**Abstract:** In 2019, several US states passed “heartbeat” bills. Should such bills go into effect, they would outlaw abortion once an embryonic heartbeat can be detected, thereby severely limiting an individual’s access to abortion. Many states allow health care professionals to refuse to provide an abortion for reasons of conscience. Yet heartbeat bills do not include a positive conscience clause that would allow health care professionals to provide an abortion for reasons of conscience. I argue that this asymmetry is unjustified. The same criteria that justify protecting conscientious refusals to provide abortion also justify protecting positive conscientious appeals regarding abortion. Thus, if the law provides legal exemptions for health care professionals who, as a matter of conscience, refuse to provide abortions where it is legal, it should also provide exemptions for health care professionals who, as a matter of conscience, feel obligated to provide abortions where it is illegal.

**Keywords:** Conscience, Conscientious Objection, Abortion, Heartbeat Laws, Health Policy

In 2019, several US states, primarily in the South, passed “heartbeat” bills, outlawing abortion as soon as a heartbeat can be detected in the developing embryo. Because this heartbeat can be detected as early as six weeks—before many people even realize that they’re pregnant—heartbeat bills severely limit an individual’s access to abortion. While at the time of writing all such bills have been blocked by a federal court, the possibility remains that such bills could go into effect. Should that happen, many health care professionals (HCPs) may find themselves deeply morally opposed to such legislation, believing that they cannot, in good conscience, deny providing an abortion to a woman who requests it, even after a heartbeat is detected. They may feel that they have a *positive obligation* to provide an abortion in line with their conscience.

Many states, including those in the South, allow HCPs to *refuse* treatment if providing such treatment would be against one’s conscience, especially regarding abortion.[[1]](#footnote-1) For example, Mississippi Code 1972, section 41-41-215 says, “A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience.” Yet there are no complementary provisions allowing for an exemption from bans on abortion (Harris 2012: 982). Indeed, as Stahl and Emanuel note, “health care conscience clauses are one-sided, protecting only those who refuse to treat patients, not those whose conscience compels them to provide medically accepted but politically contested care” (2017: 1381; see also Wicclair 2011: 219-221). With the rise of heartbeat bills in the South, this asymmetry has become even more salient.

I argue that this asymmetry in conscience clauses for abortion is unjustified.[[2]](#footnote-2) If the law provides exemptions for HCPs who, as a matter of conscience, refuse to provide abortions where it is legal, it should also provide exemptions for HCPs who, as a matter of conscience, feel obligated to provide abortions where it is illegal. I will not take a stand on whether conscience clauses in general are justified; I merely defend a consistency claim. We cannot honor negative conscience clauses for abortion and refuse to honor positive ones. If I am right, one might use my argument to show that we ought to honor more conscience clauses than we have previously appreciated. Alternatively, one might use my argument to show that we should not honor *any* conscience clauses for abortion.

The paper proceeds as follows. In section 1, I discuss conscientious objection clauses generally and review Wicclair’s 2011 argument that we cannot, as a matter of principle, rule out positive conscience claims. In section 2, I argue that whatever criteria justify protecting negative appeals to conscience regarding abortion also justify protecting positive appeals regarding abortion. In section 3, I discuss objections to my argument.

**1. Positive and Negative Appeals to Conscience**

The conscience, according to Sulmasy, isn’t just moral intuition or a set of feelings, but rather a judgment about one’s core moral commitments (2008: 137-138). It serves to alert an individual to potential value violations and to harass the individual after a violation until the violation is remedied (Morton and Kirkwood 2009: 352). Conscientious objection, then, is understood as an objection to some action or omission based on this moral judgment.

Most definitions of conscientious objection in the literature are framed in terms of *refusing* to provide a legally and professionally accepted service, which Wicclair calls *negative appeals to conscience* (2011: 219). For instance, Wilkinson defines conscientious objections as “Objections to providing legal, professionally accepted, and otherwise available medical services based on a clinician’s judgment that to do what is requested would be morally wrong” (2017: 227). Stahl and Emanuel discuss HCPs citing “personal religious or moral beliefs as a reason to opt out of performing specific procedures or caring for particular patients” (2017: 1380). Cantor and Baum 2004, Savulescu 2006, and West-Oram and Buyx 2016 focus on refusal to perform certain duties as well, and a survey of the major literature on conscientious objection shows that the vast majority of authors are concerned with when an HCP may *not* provide legally accepted care in accordance with their conscience. Although he acknowledges that the definition is too narrow, even Wicclair gives a first gloss in terms of negative appeals to conscience:

In the context of health care, physicians, nurses, and pharmacists engage in acts of conscientious objection when they: (1) refuse to provide legal and professionally accepted goods or services that fall within the scope of their professional competence, and (2) justify their refusal by claiming that it is an act of conscience or is conscience-based. (Wicclair 2011: 1)

These definitions of conscientious objection as negative appeals can be contrasted with *positive* appeals, wherein “health care professionals…claim to have a conscience-based obligation to *provide* professionally permitted goods or services…when doing so is prohibited by law, institutional rules, employer policies, and so forth” (Wicclair 2011: 219). Very few have written about positive appeals to conscience (Wicclair 2011, Harris 2012, and Hoss and Decker 2013 being notable exceptions).[[3]](#footnote-3) Some have discussed these positive appeals under the heading of *conscientious compliance*, defined as “working conscientiously within a mandate’s confines” (Buchbinder et al 2016: 23), perhaps by distancing oneself from the law, or satisfying the letter of the law but going against its spirit (see also Dickens and Cook 2011). Yet when it comes to positive claims of conscience and heartbeat bills, conscientious compliance does not go far enough. HCPs morally opposed to this legislation cannot act within the confines of the law; they are seeking permission to act *against* a law for reasons of conscience.

Perhaps as a result of the asymmetrical treatment of conscience clauses in the law, bioethicists have largely focused on negative conscience clauses (Harris 2012: 982; Wester 2015: 435, n. 1). Yet Wicclair 2011 argues forcefully that such asymmetry in general is unjustified. We cannot dismiss out of hand the idea that positive conscience clauses do not deserve protection. The general argument is that the same reasons for protecting negative conscience clauses apply to protecting positive ones. For Wicclair, conscientious objection should be respected (to a limited degree) because it protects the integrity of HCPs. Protecting this integrity is worthwhile, because integrity is intrinsically valuable and can be a key component of one’s conception of a meaningful life, and losing integrity can result in extremely negative emotional feelings, such as guilt, shame, and a loss of self-respect. Loss of integrity can also lead to a decline of moral character—something especially problematic for HCPs (Wicclair 2011: 25-27). Thus, the integrity of HCPs is worth protecting. Yet one’s integrity can be damaged not only by performing an action contrary to one’s conscience, but also by *not* performing an action that one’s conscience *requires* (222). So, if we should protect negative conscience clauses to protect integrity, we should also protect positive ones for the same reason.

