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Conscientious Objection in Medicine: Making it Public

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Abstract: The literature on conscientious objection in medicine presents two key problems that remain unresolved: (a) which conscientious objections in medicine are justified, if it is not feasible for individual medical practitioners to conclusively demonstrate the genuineness or reasonableness of their objections ("the justification problem")? (b) how does one respect both medical practitioners' claims of conscience and patients' interests, without leaving practitioners complicit in perceived or actual wrongdoing ("the complicity problem")? My aim in this paper is to offer a new framework for conscientious objections in medicine, which, by bringing medical professionals' conscientious objections into the *public realm*, solves the justification and complicity problems. In particular, I will argue that: (a) an "Uber Conscientious Objection in Medicine Committee" ("UCOM Committee")—which includes representatives from the medical community and from other professions, as well as from various religions and from the patient population—should assess various well-known conscientious objections in medicine in terms of public reason and decide which conscientious objections should be permitted, without hearing out individual conscientious objectors; (b) medical practitioners should advertise their (UCOM Committee preapproved) conscientious objections, ahead of time, in an online database that would be easily accessible to the public, without being required, in most cases, to refer patients to non-objecting practitioners.

Keywords: Conscientious Objection; Complicity; Genuineness; Reasonableness; Constructivism; Public Reason

1. Introduction

The literature on conscientious objection in medicine presents two key problems that remain unresolved: (a) which conscientious objections in medicine are justified, if it is not feasible for individual medical practitioners to conclusively demonstrate the genuineness or reasonableness of their objections ("the justification problem")? (b) how does one respect both medical practitioners' claims of conscience and patients' interests, without leaving practitioners complicit in perceived or actual wrongdoing ("the complicity problem")? My aim in this paper is to offer a new framework for conscientious objections in medicine, which, by bringing medical professionals' conscientious objections into the *public realm*, solves the justification and complicity problems. In particular, I will argue that: (a) an "Uber Conscientious Objection in Medicine Committee" ("UCOM Committee")—which includes representatives from the medical community and from other professions, as well as from various religions and from the patient population—should assess various well-known conscientious objections in medicine in terms of public reason and decide which conscientious objections should be permitted, without hearing out individual conscientious objectors; (b) medical practitioners should advertise their (UCOM Committee preapproved) conscientious objections, ahead of time, in an online database that would be easily accessible to the public, without being required, in most cases, to refer patients to non-objecting practitioners.

I proceed as follows. After presenting the justification and complicity problems (section 2), I offer a detailed account of the UCOM Committee. The account includes answers to, amongst

other things, the following questions: (a) What are the sources of the committee's authority? (b) Why should the committee focus its deliberations on public reason? (c) How would the committee avoid some of the main pitfalls that characterize bioethics committees? (section 3). I then develop the idea that medical practitioners should publicly advertise the procedures to which they conscientiously object. I also argue that the UCOM Committee can have a broad mandate in the sense that it would not only determine which conscientious objections are justified, but would also protect patient interests by limiting the approved objections to non-emergency situations and to hospitals and geographic areas in which there is a sufficient number of non-objecting practitioners (section 4). I conclude by considering objections to my account that pertain to (a) the importance of hearing out individual conscientious objectors, (b) the role of values in medicine and for medical professionals, (c) the capabilities and interests of patients, and (d) broader social aspects of conscientious objection and medicine (section 5).

2. Two Problems: Justification and Complicity

While some authors have argued that conscientious objection should not be allowed in medicine (e.g., Savulescu 2006 and Schüklenk & Smalling 2017), others have offered various reasons for respecting conscientious objection in medicine, such as the moral integrity of the objecting medical professional (e.g., Wicclair 2000 and Brock 2008), toleration for different moral points of view (e.g., Wear, Lagaipa, & Logue 1994 and Wester 2015), or even the truth of the claims of

conscience (e.g., Ben-Moshe 2019a and Ben-Moshe 2019c).[1] While these reasons pertain to the question of *whether* conscientious objection in medicine is justified, two related but different questions are *which* conscientious objections are justified and how *individual* medical professionals should justify their conscientious objections to others.[2] One possibility, which is common practice, is that a medical professional's conscientious objection to providing X is legitimate by the mere fact that she asserts that she objects to providing X. In other words, instead of providing reasons to justify the objection, the medical practitioner is usually merely required to sign a form stating "a moral, ethical, or religious objection" to the procedure in question (Meyers & Woods 1996, p. 117). However, some authors have worried that if conscientious objectors need not even state their reasons for their objections, the process of declaring conscientious objection is so simplistic that it trivializes moral decision-making and renders medical practitioners' right to conscientiously object unlimited in practice (Meyers & Woods 1996, p. 117 and Card 2007, p. 13). Following McConnell & Card (2019, p. 625), one can understand the force of this worry in one of two ways: (a) accepting problematic justifications for conscientious objections—for example, objections that are discriminatory, self-interested, arbitrary, empirically inaccurate, or otherwise normatively suspect; or (b) the harm that might be done to patients and the quality of healthcare. On the other hand, as McConnell &

[1] In previous work on conscientious objection in medicine, I have argued that (a) conscience can express *true* normative (and, more specifically, moral) claims (Ben-Moshe 2019c), and (b) the claims in question can be about medical norms rather than about general moral norms (Ben-Moshe 2019a). My aim in the current paper is not to retract my previous views about conscientious objection, but rather to offer a different account, based in part on the authority of public reason, for readers who remain unconvinced about the association between conscience and truth.

[2] One can use integrity of the objector and truth of the objection in order to assess which objections are justified. However, these criteria also explain why conscientious objection in medicine is justified in the first place: safe-guarding people's integrity, promoting truth, and so on. Genuineness and reasonableness (discussed above), on the other hand, are only used to assess which objections are justified, which is how they are presented in the literature.

Card note, if we rule out conscientious objections without assessing their grounds, then we might coerce objecting medical practitioners into acting against the verdicts of their consciences even when they have good reasons to object. Accordingly, two criteria have been offered for assessing the legitimacy of objections made by individual medical practitioners: (a) the *genuineness* of the practitioner's belief in the objection (e.g., Meyers & Woods 2007); and (b) the *reasonableness* of the objection (e.g., Card 2007).[3] Proponents of both the genuineness and the reasonableness requirements generally advocate a case-by-case assessment of the objecting practitioner's reasons by a review board (Meyers & Woods 1996, p. 119 and Card 2007, p. 13), perhaps even, as Robert Card has recently suggested, by an over-arching medical conscientious objector review (MCOR) board (Card 2014 & Card 2017).

