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Conscientious objections, the nature of medicine, and the need for reformability

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Abstract

The debate over whether the medical profession should accommodate its members' conscientious objections (COs) has raged on in the bioethics literature and on legislative floors for decades. Unfortunately, participants on all sides of the debate fail to distinguish among different types of CO, a failure that obstructs the view of which cases warrant accommodation and why. In this paper, we identify one type of CO that warrants consideration for accommodation, called Nature of Medicine COs (NoMCOs). NoMCOs involve the refusal of physicians to perform actions they reasonably judge to be contrary to the nature of medicine and their professional obligations. We argue that accommodating NoMCOs can be justified based on the profession's need to preserve reformability. Importantly, this previously underdeveloped position evades some of the concerns commonly raised by opponents of CO accommodations

KEYWORDS
conscientious objections, institutional reform, nature of medicine, professionalism

1 | INTRODUCTION

The question of whether doctors should be allowed to refuse to provide certain services such as abortion or aid-in-dying (AID) remains controversial. Such a refusal is known as conscientious objection (CO): when a doctor, on what she considers moral grounds,[1] refuses to perform a service that is medically indicated or beneficial, legally permitted, requested by a competent patient or appropriate surrogate, and regularly practiced by and expected of doctors in the relevant specialty. For example, a doctor might refuse to provide abortions for first-trimester pregnant patients who request them because she believes abortion is murder. Many bioethicists attempt to defend CO by citing toleration of moral and religious diversity,[2] respect for doctor autonomy,[3] respect for moral integrity,[4] or other principles.[5] CO opponents reject its accommodation using a variety of arguments,[6] most commonly that it wrongfully blocks patients'

[1]We do not differentiate between COs made for religious or moral reasons because religious reasons for refusal can be—and often are—a species of moral reasons for refusal.

[2]McConnell, D. (2019). Conscientious objection in healthcare: How much discretionary space best supports good medicine? *Bioethics*, *33*(1), 154–161. https://doi.org/10.1111/bioe.12477; Sulmasy, D. P. (2017). Tolerance, professional judgment, and the discretionary space of the physician. *Cambridge Quarterly of Healthcare Ethics*, *26*(1), 18–31. https://doi.org/10.1017/S0963180116000621; Wear, S., Lagaipa, S., & Logue, G. (1994). Toleration of moral diversity and the conscientious refusal by physicians to withdraw life-sustaining treatment. *Journal of Medicine and Philosophy*, *19*(2), 147–159. https://doi.org/10.1093/jmp/19.2.147

[3]Glick, S. M., & Jotkowitz, A. (2017). Response to: 'Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies' by Schuklenk and Smalling. *Journal of Medical Ethics*, *43*(4), 248–249. https://doi.org/10.1136/medethics-2016-103670; Daar, J. F. (n.d.). A clash at the bedside: Patient autonomy v. a physician's professional conscience. *Hastings Law Journal*, *44*, 51.

[4]Weinstock, D. (2014). Conscientious refusal and health professionals: Does religion make a difference? *Bioethics*, *28*(1), 8–15. https://doi.org/10.1111/bioe.12059; Magelssen, M. (2012). When should conscientious objection be accepted? *Journal of Medical Ethics*, *38*(1), 18–21. https://doi.org/10.1136/jme.2011.043646; Wicclair, M. R. (2000). Conscientious objection in medicine. *Bioethics*, *14*(3), 205–227. https://doi.org/10.1111/1467-8519.00191; Childress, J. F. (1997). Conscience and conscientious actions in the context of MCOs. *Kennedy Institute of Ethics Journal*, *7*(4), 403–411. https://doi.org/10.1353/ken.1997.0029; Blustein, J. (1993). Doing what the patient orders: Maintaining integrity in the doctor–patient relationship. *Bioethics*, *7*(4), 289–314.