One might think, however, that this asymmetry is warranted, because it’s worse to violate a negative duty than a positive duty (Wicclair 2011: 223). There is no consensus on what the difference between such duties comes to, unfortunately. Some say negative duties (N-duties) are duties not to act, while positive duties (P-duties) are duties to do something (Singer 1965). Others say N-duties are duties not to harm, whereas P-duties are duties to prevent harm (Malm 1991). Whatever such duties are, we can use clear and intuitive examples of N-duties and P-duties to concoct a moral asymmetry thesis, whereby it is worse to violate N-duties than P-duties, or violators of N-duties are more blameworthy than those of P-duties, or N-duties are stronger than P-duties.

But as Wicclair argues, this statement of the moral asymmetry thesis isn’t quite right. Throwing a tomato at protestors violates an N-duty, and not calling to save those drowning in a boating accident to avoid exorbitant roaming fees violates a P-duty. But the violation of the P-duty here is far worse (2011: 224-225). Instead, the N-duty and P-duty in question must correspond: one case must involve a duty not to take a life (N-duty) and the other a duty to save a life (P-duty). Yet even this is not enough. Fran might negligently kill the survivor of a boating accident, violating an N-duty. But Fred might deliberately refrain from saving his spouse who has fallen overboard because this spouse has had multiple affairs, thereby violating a P-duty (Wicclair 2011: 226). We therefore need some clause to capture that the intentions, motives, and burdens of the agents are similar.

Taking these lessons into account, Wicclair offers the following moral asymmetry thesis (2011: 226):

All other things being equal, at least one of the following claims is true:

1. Violations of N-duties are morally worse or more serious than violations of corresponding P-duties.
2. Agents who violate N-duties are more culpable or blameworthy than agents who violate corresponding P-duties.
3. N-duties are stricter or stronger than corresponding P-duties.

This moral asymmetry thesis includes an “all things being equal” clause to rule out differing intentions and motivations, and it includes that the N-duties and P-duties must be corresponding. Yet even if this moral asymmetry thesis is true, Wicclair argues, it would not justify protecting only negative appeals to conscience. It would only show that violations of corresponding N-duties would be worse, and so appeals to conscience based on violating N-duties have more moral weight than violations of corresponding P-duties (2011: 227). But this does not mean that being unable to fulfill a P-duty does not have sufficient moral weight to warrant protection.

The handful of authors who have discussed positive appeals to conscience merely cite Wicclair’s argument as evidence that such appeals must be recognized in some area of medicine or another (see Harris 2012; Buchbinder et al 2016; Montero and Villarroel 2018). Yet Wicclair’s argument shows only that dismissing all positive appeals to conscience is unjustified; it does not show that any positive appeal in particular *is* justified.[[4]](#footnote-4) It may turn out that even if positive appeals ought to be considered generally, they ought not be protected in some particular case for other reasons. For example, Wilkinson 2017 argues convincingly that even if Wicclair is right, we still likely have good reason not to allow HCPs to allocate limited medical resources according to their conscience rather than according to the legal and medical standards, given the harms and costs involved. Therefore, we must examine specific details regarding the impact of protecting positive appeals to conscience in cases of abortion and compare these details with negative appeals.

**2. Positive Appeals to Conscience and Abortion**

Roughly half of all US pregnancies are unintended, according to current estimates (Herd et al 2016: 421). There are a variety of reasons a woman might seek an abortion, especially in light of the fact that a pregnancy was unintended. Socioeconomic concerns are the second most common reason cited, whether such concerns relate to the direct financial costs of raising a child or the opportunity costs to do so (i.e., at the expense of one’s work or education) (Bankole, Singh, and Haas 1998: 125). Relationship problems are also a commonly cited reason (Finer et al 2005: 112). But the majority of women, when asked why they wanted an abortion, gave multiple reasons. The median number of reasons given was four, with some giving as many as eight (113).

Consider the following case, which can illustrate several of these reasons converging: Yasmine is in the ninth week of her pregnancy, and she visits her physician for a routine checkup. After hearing a heartbeat and learning the pregnancy is progressing without any problems, Yasmine begins to cry. She explains to the physician that she recently discovered that her husband had been unfaithful to her. After a recent confrontation, she is getting a divorce, yet she sees no feasible way to pay her mounting medical bills and legal fees. Yasmine already has three children to care for, and this will be even harder now that her husband, who contributed half of the household income, is gone. She also knows that her employer’s maternity leave plan leaves much to be desired, so as she progresses in her pregnancy things will become even more difficult. There is, she tells the physician, no way that she can financially or emotionally complete this pregnancy. Having her unfaithful husband’s child would contribute to her anxiety and depression, thereby negatively impacting her mental health. It would also negatively impact her ability to work and her ability to be a good mother to her children. Yasmine is desperate, and she asks the physician for an abortion before the pregnancy progresses too much further.

The reasons Yasmine cites are ordinary. While the case is fictional, there is research to suggest that unwanted pregnancies can result in negative mental health outcomes for women, as well as negative outcomes for her children. Women’s mental health during pregnancy can negatively affect fetal development and fetal health (Federenko and Wadhwa 2004: 198). And Barber, Axinn, and Thornton found that “mothers who experienced unwanted childbearing have significantly less affection for their children across the children’s early adulthood,” which results in lower quality relationships between mothers and children (1999: 244). But more important for this discussion is the effect an unwanted, completed pregnancy has on the mental health of the mother, who is the physician’s patient.

Barber, Axinn, and Thornton found that mothers with unwanted births are “substantially more depressed and less happy than mothers without unwanted births” (1999: 252). Some research suggests that women who were denied abortion services were more likely to have anxiety disorders (Herd et al 2016: 422; Biggs, Neuhaus and Foster 2015). Herd et al 2016 conducted a longitudinal study of women who had unwanted pregnancies before *Roe v Wade* to see the long-term effects of unwanted pregnancies on mental health when women lacked legal access to abortion. Such a situation would be comparable to that of women in states with heartbeat bills. They found that women who completed these unwanted pregnancies had “poorer later-life mental health outcomes, even when controlling for other variables likely to affect both pregnancy intention and mental health” (425-426). When one considers these other variables, such as stressful life events concerning legal, financial, and relationship issues, the risk of depression and anxiety is only compounded—especially among women of low socioeconomic status who face such stressors at a higher rate (Whitehead et al 2003; Seguin et al 2005: 586-587).

If Yasmine lived in a state where heartbeat bills were law, her physician could not legally satisfy her request for an abortion. For instance, in Georgia, the exceptions for abortion post-heartbeat are only to protect the life or physical health of the mother, if the developing fetus has a congenital anomaly that will be terminal, or if the pregnancy is the result of rape or incest. The bill is clear that

No such greater risk shall be deemed to exist if it is based on a diagnosis or claim of a mental or emotional condition of the pregnant woman or that the pregnant woman will purposefully engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function. (Georgia HB 481, § 4.3)

Yet Yasmine’s physician may feel quite strongly that not providing an abortion in this case is morally wrong, violating personal values as well as professional principles and obligations. The physician should respect Yasmine’s autonomy, and it is the duty of HCPs to uphold principles of beneficence and nonmaleficence. Providing an abortion would promote both Yasmine’s mental and physical health. Not providing the abortion could significantly harm her, not only from a financial standpoint, but due to her depression and the increased physical toll that the stress would have on her body. Should there be a provision in place to legally allow Yasmine’s physician to administer the requested abortion for reasons of conscience, given that there are exceptions made for negative appeals to conscience?