There are general worries associated with individual medical practitioners attempting to justify themselves before review boards: (a) some individuals are more articulate than others and so will find it easier to convey the reasons for their objection, thus giving them an unfair advantage in the justificatory process; (b) members of a review board may have (potentially unconscious) biases and so might have different reactions to the same objection raised by different people, for example, by a white man and by a woman of color. Moreover, there are practical concerns: can a case-by-case review process for objecting medical professionals be implemented in healthcare institutions, and, even more so, for professionals who practice in non-institutional settings? (Wicclair 2007, p. 22). But the main worry with the genuineness and reasonableness requirements is that it is hard to determine when these requirements have been

[3] For a defense of a hybrid view, see Kantymir & McLeod 2014.

satisfied by interviewing individual medical practitioners. It is very difficult for an individual practitioner to prove that her conscientious objection is genuine, for, whatever reasons she provides, one might always wonder whether she is lying and does not really hold the belief that providing the requested service is wrong. Indeed, even if she is not lying and she does believe that providing the requested service is wrong, she might be holding this belief for reasons other than the ones she consciously recognizes (perhaps because of an unconscious prejudice) (Ben-Moshe 2019c, p. 406). The reasonableness criterion does not seem to fare any better, for it is difficult for an individual medical professional to demonstrate that her moral or religious beliefs are true, probably true, more likely than some competing hypothesis but not necessarily probable overall, or even epistemically rational in the sense of having some property, such as internal consistency or explanatory power (Marsh 2014, p. 315). One promising solution, advocated by Robert Card, is to understand reasonability in terms of the Rawlsian ideal of public reason. I will discuss this notion in further detail in the next section, but for present purposes the basic idea is that public reason "justifies a set of rules for the governance of society that warrant endorsement by all citizens, no matter their religious or cultural affiliation"; thus, medical practitioners "must not solely appeal to their personal, comprehensive doctrine to justify such refusals of care within the institutional structure of medicine but instead must appeal to public reasons" (Card 2017, pp. 222-223). However, public reason appeals to accepted beliefs and common sense, whereas conscientious objections tend to be based on personal beliefs and involve topics of controversy (Zolf 2019, p. 149). Indeed, Card wishes to retain the idea that conscientious objection "has a deeply personal aspect: its essence is […] to invoke one's deepest beliefs in order to avoid

participation in an action one morally opposes" (Card 2014, p. 321), an idea which is in tension with his claim that medical practitioners must appeal to public reasons. Moreover, given the fact that their training is in medicine rather than in philosophy or law, it is unlikely that most medical professionals would be able to state their objections in terms of public reasons rather than in terms of their own personal reasons. This is what I will call "the justification problem."

There is a further problem. Those who wish both to allow for some degree of conscientious objection in medicine, and to protect patients' autonomy and well-being, have argued for a compromise between medical professionals' conscientious objections and their professional obligations towards their patients. For example, Dan Brock has argued for a "conventional compromise," according to which a conscientiously-objecting medical practitioner is not required to provide the requested treatment only if: (a) she informs the patient about the treatment if it is medically relevant to their medical condition; (b) she refers the patient to another professional willing and able to provide the treatment; and (c) the referral does not impose an unreasonable burden on the patient (Brock 2008, p. 194). The main problem with the compromise approach is that medical practitioners are still required to be complicit in actions they *believe* are morally wrong (which I will call "subjective complicity") and/or in actions that are *in fact* morally wrong (which I will call "objective complicity"). Consider, for example, X, who conscientiously objects to fulfilling Y's request to kill Z. If we focus on subjective complicity, it will be of little comfort to X to require of him that he refer Y to W, who can and will kill Z. After all, X would be assisting Y in what he takes to be an immoral action by serving as the means to the completion of that action. Thus, if murdering Z would undermine one or

more of X's core moral beliefs, and hence his integrity, surely serving as the means to the murder of Z would also undermine one or more of X's core moral beliefs, and hence his integrity.[4] If we focus on objective complicity, it will also be of little help to require of X that he refer Y to W, who can and will kill Z. After all, X would be assisting Y in what is in fact an immoral action by serving as the means to the completion of that action. In this case, if it is in fact morally wrong to kill Z, X would bear some degree of responsibility for Y and W's actions.[5] To be sure, there are *degrees* of complicity in perceived and in actual wrongdoing (Sulmasy 2008, p. 141). Furthermore, the conscientious objector might come to recognize that even though providing the service is generally morally objectionable, informing or referring the patient *under the circumstances* is, all things considered, morally permissible (Blustein 1993, p. 314). However, in most cases a compromise will leave practitioners too complicit in perceived or in actual wrongdoing and so protecting patients' interests and respecting practitioners' objections in a satisfactory manner will be impossible.[6] This is what I will call "the complicity problem."

[4] I discuss this example in Ben-Moshe 2019c, p. 409.

[5] The conditional in this claim is important. If we focus on the objective conception of complicity, then there will be many instances in which we will not have a clear answer to the question of whether the action objected to is, in fact, morally impermissible. However, if it turns out that the action is morally impermissible, the practitioner who objects to performing the action, but aids the patient in performing it, would have been complicit in actual wrongdoing.

[6] Even Brock (2008, p. 198) is well aware that a significant degree of complicity will remain if objecting medical practitioners are required to refer patients to other practitioners; he therefore insists, however, that if a medical practitioner is not willing to adhere to the proposed compromise, then they should leave their professional role.