[5]Ben-Moshe, N. (2019). Might there be a medical conscience? *Bioethics*, *33*(7), 835–841. https://doi.org/10.1111/bioe.12611; Cowley, C. (2016). A defence of conscientious objection in medicine: A reply to Schuklenk and Savulescu. *Bioethics*, *30*(5), 358–364. https://doi.org/10.1111/bioe.12233

[6]Giubilini, A., & Savulescu, J. (2020). Beyond money: Conscientious objection in medicine as a conflict of interests. *Journal of Bioethical Inquiry*, *17*, 229–243. https://doi.org/10.1007/s11673-020-09976-9; Rhodes, R. (2020). Professional responsibility and conscientious

access to legal medical services—services that, opponents argue, doctors in the relevant specialty are professionally obligated to provide. Numerous pieces of legislation have upheld CO accommodations,[7] which the American Medical Association (AMA) has publicly endorsed: with the exception of emergencies and discrimination, the AMA states that COs should be accommodated in virtue of doctors' autonomy and moral integrity.[8] Still, the CO debate is hardly settled. Given its continued significance and controversy, we will clarify in what instances and for what reasons COs may warrant accommodation.

We agree with Cowley and Wicclair that only one type of CO, which we call Nature of Medicine COs (NoMCOs), warrant consideration for accommodation.

> *Nature of Medicine CO: The doctor refuses to provide a service because she believes it is against the nature of medicine and its ethic, such that no doctor qua doctor should provide it.*

Two features of NoMCOs deserve special attention. First, the doctor is adopting a profession-specific and sharable moral perspective—that is, the objection is based on one's moral commitments qua doctor. Second, the doctor's moral judgment has universalizable content: her judgment is that no doctor, rather than merely not herself, should be performing the action in question. These features of form and content make NoMCOs different from other types of CO, and they make all the difference to a NoMCO's claim to be taken seriously.

The moral assertion implicit in NoMCOs is that the refused services are incompatible with core values or moral principles of medicine. These refusals, as Cowley describes them, "[have] to do directly with the nature of medicine as [the doctor] understands and identifies with it, an understanding grounded in the role of doctor as healer."[9] For example, a doctor may believe that it is part of the nature of medicine (i.e., it follows from core principles of medical ethics) that its practitioners never end or assist in ending a human life unless that life is ending on its own (e.g., Do Not Resuscitate orders or the withdrawal of life support) or is sacrificed to save another life (e.g., an ectopic pregnancy abortion, without which the mother would die). Such a doctor would conclude that AID and nonemergency abortions oppose the nature of medicine. Wicclair emphasizes that this is the only type of CO worth considering for accommodation: "An appeal to conscience has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine."[10]

In Section 2, we outline some of the reasons that CO opponents are unconvinced by two common defenses of CO accommodation, and we demonstrate how NoMCOs are immune to those worries. In Section 3, we encourage accommodating NoMCOs for a reason that is unlike the two common defenses and remains underdeveloped in the bioethics literature:[11] namely, the medical profession must be designed and function in ways that ensure the possibility of its own moral reform. Our argument, which we call the Reform Argument, not only gives a compelling reason to accommodate NoMCOs, but also offers a new framing of NoMCO accommodations as a system-level feature allowing moral self-correction based on profession-wide democratic debate rather than a practice of catering to stubborn idiosyncrasies of noncompliant individuals. Finally, in Section 4, we raise and respond to potential objections to our position.

We provide four caveats to delineate the paper's scope. First, although we speak of doctors throughout, in most cases it would be just as appropriate to speak of medical professionals. Second, we only deal with cases of negative action (the doctor refuses to do something), not positive action (the doctor insists on doing something). Third, we are considering only *reasonable* NoMCOs, that is, ones that are at least plausibly true, thus excluding scientific or logical mistakes such as the false belief that vaccines cause autism. Lastly, because the process of assessing the reasonability of NoMCOs is outside the scope of this paper (as a pragmatic question of implementation), we assume that NoMCOs against abortion and AID may be reasonable at least in the context of the United States in virtue of the extensive debates around each (and our need for concrete examples). Ultimately, though, we remain agnostic to the morality of both actions; our paper is not meant to issue judgment on these services, but rather to examine how the profession should shape its policies in light of the moral controversy surrounding them.

