Literature Review:
Conscientious Objection in Medicine

Reviewed by Samuel Deters, Ph.D. Student

Stahl, Ronit and Ezekiel Emanuel. "Physicians, Not Conscripts — Conscientious Objection in Health Care." *New England Journal of Medicine* 376, no. 14 (April 2017): 1380-1385. doi:10.1056/NEJMsb1612472.

Amidst a flurry of conscience clause legislation in the United States, Stahl and Emanuel advance an argument for limiting conscience protections. Rather than approach conscientious objection in health care from a political or legal perspective, this article attempts to situate the discussion of conscience clauses purely within the realm and competence of professional societies. They do this in three stages: First, by distancing conscientious objection in medicine from conscientious objection in the military; second, by establishing an internal inconsistency within many professional codes of ethics that include conscience clauses; and third, by establishing the professional society as a whole, rather than individual physicians, to be the proper authority for elucidating and interpreting the limits of the primary interest of medicine. They conclude that conscientious objection in medicine should serve a narrow role, stating: "It provides limited recourse in professionally contested interventions" when the professional community has yet to decide whether a particular intervention is appropriate or not.

The authors differentiate between military and medicine by stating: "Unlike conscripted soldiers, health care professionals voluntarily choose their roles and thus become obligated to provide, perform, and refer patients for interventions according to the standards of the profession." However, while they are right about the difference between conscripted soldiers and health care professionals, they fail to account for the fact that the U.S. Army, now an all-volunteer force, still contains conscientious objectors. Turning to their second point, Stahl and Emanuel argue that professional societies, including the AMA, ANA, and APhA, contain internal inconsistencies between the physician's primary ethical responsibility for patient welfare that goes above the physician's self-interest and the physician's right to exercise conscientious refusal on grounds of deeply held personal, religious, or moral beliefs. In their third point, the professional society is established as the interpreter of the limits of the primary interest of medicine. The process characterized by John Rawls as reflective equilibrium allows for professional debate until consensus is reached. At this point objecting physicians,

who voluntarily choose their subspecialty, must honor their obligation to place the well-being of the patient first and offer those interventions that the society has deemed medically appropriate, or choose a different career.

Ultimately, Stahl and Emanuel's article suffers from two major shortcomings. First, the authors offer no definition of conscience. They equivocate between self-interest and deeply held religious or moral belief. Second, Stahl and Emanuel establish reflective equilibrium as the process through which professional societies self-correct. Even after admitting that these societies can make grave errors, such as by endorsing eugenics, they recommend forcing conscientious objectors to leave the professional society. But removing objectors risks dampering the society's ability to hear diverse viewpoints or uncover grave error. Despite these shortcomings, Stahl and Emanuel offer a representative argument from a social-constructivist framework that has drawn considerable attention over the last couple years. Their attempt to circumvent legal conscience protections by first establishing a stricter ethical imperative to fulfill the primary interest is one that may receive more attention and support by those who oppose conscience protections in the future.

Myskja, Bjørn and Morten Magelssen. "Conscientious Objection to Intentional Killing: An Argument for Toleration." *BMC Medical Ethics* 19, no. 1 (October 1, 2018): 1 – 9. doi:10.1186/s12910-018-0323-0.

Myskja and Magelssen offer an interesting approach to conscientious objection. Deriving their argument from political philosophy, they seek to establish a limited legal right to accommodation as well as a broader conception of accommodation as a "moral courtesy." To do this, they make four arguments: "(1) The need to protect the health professional's moral integrity. (2) The fact that we may be mistaken in moral judgements, even when we are convinced that we know the truth. (3) The right of minorities to live according to their deeply held convictions, following from basic moral principles of liberal democracies. (4) The special moral and political significance of taking lives." The first three arguments "support a right to be heard and to be accommodated as a moral courtesy" while the last argument offers a basis for granting a legal right to accommodation.

While it is possible for any number of the four arguments to establish a legal right to accommodation, Myskja and Magelssen argue that it must be one "that all reasonable citizens in a liberal democracy should accept [even if they disagree], such as the constitutive role of the inviolability of human life in liberal democracies." Because liberal democracy cannot privilege any particular worldview, one's argument cannot be based on any comprehensive doctrine (like divine command). Further, since accommodation will require some sacrifice from others, it should be framed in terms they can accept. As a result, the authors hold that any argument "must be presented in a minimally secular frame."

Another way of looking at Myskja and Magelssen's argument is in terms of reasonable objection and genuine objection. While any genuine objection holds moral weight and is worthy of respect (moral courtesy), it is only reasonable objections that deserve legal protection. Any health professional who objects to a particular medical practice may

receive accommodation from their employer as a "moral courtesy," but only those whose arguments are based on shared principles like the value of life merit added legal protection.

This article offers some valuable insight into the British mentality surrounding conscientious objection. The conclusions that are drawn here correspond closely to the position of the British Medical Association, which acknowledges the legal right to object to procedures like abortion while encouraging accommodation in other areas as long as such accommodation is not discriminatory or overly burdensome.