3. Solving the Justification Problem: Public Reason Revisited

Given the problems associated with individual medical professionals proving the genuineness or reasonableness of their objections to review boards, I suggest doing away with this process altogether. I wish to argue that an "Uber Conscientious Objection in Medicine Committee" ("UCOM Committee") should be formed that includes representatives from the medical community, in conjunction with other professionals—e.g., philosophers, sociologists, and lawyers—and representatives from various religions and from the patient population. This committee would deliberate and decide which *types* of conscientious objections are justified in medicine, rather than hearing out individual objecting medical professionals and making decisions on a case-by-case basis. The UCOM Committee would conduct its deliberations by assessing various well-known conscientious objections in medicine in terms of *public reason*, that is, by constructing arguments that appeal to reasons which can be accepted by all reasonable and rational agents, regardless of the comprehensive doctrines that they happen to endorse. Consider, for example, the conscientious objection to performing abortions. Medical professionals might object to performing this service for various personal reasons, such as "scripture states that abortions are morally impermissible" or "the purpose of women is to reproduce and that is not to be obstructed." However, such reasons will presumably not be accepted by all: many will not accept the authority of scripture or the claim that the purpose of women is to reproduce. On the other hand, the conscientious objection to abortion could be framed in terms of public reason, regardless of the comprehensive doctrine on which it is based. Thus, the objection could, in principle, be formulated as follows: (P1) it is morally impermissible

to kill persons unjustly; (P2) abortion is an unjust killing of the fetus; (P3) fetuses are persons; (C) so abortions are morally impermissible. We might disagree, for example, whether fetuses are in fact persons or whether abortion is an unjust killing of the fetus in all circumstances. However, note that deliberation in light of public reason will presumably lead to the endorsement of P1 on the grounds of the truth of the claim and of P2 and P3 on the grounds of epistemic humility, for there are some circumstances in which abortion is an unjust killing of the fetus and there are good arguments for and against attributing personhood to fetuses. Of course, this does not mean that the argument is sound, since, at the very least, premises P2 and P3 have not been shown to be true. However, given the uncertainty about the truth of some of the premises, and hence of the conclusion, agents utilizing public reason would presumably tolerate conscientious objections to abortions, since performing abortions might very well be morally wrong, as shown by reasons that we can all share, and so conscientious objectors should be protected against potential complicity in such actions.

In order to fill out this sketch of the workings of the UCOM Committee, the following three questions require answers: (a) What are the sources of the committee's authority? (b) Why should the committee focus its deliberations on public reason? (c) How would the committee avoid some of the main pitfalls that characterize bioethics committees? Let's start with the first question. I introduced the UCOM Committee in order to address a certain practical concern, namely, how can we go about determining which conscientious objections in medicine are justified, and hence permissible, without requiring individual medical practitioners to justify themselves to others. Nevertheless, given the fact that the mandate of this committee is to *justify*

certain normative claims, an account of its authority needs to be provided. I wish to argue that the political authority of the committee is a function of its *representational* nature and its moral authority is a function of *constructivist* reasoning. Regarding the committee's political authority, I noted that the UCOM Committee should include representatives from the medical community, other professions (such as philosophers, sociologists, and lawyers), various religions, and the patient population. This diversity within the committee ensures that the viewpoints and interests of all relevant stakeholders are taken into account. The adequacy of the representation in question can be understood along two dimensions. First, we want to represent the viewpoints and interests of both medical practitioners and patients, since these are the two parties that have the greatest stake in the range and types of conscientious objections that will be permitted. In particular, medical practitioners will be permitted to object to providing some services but not others, and some practitioners may need to do additional work in place of the objecting practitioners. Patients, in turn, may have more restricted access to those medical services to which many medical practitioners object.[7] Second, we want to represent the viewpoints and interests of both those supporting and those objecting to conscientious objection in medicine, since both of these parties quite naturally have a stake in the decisions of the UCOM Committee. So, for example, conscientious objectors who object to X for religious reasons would be represented by a member (or members) of their religion and conscientious objectors who object

[7] If the committee were comprised *only* of representatives from the medical community, we would risk a version of what John Arras (2001, pp. 653-656) calls "historical professionalism," namely, the position that physicians determine, through agreement, the norms of medicine in a historically evolving manner. As Arras points out, the mere fact that members of a given group have agreed upon certain norms is not sufficient to justify the norms to outsiders, especially when the behavior of the group in question impinges on the interests of those outside the group.

to X for moral reasons would be represented by philosophers, sociologists, and lawyers. However, the committee should also include representatives from the various religions and other professions who do not support conscientious objection in medicine, so that the viewpoints and interests of those opposing conscientious objection in medicine are taken into account. I believe that, because it adequately represents all of the relevant stakeholders along both of these dimensions, the UCOM Committee has the right kind of political authority.

The UCOM Committee not only has the right type of political authority, but can also acquire the right type of moral authority by appeal to constructivist reasoning.[8] According to constructivist reasoning, it is the agreement of agents *under suitable conditions* that determines the norms in a given normative domain (in our case, the relevant normative domain is conscientious objection in medicine). Of course, the conditions in question cannot be defined in terms of these agents getting the right results, on pain of circularity. However, the conditions are required to guarantee that the agents' responses are in fact reliable, and one well-known strategy is to *idealize* them. Such idealization could include, for example, knowledge of all the facts relevant to the decision and impartiality, as well as a suitable conception of reasonableness.[9] While I will discuss the notion of reasonableness that is most relevant for such a committee shortly, here I wish to point out that the diverse representation in the UCOM Committee satisfies

[8] By attributing moral authority to the UCOM Committee, I am implying that the verdicts of the committee will be authoritative over existing laws in one or both of the following ways: (a) existing laws may need to be modified if they are inconsistent with the verdicts of the UCOM Committee; (b) the verdicts of the UCOM Committee would justify exceptions, under certain circumstances, to existing laws without necessarily altering them.