2 | TWO COMMON DEFENSES OF CO ACCOMMODATIONS

In this section, we briefly rehearse two of the most common pro-CO arguments, which appeal to respect for autonomy and respect for moral integrity. This rehearsal will not do justice to the full debate

objection. In *The trusted doctor: Medical ethics and professionalism* (pp. 321–344). Oxford, U.K.: Oxford University Press; Savulescu, J., & Schüklenk, U. (2017). Doctors have no right to refuse medical assistance in dying, abortion or contraception. *Bioethics*, *31*(3), 162–170. https://doi.org/10.1111/bioe.12288; Schüklenk, U., & Smalling, R. (2017). Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of Medical Ethics*, *43*(4), 234–240. https://doi.org/10.1136/medethics-2016-103560; Stahl, R. Y., & Emanuel, E. J. (2017). Physicians, not conscripts—conscientious objection in health care. *New England Journal of Medicine*, *376*(14), 1380–1385. https://doi.org/10.1056/NEJMsb1612472; Schüklenk, U. (2015). Conscientious objection in medicine: Private ideological convictions must not supercede public service obligations. *Bioethics*, *29*(5), ii–iii. https://doi.org/10.1111/bioe.12167; Savulescu, J. (2006). Conscientious objection in medicine. *British Medical Journal*, *332*(7536), 294–297.

[7]U.S. Department of Health & Human Services. (2010, October 14). *Conscience protections for health care providers*. Retrieved from https://www.hhs.gov/conscience/conscience-protections/index.html [Accessed Jul 2, 2020].

[8]American Medical Association. (2015, June 8). *Physician exercise of conscience: Code of medical ethics opinion 1.1.7*. Retrieved from https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience [Accessed Jul 2, 2020].

[9]Cowley, op. cit. note 5, p. 362.

[10]Wicclair, op. cit. note 4, p. 217.

[11]The following sources mention considerations resembling the Reform Argument only briefly, but they fail to develop the argument at all: Wicclair, M. R. (2016). Conscientious objection. In H. ten Have (Ed.), *Encyclopedia of global bioethics* (pp. 729–740). New York, NY: Springer International Publishing. https://doi.org/10.1007/978-3-319-09483-0_118; Lewis-Newby, M., Wicclair, M., Pope, T., Rushton, C., Curlin, F., Diekema, D., …ATS Ethics and Conflict of Interest Committee. (2015). An official American Thoracic Society Policy Statement: Managing conscientious objections in intensive care medicine. *American Journal of Respiratory and Critical Care Medicine*, *191*(2), 219–227. https://doi.org/10.1164/rccm.201410-1916ST

over these arguments. Our aim is not to definitively reject these arguments, but rather to identify the reasons that bioethicists have given for being unconvinced by them, and to illustrate how NoMCOs evade these worries. Subsequently, the Reform Argument we describe in Section 3 will offer new food for thought to those who are unsympathetic to COs or their accommodation.

The respect for autonomy argument claims that just as patient autonomy should be respected (by granting their wishes, if they have decisional capacity), so too must doctor autonomy be respected (by not forcing them to do anything they find unethical).[12] Schüklenk, Stahl, and Emanuel deny that requiring doctors to perform all the tasks explicitly listed on their job description violates their autonomy, because nobody forced them to become doctors in the first place.[13] On their view, doctors who object to the standard practice of their profession owing to their idiosyncratic, personal moral beliefs are free to quit or to switch specialties, just as they freely joined the profession, but they are not free to violate their professional obligations. CO opponents may therefore be unconvinced by the autonomy argument: either it is not coercive for an employer to hold her employees to their professional standards and obligations; or, if it is coercive, then employees contractually submit themselves to such coercion when they voluntarily accept the job. Autonomy alone does not justify unprofessionalism.

The moral integrity argument is more compelling, and it has garnered much support.[14] The AMA defends COs on these grounds, stating that doctors should be free, albeit with some constraints, "to practice in accord with well-considered, deeply held beliefs that are central to their self-identities."[15] Two reasons are offered for accommodating COs for the sake of physicians' maintaining integrity: integrity's intrinsic value and its instrumental value. As for its intrinsic value, Jeffrey Blustein posits that integrity is a *virtue*:[16] if it is a virtue, then to damage it is to lose something of moral value; and to fail to preserve it is to suffer some moral harm. As for its instrumental value, disregarding or injuring one's integrity takes a severe psychological toll. Wicclair reasons, "if [a doctor] were not permitted to follow the dictates of her conscience and preserve her moral integrity, she would have to engage in a form of self-betrayal. As a result, she may experience a significant loss of self-respect."[17] Daniel Weinstock predicts that a doctor in this scenario would experience guilt, shame, and the sense that her profession has disrespected her as a moral agent.[18]

We do not discount the value of moral integrity; doctors should not be left with self-betrayal as their only option. However, CO opponents can extend their counterargument against respect for autonomy to this case.[19] Doctors have other options: quitting or switching specialties. If someone sincerely believes that aspects of a job are morally wrong, then she is likely not a good fit for that medical specialization or that profession. Someone who is morally opposed to killing animals should not seek employment at an animal research lab where animal test subjects are regularly sacrificed. As Weinstock puts it, "One cannot dissent from performing actions within [a core of services] without at the same time dissenting from the role itself."[20] So, CO opponents may not see a doctor's personal moral integrity as justifying CO accommodations.