To answer this question, it is instructive to first examine the limits on conscientious objection more generally. Few think that conscientious objection should be unrestricted; allowing any HCP to act on their conscience would be “unreasonable” (Tollefsen 2013: 236). Much more common is a limited or restricted acceptance of conscientious objection, only when certain conditions are satisfied.[[5]](#footnote-5) I am not arguing that positive appeals to conscience in abortion cases are, in fact, justified. Instead, my point is that *if* negative appeals to conscience are justified for abortions, positive appeals are similarly justified for abortions. To make the case, I first examine the conditions under which some have argued that negative appeals are justified. These same criteria, I argue, either are inapplicable when applied to the positive appeals to conscience, or else they are satisfied just as well or better. Ultimately, protecting positive appeals to conscience regarding abortion has more benefits to patients and HCPs than protecting negative appeals, and it has fewer drawbacks. Whatever drawbacks it has are shared with protection of negative appeals to conscience. Thus, if negative appeals to conscience in the case of abortion are justified, so are positive appeals.

Magelssen 2012 offers one of the most comprehensive lists for when negative appeals to conscience ought to be accepted. His list includes criteria that Wicclair 2011 and Wester 2015 recommend, but also includes additional conditions. According to Magelssen, the following conditions are jointly sufficient, though none is individually necessary (since it may not apply in some case) (2012: 19):

When the following criteria are met, conscientious objection ought to be accepted:

1. Providing health care would seriously damage the health professional’s moral integrity by
	1. constituting a serious violation…
	2. …of a deeply held conviction
2. The objection has a plausible moral or religious rationale
3. The treatment is not considered an essential part of the health professional’s work
4. The burdens to the patient are acceptably small
	1. The patient’s condition is not life-threatening
	2. Refusal does not lead to the patient not getting the treatment, or to unacceptable delay or expenses
	3. Measures have been taken to reduce the burdens to the patient
5. The burdens to colleagues and healthcare institutions are acceptably small

Magelssen’s criteria are framed for negative appeals, but we can alter them to apply for positive appeals regarding abortion and heartbeat bills.

*(1)* Not *providing an abortion would seriously damage the health professional’s moral integrity by constituting a serious violation of a deeply held conviction.*

Essentially, providing an abortion must be something that one can be compelled to do as a matter of conscience, according to (1). There are some who might well make the case that it isn’t—perhaps even Wicclair. Wicclair’s understanding of conscientious objection is fairly strict. For him, conscientious objections are a subset of moral objections, but they are based on *core* moral beliefs (2011: 5). He writes, “Core moral beliefs are an agent’s fundamental moral beliefs. They comprise the subset of an agent’s moral beliefs that matter most to the agent” (4). Such beliefs are integral to an agent’s identity, so acting contrary to them is akin to self-betrayal (5). One may believe refusing some service is wrong, but unless that belief is fundamental in this way, such a refusal does not count as a conscientious refusal, according to Wicclair.

In addition to being a core moral belief, the belief must be *personal*, not professional. Some refusals to provide care may be based in the HCP’s understanding of professional norms and standards. A physician may have no personal moral qualms about aid-in-dying, but may refuse to provide such aid to a patient due to a belief that there are better options for patients who are terminally ill (6-7). In order to satisfy (1), then, those HCPs who would claim to be compelled by their conscience to provide abortions must be acting from a *personal* *core* moral belief.

Some HCPs likely would make a positive appeal to conscience regarding abortion for professional reasons, holding that they

have been entrusted with power and authority, as well as certain rights and privileges, as the sole providers of goods and services of vital public importance. In return, they have incurred certain responsibilities and obligations to society, most importantly to ensure the availability and adequacy of the standard range of services. (Wester 2015: 431)

They may view abortion as within the standard range of services. Such objections would not count as conscientious for Wicclair, because they are professional, not personal. Yet whether this distinction between personal and professional beliefs is tenable for HCPs is contentious, since HCPs, perhaps more than other professionals, are expected to uphold some fundamental ethical commitments, such as benevolence and honesty, as part of their profession (Lynch 2008). Because HCPs strongly identify with their professional role, “the lines between personal and professional values may be blurred; the subjective experience of acting against one’s professional values may not be much different from acting against one’s ‘personal’ moral convictions” (Wester 2015: 428). For instance, Yasmine’s physician in the case above feels the pull of conscience due to values like beneficence and nonmaleficence, but these are both personal and professional values. HCPs have an obligation to uphold these values, but one might also be compelled by a deep personal conviction to help others in a desperate situation or to not make someone’s life harder when one has the knowledge and ability to help. Perhaps this line is not as sharp as some have thought.

Additionally, exactly what constitutes a *core* moral belief is an open question. Those who are opposed to heartbeat bills as a matter of justice would likely not qualify for conscientious objections, according to Wicclair, since it is unlikely that the HCP’s conception of justice is integral to her identity and therefore among her core moral beliefs. Instead, injustice is just something we’ve learned to live with and tolerate, not something that is likely to lead to guilt, remorse, or loss of self-respect (Wicclair 2011: 8). Of course, there may be some tenderhearted individuals who can rightly claim justice as among their core moral beliefs, but their number is likely few.

Suppose that we understand conscientious objection strictly, as Wicclair does. While this may limit the number of HCPs who could legitimately claim to make a positive appeal to conscience in the face of heartbeat bills, there would still likely be some HCPs who could claim that offering an abortion is rooted in their personal core moral beliefs. After all, before *Roe v Wade*, some doctors offered abortions despite the fact that they were illegal. These doctors claim that they were compelled to do so by their conscience:

They saw women die from self-induced abortions and abortions performed by unskilled providers. They understood safe abortion to be lifesaving. They believed their abortion provision honored ‘the dignity of humanity’ and was the right—even righteous—thing to do. They performed abortions ‘for reasons of conscience’. (Harris 2012: 982)

If we take these doctors at their word, they satisfy this first criterion. There may be other HCPs like them in the future, should these heartbeat bills stand as law. And if we should understand conscientious objection in a broader sense than Wicclair does, even more HCPs would be able to justifiably claim that they have a positive appeal to conscience.

*(2) The objection has a plausible moral or religious rationale.*

One might well have a plausible moral (or perhaps even religious) rationale for judging that one ought to provide an abortion. The doctors who illegally provided abortions before *Roe v Wade* appealed to human dignity, and one could appeal to values such as autonomy, choice, and compassion in justifying an abortion. An HCP might also claim that not providing an abortion to someone who cannot afford to have another child and who does not want another child seems cruel, both for the parent and the child. Yasmine’s physician has several plausible moral rationales available, including those of autonomy, compassion, beneficence, and nonmaleficence.

*(3)* Refraining from *the treatment is not considered an essential part of the health professional’s work.*

Professionally, abortion has been accepted as legitimate medical treatment for many years. In their *Code of Ethics*, the American Medical Association (AMA) writes, “The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law” (Opinion E-4.2.7). And the American College of Obstetricians and Gynecologists (ACOG) Abortion Policy statement reads, “Induced abortion is an essential component of women’s health care.”