[9] Knowledge of the relevant facts and impartiality are familiar from ideal observer theory and modest ideal observer theory (see Firth 1952 & Smith 1976, respectively), but they can easily be incorporated into a constructivist procedure. Reasonableness is familiar from Rawls's (1980) Kantian brand of constructivism.

the first two conditions: (a) it ensures that participants in the deliberations have the relevant knowledge, such as medical knowledge, knowledge of philosophical theories, sociological and legal knowledge, and knowledge of various religious doctrines and patient interests; (b) given the various viewpoints that these participants have, dialogue between them could potentially minimize biases and lead to greater impartiality.[10] In terms of the output of the constructivist procedure, note the following two things. First, the task of this committee is not to determine *whether* conscientious objection in medicine is justified, but rather *which* conscientious objections are justified. On the assumption that conscientious objection in medicine is justified, we need a method for determining which objections are justified without appealing to the personal beliefs of individual medical professionals. Accordingly, the output of the committee are norms about the types of conscientious objections that should be permitted in medicine. Second, the committee need not identify normative *truths* but rather the norms that are most *reasonable*. Indeed, when Rawls (1980, pp. 519 & 569) discussed his Kantian constructivism, he argued that the result of a constructivist procedure need not be truth, but rather reasonableness.[11]

One could object that while most well-known constructivist approaches, including Rawls' (1980), have opted for a *hypothetical* procedure, my talk of a constructivist procedure within the workings of a committee suggests that the procedure is an *actual* one. This raises certain worries that will need to be addressed: How do we know if and when the procedure is successful? Are

[10] Both of these features are taken from my constructivist account of the internal morality of medicine (see Ben-Moshe 2019b, p. 4458).

[11] As Rawls (2005a, p. 129) puts it elsewhere, "once we accept the fact that reasonable pluralism is a permanent condition of public culture under free institutions, the idea of the reasonable is more suitable as part of the basis of public justification for a constitutional regime than the idea of moral truth."

the actual results of the constructivist procedure necessarily correct, or is it possible for participants to converge on the wrong norms? Why should someone accept the committee's norms, even if it is the case that they are the result of the procedure done correctly? A constructivist procedure is successful if and only if certain conditions were satisfied during the construction process; that is, if the procedure was carried out correctly: Did all of the relevant participants take part in the process? Did they have all of the relevant knowledge? Did participants engage as equal interlocutors? Was the agreement between participants unforced? The key idea is that the relevant agents deliberating under suitable conditions determine the norms in question. This hypothetical understanding of the procedure can serve as the ideal that actual discussions need to approximate in order to be normatively significant. Therefore, even if the procedure in question is an actual one, there will be instances in which the relevant conditions will have been met and the norms arising out of actual interactions will be correct; however, there will also be instances in which these conditions will not have been met and the participants will converge on the wrong norms (for example, when not all of the relevant participants took part, or they did not have relevant knowledge, or public reason was not utilized, and so on). As to the final question—namely, why someone should accept the committee's norms, even if it is the case that they are the result of the procedure done correctly—the answer lies, I believe, in both the committee's representational dimension and in its constructivist component: a committee that represents all of the relevant stakeholders has determined the norms governing conscientious objection in medicine by approximating ideal conditions of full

knowledge and impartiality to the greatest degree possible and by utilizing reasons that all reasonable and rational agents can share.[12]

I have repeatedly argued that the committee should make use of the Rawlsian ideal of public reason; more needs to be said, however, about the nature and use of this ideal. According to Rawls (2005a, p. 213), public reason "is characteristic of a democratic people: it is the reason of its citizens, of those sharing the status of equal citizenship. The subject of their reason is the good of the public: what the political conception of justice requires of society's basic structure of institutions, and of the purposes and ends they are to serve." Importantly, in order to establish "a basis of political reasoning that all can share as free and equal citizens," it is crucial that "ideas of truth or right based on comprehensive doctrines are replaced by an idea of the politically reasonable addressed to citizens as citizens" (Rawls 2005b, p. 481). So why would public reason be appropriate for justifying which conscientious objections are permitted in medicine? The primary reason is that conscientiously-objecting medical practitioners are asking to be exempt from role-based duties that are defined by the law, and they need to provide a justification for this exemption that their fellow citizens would accept. If they provide a justification in terms of their own comprehensive doctrines, there is no reason why others, who do not share the assumptions of the doctrines in question, should accept these justifications. Likewise, it is not obvious that citizens should accept appeals to considerations of personal integrity, since the way to assess conscientious objections based on appeals to personal integrity is via the sincerity of the

[12] Many of the points in this paragraph are taken from my constructivist account of the internal morality of medicine (see Ben-Moshe 2019b, pp. 4459-61).

objector, which, as I argued at the outset, is extremely difficult to do. Rather, the way to justify the exemptions associated with conscientious objection in medicine in a liberal society is by providing reasons that all citizens can share, that is, by appealing to the reason of the citizens, as Rawls put it. And this was exemplified in the objection to abortion that I discussed earlier, which included premises about the moral impermissibility of killing persons unjustly and the normative status of fetuses, premises that appealed to assumptions that all citizens could endorse—at the very least on grounds of epistemic humility—and not to any comprehensive doctrine. Of course, in my account it is not the citizens or medical practitioners who are providing and accepting the reasons for the conscientious objection, but rather their representatives in the UCOM Committee.

I wish to clarify some additional features of the use of public reason as it pertains to the UCOM Committee. First, I noted that the UCOM Committee might grant certain conscientious objections in medicine on grounds of epistemic humility. Epistemic humility in such cases is warranted given the values that are inherent to public reason, which include not only "the appropriate use of the fundamental concepts of judgment, inference, and evidence, but also the virtues of reasonableness and fairmindedness as shown in abiding by the criteria and procedures of commonsense knowledge and accepting the methods and conclusions of science when not controversial" (Rawls 2005a, p. 139). Given the uncertainty about some of the normative claims pertaining to, for example, abortion, and in light of the appropriate use of judgment, inference, evidence, fairmindedness, and reasonableness, the UCOM Committee should err on the side of caution. Second, and relatedly, given the values of public reason listed above, the utilization of public reason would presumably not allow objections that are discriminatory, self-interested,

arbitrary, empirically inaccurate, or otherwise normatively suspect. Third, note that in my first quote from Rawls in the previous paragraph, Rawls claims that the subject of public reason is "the good of the public." This claim was implicit in my abortion example. In particular, the abortion example rests on the assumption that citizens should not be forced into complicity in actions that are potentially morally wrong. Such an assumption is justified by the ideal of the good of the public, for it is arguably within the good of the public—whether one understands this claim in deontological, consequentialist, or virtue ethics terms—that citizens are not forced into complicity in actions that are potentially morally wrong. Fourth, Rawls (2005a, p. 214) argues that the questions that are within the purview of public reason are fundamental in the sense that they involve constitutional essentials and questions of basic justice, such as "who has the right to vote, or what religions are to be tolerated, or who is to be assured fair equality of opportunity, or to hold property." While questions pertaining to conscientious objection in medicine do not involve constitutional essentials or basic justice *simpliciter*, one can see them as involving questions of basic justice *within the medical profession*: these are fundamental questions about who has the right not to provide beneficial and legal medical services, which conscientious objections should be permitted in medicine, and how we assure fairness and equality in the distribution of healthcare (an issue I discuss at greater length in the next section).[13]

[13] Rawls (2005a, p. 215) entertains the idea of applying public reason to "all questions in regard to which citizens exercise their final and coercive political power over one another." He does not object to doing so, noting that his aim is "to consider first the strongest case where the political questions concern the most fundamental matters. […] Should [the limits of public reason] hold here, we can then proceed to other cases." Indeed, he notes that it is "usually highly desirable to settle political questions by invoking the values of public reason."

