# Conscientious Refusals in Health Care

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In light of the U.S. Supreme Court's decisions legalizing abortion, the U.S. Congress passed an amendment to the 1973 Health Programs Extension Act — known as the Church Amendment — which protects the right of health care institutions, and individual health care providers employed by such institutions, that receive federal funding to refuse to offer abortion or elective sterilization procedures. Recently, debate over whether health care institutions or individual providers should have a legally-protected right to conscientiously refuse to offer legal services to patients who request them has grown exponentially due to increasing legalization of physician-assisted suicide in various countries and U.S. states, as well as greater expansion of the rights of transgender individuals who may request gender-affirming hormonal treatments or surgeries. Other cases of conscientious refusal include pharmacists who refuse to fill prescriptions for abortifacient post-coital contraceptives. The question of whether there should be a legally-protected right to conscientiously refuse to provide specific medical services has been particularly acute for Catholic health care institutions insofar as they are governed by the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services*, which also inform the consciences of individual Catholic health care professionals.

## DEFINING "CONSCIENCE"

Definitions of "conscience" range from being some sort of moral feeling or intuition to an intellectual faculty by which one arrives at reasoned moral judgments. The former definition figures prominently in the arguments of critics of a 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.[1]

On this understanding of the nature of conscience, the only criterion for putatively valid claims of conscientious refusal is the "sincerity" or "genuineness" of one's relevant moral feelings or beliefs. As critics rightly note, however, this can lead to a "Pandora's box of



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idiosyncratic, bigoted, discriminatory medicine."[2] Contrary to the subjective emotivism of the first definition of conscience, the latter definition is rooted in *reason and communal practice*.[3] This understanding of conscience can be traced back historically to thinkers such as Thomas Aquinas. Aquinas's view of 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 may understand certain "first principles" of practical reasoning — i.e., 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 present set of circumstances.[4] It is important to emphasize that, in Aquinas's view, one is not born with their conscience fully formed as some sort of infallible moral database. Rather, one's conscience must be *cultivated* through moral education by others and one's own history of practical reasoning. Hence, depending on the quality of one's moral upbringing or how one has reasoned in past instances, one's conscience may become ill-formed. Yet, Aquinas affirms that one should adhere to the dictates of even an erring conscience insofar as not doing so would entail acting contrary to what one believes they ought to do. Conscience thus aims, if fallibly, at moral truth; however, one's rational deliberation, impacted by various social influences and internal factors in one's psychological make-up, may or may not lead to such truth. The dictates of one's conscience thus lie between knowledge — in the sense of *certainty* — and subjective feeling or intuition. An individual's conscience may err, but it is more than one's "gut feeling" of either approbation or repugnance; furthermore, it ought to be cultivated and exercised within the context of a *moral community*.[5]

## THREE POSITIONS ON CONSCIENTIOUS REFUSALS IN HEALTH CARE

There are three main positions regarding whether health care professionals should have a legally-protected right to conscientiously refuse to provide specific medical services. An *absolutist* argues that such a right ought to be protected based on whatever grounds an individual practitioner or health care institution justifies their refusal. A typical rationale given to support this position is that, outside of emergency services, health care professionals have a right to define the scope of their own practice and, in some health care systems, even to refuse care to certain patients. Another supportive rationale is that an individual right to, say, reproductive autonomy is merely a *negative* right that protects one from state interference with procuring an abortion; it does not entail a *positive* claim-right on health care professionals, or society in general, to provide abortion services.

> At the other end of the spectrum is the *incompatibility* thesis:
>
> 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. Doctors should not offer partial medical services or partially discharge their obligations to care for their patients.[6]



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If one cannot conscientiously provide abortion or certain other legal services that fall under the professionally-defined scope of medicine, then one should not become a physician or select a specialty, such as radiology, that would not put one in the position of having to provide such services. The same reasoning would inform whether a religious group should sponsor a health care institution.