NoMCOs evade both worries, of self-interest and unprofessionalism, because (1) NoMCOs are based on patient-directed moral obligations rather than self-interested appeals to autonomy or moral integrity, and (2) the objectors bear those obligations *in virtue of* being doctors. Indeed, objectors' reasons are universalizable in that they believe *no* doctor should provide the services in question. They refuse qua professionals, for their refusals are based on values they hold and principles to which they commit qua doctors. In fact, objectors would judge it unprofessional *not* to refuse.

Because their objections are not derived from idiosyncratic personal values or religious beliefs (i.e., qua me or qua member of some religious group), objectors cannot be accused of being unprofessional or unfit for the profession. The objector finds the *way* she is expected to be a doctor problematic, not being a doctor in and of itself. She endorses what she takes to be core medical values and principles even as she disagrees with contemporary medical *norms* (i.e., how her profession presently interprets and implements those values and principles). The objector should not necessarily change specialties or quit: although she diverges from the profession *as it is now*, it is because she is modelling the profession *as it ought to be*. In such a case, it may be the profession, not the doctor, that should reconsider its stance.

NoMCOs are immune to the objections of unprofessionalism and self-interest raised against autonomy- and integrity-based arguments for accommodating COs. Indeed, rather than being a counterforce to the objector's refusal, a sense of professional obligation is the *source* of that refusal. Thus, accommodating NoMCOs warrants serious consideration. Accordingly, we now offer a reason for NoMCO accommodations: the need to protect the medical profession's ability to reform.

3 | THE REFORM ARGUMENT

Here is a distilled version of the Reform Argument.

1. The medical profession should be epistemically humble and self-critical about potentially unethical policies so that it can morally self-correct when necessary.
2. NoMCOs criticize potentially unethical policies in an appropriately universalizable manner.

[12]Glick & Jotkowitz, op. cit. note 3.
[13]Schüklenk, op. cit. note 6; Stahl & Emanuel, op. cit. note 6. Quote from Schüklenk.
[14]Ben-Moshe, op. cit. note 5; Wicclair, op. cit. note 4; Magelssen, op. cit. note 4; Childress, op. cit. note 4; Blustein, op. cit. note 4.
[15]American Medical Association, op. cit. note 8.
[16]Blustein, op. cit. note 4, p. 290.
[17]Wicclair, op. cit. note 4, p. 214.
[18]Weinstock, op. cit. note 4, p. 9.
[19]Schüklenk, op. cit. note 6; Stahl & Emanuel, op. cit. note 6.
[20]Weinstock, op. cit. note 4, p. 12.

3. Policymakers give greatest consideration to those who are most directly impacted by their decisions—in this case, patients and *active doctors in the relevant specialties*.
4. Without NoMCO accommodations, objecting doctors would likely switch specialties or leave the profession altogether.
5. Without NoMCO accommodations, policymakers would give less consideration to objections to current policies [3, 4].
6. Therefore, the medical profession should accommodate NoMCOs to preserve its ability to morally self-correct [1, 2, 5].

3.1 | Epistemic humility and moral self-correction

Wicclair reminds us that medicine is rife with decisions and actions with significant moral consequences, but he clarifies: "The implication is not that physicians should be guided by their personal values, irrespective of their content. Rather, the implication is that physicians should be guided by the goals and values of medicine."[21] We agree and would add that doctors should be guided by those goals and values *as correctly understood*, which may differ from how they are presently commonly understood (medical norms). Pellegrino notes that if society were to deviate significantly, doctors who conform to de facto medical norms may act contrary to the nature of medicine, such as by performing cruel and unethical research.[22]