Recall that Zolf argues that conscientious objections are generally based on personal beliefs and involve topics of controversy rather than on common sense and public reasons. However, if we agree that such objections *should* be assessed in terms of public reasons, the key question is not whether conscientious objections are in fact based on personal beliefs rather than on public reasons, but whether such objections *could* be based on public reasons. I believe that the answer to this question is affirmative and that the members of the UCOM Committee, such as philosophers, lawyers, and sociologists, are precisely the types of agents who would have the relevant knowledge and skills to work out reasons that all members of a liberal society could share. While Card also argues for the public reason standard, my account does better because of its *impersonal* and *informed* nature. My account is impersonal in the sense that it does not rely on individual medical practitioners appearing before review boards and stating the reasons for their objections. My account is informed in the sense that it relies on experts, who represent the relevant stakeholders, to do the relevant justificatory work, namely, to determine which types of conscientious objections in medicine are justified. The fact that my account does away with the hearing individual practitioners also means that it does away with the unfairness associated with: (a) the worry that some individuals are more articulate than others and will thus find it easier to convey the reasons for their objection; and (b) the worry that members of a review board may have (potentially unconscious) biases and so may have different reactions to the same objection raised by different people. Moreover, a single committee making all the decisions would be far cheaper than convening committees (or even Card's overarching MCOR board) whenever an individual medical professional wanted an objection considered for accommodation. Finally,

note that while I am arguing that individual medical professionals need not appear before a review board and thus need not state their reasons for their conscientious objections, my proposal does not trivialize moral decision making. This is so because decisions about the legitimacy of certain types of conscientious objections are made following deliberations by representatives of the relevant stakeholders who have the suitable forms of knowledge and who utilize reasons that we all can share. Furthermore, my proposal does not make practitioners' right to conscientiously object unlimited, since there are clear guidelines regarding which conscientious objections are legitimate. Of course, as new technologies develop and new conscientious objections arise, the medical profession will need to refresh the list of permitted objections. Thus, a mechanism for hearing out individual practitioners will need to be set up when an entirely new type of objection is raised. The committee would then need to make a decision about the legitimacy of the *type* of objection in question, above and beyond the idiosyncrasies of the case presented to them.

Finally, there are widely discussed problems associated with bioethics committees. In particular, many authors have noted difficulties associated with reaching agreement and consensus in bioethics committees and more generally (Engelhardt 1996, ch. 3-4; Wildes 2000, ch. 6). Now, I have already explained how my proposal can deal with some of the worries associated with agreement and consensus. For example, one might ask what the moral justification for our agreement and consensus is (Wildes 2000, p. 143). My discussion of the constructivist dimension of the agreement in question was supposed to provide the requisite moral justification: the agreement of the committee derives its moral authority from approximating a certain idealized state of affairs of full knowledge, impartiality, and

reasonableness. Alternatively, one might worry that different committees might reach different conclusions and that this might be the result of various sociological factors, such as the composition of the committee and crucial assumptions about society and healthcare that members do or do not share (Wildes 2000, p .156).[14] By making the committee as diverse as possible, I believe that my proposed UCOM Committee can rise to these challenges: the diversity in the composition of the committee is supposed to make the committee as adequately representative as possible and, accordingly, include members who hold a very wide range of assumptions about society, healthcare, and other matters of importance. Of course, the problem with such diversity is that it would seem to make actually attaining agreement and consensus especially difficult. This is where public reason can aid in the process. The use of public reason in the UCOM Committee's deliberation is justified, in the first instance, in terms of the way we interact as free and equal citizens in a liberal society. However, a further justification of the utilization of public reason is a practical one: it facilitates the attainment of agreement and (hopefully) consensus, since parties to the agreement can converse in terms of reasons that they can all share.[15] Of course, some disagreement might remain, as was the case vis-à-vis some of the premises in the abortion example. However, reasonable disagreement about certain norms does not undermine the procedure through which those norms were attained. Indeed, Rawls (2005a, pp. 56-57) himself notes that there can be reasonable disagreement between reasonable persons which can be the result of, amongst other things, the empirical and scientific evidence

[14] Different bioethics committees have come up with different guidelines: Clinton's bioethics committee affirmed liberal agenda items that Bush's committee did not. I am indebted to an anonymous referee for this example.

[15] For other ways of facilitating agreement and consensus in bioethics committees, see, for example, Moreno 1994.

bearing on the case being conflicting and complex, disagreement about the weights of the considerations that are relevant, concepts being vague and subject to hard cases, and the existence of various normative considerations of different force on both sides of an issue.