The currently predominant 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 (1.1.7) issued by the AMA's Council on Ethical and Judicial Affairs and ACOG's Committee on Ethics both acknowledge a health care professional's liberty to conscientiously refuse to provide medical services provided that certain conditions are met, including providing "accurate and unbiased information" on all available services, even those to which the professional morally objects, referring patients to other health care professionals willing to provide such services, and providing such services in emergency situations in which no other willing professional is available.[7]

We concur with the standard requirements of the compromise view that providers should disclose all medically appropriate and legal treatment options to their patients. We also agree that providers who refuse to perform certain services should disclose that fact to their patients early on in the therapeutic relationship: a woman who desires an elective termination of her pregnancy should not be surprised when her obstetrician refuses, the same for a terminally ill patient who requests assisted-suicide — the time of the request is not the appropriate time for a provider to initially state her refusal. This requirement should be even more stringent for Catholic and other health care institutions whose mission identity precludes offering specific services.

## CONCERNS REGARDING MORAL COMPLICITY

Requiring health care providers to disclose treatment options which they refuse to perform, as well as to refer patients to other providers raises the specter of *moral complicity* — i.e., illicit cooperation with moral wrongdoing.[8] The basis for distinguishing licit from illicit cooperation rests in the *intention* of the cooperating agent and the distance between their act and another's evil act. *Formal* cooperation occurs when an agent approves of another's evil act and may be either *explicit* or *implicit*. In the former, an agent directly intends to cooperate in another's evil act for the end of the act itself. In the latter, an agent intends to cooperate in evil, not for the end of the evil act, but rather for the end of some concurrent good. Both explicit and implicit formal cooperation are illicit because it is morally wrong to intend evil, either as means to an end or as an end in itself.[9]

*Material* cooperation occurs when an agent is instrumental in another's evil act without approving of the act. Material cooperation can be licit, but only if sufficiently removed from the evil act; in particular, we must look at the causal chain of mediating agents between the acting agent and the commission of the evil act. If the material cooperation is *immediate*, meaning that the cooperating agent is causally proximate to another's commission of the evil act, then the cooperation is illicit. If the



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material cooperation is *mediate*, meaning that the agent is causally remote from the commission of the evil act, then cooperation may be licit, provided there is a proportionate reason for the agent to cooperate in the commission of the act.

No sweeping determination of the liceity of referrals can be offered because the particular circumstances matter. We contend that a physician may refer a patient to another specialty without engaging in illicit cooperation except when a) the referred-to physician group or institution is known largely on the basis of providing the objectionable service, or b) a particular specialist is referred to on the basis of knowing they would provide the objectionable service. If, however, the physician simply provides a list of relevant specialists covered by the patient's insurance and lets the patient choose, such cooperation would be licit. In referring on the basis of knowing a particular specialist, physician group, or institution would provide the objectionable service, the physician at least implicitly shares in the patient's intention to obtain that service; in the latter case, the physician merely provides the patient with a list of specialists with no guidance on whom to choose or for what reason.

## FROM TAX-LAWYERS TO PILGRIMS ON THE WAY

Bishop Anthony Fisher contends that, if we live in the world, we "will engage in cooperation from time to time — indeed sometimes it is [our] duty to do so … [to] avoid all cooperation in evil would require that we abandon almost all arenas of human activity … [and] could well constitute a sin of omission."[10] Since cooperation is unavoidable and sometimes necessary, Fisher is concerned that some theologians might be tempted to approach questions of cooperation as "moral tax-lawyers," where the role of the "moral advisor is to help people find a way around the moral tax-law." Fisher criticizes this approach, noting that the "presumption is *against* cooperating even materially, unless there is a sufficiently strong reason to warrant proceeding." He further worries that we will become comfortable with collaborating with "the powers of this world," rather than "offering a distinctively Christian form of witness to the life of God's kingdom."