Since a profession's de facto norms can depart from its true values and obligations, the medical profession may be better off with objectors' understanding of medicine, assuming the objectors have reasonable positions that are not blatantly incorrect. When in such a position of epistemic humility about the morality of its policies, the medical profession should accommodate NoMCOs. Importantly, this accommodation functions at the system rather than at the individual level. Its purpose is not to cater to the wishes of individual objectors; it is to allow the profession to morally self-correct by protecting its potential reformers.[23] The Reform Argument therefore does not justify non-NoMCO COs, which lack universalizability and consequently are inappropriate for systemic reform. Just as the scientific community allows for dissension and revision out of recognition of its fallibility, NoMCO accommodations enable the medical profession to revise its stances on morally ambiguous services. Put another way, science and ethics progress as institutions because of their analogous design features—features that make room for fallibility and enable self-correction.[24]

Science is, as Wilfrid Sellars put it, "a self-correcting enterprise which can put *any* claim in jeopardy."[25] Analogously, the medical profession must be designed in such a way that moral self-correction remains possible. For the profession to be *correcting*, it must acknowledge that its current norms are defeasible. For the profession to be *self-correcting*, it must accommodate NoMCOs. To be the product of self-correction, medicine's moral reform must arise intra-professionally: doctors qua doctors must be able to express and implement their sharable vision of what any doctor qua doctor ought to do or ought not to do. As we will argue in Section 3.2, accommodating NoMCOs is necessary for the profession's reformability. Forced compliance with de facto norms and the ejection of those who are unwilling to so comply interfere with moral self-correction of the profession by its members. Clamping down eliminates the possibility of reform.

According to the Reform Argument, the medical profession as an institution ought to accommodate NoMCOs for the sake of moral progress and self-correction. It follows that by performing such NoMCOs, individual objectors fulfill the obligation that consequently falls on them to contribute to that process of moral self-criticism. Thus, although CO opponents may worry that NoMCOs are violations of professional obligations pertaining to patient care, NoMCOs are consistent with other obligations that the profession and its members have (viz., being morally self-critical). And the latter obligations have greater weight because they have long-term consequences on the evolution and ethical behavior of the profession, as opposed to the short-term consequences of refusing to provide certain services presently. Granted, other parties (e.g., patients) are also affected by this situation, and we deal with the burdens they bear later in Response (5) of Section 4.

3.2 | The necessity of NoMCO accommodations

Savulescu and Schüklenk acknowledge the importance of reforming the profession's mistaken norms, but they would deny that NoMCO accommodations are necessary for reform. In fact, they insist that objectors' pursuits of reform should be prohibited from affecting patient care. On their view, a doctor at the bedside may discuss moral concerns about services with a patient, but must ultimately comply with requests for legal, medically indicated or beneficial services. As they see it, the clinical setting is not the appropriate avenue for

[21] Ibid: 216.

[22] Pellegrino, E. D. (2001). Philosophy of medicine: Should it be teleologically or socially constructed? *Kennedy Institute of Ethics Journal*, *11*(2), 169–180. https://doi.org/10.1353/ken.2001.0015

[23] Some readers might worry that our use of the term "self-correction" implies a commitment to moral realism since the very notions of truth and correctness imply objective moral truthmakers. However, the idea of moral progress can be meaningful to those of us who reject moral realism and instead embrace its alternatives (e.g., constructivism). For helpful discussions of how the idea of moral progress can find a home in nonrealists' accounts, see Jamieson 2017 and Wilson 2010: Jamieson, D. (2017). Slavery, carbon, and moral progress. *Ethical Theory and Moral Practice*, *20*(1), 169–183. https://doi.org/10.1007/s10677-016-9746-1; Wilson, C. (2010). Moral progress without moral realism. *Philosophical Papers*, *39*(1), 97–116. https://doi.org/10.1080/05568641003669508

[24] Science and ethics are different enterprises, but progress can be made in both as marked by improvements in their respective functions. Just as scientific theories are evaluated in terms of how well they preform explanatory and predictive functions, moral principles are evaluated in terms of how well they serve our commitment to the well-being of our community and its members. Thus, moral progress occurs through the development and spread of better moral principles or the better implementation of our principles in practice. For a valuable discussion on the analogy between justification in science and justification in ethics, see Sellars 1967. Sellars, W. S. (1967). Science and ethics. In *Philosophical perspectives: Metaphysics and epistemology*. Springfield, IL: Charles C. Thomas.

