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Carolyn McLeod: *Conscience in Reproductive Healthcare: Prioritizing Patient Interests*
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Carolyn McLeod's *Conscience in Reproductive Healthcare: Prioritizing Patient Interests* offers a bold and novel account of conscientious objection in medicine—especially as it pertains to reproductive health—and, with it, of the relationship between healthcare professionals and patients. McLeod argues that the conscience of healthcare professionals has moral value—thus distinguishing herself from those authors who argue that healthcare professionals' conscience has no place in medicine (e.g., Schüklenk & Smalling 2016; Savulescu & Schüklenk 2017)—but that conscientious objectors should nevertheless subordinate their conscience to the healthcare interests of both current patients and prospective patients. This, McLeod argues, is the result of a fiduciary role that healthcare professionals have towards their patients and the public more generally.

McLeod's book is divided into two parts. The first part, entitled "What's At Stake," includes three chapters. In chapter 1, McLeod discusses the value of conscience. She focuses on the *integrity* approach to justifying conscientious objection in medicine, which she understands primarily in terms of protecting the inner psychological unity of the conscientious objector. McLeod argues that this type of "unity view" is unsatisfactory. Among other things, unity is not necessarily valuable: for example, a woman could be unified around her low self-worth if she has internalized views about women being inferior. McLeod then presents her own approach to conscience, which focuses on *our best moral judgment* in the sense that "having a conscience encourages us to take our moral values seriously and to revise our values when they do not fit with what we actively endorse" (p. 20). According to this "dynamic view," as McLeod calls it, conscience therefore has

value “when it encourages us not simply to do what we think we morally ought to do, but also to revise those thoughts when necessary to give voice to what we genuinely value” (p. 37).

In chapter 2, McLeod shows that patients are not merely inconvenienced by conscientious objections to emergency contraception and abortion; rather, they are *harmed* by such objections. Following Feinberg, she understands a harm in terms of a setback to an interest and argues that certain patient interests—their reproductive autonomy, moral identity as a good person, and sense of security that goes along with living in a society that respects them—are harmed by conscientious objections. McLeod does an impressive job of showing that these harms occur regardless of whether patients can access the service elsewhere. She also pays special attention to the potential reinforcement of stereotypes about women and minorities by the objections in question. In chapter 3, McLeod discusses, at length, another harm that is brought about by conscientious objections: undermining the *trust* that patients have in healthcare professionals and healthcare professions.

The second part of the book, entitled “Regulating Conscientious Refusals,” also includes three chapters. In chapter 4, McLeod argues that the compromise approach to conscientious objection in medicine—which generally involves providing a referral to a nonobjecting provider—will not work. McLeod first examines the nature of compromises and considers what makes a compromise true and good: in the former, the parties make the compromise for *reasons*, rather than having it imposed on them; in the latter, the parties also compromise for *good* reasons. She then considers various reasons that could support a true and good compromise for most objectors in medicine and argues against their feasibility. The thought underlying much of her argumentation is that we need reasons that are stronger than the reasons both parties have to refuse to make any concessions; but that, because of the strength of the moral convictions of typical objectors, it is unlikely that such reasons are to be had. So, a true and good compromise for objectors in medicine is not forthcoming.

In the final two chapters, McLeod presents an alternative approach to regulating refusals, one that prioritizes the interests of patients and the public. In chapter 5, she develops this “prioritizing approach” by conceptualizing healthcare professionals as *fiduciaries*, whose primary duty is one of loyalty towards their patients, and who have discretionary authority over the healthcare interests of their patients. Acting in accordance with their conscience means that healthcare professionals would not necessarily prioritize patient interests (or prioritize them for the wrong reasons), and so, McLeod argues, conscientious objections should not be permitted in established relationships with patients. While chapter 5 focuses on *current* patients, chapter 6 focuses on *prospective* patients. In chapter 6, McLeod argues that healthcare professionals have a fiduciary duty to promote public health and equitable access to care, which restricts their liberty to decline new patients on grounds of conscience. Nevertheless, in the case of prospective patients, McLeod does make room for conscientious objections, but on the condition that healthcare professionals do *not* allow their conscience “to dictate who becomes their patient in circumstances where they cannot ensure (e.g., by giving proper referrals) that prospective patients will receive the health care they need” (p. 177).

McLeod’s book is a tremendous achievement and will be of great interest to academics and healthcare professionals alike. Let me conclude, however, with some critical remarks. First, I am not convinced that McLeod’s view is substantially different from that of her opponents: McLeod wishes to distinguish herself from those who argue that conscience has no place in medicine, but ultimately argues that conscientious objections should *not* be permitted with current patients. McLeod might respond, as she in fact does, that healthcare professionals have “outlets for their conscience other than the clinic, such as professional meetings, the media, and the blogosphere” (p. 150); she might also insist that she does allow for conscientious objections with prospective patients. But now proponents of conscientious objection in medicine are likely to argue that the

moral value of conscience is exhibited no less—and perhaps even more so—in the *clinic* with *current* patients. Moreover, given the fact that McLeod allows for referrals in connection with prospective patients, it is not clear how her view is different, *de facto*, from the compromise approach.

Second, the book is set up as a clash between healthcare professionals' conscience-based interests and patients' interests. But should the demands of conscience be conceptualized in terms of the objector's *interests*? While this might make sense if what justifies conscientious objection is the objector's integrity, it is harder to use the terminology of interests if the justification is toleration for different moral points of view (e.g., Wear, Lagaipa, & Logue 1994; Sulmasy 2017)—perhaps in the context of moral disagreement and liberal neutrality (e.g., Wester 2015)—or the potential truth of the claims of conscience (e.g., Ben-Moshe 2019a & 2019b). Here there seems to be more at stake than any given agent's interests. (As a side note, I am not convinced that integrity is a mere interest of the objector; rather, being sufficiently unified—or having an identity and acting authentically—may be a *condition* on being a fully autonomous agent, and therefore on being able to have certain interests in the first place.) Accordingly, the key move is not, after all, the claim that the fiduciary model of the patient-healthcare professional relationship prioritizes the interests of the former over those of the latter: any plausible model of the patient–healthcare professional relationship would yield this result. Rather, the key move is setting up the demands of conscience as *interests* that can be overcome; and there is reason to question this move.

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