Cathleen Kaveny counters that Fisher's concept of "Prophetic Witness" does not acknowledge "specifically Christian commitments" that might lead one to cooperate with another's evildoing.[11] She hhhcontends that we must see ourselves as "Pilgrims on the Way to the New Jerusalem." Drawing on Augustine, Kaveny describes the Pilgrim on the Way as one who "respond[s] to those suffering the effects of the sin that is still in our midst." She emphasizes, "while the Prophetic Witness emphasizes the risks and dangers of cooperating with evil, the Pilgrim on the Way highlights the good that it can accomplish"; furthermore, the Pilgrim sees "this good not merely as a secular or natural good, but also as a crucial part of the evangelical mission of the Church." From an institutional standpoint, one solution to avoid illicit cooperation or scandal might be to close one's doors. Kaveny argues that the Pilgrim on the Way would reconsider such a decision: "eliminating a Catholic institutional presence could mean the loss of the crucially important insight that health care is best viewed as a corporal work of mercy rather than a commodity" and Catholic health care is essential in protecting marginalized



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populations like the unborn, the terminally ill, and those with physical and intellectual disabilities.

We concur with Kaveny's insight that sometimes cooperation is warranted *because* of our specifically Christian obligations, especially in light of Catholic Social Teaching, and we are challenged to prudently draw out the implications of this insight as we continue the healing ministry of Jesus. ✣

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## ENDNOTES

1. Julian Savulescu and Udo Schuklenk, "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception," *Bioethics* 31:3 (2017): 162-70, at 164.
2. Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 332 (2006): 294-7, at 297.
3. See John J. Hardt, "The Conscience Debate: Resources for Rapprochement from the Problem's Perceived Source," *Theoretical Medicine and Bioethics* 29:3 (2008): 151-60.
4. For further elucidation of Aquinas's account, see his *Summa theologiae*, trans. English Dominican Fathers (New York: Benziger, 1948), Ia, q. 79, aa. 11-13; and *Quaestiones disputatae de veritate*, trans. J.V. McGlynn (Indianapolis: Hackett, 1954), qq. 16-17; Eberl and Ostertag (forthcoming).
5. Aquinas 1948, IIa-IIae, q. 33.
6. Savulescu 2006, 294.
7. See B.J. Crigger, P.W. McCormick, S.L. Brotherton, and V. Blake, "Report by the American Medical Association's Council on Ethical and Judicial Affairs on Physicians' Exercise of Conscience," *Journal of Clinical Ethics* 27:3 (2016): 219-26; ACOG Committee on Ethics, "The Limits of Conscientious Refusal in Reproductive Medicine (2007), https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine, accessed 12 October 2017.
8. A related moral concern, even if one is not complicit with another's wrongdoing, is causing *scandal*. We discuss scandal in Eberl and Ostertag (forthcoming).
9. *Catechism of the Catholic Church* (1997), http://www.vatican.va/archive/ENG0015/_INDEX.HTM, accessed 28 February 2018, nos. 1752, 1755. The *locus classicus* for the distinction between formal and material cooperation with moral evil is Alphonsus Liguori, *Theologia Moralis*, ed. L. Gaudé, 4 vols. (Rome: Ex Typographia Vaticana, 1905-1912), II.3.ii dub. 5, art. 3, no. 63. For a more contemporary formulation, see Kevin L. Flannery, *Cooperation with Evil: Thomistic Tools of Analysis* (Washington, DC: Catholic University of America Press, 2019).
10. This and subsequent quotations in this paragraph are from Anthony Fisher, "Cooperation in Evil: Understanding the Issues" in *Cooperation, Complicity, and Conscience: Problems in Healthcare, Science, Law and Public Policy*, ed. Helen Watt (London: The Linacre Center, 2005), 27-64.
11. This and subsequent quotations in this paragraph are from M. Cathleen Kaveny, "Tax Lawyers, Prophets and Pilgrims: A Response to Anthony Fisher" in Watt 2005, 65-88.



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