[25] Sellars, W. S. (1963). Empiricism and the philosophy of mind. In *Science, Perception, and Reality* (pp. 127–196). New York, NY: Humanities Press.

reforming policy.[26] Instead, these efforts should take the form of lobbying, protesting at rallies, signing petitions, and engaging in public or written debates, which are likely to be the most effective means of changing policymakers' minds.

Pace Savulescu and Schüklenk, we argue that NoMCO accommodations are in fact necessary for maintaining the profession's reformability. Without NoMCO accommodations, it is reasonable to expect many doctors to quit or to switch specialties, given that moral distress increases rates of burnout and fatigue.[27] If providing the services truly is wrong, then not only would the medical profession be off course, but also the objectors would be replaced by willing doctors. In this way, a generation of doctors with ethical views and frameworks that converge with errant de facto norms would arise, and the medical profession's commitment to unethical practices would be further entrenched.

This compounding effect, combined with the fact that the doctors leaving or avoiding the profession would be those most likely to generate reform, would ultimately make the profession less likely to or incapable of change. While objectors could still pursue reform from outside the profession, that fight would best be fought from within. For better or worse, policy debates are determined in part by logically irrelevant factors, including the identities of those who present the arguments and testimonials for either side. Policymakers should and do give extra attention to the two biggest stakeholders, patients and *active* doctors, not because they have the epistemic authority of personal experience but because they are directly affected by policies. This heightened consideration does not strengthen the arguments that key stakeholders present. Policymakers can and should override weak arguments, but they should also carefully and seriously reassess their own analyses when they disagree with key stakeholders.

Because inactive doctors would not be affected by policy changes, they would receive less consideration than active doctors do. Even if inactive doctors promise to rejoin the profession if it changes, the profession would have already replenished its supply of doctors[28] and therefore have no incentive to accept their claim as key stakeholders. Similarly, doctors who switch specialties but do not leave medicine altogether would also lose their claim as key stakeholders. A gynecologist who switches to dermatology is no longer expected to provide abortions, and is therefore no longer *directly* affected by policymakers' decisions about abortion. Objectors must therefore remain in the *specialty* that provides the service in question in order to be duly heard.

3.3 | Summary

Applying the Reform Argument to our concrete examples, the medical profession and its representative organizations (e.g., the AMA) should be epistemically humble about controversial issues such as abortion and AID. Cowley points out that "there is a real debate to be had about abortion.... Each side has a *prima facie* respectable point of view, and there are no grounds for thinking that one side is necessarily ignorant or prejudiced in some way."[29] Insofar as these practices may in fact be unethical, the profession should accommodate objectors because they may be correct. Hindering change may be preferred in a system with definitively good policies in order to prevent regression, but it can also entrench a system in unethical policies if that system is not sufficiently self-critical. NoMCO accommodations are a key feature of the medical profession that enables progressive reform and self-correction when it deviates from or fails to live up to its core values and principles, because it ensures that the medical profession gives due consideration to its self-critics.

The Reform Argument relies on two empirical assumptions: (1) objectors will likely leave the profession without NoMCO accommodations; and (2) objectors will actively pursue reform in addition to refusal-based inaction. Although relevant data are lacking because of this country's long history of NoMCO accommodations, we believe that the strength of the Reform Argument is independent of the first assumption. Even if it is false—that is, if objectors who must comply do not leave the profession—we argue that their reform efforts would still be jeopardized. Such objectors may be accused of hypocrisy: they claim that the services oppose the nature of medicine, yet they qua doctors provide them. "Clearly," policymakers or the public might think, "these advocates don't think the services are unethical, or else they would not be doing them." Again, policy debates are determined in part by logically irrelevant factors, and these appearances may hinder necessary reform.

We acknowledge that the second assumption may be false—indeed, objectors might be *less* incentivized to push for reform if their NoMCOs are accommodated. If so, the Reform Argument would be significantly weakened in its justification of NoMCO accommodations. Granted, if objectors believe *no* doctor should provide the services, then they should view their own noncompliance as insufficient. If objectors are concerned about the moral state of their profession rather than just wanting to keep their hands clean, then they should additionally actively pursue its reform through public means.

4 | OBJECTIONS AND REPLIES

Here, we raise and respond to five objections to our argument that the profession's need to allow for moral self-correction justifies its accommodating NoMCOs.

[26]Savulescu & Schüklenk, op. cit. note 6.

