

Justification for Conscience Exemptions in Health Care*

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ABSTRACT: Some bioethicists argue that conscientious objectors in health care should have to justify themselves, just as objectors in the military do. They should have to provide reasons that explain why they should be exempt from offering the services that they find offensive. There are two versions of this view in the literature, each giving different standards of justification. We show these views are each either too permissive (i.e. would result in problematic exemptions based on conscience) or too restrictive (i.e. would produce problematic denials of exemption). We then develop a middle ground position that we believe better combines respect for the conscience of health care professionals with concern for the duties that they owe to patients. Our claim, in short, is that insofar as objectors should have to justify themselves, they should have to do it according to the standard that we defend rather than according to the standards that others have developed.

In many parts of the world, physicians are free to object conscientiously to providing medical services that are legal and often deemed essential, but that they find morally offensive, such as abortions and contraception. In some

jurisdictions, other health care professionals, such as pharmacists, have this freedom as well. The right of these professionals to refuse such services tends to be “unlimited in practice,” because no one evaluates the objections that the professionals make.¹ They do not have to explain to anyone why they are objecting. They do not even have to prove that their objection stems from conscience, rather than from some other source (e.g. mere preference).

Some commentators find this state of affairs untenable. They argue that conscientious objectors in health care should have to justify themselves, just as objectors in the military do. They should have to provide reasons that can excuse them from offering services that, according to their profession, they are duty-bound to offer. There are two versions of this view in the literature. One, from Christopher Meyers and Robert Woods, states that objectors in health care should be required to show that the beliefs on which their objections rest are passionately-held moral or religious beliefs that they must adhere to for the sake of their mental well-being.² The other view is from Robert Card: objectors should be required to prove that the beliefs that ground their objections are “reasonable” and “justifiable.”³ To be clear on the difference between these

¹ R. F. Card. Conscientious Objection and Emergency Contraception. *AJOB* 2007; 7(6): 8-14: 13.

² An obligation to provide abortion services: what happens when physicians refuse? *J Med Ethics* 1996; 22: 115-120; Conscientious Objection? Yes, But Make Sure it is Genuine. *AJOB* 2007; 7(6): 19-20.

³ *Op. cit.* note 1, p. 13; R. F. Card. Conscientious Objection, Emergency

positions: Meyers and Woods demand that objectors reveal what motivates their objection in an effort to prove that it is genuinely conscientious; but, at the same time, they need not demonstrate that what motivates them is justifiable and thus ought to motivate others. Card, by contrast, requires that they do the latter. Call the first view, Proving Genuineness, and the second, Proving Reasonableness.

We are sympathetic to the general view that conscientious objectors in health care should have to justify themselves (i.e. justify why they, or anyone, should be exempt from performing what is taken to be a professional duty). In the first part of this paper, we discuss why such sympathy is warranted. We then move on to explain that the positions found in the literature on what objectors need to do to justify themselves are problematic. As we demonstrate, Proving Genuineness is not enough, and Proving Reasonableness is too much. We defend a middle-ground position that we believe better combines respect for the conscience of health care professionals with concern for the duties that they owe to patients.

1. Why push for some justification?

Some commentators would not push for any requirement that health care professionals justify their conscientious objections. These people might lack sympathy for objectors, believing that they could never be justified in doing what they are doing.⁴ Alternatively, they might feel that managing

Contraception, and Public Policy. *J Med Philos* 2011; 36(1): 53-68.

⁴ Julian Savulescu suggests as much when he writes, “[i]f people are not

conscientious objections in the way that they are currently managed, especially in medicine, is appropriate: that is, do not evaluate whether objections are genuine or reasonable; simply demand that objectors give referrals to health care professionals who will perform the requested service.⁵ Finally, some might oppose having objectors justify themselves because of the need this creates for committees to examine objectors' reasons for objecting. The concern might be that having all objectors appear before a committee is not feasible or that the adjudication of reasons by the committee will be unavoidably unfair.⁶

We think that each of these concerns is important but that none of them weighs heavily enough against the idea of objectors justifying themselves that we should abandon this idea. Since our primary goal is the modest one of defending a proposal in favour of justification for conscience exemptions that improves upon the proposals made by Card and by Meyers and Woods, we will

prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors" (quoted in M. Wicclair. 2011. *Conscientious Objection in Health Care: An Ethical Analysis*. New York, NY: Cambridge University Press: 33; Savulescu. Conscientious Objection in Medicine. *BMJ* 2006; 332(2): 294.)