Providing an abortion might well be seen as a part of an OB/GYN’s work, though not necessarily an essential part. If so, then it wouldn’t be essential for the HCP to refrain from providing an abortion. This is especially true in early stages of pregnancy, as in Yasmine’s case. Perhaps one could argue that (3) is not satisfied because refraining from killing is an essential part of the HCP’s work, and abortion involves killing. Yet this would certainly not be the professional standard. Even if one denies that providing abortions is an essential part of the health professional’s work, one cannot deny that providing them is a part of at least some HCP’s work. Unless professional standards change, (3) is satisfied.

*(4) The burdens to the patient are acceptably small.*

The burdens to the patient in the negative appeals to conscience are of crucial importance, since an HCP’s refusal to provide legal treatment could result in more harm and burden to the patient, or even death. To illustrate, Zolf reports that although abortion has been legal in Italy for over 40 years, so many HCPs conscientiously object to providing them that roughly 20,000 illegal and unsafe abortions are performed in the country every year (Zolf 2019: 146).

Yet Magelssen’s criteria in the negative case do not seem to apply in the positive case. Whatever burdens there are to the patient in *not* having an abortion are imposed not by the HCP, but by whatever state legislation is in place. So if an HCP were to conscientiously object to the law and want to *provide* an abortion to a patient who requests it, the patient receives *more* care than she otherwise would.[[6]](#footnote-6) If an HCP were to make a positive appeal to conscience in the abortion case, they would provide a *benefit* to the patient, not a burden. Yasmine’s physician would be helping her significantly by providing an abortion, as terminating the pregnancy would relieve financial and emotional burdens on Yasmine and allow her to regain some autonomy over her body and her life. And the physician would likely not harm Yasmine by providing the wanted abortion, as no studies have found any evidence of mental health harms from women who receive an abortion (Biggs, Neuhaus, and Foster 2015: 2557).

Yasmine is desperate, and her physician has no way of knowing to what extremes she might go to avoid completing this pregnancy. Given her financial concerns and her current life situation, it is safe to assume that Yasmine lacks the ability to travel out of state to obtain an abortion elsewhere. If positive appeals were accepted for abortions, patients seeking abortions may not have to travel out of the state for the service, and the burden of travel is a significant barrier to abortion access (Cameron et al 2016). Unlike in the case of conscientious refusals, there can be no concerns about a shortage of access to the desired care if positive appeals to conscience are protected for abortions. The alternative for the patient is no abortion at all, but instead a reliance on alternative forms of care that may not be desired, such as prenatal care or social workers to aid in adoption procedures.

In addition, one cannot claim that positive appeals are discriminatory in themselves, or that they risk burdening a patient with the knowledge that an HCP morally disapproves of their lifestyle or behavior. Such burdens to the patient in the negative case, while less significant than the physical burdens of not receiving care, can nevertheless be psychologically damaging (Myskja and Magelssen 2018). Yet no such drawback exists to be weighed in the positive case.

Perhaps the only burden to the patient in accepting positive appeals to conscience concerns fairness. As Wilkinson writes, “It seems worryingly arbitrary that whether or not a patient is offered cardiac surgery, or intensive care is continued depends on which doctor happens to be on call” (2017: 228). Something similar could be said about abortion in the case of positive appeals. One might think it is arbitrary, and therefore unfair, that whether or not one has access to abortion depends upon whether there is a nearby HCP who conscientiously objects to not providing an abortion when the patient wants one. This could create a burden of unfairness on patients.

It may be arbitrary and, in a sense, unfair that whether one has access to an abortion in a state with heartbeat legislation is a matter of whether one has the good fortune to be near an HCP who conscientiously objects to not providing one. Yet this is not a problem unique to positive appeals to conscience. The same can be said about negative appeals: whether one has access to abortion if negative appeals are respected is also arbitrary fortune. Given that my claim is only conditional—*if* negative appeals are accepted for abortion, positive appeals should be as well—this arbitrariness is no unique, additional reason to refuse to honor positive appeals.

Additionally, and crucially, the unfairness seems rooted in a different place when it comes to positive appeals and abortion. If one thinks that it is unfair that only some have access to abortion, this unfairness is not due to the actions of individual HCPs, some of whom are allowed to perform abortions to satisfy their conscience. The unfairness lies in the heartbeat legislation itself, which restricts this access to medically accepted treatment. So, if there is a concern of unfairness here due to limited or arbitrary access, the solution is not to refuse to accommodate positive appeals to conscience, but rather to repeal the heartbeat legislation that limits the access and creates the unfairness in the first place.[[7]](#footnote-7)

One might press further that there is the potential for outright discrimination with positive appeals. For instance, an HCP may only feel compelled to grant abortions to those who took what they deem to be proper precautions to avoid pregnancy, perhaps by using contraception. If so, allowing for positive appeals would discriminate against some patients, and would, in fact, create significant burdens on them—both physical and psychological.

Yet it is important to remember that not just any positive appeal ought to be accepted. If a negative appeal would not be accepted because it is discriminatory, then neither should a positive appeal. We ought not honor negative appeals to conscience when, for instance, an HCP believes that a woman should not have an abortion because of her race or her lifestyle (assuming these would even qualify as appeals to conscience in the first place). Similarly, an HCP who relies on discriminatory reasoning for their positive appeal should not have their appeal honored. A further constraint could be added to minimize this discrimination, such that the HCP must provide justification for their conscientious objection using public reason (Card 2007), or perhaps a medical committee must review and approve such appeals (Wicclair 2014). Regardless, the worrisome conclusion that allowing positive appeals would create unfair discrimination and moral judgment seems unjustified once we appreciate that the same sorts of reasonability constraints that apply to negative appeals must apply to positive ones as well.

*(5) The burdens to colleagues and healthcare institutions are acceptably small.*

In negative appeals to conscience regarding abortion, the salient conflict is between the HCP’s conscience and patient autonomy and rights. In positive appeals, however, patient autonomy and HCP conscience are aligned and thrown into conflict with society or healthcare institutions instead. So while there may not be significant burdens to patients in accepting positive appeals for abortion, the potential for burdens and costs to society and healthcare institutions is much higher. Allowing HCPs to provide abortions if they are compelled to do so by their conscience seems as though it would create increased costs and strain on the health care system. Someone has to pay for these abortions, after all. Insurance companies would likely refuse to pay for care that has been made illegal in some state, and may in fact be legally prohibited from doing so. There are also costs to healthcare facilities when some service is provided, and in a state where many abortions services are broadly illegal, facilities could expect no taxpayer money to fund such services. Additionally, depending on how far along the patient is in pregnancy, providing an abortion might not be something one HCP can do alone, requiring other HCPs of similar conscience to assist. Protecting HCPs’ positive appeals to conscience regarding abortions could be an expensive endeavor that involves too many burdens to society and institutions.