[27]Meltzer, L. S., & Huckabay, L. M. (2004). Critical care nurses' perceptions of futile care and its effect on burnout. *American Journal of Critical Care*, *13*(3), 202–208. https://doi.org/10.4037/ajcc2004.13.3.202; Bischoff, S. J., DeTienne, K. B., & Quick, B. (1999). Effects of ethics stress on employee burnout and fatigue: An empirical investigation. *Journal of Health and Human Services Administration*, *21*(4), 512–532.

[28]Savulescu and Schüklenk are quick to assert how abundant the pipeline is: Savulescu & Schüklenk, op. cit. note 6, p. 163.

[29]Cowley, op. cit. note 5, pp. 360–361.

(1) Savulescu, Schüklenk, and Alberto Giubilini argue that to accommodate NoMCOs is ultimately to endorse ethical relativism—the view that moral judgments are true or false only relative to an individual's (or society's) moral framework.[30] That is, to allow individual doctors to object based on their personal conceptions of medicine is to recognize and to legitimize those conceptions *just because* those doctors hold them. If NoMCO accommodations really are relativistic, then we are endorsing a problematic metaethical position.

We reject ethical relativism and maintain that there are objective medical ethics principles (e.g., beneficence and nonmaleficence) that dictate how doctors ought to act. We argue instead that NoMCO accommodations are the appropriate expression of epistemic humility. Judgments that abortion or AID are opposed to the nature of medicine are not true *just because* certain doctors happen to hold them, and they should not be accommodated just for toleration's sake. Rather, the reason for accommodation is that the judgments informing the refusals *might* be correct, and the argument for those judgments appeal to reasonable interpretations of shared medical ethics principles. This distinct position of epistemic humility, not relativism, justifies accommodating NoMCOs in order to preserve the profession's capacity for reform.

(2) One might worry that while we are defending NoMCO accommodations in virtue of epistemic humility, the objectors we defend lack an epistemically humble attitude. The objectors might be incorrect, and they lack certainty in their convictions. Nevertheless, they intend to change the governing policies so as to ban the services to which they object. So, we are inconsistently demanding epistemic humility of CO critics, but letting objectors off the hook.

Epistemic humility requires only being willing to debate, acknowledging the possibility of being incorrect, and trying to reach consensus with one's fellows. It does not prohibit drawing conclusions about ambiguous questions, nor desiring or advocating for reform. We argue that conscientious objectors should be accommodated because otherwise that debate would be conservatively biased. By protecting NoMCOs, the profession would keep the conditions for debate ideal and impartial, and thus keep alive the possibility of reform or increase our confidence in the reasons for conservation.

(3) We described NoMCOs as being universalizable in the sense that the objector believes *no* doctor should perform the services qua doctor. One might wonder whether the "qua doctor" perspective requirement excludes religiously and extra-professionally motivated COs, which would be problematic given how many COs in America are made for religious reasons.[31] Suppose a doctor believes abortion is wrong in virtue of her religious beliefs. She can still insist that no doctor should provide abortions, but she makes that judgment qua religious person, not qua doctor. Because the profession is not committed to the same religious beliefs, her judgment cannot be universalized to all doctors and lacks the proper perspective (i.e., qua doctor) for professional reform. Moreover, her reasons cannot move secular policymakers and colleagues. This religiously motivated CO would not be a NoMCO.

We agree that COs cannot be justified with religious or extra-professional reasons alone. However, it is pragmatically irrelevant to reform efforts whether doctors privately object for religious reasons *so long as* they can also provide compelling secular reasons for their beliefs. Arguments that are "unmoored from the theological or otherwise metaphysical contexts that may have given rise to them"[32] have the proper perspective (i.e., qua doctor) to be respected and admitted in the policy debate—and thereby effectively make the CO a NoMCO.

(4) Another objection concerns how NoMCO accommodations impact patients. If objectors are incorrect, then their refusals harm patients by withholding care they autonomously request and burdening them with the task of finding a doctor who adheres to de facto norms, thus violating the principles of beneficence and patient autonomy. More than that, Schüklenk posits that patients are *entitled* to legalized medical services and therefore are not given what they are *owed*.[33] Simultaneously, Rosamond Rhodes insists that doctors *promised*—and thereby have a moral duty—to fulfill patient requests for legalized, medically indicated or beneficial services.[34] Cowley responds to Schüklenk by noting:

> [The patient's right to medical treatment] does not include a right to a *particular* treatment.... The patient has a right to medical attention ... but it will be for the doctor, using her expertise, skills and judgement, to decide the most appropriate course(s) of treatment.... Under the principle of medical discretion, therefore, the doctor can refuse to provide [physician-assisted suicide], and instead offer different treatment.[35]

For example, suppose a patient reports abdominal pain and requests an appendectomy. He is entitled to medical attention, and he is entitled to appendectomies in the sense that they are legal. However, it is up to the doctor to discern whether performing the surgery would be appropriate—in this case, whether it is medically indicated by appendicitis.