I wish to note, briefly, some further practical considerations pertaining to the UCOM Committee. First, even if disagreement is reasonable, we need a method for the committee to deal with disagreement among its members. In particular, if disagreement remains, even after deliberations cast in terms of public reason, members of the committee would need to vote on whether or not a certain conscientious objection is permissible. Rawls (2005a, pp. liii-liv) himself argues that even when making use of public reason, some "disputed questions, such as that of abortion, may lead to a stand-off between different political conceptions, and citizens must simply vote on the question. […] [T]he outcome of the vote is to be seen as reasonable provided all citizens of a reasonably just constitutional regime sincerely vote in accordance with the idea of public reason." In the case of the UCOM Committee, such a vote is legitimate because it is made by the most fully informed representatives of the relevant stakeholders after a genuine attempt to reach unanimous agreement by appeal to the criterion of public reason. Second, we need a method for selecting committee members that would avoid a hyper-politicized body which would be loaded with either conservatives or liberals. One way such a committee could be formed is via a well-rounded selection committee that would include, for example, members of parliament/congress from all parties as well as retired judges and prominent physicians. Once the committee is in place, its members could also have a say in the selection of new committee members. Third, we would need a way of avoiding biases from

influencing the committee's judgments. I have already noted that diverse representation can reduce biases. However, even after we have guaranteed diverse representation, dynamics within the committee might lead to the emergence of certain biases. For example, representatives from the patient population may be at risk of being persuaded to accept things they shouldn't by overbearing lawyers, philosophers, and so on. One way of avoiding this problem is to have an official moderator of the committee, such as a retired judge, who would see to it that everyone has equal opportunity to speak. There might also be some form of oversight on the committee—for example, by parliament/congress—which would see to it that deliberations are taking place under fair conditions, conditions that show "respect to the precepts governing reasonable political discussion," as Rawls (2005a, p. 139) put it when discussing public reason. Fourth, those amenable to conscientious objection in medicine might feel aggrieved because some conscientious objections will not be accepted by the committee. Indeed, it is the case that those conscientious objectors who do not have their objections accepted by the committee will have to go against their consciences or look to avoid positions where their consciences are challenged. While these objectors ought to recognize that the UCOM Committee's decisions are legitimate, I grant that a method for allowing individual medical practitioners to appeal the committee's decisions should be institutionalized.[16]

[16] Rawls (2005b, p. 480) notes that some may reject a legitimate decision made in light of public reason, for example, Roman Catholics may reject a decision to grant a right to abortion. They may even argue in terms of public reason, but fail to win a majority. While they need not exercise the right to abortion and they may even continue, in line with public reason, to argue against the right to abortion, they should recognize the right as belonging to a legitimate law enacted in accordance with legitimate political institutions and public reason.

4. Solving the Complicity Problem: The UCOM Committee and Beyond

The next question is how the verdicts of the UCOM Committee relate to individual medical practitioners. One possibility is that this committee simply publicizes its decisions, which would, in turn, allow individual medical practitioners to object to providing services that the committee has approved. However, this would be insufficient, since in order for the medical community to discharge its professional obligations and to protect the well-being of patients, objecting medical practitioners would need to refer patients to non-objecting practitioners. Therefore, we encounter the complicity problem once again. I wish to offer a solution to the complicity problem that is more radical than many proposals found in the literature, according to which medical professionals should inform patients of possible treatment limits due to conscientious objections "up front" (Wear, Lagaipa, & Logue 1994, p. 155), "at the outset of the encounter" (Dresser 2005a, p. 9), or "during their initial meeting" (Wicclair 2011, p. 116). Indeed, it is also more radical than Minerva's (2017, p. 117) more recent suggestion according to which a sign could be placed either at the entrances of hospitals or on individual medical professionals' doors, informing patients of medical professionals' conscientious objections. In particular, I wish to argue that in addition to the committee making its decision public, a further step that brings conscientious objection in medicine into the public realm should be taken: instead of insisting that objectors refer patients to non-objectors, medical practitioners should *publicly advertise*, ahead of time, their (UCOM Committee preapproved) conscientious objections. More specifically, a national (or state-wide) online database, which would be easily accessible to the public, should be compiled, in which all of the treatments to which each medical professional

conscientiously objects are listed.[17] Furthermore, software could be developed with a search function integrated with an online map that could flag which of the local medical practitioners object to what as well as show the closest non-objectors. In other words, individual practitioners would simply list their conscientious objections in this database, without appearing before any review board, on the condition that these types of objections have been approved by the UCOM Committee. Patients would then know about a given medical practitioner's conscientious objections *before* they decide to use his or her services and would thus be able to choose practitioners according to their (the patients') preferences. Conscientiously-objecting medical practitioners would *not* be expected to refer patients to non-objecting practitioners and, therefore, the complicity problem would not arise.

One might worry that my proposal is not feasible, since it will not work in various contexts, namely, in emergency situations and in hospitals or geographic areas in which a sufficient number of non-objecting medical practitioners simply does not exist. I wish to offer both a "partial solution" and a "comprehensive solution" to this worry. According to the partial solution, the UCOM Committee would have a rather broad mandate: it would not only determine which conscientious objections are justified, but would also protect patient interests. Given my discussion of the nature of the UCOM Committee in the previous section, this is a natural extension of the mandate of the committee. First, recall that this committee includes

[17] Card (2017, p. 225) does briefly note that "as part of establishing CO status in medicine, we should create an online database accessible to patients so that they can be aware of any successful petitions for CO status by their physician and therefore avoid a refusal." However, it is clear that Card does not use this idea to solve the complicity problem, for he continues by saying that, "given the public knowledge of such CO status, this provides objecting practitioners with the means to quickly ensure they are referring their patient to a willing provider." Referral would, as argued above, leave objecting practitioners complicit in perceived or even in actual wrongdoing.

representatives from the patient population. I argued that this means that patients can both be represented as relevant stakeholders and contribute knowledge regarding their own interests during the UCOM Committee's deliberations. Second, I argued that the use of public reason in the UCOM Committee's deliberation is justified, in the first instance, in terms of the way we interact as free and equal citizens in a liberal society, which includes, of course, patients. Third, I noted that part of the public good—an idea that is key to the ideal of public reason—is that citizens are not forced into complicity in actions that are potentially morally wrong. Likewise, it would seem that it is part of the public good that citizens receive healthcare services that are beneficial to them and to which they are legally entitled. Hence, the UCOM Committee should not determine which conscientious objections are permitted in medicine *simpliciter*, but rather which conscientious objections are permitted in medicine on the condition that patients' interests are safeguarded. The committee might thus limit the approved objections to non-emergency situations and to hospitals and geographic areas in which there is a sufficient number of non-objecting medical practitioners. For example, the committee could specify in which emergency situations an otherwise justified conscientious objection is not permitted and what the desirable ratio is of conscientious objectors to non-conscientious objectors in a given hospital or geographic area.[18]

