, ethnicity, religious affiliation, or LGBT identity. Discrimination does not provide a valid foundation for conscientious refusal of treatment.

Requiring health care professionals and institutions to disclose the treatment options that they refuse to perform, as well as to refer or transfer patients to other providers, raises the specter of moral complicity.[18] Consider a standard example used in ethics lectures to illustrate this concern: A friend asks you to help her murder her husband so she can claim his life insurance; you conscientiously refuse, but you give your friend the contact information for a hitman who would readily help her out (though why exactly you would have a hitman's number on file remains a mystery). Clearly, you are not absolved of guilt in her husband's death, even if you are not guilty of first-degree murder per se in that you were not the one who committed the act of killing. This analogy fails for two reasons. First, there is a relevant disanalogous feature between the two cases. In the hitman case, there is a clear societal consensus that killing someone's husband for financial benefit is morally wrong, whereas in the case of procured abortion or PAS/PAD, there is no clear societal consensus on whether such actions are morally justifiable. Second, since there is no legal or other compulsion for you to provide your friend with the hitman's contact information, by doing so you must on some level approve of your friend's desire to kill her husband—you just do not want to do the deed yourself. This would be a case of *formal cooperation* with a morally wrong action. There are, however, cases of mere *material cooperation*, in which one is compelled in some way to provide

[17] In refusing to perform a requested service, a health care provider inveitably makes a judgment about the morality of the patient's request and seemingly, by extension, calls into question the patient's moral character [75, pp. 2576–2578]. Yet judging a patient's request to be immoral does not necessarily entail (a) failing to understand the patient's reasons for requesting the service at issue, which may themselves be morally justifiable in isolation; (b) treating the patient in a disrespectful, discriminatory fashion; or (c) refusing to provide the patient other forms of unobjectionable care.

[18] The concept of moral complicity and its ramifications for the issue at hand are explored in greater depth in [23].

means that support the performance of a morally wrong action, but one does not approve of the action being performed.[19]

This distinction is only a first step in the analysis of moral complicity, however—a physician who morally objects to abortion but nevertheless feels compelled to perform an elective abortion cannot merely excuse his action by claiming that he only materially cooperated with the patient's desire for an abortion without formally approving of it. Justifiable material cooperation must also be remote, as opposed to proximate, meaning that one's action does not directly result in the performance of the morally objectionable action—let alone constituting the act itself. Rather, there should be a series of intervening events, involving the actions of other moral agents, that lie between one's action and the performance of the objectionable action. In the case of disclosure or referral/transfer, while one has provided material means of performing an action that is (in one's view) morally objectionable, there are other moral agents involved—the patient and at least one other health care professional—whose decisions will ultimately result in the action's being performed. Mere disclosure of a patient's legally available options constitutes justifiable material cooperation given a proportionately serious reason [78, p. 163], such as respecting the patient's intrinsic dignity as a person and an autonomous moral agent.

A potentially complicating factor, though, is the necessity of one's referral or transfer facilitation for the patient's ability to access the objectionable service. One's level of complicity is diminished inasmuch as one's material support is replaceable by that of another agent, such that the action is likely to occur no matter what one does. An example would be a nurse who assists a physician in performing an abortion to which he morally objects; it is not as though the nurse's refusal to provide material support would result in the physician's not performing the abortion, as the former could easily be replaced by another non-objecting nurse. In the case of referral or transfer, however, physicians have a greater degree of control over patients' ultimate ability to access the objectionable service. This raises a larger question regarding the current design of various health care systems. In the United States, referrals from one's primary care physician are often required for insurance coverage. Furthermore, it is not always easy to ascertain where one may find willing providers for specific services.

Systemic reform may thus be warranted to diminish the need for material cooperation by conscientiously refusing practitioners or institutions in facilitating patients' access to requested services by willing providers. For example, in Canada, Ontario's Medical Assistance in Dying Statute Law Amendment Act mandates that the Minister of Health establish "a care co-ordination service" (essentially a hotline) that provides information and referrals to ensure patients' access to PAS/PAD [79, § 13.10]. This type of systemic solution allows for merely remote material cooperation on the part of conscientiously refusing health care providers, who are required to disclose to patients only that such a government-provided service exists should they wish to

[19] The *locus classicus* for the distinction between formal and material cooperation with moral evil is [76, 2.3.2 dub. 5, art. 3, no. 63]. For a more contemporary formulation, see [77]. While this distinction originated with Roman Catholic moral theology, it has since become part of secular ethical discourse as well.

avail themselves of it [80, p. 265]. If a particular political state recognizes a positive claim-right to morally contested services, such as abortion or PAS/PAD, then it is only fitting that the state should bear the primary responsibility for ensuring access to such services, instead of burdening the consciences of individual or institutional health care providers [81, p. 81; 82, p. 74].

Provision of emergency services

Another standard requirement of a compromise view is the emergency provision of objectionable services when no alternative is available [6]. This type of requirement is problematic insofar as the reasons justifying a health care professional's or institution's conscientious refusal do not change just because the situation has altered from one in which referral/transfer is logistically feasible to one in which it is not, given a manifest threat of death or other grave harm. Nevertheless, there is a responsibility on the part of professionals and institutions to maintain epistemic humility with respect to their own moral viewpoints [83, p. 149]. While professionals or institutions may believe themselves to be perfectly justified in their view that, say, directly intending abortion is morally impermissible, there is certainly no general societal consensus favoring that conclusion; conversely, there is a general societal consensus that the termination of pregnancy is justifiable in cases of "vital conflict" between a pregnant woman and the fetus she is carrying, a consensus that even some Catholic and pro-life ethicists have argued in favor of [84; 85, pp. 63–70; 86, pp. 163–167; 87]. Thus, while I have defended a general right to conscientious refusal, a reasonable limit on that *prima facie* right would apply to procedures in emergency cases threatening grave morbidity or mortality, where professionals' or institutions' moral objections to such procedures defy general societal consensus—and particularly when consensus support for their refusals in this type of case may be lacking within their own moral tradition.

Conclusion

My aim in this paper has been to show how a particular, classical understanding of the nature and role of conscience in moral deliberation and choice justifies the intrinsic value of respecting the consciences of health care professionals and institutions, with consequent legal protections, while eschewing moral subjectivism. I have argued that conscientious refusals to provide specific health care services should not be based upon idiosyncratic religious tenets, but rather ought to be rationally defensible in the public square. I further affirmed stipulated conditions of the standard compromise view espoused by professional organizations such as the AMA and ACOG, which require conscientiously refusing providers to disclose all relevant medical information to patients—including information about morally objectionable services—and, when needed, to provide referrals or transfer care to providers willing to provide such services. Finally, I concluded that providers cannot licitly refuse to provide legal, but morally objectionable, services in emergency situations

due to epistemic humility in light of reasonable disagreement among conscientious individuals representing contrary sides of the intractable debates at issue.

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