Importantly, the appropriateness of a service depends on whether it is not only autonomously requested, legal, and medically indicated or beneficial, but also ethical to do.

[30]Savulescu & Schüklenk, op. cit. note 6, p. 167; Giubilini & Savulescu, op. cit. note 6.
[31]Schüklenk, op. cit. note 6.
[32]Weinstock, op. cit. note 4, p. 14.
[33]Schüklenk, op. cit. note 6.
[34]Rhodes, op. cit. note 6, p. 342.
[35]Cowley, op. cit. note 5, p. 363.

Pellegrino remarks that patient autonomy should not be the supreme rule of medical decision-making: "The total good … *must not be equated with the patients' perception of the total good*."[36] We do not necessarily endorse Pellegrino's conception of the "total good," but we do agree that doctors cannot consider only patient's medical welfare and autonomy. Objectors are therefore not necessarily breaking their promises, as Rhodes suggests, because they promised to provide autonomously requested services that are *appropriate*, not merely legal and medically indicated or beneficial. If it is reasonable for them to judge

the services inappropriate, then their refusals should be accommodated.

Savulescu and Schüklenk respond that while patients may be mistaken about what is best for them, their autonomy should be respected "if [their wishes remain] stable over time,"[37] since it would be more likely that their interests would actually be best served by the requested service. This is especially true given that patient autonomy is a core medical principle and crucial patient interest. Cowley's rebuttal here is also very insightful:

> [Doctors] may reluctantly admit that the autonomous patient has a moral right to commit suicide; they may even claim to understand why the patient wants to commit suicide; and they might even feel inclined to assist the patient in that suicide as *private individuals*. But as *doctors*, they will say that assisting such a suicide contravenes the ideal of medicine—an otherwise eminently plausible ideal—with which they identify, and therefore they conscientiously 'object' to volunteering.[38]

Objectors can argue that while, say, death may be in the apparent best interests of a *particular* patient, doctors may still be bound by duty to never end or assist in ending their patients' lives.[39] We are not endorsing this view; the fact that it is *reasonable* is sufficient to justify accommodation.

(5) One might worry that patients are unfairly burdened in that while they did not choose to be in the circumstances that necessitate, say, abortions, the gynecologists to whom they turn *did* choose a career that expects them to perform abortions. Moreover, one might insist that patients can reasonably expect to receive legal and medically indicated or beneficial services that are consistent with the medical profession's current principles, such that their access to those services should not be impeded by doctors who happen to disagree about what those principles should be. Non-objecting doctors are also burdened, for they must carry the additional patient load of those whom the objectors turn away.

We recognize the burdens that patients and non-objecting doctors must bear, and while we lack the space to fully respond to these concerns, we agree with implementing policies that minimize those burdens, such as having a database of objectors that would save patients time in identifying which doctors to avoid.[40] We also suggest imposing burdens on objectors that would make the situation fairer, such as requiring an "objector fee" that could bolster the pay of willing doctors and reduce the cost of the service in question for patients. After all, the medical profession may be correct in its policies, and doctors who agree with those policies should not be punished. And as valuable as NoMCOs may be, the unfairness generated by their imposing burdens on patients and willing doctors must be rectified. Ultimately, though, the benefits of reformability outweigh the costs of preserving it. Several years of individual-level burdens are, in the long run, a small price to pay if the system can thereby retain the ability to morally self-correct.

5 | CONCLUSION

NoMCOs, unlike other forms of CO in medicine, warrant serious consideration. NoMCOs comprise a relevant and shareable perspective (i.e., qua doctor) and apply to anyone who occupies that professional role (i.e., are universalizable). The medical profession must accommodate NoMCOs to ensure that moral reform is possible when it is necessary.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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[38]Cowley, op. cit. note 5, p. 363.

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