It is worth emphasizing that I am arguing that when the UCOM Committee has approved a conscientious objection to providing service X under certain conditions, medical practitioners

[18] For an excellent discussion regarding the desirable ratio of conscientious objectors to non-conscientious objectors in a hospital or in a given geographic area, see Minerva 2017, pp. 116-118.

need not refer the patient to a different practitioner if they object to providing service X and find themselves under the specified conditions (it is not an emergency situation, there are enough non-objecting practitioners in their area, and so on). Hence, the practitioners in question would not be complicit in perceived or actual wrongdoing. Of course, if the relevant conditions are not met, medical practitioners will need to refer patients to other practitioners and will thus be, on the face of it, complicit in perceived or actual wrongdoing. In response, one could argue that any residual *prima facie* complicity is justified, since a committee that has the authority to determine the status of conscientious objections and protect patient interests has judged that conscientious objection X is justified, all-things-considered, *only if* conditions A, B, C are met. Moreover, my suggestion is a substantial improvement on Brock's conventional compromise, since it limits the number of medical practitioners who would be required to refer patients to non-objecting practitioners; for example, if there is a sufficient number of non-objecting practitioners in a certain area, referral of patients would not be mandatory. However, an objector might further argue that my proposal is unfair towards some medical professionals, for example, to those who, without any fault of their own, happen to practice medicine in remote areas. Hence, this is only a partial solution. A comprehensive solution is possible, I believe, but it would require more than an appeal to the UCOM Committee. In particular, if the medical community wishes to take conscientious objection seriously, then it might need to see to it that if, for example, the only medical practitioner in town has a justified objection to providing treatment X, there is an additional practitioner in town who does provide treatment X (this could also be done in certain settings in which emergency situations arise). This solution would require providing medical

professionals with incentives to move to a new region or workplace and would require resources, but it is a way of balancing medical professionals' conscientious objections with patients' interests without making medical practitioners complicit in wrongdoing. The UCOM Committee, for its part, might need to consider which objections society can afford and so consider questions of distributive justice. Finally, if incentives prove to be insufficient, then the medical community might need to establish a mechanism for monitoring the number of conscientious objectors admitted to medical schools. This is a much more radical solution—and one which might prove to be unnecessary—but it is a solution that would allow for substantial conscientious objection in medicine without leaving *any* objectors complicit in perceived or actual wrongdoing.[19]

5. Objections and Replies

One could raise the following three objections to my account that pertain to the importance of actually hearing out individual conscientious objectors. First, one could object that hearing out the conscientious objector is important, since conscience has an inherently *personal* aspect in the sense that it is intimately tied to one's own actions, given the type of person that one is (Blustein 1993, pp. 229-300). I am not denying that conscience should be intimately tied to one's own actions, given the type of person that one is. I am simply arguing that (a) an individual

[19] There is an additional worry that the law often makes it difficult to practice medicine, for example, at a Roman Catholic hospital with Roman Catholic religious commitments. Indeed, there are a number of lawsuits pending in the United States trying to force Roman Catholic hospitals to perform abortions, sterilizations, and so on. I will not be discussing the hostility of the law to such matters, since my argument pertains not to what *is* the case, but to what *ought* to be the case. Thus, the verdicts of the UCOM Committee might render current laws problematic, so that they may need to be revised accordingly. I am grateful to an anonymous referee for bringing this issue to my attention.

conscientiously-objecting medical practitioner cannot determine which conscientious objections are justified, and (b) once a certain type of conscientious objection is considered legitimate by the UCOM Committee (under the relevant conditions), an individual practitioner who wishes to object to an instance of that type of objection need not justify himself to others. Thus, the conscientious objector is free to allow his conscience to guide his actions in the medical realm, on the condition that the UCOM Committee has approved the type(s) of conscientious objection that serve as the basis for his request for accommodation. Second, one could object that hearing out the objecting medical professional is important in order to ascertain the *genuineness* of the objection. However, genuineness, in my account, can be attained by virtue of the fact that the medical professional is willing to advertise his conscientious objection at potential cost to himself, such as publicizing his own values and losing potential patients who do not share his values. Moreover, additional steps can be taken to determine the genuineness of the objector: (a) the objector may be required to sign a document stating that he conscientiously objects to providing service X under penalty of perjury; (b) the objector may be required to make up for the work he pushes on to non-objecting medical practitioners. Third, one could insist that hearing out the objecting practitioner is important, since we should hear her own reasons for the objection. However, apart from ascertaining the genuineness of the objection, it is not clear what is lost if we do not hear the objector out, and, as I have argued, there are other and better ways to ascertain genuineness. Furthermore, given my emphasis on *public* reason, there is no special importance to hearing out the medical practitioner's own personal justifications for her conscientious objection, nor should we expect her to state such an objection in general terms.

One could also raise two objections pertaining to the role of values in medicine as well as for medical professionals. First, my proposal entails that medical professionals advertise their own values: doesn't this undermine the idea of the medical encounter as a value-free enterprise, in which medical practitioners merely provide patients with non-value-laden medical information and patients then choose their preferred intervention? A reply to this objection is that this fact-provider model of medicine has by now been discredited, since the assumption underlying this picture, according to which there is a clear distinction between facts and values, is untenable, and so medical professionals cannot avoid making value judgments (Savulescu 1995, pp. 328-329; see also Emanuel & Emanuel 1992.). Given the recognition that medicine is a *value-laden* enterprise, the claim that medicine is a value-free enterprise cannot support, in and of itself, the conclusion that medical practitioners' values have no place in medicine. One would need to use different arguments (or at least add premises) in order to support this conclusion. Second, despite the fact that public announcement is a way for medical professionals to prove that their objections are genuine, one could object that medical professionals might not be willing to advertise their conscientious objections, precisely because they believe that their own values should not become public knowledge or because they fear they might lose potential patients. A response to this objection is that my proposal already protects objecting medical professionals more than most other proposals in the literature, in the sense that in most cases they are not required to refer patients to non-objecting practitioners and so are not complicit in perceived or actual wrongdoing. Furthermore, my proposal also protects the objector's privacy in the sense that apart from publicly advertising her objections in the database, the conscientious objector

need not justify herself to others—whether to review boards at the institutional level or to Card's over-arching medical conscientious objector review board—and, therefore, need not reveal to others her private reasons for holding her conscience-based beliefs. Finally, if medical professionals are not even willing to advertise their conscientious objections, then they are not taking these objections seriously enough, for given the overriding normative weight of moral considerations, which are usually central to conscientious objections, these considerations should trump all others, including those of a given objector's privacy and personal gain.[20]