Undoubtedly, protecting positive appeals would create a burden for society and healthcare institutions. Protecting negative appeals also creates such a burden, since these institutions have to spend resources finding other HCPs to provide the service in question. The relevant question is whether the burden such positive appeals creates is “acceptably small”—as acceptably small as the burden created by protecting complementary negative appeals. This is, in large part, an empirical question. But it isn’t clear that whatever burdens are created are too large to bear, and there are ways to limit these burdens. Patients may partly or completely pay for their own abortion, for instance, or HCPs could provide abortions compelled by conscience for free (Wilkinson 2017: 229). Of course, this would likely limit the number of abortions that are provided via conscientious objection, and there is a threat of social injustice if patients are required to pay for their own abortion—a threat that pushes against (4) above. After all, Yasmine is likely not in a financial position to pay for her own abortion. Perhaps those with the greatest need could have their abortions funded by humanitarian organizations that rely on donations.

The lesson is that while protecting positive appeals to conscience would create burdens for healthcare institutions, there are some ways to limit these burdens and to try to keep them to acceptable levels. Doing so will likely minimize the number of conscientious objections that can be respected. But it does not eliminate the possibility of protecting at least some positive appeals to conscience in the case of abortion.

Let’s return to the question I raised toward the beginning of this section: Should there be a provision in place to legally allow Yasmine’s physician to administer her requested abortion for reasons of conscience, given that there are exceptions made for negative appeals to conscience? The answer to that question seems to be yes. Appeals to autonomy, beneficence, and nonmaleficence are all legitimate moral rationales for making a serious conscientious objection to not providing an abortion—just as they are for making an objection to providing one. Refraining from providing an abortion is not an essential part of Yasmine’s physician’s work. The burdens to Yasmine are not only acceptably small, but there are great benefits to providing her with an abortion. While this may require time and resources from the physician’s colleagues and institution, such resources can be limited to acceptable levels. If these criteria are good enough for negative appeals to be justified, cases like Yasmine’s show that they can also be satisfied as well, if not better, with respect to positive appeals.

To summarize, Wicclair has shown that asymmetrical protection of only negative appeals to conscience is unjustified. Positive appeals to conscience can protect an HCP’s moral integrity and respect their autonomy as well, and there is no moral reason to think that only violations of negative duties need protection. Yet Wicclair does not go so far as to show that positive appeals to conscience with respect to abortions are justified or ought to be protected. To show this, I have reviewed the most comprehensive list of criteria that allegedly justifies negative conscientious objections: Magelssen’s five jointly sufficient criteria. I argued that positive appeals to conscientious objection in the case of abortion can satisfy complementary versions of (1)-(5), and there is even more benefit to protecting such positive appeals given that they align with patient wishes and benefit the patient. Thus, if negative appeals to conscience in the case of abortion are justified, then positive appeals are also justified.

**3. Objections and Replies**

Accepting these positive appeals to conscience in the case of abortion will likely seem quite radical to many. Accordingly, I address some of the most salient objections to my argument here.

***3.1 The Argument Generalizes Too Easily***

One might worry that my argument generalizes too easily, thereby creating counterintuitive or undesirable implications.[[8]](#footnote-8) Specifically, one might worry that if we allow HCPs to conscientiously object to patient requests for aid-in-dying in those states where it is legal, my argument entails complimentary protections must be in place for those who, as a matter of conscience, feel obligated to provide aid-in-dying where it is otherwise illegal.

I do not think that what I say here entails that positive claims of conscience regarding aid-in-dying should be honored if conscientious refusals are protected. Nor do I think it is a straightforward or easy argument to make. This is because it’s not clear that all the conditions I lay out would be satisfied in the case of aid-in-dying. Consider condition (3) above, which holds that refraining from the treatment must not be considered an essential part of the health professional’s work. One might make a compelling case that refraining from aid-in-dying *is* considered an essential part of an HCP’s work. Although members of the AMA remain divided over the issue, according to the AMA’s *Code of Medical Ethics* Opinion E-5.7, “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.” This is in stark contrast with professional statements regarding abortion from the AMA and ACOG.

Additionally, as Opinion E-5.7 states, there are potentially significant societal risks that must be addressed, and these bear on conditions (4) and (5) concerning burdens to patients, colleagues, and healthcare institutions. Any institution that allows for aid-in-dying must carefully monitor all such instances to ensure there has been no abuse or coercion and that patients have willingly consented to any aid-in-dying. Many have raised concerns about genuine consent in this area. For instance, Velleman 1992 argues that once the option to die becomes available, one becomes responsible for their choice to continue existing. Whereas continuing to live was the default previously, now one may feel psychological pressure to explain why one’s life is yet worth living, and this pressure may become coercion that threatens true consent. Ensuring such proper consent will likely create significant legal and administrative burdens. Whether these burdens and risks are acceptably small is an open question, but someone who has received an abortion without consent may call attention to such abuses in the system. A patient who was pressured into aid-in-dying cannot. Nevertheless, if the risks to patients, society, and healthcare institutions are acceptably small, and if aid-in-dying is not fundamentally incompatible with the role of an HCP, then perhaps we ought to honor positive appeals to conscience regarding aid-in-dying. The burden of explaining why this conclusion is counterintuitive or problematic—especially if these other conditions are satisfied—would then fall to the objector.

***3.2 Moral Uncertainty Should Lead to Caution***

The moral permissibility of abortion is clearly hotly contested. I do not expect that we will reach a consensus on that issue anytime soon. Yet we can respect conscientious objections even when the underlying debate has not been settled. In fact, this is perhaps the most important time to allow for such objections. One might be concerned, however, that this moral uncertainty regarding whether an embryo at six weeks has moral standing means that we should be cautious. If one does not know whether some action *A* is wrong, then one should refrain from *A*-ing out of moral caution. So even though we have not settled whether the embryo has moral standing, we should not allow HCPs to conscientiously provide abortions when they might be doing something wrong as a result.

The moral caution principle on which this objection relies is not quite right as stated, however. If one does not know whether some action *A* is wrong, then one should refrain from *A*-ing out of moral caution, *provided refraining from* A*-ing does not create significant harms itself.* Once we consider what is at stake for those who are denied an abortion, however, it becomes clear that not providing abortions creates significant harms. The burden of not having an abortion is often significant for a mother’s life, as she must at least bear the physical and emotional costs of bringing a fetus to term, and perhaps even bear the responsibility of raising a child she cannot afford or does not want. Forbidding abortions also cuts against patient autonomy, which is itself a harm, and which can also contribute to further psychological harms. Additionally, there may be damage to the moral integrity of many HCPs to consider.

The uncertainty regarding an embryo’s moral standing is an important consideration to be weighed, but we must also consider the costs of not allowing abortions. In view of what is at stake for women, it is not morally cautious or safe to only protect embryos and fetuses.

***3.3 It’s Worse to Actively Violate The Law***

One might protest that we are justified in protecting only negative appeals to conscience because those seeking positive appeals are seeking permission to violate the law (Wicclair 2011: 228). Heartbeat bills outlaw many abortions, and HCPs making positive appeals to conscience would ask permission to break that law. It seems worse, the objection goes, to break the law in this way.

This objection simply begs the question (Wicclair 2011: 228-229). It would *currently* be a violation of the law to allow HCPs to provide abortions based on conscience in those states where abortions have been legally restricted. But the issue is whether it *should* be a violation of the law. It is not illegal for HCPs to refrain from providing services to which patients are legally entitled because such HCPs are legally protected. We have allowed that it is legal to not provide such a service. If HCPs were conscientiously compelled to provide a service that was medically acceptable but not legal in the area, we could make a legal exception for such individuals. In this case, it would not be illegal for such HCPs to provide the service.