⁵ See, e.g. J. Cantor & K. Baum. The Limits of Conscientious Objections: May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception? *New Engl J Med* 2004; 351(19): 2008-2012.

⁶ M. Wicclair. Reasons and Health Care Professionals Claims of Conscience. *AJOB* 2007; 7(6): 21-22.

not provide a knockdown argument for why justification of *any* kind is necessary. Still, before getting to our main argument, let us explain briefly why we believe that some justification is important and why each of the opposing positions just outlined is wrong-headed.

For at least two reasons, we reject the claim that conscientious objection in health care is never justified, which would make attempts at justifying objections pointless. First and foremost, this view fails to appreciate that some objections will be morally justified and that the moral integrity of the profession may require that they be made. The example that stands out for us is the refusal by some health care professionals to participate in prenatal sex selection.⁷ Second, to be opposed to all conscientious objection in health care—whatever the reason for it and regardless of whether it causes harm—is to fail to take seriously enough the moral gravity of requiring someone to act against sincerely held moral beliefs, especially those that concern life or death, which influence many objections in health care.

But why not just accept the *status quo* on conscientious objection in medicine—that is, allow objectors to refuse requests for procedures that they find offensive but require that they make a referral? Even if their objections are not justified in any way, patients should still get what they need because of the referrals. This is the second position we described above that opposes justification. In our view, there are four problems with it. One is that some

⁷ B. Leier & A. T. Thiele. Towards an Ethical Policy for the Prevention of Fetal Sex-Selection in Canada. *JOGC* 2010; 32(1): 54-57.

objectors simply cannot adhere to the *status quo*, because they are the only doctor in town or all of the other doctors are conscientious objectors. This problem reveals that the *status quo* cannot function in all cases to protect physician conscience and patient access to services.

A further problem is that the *status quo* appears to ignore concerns about complicity. Consider that a physician's conscience can demand that she refuse not only to perform certain interventions, but also to make referrals for them, because doing so would make her complicit in what she takes to be an immoral act. Indeed, in her mind, the acts of providing the care herself and giving a referral for it might be equally blameworthy. As Mark Wicclair points out, "considerable deference should be given to a health care professional's conception of moral complicity," if the goal is to respect this person's conscience.⁸ It follows that insofar as the *status quo* aims, in part, to respect conscience, it probably does so poorly in some cases.

Yet another problem—one that we believe is particularly grave—is that by omitting any requirement that objectors explain their objections, the *status quo* leaves the door open for discriminatory refusals. Do we really think that racist, sexist, or homophobic health care professionals should be free to refuse care to the people they deem to be morally inferior, just so long as they give referrals? Some would say that it is worse to require them to treat these people, because the "care" they provide will inevitably be substandard. But we think the better response is to deny these professionals the opportunity to care for

⁸ *Op. cit.* note 4, p. 42.

anyone until they learn the error of their ways. They could undergo mandatory sensitivity training, and if they fail at that, look elsewhere for employment.

One final problem is that referrals are not appropriate when the objection itself is morally justified. An example is an objection to giving a woman an eleventh round of IVF (one involving ovarian stimulation), when the first ten rounds were unsuccessful and there is no reason to think the eleventh round would go any better. Such an objection is arguably justified because, again, there is no reason to think that the intervention would be effective and also because of documented risks to women's health, of ovarian stimulation in particular.⁹ In our view, conscientious objections by health care professionals that are morally justified should not be followed up by referrals.