One could also raise two objections pertaining to the capabilities and interests of patients. First, it might be objected that my proposal demands too high a degree of literacy on the part of patients, since patients are expected to investigate whether or not medical practitioners object to providing services before they meet them. However, sufficient advertisement of this new policy, coupled with the support of patient advocacy groups, could aid patients in learning about the new policy in general and about how to look up specific medical professionals in particular. Moreover, my proposal can increase patient autonomy by providing patients with information relevant to their decision and by making patients think through their own values and preferences. It can also deal with the worry that conscientious objection in medicine might lead to inequity—in the sense that some patients are more informed than other of their entitlements (Savulescu 2006, p. 295)—since all patients would have the same opportunity of being fully-informed about medical practitioners' objections. Second, one could object that patients would not necessarily know ahead of time which services they might want in the future, and so the idea of a database of

[20] One could make a similar case for religious considerations, but I will not pursue that possibility here.

conscientious objections would be of little use to them. So, for example, a patient who thinks that she might never want an abortion goes to a gynecologist who has advertised that she does not perform abortions. The patient then gets pregnant and decides that she does want an abortion after all. Would the gynecologist not be obligated to refer the patient to another physician (assuming there are enough non-objecting physicians in the area)? My suggestion puts more responsibility on patients to think though their own desires and values, and, of course, patient desires and values may change over time. However, note two things: (a) there are other domains in medicine in which we know that a patient's desires and values might change with time and still maintain that it is the patient's responsibility to make the necessary arrangements, as is the case in advance directives; (b) if the patient's desires or values have changed after choosing a certain medical practitioner, the patient is free to choose a different practitioner who does not object to the requested service. I have argued that in most cases the objecting practitioner should not be obligated to refer the patient to another practitioner. However, there are other solutions to helping patients find a different practitioner; for example, patient advocacy groups could come to patients' assistance. This solution would require resources, but it may be a reasonable price to pay if the medical community wishes to take conscientious objection in medicine seriously.

Finally, one could raise two objections pertaining to broader social aspects of conscientious objection in medicine. First, is it not the case that my proposal would only apply to private healthcare systems, where patients can choose their healthcare provider, and not to public healthcare systems, where patients cannot choose their healthcare provider? The answer is no: there are plans within a private healthcare system that allow for substantial provider choice and

plans that allow for virtually no provider choice; likewise, there are public healthcare systems that allow for substantial provider choice and public healthcare systems that allow for virtually no provider choice. However, my suggestion does entail that whether the healthcare system is private or public, patients should be able to choose their healthcare provider, and so the objector might press: if we allow patients to shop around, might this not lead to greater inefficiency and wasting of resources (Savulescu 2006, p. 295)? Inefficiency would probably result if we allowed for conscientious objection in medicine *without* my proposal, for patients might find themselves first going to a medical professional who objects to providing the sought-after service and thus needing to shop around for other providers who do not object to providing the service. On my proposal, the shopping around occurs *before* the patient sees any healthcare provider and so there is no inefficiency or wasting of resources involved. Second, one could object that my account is unfair towards conscientious objections based on religious grounds, since, so the objection goes, public reason is less amenable to religious considerations than to secular ones. However, as McConnell & Card (2019, p. 628) argue, secular and religious conscientious objectors are faced with the same task in the sense that both type of objectors need to translate their objections into the language of public reason. Rawls (2005a, p. xxxviii & 2005b, p. 452), for his part, made it clear that his project of political liberalism is distinct from both religious and nonreligious comprehensive doctrines and that public reason is not secular reason (reasoning in terms of comprehensive nonreligious doctrines). Therefore, the religious conscientious objector needs to justify his objection by appealing to public reason, instead of scripture or tradition, much in the same way that the nonreligious conscientious objector cannot appeal to his own comprehensive

doctrine of the good. I grant that this might be easier to do if the religious objections are also moral in nature, since it is presumably easier to translate moral considerations into the language of reasons that we can all share. However, this will also be true of nonreligious objections. Furthermore, note that the religious objections we tend to accept in medicine—for example, objections to performing abortions—could have been easily formulated as moral objections within the public reason framework and those that we do not tend to accept—for example, objections to treating gay patients—could not have been thus formulated.[21] Accordingly, the UCOM Committee's deliberations and verdicts should be no less amenable to religious conscientious objections than to nonreligious ones, especially if the objections in question are also moral in nature.

6. Conclusion

I have offered a new framework for conscientious objections in medicine that solves the justification and complicity problems by bringing medical practitioners' conscientious objections into the public realm. In particular, I argued that an "Uber Conscientious Objection in Medicine Committee," which includes representatives from the medical community, in conjunction with other professionals and representatives from various religions and from the patient population, should assess conscientious objections in medicine in terms of public reason and decide which conscientious objections should be permitted, without hearing out individual conscientious

[21] I have previously made this last point in connection with conscientious objections that are made from the standpoint of Adam Smith's impartial spectator (see Ben-Moshe 2019c, p. 409).

objectors. I also argued that medical practitioners should advertise their (UCOM Committee preapproved) conscientious objections in an online database that would be easily accessible to the public, without being required, in most cases, to refer patients to non-objecting practitioners. Furthermore, I made the case that, amongst other things, this account: (a) takes the burden of proving the genuineness or reasonableness of specific conscientious objections off of individual medical professionals, and takes the related burden of assessing individual practitioners' conscientious objections off of review boards; (b) provides clear guidelines that delineate which conscientious objections are justified in medicine; (c) protects the conscientious objector, to the greatest degree possible, from perceived and actual wrongdoing; (d) provides an (indirect) way for medical professionals to demonstrate the genuineness of their objections; (e) protects the objector's privacy, since she is not required to reveal to others her private reasons for holding conscience-based beliefs; and (f) increases both patient autonomy and equity among patients, while not leading to greater inefficiency and to the wasting of resources.

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