***3.4 Positive Appeals to Conscience Defeat the Purpose of the Law***

One might press that protecting positive appeals to conscience defeats the purpose of the law altogether. It would seem to leave it to individuals to decide whether they wanted to follow the law or not. In fact, this would leave those HCPs who object to the law in a position of “exercising quasi-legislative powers without equivalent democratic legitimacy” (Lynch 2008: 69). In a state with a heartbeat bill in place, some patients might be informed that certain doctors do perform abortions to serve their conscience, leaving such patients to seek out abortions from these professionals. Such a result “would potentially defeat the purpose of making community-level decisions” about abortion (Wilkinson 2017: 228). Instead, HCPs should simply spend the time campaigning and trying to reform the law rather than exercising a power that seems to render the law ineffective (Savulescu and Schuklenk 2017).

In response, it is important to emphasize that granting exemptions for HCPs with conscience-based objections is itself a community-level decision.[[9]](#footnote-9) *As a community*, we decide that we will allow some to follow their conscience and not provide treatment that is otherwise available or provide treatment that is otherwise unavailable. These are not individual decisions, where vigilante HCPs act outside the law. If we grant these legal exemptions as a community, such HCPs would be following their conscience and acting *within* the law, as dictated by the community.

To that end, it is open to us, as a community, to set up certain safeguards to ensure such HCPs are acting responsibly. Because we are concerned with *conscientious* objection, it bears repeating that an HCP cannot provide an abortion simply because they *want* to. It is unclear how many HCPs might feel an *obligation* to provide an abortion that rises to the level of conscience, such that not providing the abortion threatens their core beliefs. It may be reasonable, for example, to require individuals to explain to some tribunal why they feel they *must* provide an abortion to satisfy their conscience. Of course, one may have significant concerns about medical tribunals.[[10]](#footnote-10) Who would compose such a tribunal, how would these individuals be appointed, and what safeguards would be in place to protect against biased or unjustified judgments being rendered? To complicate matters further, Cowley 2016 raises several theoretical concerns, including whether such tribunals would really be necessary or effective when it comes to refusing to provide abortions. He argues that, unlike with military conscription, HCPs do not seem to have much non-moral reason to refuse to provide abortions (70). And there is little concern regarding discrimination, since the HCP would be refusing to provide abortions to *anyone* (70). Thus, there is little risk of HCPs abusing conscientious refusals to provide abortion. And in any case, it would be difficult, if even possible at all, for a tribunal to determine whether an applicant genuinely holds some belief (71).

I agree that there are a variety of practical and theoretical complications pertaining to medical tribunals, though even after Cowley’s arguments it is not clear that medical tribunals should not be used—at least in the US. While Cowley is focused on health care in the UK, the US healthcare system raises different concerns. There are some compelling non-moral reasons why an HCP may refuse to provide abortions in the US, including economic reasons (e.g., losing other pro-life patients, abortion not being a lucrative service) (Meyers and Woods 1996: 118) or self-interested reasons (e.g., to protect oneself from physical harms due to protestors) (Wicclair 2011: 6). Cowley does not yet show that tribunals, flawed as they might be, aren’t necessary in the US. So, even if the details of a tribunal are a problem for positive appeals to conscience regarding abortion, this is not a unique problem. Advocates of negative appeals to conscience must also grapple with the practical and theoretical complications of tribunals. Additionally, Cowley’s arguments against the usefulness of tribunals are even weaker when it comes to positive appeals to conscience. Marsh 2014 and Card 2014 both raise the concern that objecting to some service would be “too easy,” and Cowley dismisses this idea because there are few reasons other than moral conviction that would compel one to refuse to provide abortions. Yet the “too easy” concern looms large for positive appeals; there may be a variety of reasons why an individual wants to provide an abortion that need not be rooted in a core moral belief.

In any case, I need not solve all the problems with tribunals here, because I need not advocate for tribunals, specifically. I’m only recommending that *some* safeguard to be in place to prevent abuse or misuse of the system. The key point is that whatever safeguards are put into place can be decided by the community, and we will not have individuals acting entirely outside of the law, free to follow it or not, at their whim.

Finally, consider Savulescu and Schuklenk’s claim that HCPs should work to reform the law rather than make conscientious objections (2017: 166). I agree that HCPs should campaign against laws they view as immoral, but this is a long-term solution. Any such reforms would take a long time to be implemented, and by that point, the damage to one’s integrity has been done. What are HCPs to do in the meantime while they wait for the fruits of their political participation?

Savulescu and Schuklenk suggest that HCPs could work within the law to convince their patients not to take actions that would be contrary to the HCP’s conscience. For instance, they describe a law in the UK and Australia in which a couple’s embryos created in the process of assisted reproduction can be destroyed once the couple decides they are finished reproducing. Savulescu and Schuklenk think that this law is immoral, and that patients shouldn’t be allowed to destroy embryos that could be used in research or donated to other infertile couples. They say that while campaigning to change the laws, “doctors should engage patients in argument and try to convince them rationally, using evidence, to donate their excess embryos” (2017: 166).

Savulescu and Schuklenk are focused on negative appeals here. There seems no relevant analogy with positive appeals for abortion. The patient is asking for something that is medically accepted and that is legal in other states. An HCP might try to convince the patient to travel to where abortion is legal and have the procedure done there, but for patients who lack the resources, this is simply not an option. The HCP is not acting against patient wishes in positive appeals for conscientious abortion. There is no need to convince the patient of anything; instead there is only the need to convince legislators. And while that should be a goal, it is no help in the short-term, when one’s conscience and integrity are potentially threatened regularly.

***3.5 Positive Appeals Destroy Religious Freedoms***

Finally, Tollefsen has raised concerns that protecting positive appeals of conscience “would be, in effect, a law that destroyed the ability of religious groups to govern themselves in accordance with their religious convictions in the field of health care” (2013: 238). Suppose HCPs are allowed to provide abortions if they feel compelled to do so by their conscience. If those HCPs are employed by Catholic institutions, which collectively hold that life is sacred and which refuse to provide abortions, this creates a problem. Such individuals could act contrary to the values of the institution in which they are employed and of which they are a part. Tollefsen writes, “To protect judgments and actions within the institutions that are radically contrary to those commitments, however, is to deny the institution the liberty necessary to act socially for the sake of those shared commitments; hence it is to violate the religious liberty of the group” (2013: 238).

There has always been a balance to strike between religious freedom and equality. Even if Tollefsen’s concerns here are legitimate, it’s unclear how significant of a threat this is provided that institutions take reasonable precautions. Catholic institutions can and should make clear to current and potential employees that those institutions abide by the *Ethical and Religious Directives for Catholic Health Care Services*, and that all employees are similarly expected to abide by such directives. Those who are unwilling to abide by such directives would be wise not to seek employment at a Catholic institution. Provided that HCPs do not promise to abide by such directives when they have no intention of doing so, the number of potentially problematic cases can be mitigated.