Corby, Paschal M. "The Imperative of Conscientious Objection in Medical Practice." *National Catholic Bioethics Quarterly* 18, no. 4 (2018): 611-618).

Corby offers his own analysis of the issue of conscientious objection, differing substantially from the previous two articles. He engages the issue in terms of conscience itself. Drawing from Jürgen Habermas, Corby establishes an argument for "the relevance of religious truths in public debate and the legitimacy of public dissent." He directly engages Stahl and Emanuel's argument and similar arguments advanced by Julian Savulescu. Those arguments reject conscientious objection because the medical profession is a freely entered field, guided by legal and professional practices that place patients first and grant them the right to be fully informed of all medically relevant legal options and receive services in an efficient and beneficial manner.

Corby asks if this line of argumentation removes conscience from the public sphere, or whether "the voice of conscience [could] find a place at the table of reflective discourse in the process of reaching consensus — a process that, by admission, continues in the search for ethical solutions." The modern trend of conflating conscience with self-interest and personal belief is hard to reconcile with traditional conceptions of conscience. The medieval world granted conscience two levels: First, conscience as synderesis operates as a habit of practical reason. *Synderesis* "participates in an objective moral truth that preexists the individual conscience." Far from representing subjective truth or self-interest, it allows truth and reason to speak to the depths of one's soul. The second level of conscience, termed *conscientia*, applies this truth to a concrete set of circumstances, generating judgments and decisions. *Conscientia* operates at the practical level of act. While contemporary assumptions conclude that individual conscience should have no bearing on medical practice, traditional notions that directly relate conscience and action contradict those conclusions. Rather than a mere psychological reaction, conscience directly forms one's judgments and action.

In our post-religious society, "the presumption is that personal belief and religious faith are not subject to reason or scrutiny, and therefore the directives of conscience that flow from them cannot be reasonably engaged." But liberal society also requires the toleration of a plurality of worldviews, sustained by the neutrality of the liberal state. "This neutrality 'guarantees the same ethical freedom to every citizen'" and enables diverse entities to embed into and influence society through the public political sphere. While Myskja and Magelssen claim that arguments must be made in secular terms, Corby states that "in the neutral playing field of public debate, Habermas insists that those

from a secular perspective 'must not deny in principle that religious images of the world have the potential to express truth.'" Further, citing Ratzinger, Corby notes that "reason becomes 'pathological' when it is closed to realities that lie beyond its competence" and "tends toward a form of totalitarianism, oppressive in its intolerances of alternative views, especially those which are expressed in action."

Corby finds his parallel in civil disobedience, rather than military conscientious objection. Opponents of civil disobedience argue that breaking the law under appeal to conscience arrogates rights to disobeyers which undermine the security and freedom of citizens. However, Corby notes Habermas' argument "that the capacity to accommodate acts of civil disobedience is constitutive of the democratic state." But this disobedience must obey six criteria: 1) It requires more than private conviction or self-interest. 2) It must be public. 3) An individual legal norm — not law as a whole — must be challenged. 4) One must accept the legal consequences of transgression. 5) The act must be essentially symbolic in character. 6) It must be achieved through nonviolent means. While representative democracy and legal reform are the ordinary measures of correcting wrongs, civil disobedience must be preserved as a means of awakening society's moral conscience.

Conscientious objection in medicine can parallel civil disobedience. At least in the United States, conscientious objection does not generally violate the law. But objecting to morally questionable practices can do more than preserve personal moral dignity. It can, Corby argues, challenge standard practice and influence the process of reflective equilibrium, allowing professional societies to self-correct.

As his article concludes, Corby mentions some limits to conscientious objection. Claims to conscience require an objective basic value like those found in natural law and the traditional foundations of society. For medical practice, "life itself, on which all other human goods and rights depend, is that basic value." There is no room for denying treatment on the basis of one's race, as this denies a fundamental human right of equality. But there is room to conscientiously object to abortion on the grounds that it requires denying the existence of another human being.

SYNTHESIS

While conscientious objection is hardly a new issue, recent literature demonstrates that it is far from a settled one. The above articles demonstrate the depth of discussion, which takes place at the levels of person, profession, and politic. Ethicists who engage in discussions surrounding conscientious objection must question how we understand conscience, social and professional responsibilities, the role of professional/ethical guidelines, and the rule of law.

Conscientious objection's legal status varies greatly throughout the world and continues to change. In the United States, Ohio recently enacted conscience clause legislation. This occurred just days after the United Nations adopted a report that describes abortion as

"essential healthcare" and sought to redefine conscientious objection as a "denial of medical care" (NCR, "Pope Francis Meets European Parliament President After Abortion Vote"). Fortunately, our religious tradition offers a rich intellectual tradition we may draw upon in discussions of conscience. Whether we engage at the individual, institutional, political, or legal level, this tradition can assist us as we seek to prevent discrimination against any patient and protect the value of human life.

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