Of course, conflicts may inevitably arise; employees may misrepresent themselves, their only employment option may be at a Catholic institution, or their values may change after accepting employment with such an institution. But Tollefsen has merely shown a conflict between protecting individual conscience and protecting institutional values. He has not yet shown that institutional values are weightier than those of the individual; instead he seems to assume that they are.

In any case, it is unclear why this is a problem that only affects positive appeals to conscience. An institution may be committed to providing care to every individual equally, yet some HCP within that institution conscientiously objects to providing care in accordance with the institution’s mission. These sorts of conflicts between the individual and collective are bound to happen. It does not yet mean that we cannot or should not protect individual rights and conscience, even at the expense of institutional values. And even if it did, this is not exclusive to positive appeals to conscience, and so does not provide reason for asymmetrical protection of conscience.

**4. Conclusion**

I have argued that if we have good reason to protect negative appeals to conscience regarding abortion, we also have good reason to protect positive appeals. I have not touched on any political issues here, but it is no secret that negative appeals are often championed by those with conservative values. If my argument has merit, however, then liberals may also find reason to champion conscientious objection. Of course, when it comes to abortion, one cannot champion conscientious objection only when it suits one’s political purposes. If one type of appeal is justified, so is the other.

Ultimately, however, I have not settled whether we ought to protect conscientious objection. I have only argued that consistency demands that if we protect negative appeals to conscience regarding abortion, we should also protect positive appeals. But there is more than one way to resolve inconsistency. We could resolve to protect positive appeals to conscience regarding abortion, given that we protect negative appeals. But we could also protect no appeals to conscience at all. In fact, Giubilini 2020 is clear that while he thinks the asymmetry is unjustified, the inconsistency should be resolved by denying *all* claims of conscience. I have not given sufficient reason here to opt for one choice or the other, and given the volumes written on whether conscientious refusals ought to be protected, it would be overzealous to think I could make a case here in closing. Instead, I will offer a few reasons why we might favor each side, and leave aside the question of how best to resolve the inconsistency.

There are strong reasons to support protecting conscientious objection, and Wicclair 2011 articulates many of these reasons. Besides protecting the integrity of HCPs, respecting conscientious objection can be seen as a way to respect reasonable pluralism and tolerance (Giubilini 2014: 160). Dickens and Cook have even argued that living according to one’s conscience is a human right, protected by Article 18(1) of the UN’s Universal Declaration of Human Rights (2011: 163).

Yet there are also significant concerns with protecting conscientious objection. Giubilini 2014 raises a variety of objections to integrity-based arguments, and I have addressed none of those here. Additionally, both negative and positive appeals can create burdens on the patient as well as the healthcare system. Whether these burdens are acceptably small is yet unanswered, and likely requires empirical research. There are similarly practical questions about what safeguards should be implemented—and how—to prevent abuse of conscientious objection and discrimination in their use by HCPs.

Given these issues that remain unresolved, I restrict myself to a more modest, yet nevertheless controversial claim: *if* negative claims of conscience are to be respected for reasons of integrity in the case of abortion, then positive ones ought to be respected as well for these same reasons. Whether conscientious objection clauses themselves are justified is a topic for another day.

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**Works Cited**

American Medical Association. 2016. *AMA Code of Medical Ethics*. Retrieved May 20, 2020, from <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview>.

American College of Obstetricians and Gynecologists. 2017. “Abortion Policy.” Retrieved May 20, 2020, from <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2017/abortion-policy>.

Bankole, Akinrinola, Susheela Singh, and Taylor Haas. 1998. Reasons why women have induced abortions: evidence from 27 countries. *International Family Planning Perspectives* 24(3): 117-127 & 152.

Barber, Jennifer S., William G. Axinn, and Arland Thornton. 1999. Unwanted childbearing, health, and mother-child relationships. *Journal of Health and Social Behavior* 40(3): 231-357.

Biggs, M. Antonia, John M. Neuhaus, and Diana G. Foster. 2015. Mental health diagnoses 3 years after receiving or being denied an abortion in the United States. *American Journal of Public Health* 105(12): 2557-2563.

Brummett, Abram L. 2020. Should positive claims of conscience receive the same protection as negative claims of conscience? Clarifying the asymmetry debate. *The Journal of Clinical Ethics* 31(2): 136-142.

Buchbinder, Mara, Dragana Lassiter, Rebecca Mercier, Amy Bryant, and Anne Drapkin Lyerly. 2016. Reframing conscientious care: providing abortion care when law and conscience collide. *Hastings Center Report* 46(2): 22-30.

Cameron, Sharon T., Julie Riddell, Audrey Brown, Andrew Thomson, Catriona Melville, Gillian Flett, Lucy Caird, and George Laird. 2016. Characteristics of women who present for abortion towards the end of the mid-trimester in Scotland: national audit 2013–2014. *The European Journal of Contraception & Reproductive Health Care* 21(2): 183-188.

Cantor, Julie, and Ken Baum. 2004. The limits of conscientious objection—may pharmacists refuse to fill prescriptions for emergency contraception? *The New England Journal of Medicine* 351(19): 2008-2012.

Card, Robert. 2014. Reasonability and conscientious objection in medicine: a reply to Marsh and an elaboration of the reason-giving requirement. *Bioethics* 28(6): 320-326.

Card, Robert. 2007. Conscientious objection and emergency contraception. *The American Journal of Bioethics* 7(6): 8-14.

Cowley, Christopher. 2016. Conscientious objection and healthcare in the UK: why tribunals are not the answer. *Journal of Medical Ethics* 42: 69-72.

Dickens, Bernard M. and Rebecca J. Cook. 2011. Conscientious commitment to women’s health. *International Journal of Gynecology and Obstetrics* 113: 163-166.

Federenko, Ilona S., and Pathik D. Wadhwa. 2004. Women’s mental health during pregnancy influences fetal and infant developmental and health outcomes. *CNS Spectrums* 9(3): 198-206.

Finer, Lawrence B., Lori F. Frohwirth, Lindsay A. Dauphinee, Susheela Singh, and Ann M. Moore. 2005. Reasons U.S. women have abortions: quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health* 37(3): 110-118.

Georgia General Assembly. House. *Living Infants Fairness and Equality (LIFE) Act*. HB 481, 2019-2020 Regular Session. Introduced in House February 25, 2019. <http://www.legis.ga.gov/Legislation/en-US/display/20192020/HB/481>.

Giubilini, Alberto. 2020. Conscientious objection in healthcare: neither a negative nor a positive right. *The Journal of Clinical Ethics* 31(2): 146-153.

Giubilini, Alberto. 2014. The paradox of conscientious objection and the anemic concept of ‘conscience’: downplaying the role of moral integrity in health care. *Kennedy Institute of Ethics Journal* 24(2): 159-185.

Harris, Lisa H. 2012. Recognizing conscience in abortion provision. *The New England Journal of Medicine* 367(11): 981-983.

Herd, Pamela, Jenny Higgins, Kamil Sicinski, and Irina Merkurieva. 2016. The implications of unintended pregnancies for mental health in later life. *American Journal of Public Health* 106(3): 421-429.

Hoss, Mary Ann Keogh, and Kevin S. Decker. 2013. When all roads lead to Rome: the Catholic hospital dilemma impacts entire US healthcare system. *Open Journal of Leadership* 2(4): 106-109.

Lynch, Holly F. 2008. *Conflicts of conscience in health care.* Cambridge, MA: MIT Press.

Magelssen, Morten. 2012. When should conscientious objection be accepted? *Journal of Medical Ethics* 38(1): 18-21.

Malm, H.M. 1991. Between the horns of the negative-positive duty debate. *Philosophical Studies* 61: 187-210.

Marsh, Jason. 2014. Conscientious refusals and reason-giving. *Bioethics* 28(6): 313-319.

Meyers, Christopher, and Robert D. Woods. 1996. An obligation to provide abortion services: what happens when physicians refuse? *Journal of Medical Ethics* 22: 115-120.

Mississippi Code 41-41-215. 1998. http://www.michie.com/Mississippi/lplext.dll (accessed 29 Sept. 2019).

Montero, Adela, and Raul Villarroel. 2018. A critical review of conscientious objection and decriminalisation of abortion in Chile. *Journal of Medical Ethics* 44(4): 279-283.

Morton, Natasha T. and Kenneth W. Kirkwood. 2009. Conscience and conscientious objection of health care professionals refocusing the issue. *HEC Forum* 21(4): 351-364.

Myskja, Bjorn K. and Morten Magelssen. 2018. Conscientious objection to intentional killing: an argument for toleration. *BMC Medical Ethics* 19.

Savulescu, Julian. 2006. Conscientious objection in medicine. *BMJ* 332: 294-297.

Savulescu, Julian, and Udo Schuklenk. 2017. Doctors have no right to refuse medical assistance in dying, abortion or contraception. *Bioethics* 31(3): 162-170.

Seguin, Louise, Louise Potvin, Michele St.-Denis, and Jacinthe Louiselle. 2005. Chronic stressors, social support, and depression during pregnancy. *Obstetrics & Gynecology* 85(4): 583-589.

Singer, Marcus G. 1965. Negative and positive duties. *The Philosophical Quarterly* 15(59): 97-103.

Stahl, Ronit Y. and Ezekiel J. Emmanuel. 2017. Physicians, not conscripts—conscientious objection in health care. *The New England Journal of Medicine* 376(14): 1380-1385.

Sulmasy, Daniel P. 2008. What is conscience and why is respect for it so important? *Theoretical Medicine and Bioethics* 29(3): 135-149.

Tollefsen, Christopher O. 2013. Protecting positive claims of conscience for employees of religious institutions threatens religious liberty. *American Medical Association Journal of Ethics* 15(3): 236-239.

The United Nations. 2011. *Universal Declaration of Human Rights.*

United States Conference of Catholic Bishops. 2018. *Ethical and religious directives for Catholic health care services, 6th ed*. Retrieved May 20, 2020, from <http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf>.

United States Department of Health & Human Services (HHS). 2018. Conscience protections for health care providers. Retrieved May 20, 2020, from <https://www.hhs.gov/conscience/conscience-protections/index.html>.

Velleman, J. David. 1992. Against the right to die. *Journal of Medicine and Philosophy* 17(6): 665-681.

West-Oram, Peter and Alena Buyx. 2016. Conscientious objection in healthcare provision: a new dimension. *Bioethics* 30(5) 336-343.

Wester, Gry. 2015. Conscientious objection by health care professionals. *Philosophy Compass* 10/7: 427-437.

Whitehead, N.S., D.J. Brogan, C. Blackmore-Prince, and H.A. Hill. 2003. Correlates of experiencing life events just before or during pregnancy. *Journal of Psychosomatic Obstetrics & Gynecology* 24: 77-86.

Wicclair, Mark R. 2014. Managing conscientious objection in health care institutions. *HEC Forum* 26: 267-283.

Wicclair, Mark R. 2013. Positive claims of conscience and objections to immigration law. *American Medical Association Journal of Ethics* 15(3): 188-192.

Wicclair, Mark R. 2011. *Conscientious objection in health care: an ethical analysis*. Cambridge: Cambridge University Press.

Wilkinson, Dominic. 2020. Positive or negative? Consistency and inconsistency in claims of conscience. *The Journal of Clinical Ethics* 31(2): 143-145.

Wilkinson, Dominic. 2017. Rationing conscience. *Journal of Medical Ethics* 43: 226-229.

Zolf, Benjamin. 2019. No conscientious objection without normative justification: against conscientious objection in medicine. *Bioethics* 33: 146-153.

1. Conscientious refusals to provide treatment are also protected at the federal level, at least when it comes to abortion. The US Department of Health & Human Services (HHS) lists The Church Amendments (42 U.S.C. § 300a-7 et seq.), The Public Health Service Act (42 U.S.C. § 238n), The Weldon Amendment, and even the Affordable Care Act (see § 1303(b) (4)) as providing such protection. This compounds the problem of inconsistency, but because heartbeat bills are being passed at the state level, I focus on the asymmetry of state policy. [↑](#footnote-ref-1)
2. I limit my discussion here to abortion, though the asymmetry of legally recognized conscience clauses may be applicable in other areas of medicine as well. For instance, Wicclair 2013 writes, “In 2011, two states, Alabama and Georgia, enacted laws (HB 56 and HB 87, respectively) that prohibit ‘concealing, harboring, or shielding’ undocumented immigrants” (189). Yet neither law includes an exemption for health care professionals, so depending on the interpretation of the law, providing health care to undocumented immigrants might violate the law. Since each area of medicine raises its own distinct issues, I take no stand here on whether other asymmetries are unjustified. [↑](#footnote-ref-2)
3. Just before publication of this article, *The Journal of Clinical Ethics* published three articles discussing whether there is an unjustified asymmetry between positive and negative claims of conscience (see Brummett 2020; Wilkinson 2020; and Giubilini 2020). These articles may be an indication that the topic will see more attention in the future. [↑](#footnote-ref-3)
4. Brummett 2020 criticizes Wicclair’s argument that the asymmetry is unjustified. Yet Wilkinson 2020 and Giubilini 2020 compellingly respond to Brummett’s criticisms, suggesting that the asymmetry is unjustified, at least in many cases. [↑](#footnote-ref-4)
5. Even those who oppose conscientious objection in healthcare allow that there could be *some* place for it. Savulescu writes, “When a doctor’s values can be accommodated without compromising the quality and efficiency of public medicine they should, of course, be accommodated” (2006: 296). And Savulescu and Schuklenk allow that “when the stakes are high, and their conscience is right,” doctors should act on their conscience (2017: 167). [↑](#footnote-ref-5)
6. I assume, of course, that as in Yasmine’s case above, the patient wants an abortion and the HCP is acting in accordance with the patient’s wishes. The HCP must respect the patient’s autonomy and the value of consent. [↑](#footnote-ref-6)
7. Thanks to an anonymous referee for suggesting this response. [↑](#footnote-ref-7)
8. Thanks to an anonymous referee for raising this objection and pressing me to answer it. [↑](#footnote-ref-8)
9. Thanks to an anonymous referee for suggesting this line of response. [↑](#footnote-ref-9)
10. Thanks to an anonymous referee for pressing me on this point. [↑](#footnote-ref-10)