To be clear, our point is not that conscientious objectors should never have to give referrals, but simply that always requiring referrals, and only referrals, is problematic. Someone might object that insisting on some justification from conscientious objectors would be equally problematic. Is it really feasible to have all objectors come before committees and explain why they ought to be excused from providing certain services? Can we trust that the committees will be fair in their assessments of objectors' reasons for objecting? Those who adopt the third position outlined above against justification give negative answers to both of these questions.

⁹ See A. Girolami *et al.* Arterial thrombosis in young women after ovarian stimulation: case report and review of the literature. *J Thromb Thrombolys* 2007; 24: 169–74

We take concerns about feasibility and fairness seriously. Indeed, the concern about fairness, in particular, influences what we recommend in terms of what kind of justification objectors should have to provide. But we do not think justification for conscientious objection is a non-starter because the adjudication of reasons would be neither feasible nor fair. To respond to the complaint about feasibility, surely there are ways in which the adjudication could happen. Objectors could have to apply for conscience exemptions, and state licensing boards or professional societies could be responsible for deciding how the applications will be reviewed and who will review them.¹⁰ We deny not that this task would be complicated, but only that it is impossible.

We also believe that continuing with the *status quo* is not feasible. Too much conscientious objection in some parts of the world has made it impossible for health care professions or governments to meet their commitments to provide certain kinds of health care, especially abortions.¹¹ By restricting conscientious objections in health care to those that can be justified, we will likely cut down on the number of objections and on the shortages that

¹⁰ At least one other theorist has suggested using licensing boards to help solve conflicts of conscience in health care: H. F. Lynch. 2008. *Conflicts of Conscience in Health Care: An Institutional Compromise*. Cambridge, MA: MIT Press.

¹¹ See, e.g. J. Laurance. Abortion crisis as doctors refuse to perform surgery. *The Independent* 2007; April 16.

objections create.¹²

The worry that committees will not evaluate reasons for objecting fairly is a worry about bias on the committees: that they will simply promote the interests of “powerful elites,” for example.¹³ To calm this worry, we follow Meyers and Woods in recommending that the committee members be diverse in terms of their race, ethnicity, religious beliefs, academic training (and, we would add, gender, class, and sexual orientation).¹⁴ We do not presume that diversity alone, however, can answer the concern about fairness. Thus, we return to this problem and respond to it more thoroughly below.

2. Proving Genuineness: Meyers & Woods

In their paper, “Conscientious Objection? Yes, But Make Sure It is Genuine,” Meyers and Woods remind readers of an argument they made in a previous paper¹⁵ about the need for physicians who conscientiously object to abortion to justify not having to provide abortion services. The argument goes as follows. Physicians have a duty to offer “vital and socially sanctioned” medical services,

¹² So why not require that objections be justified only in places where they might seriously inhibit access to services (J. Marsh. Conscientious Refusal and Reason-giving. *Bioethics* forthcoming)? To reply, safeguarding access is not the only reason to require that objectors justify themselves. Another reason is to prevent discrimination.

¹³ Meyers & Woods 1996, *op. cit.* note 2, p. 118.

¹⁴ *Ibid.*: 119.

¹⁵ *Ibid.*

and these include abortions.¹⁶ Since objectors are asking not to have to perform what is in fact their duty, they should have to justify themselves. They can do so, moreover, by proving that their objection is genuinely conscientious, which, by and large, entails that the beliefs motivating it are moral or religious and are central to their value framework.

Meyers and Woods claim that proving genuineness is tantamount to objectors proving that having to perform the relevant duty would cause them unwarranted moral and psychological distress. The harm they would suffer in having to perform abortions is impermissible, according to Meyers and Woods, only if this harm is greater than what patients would suffer in having one less abortion provider. But Meyers and Woods appear to assume that the harm to the objector will always be greater, that is, if this person is experiencing a “true crisis of conscience.”¹⁷ To show, then, that her objection is justified, the objector simply has to show that it is genuine.¹⁸

¹⁶ Ibid: 117.

¹⁷ Ibid: 119.

¹⁸ Meyers and Woods list criteria for evaluating conscientious objections, most of which concern whether the objections are genuine (ibid). One exception is the following criterion: “all reasonable alternatives must be explored, for example, finding another physician to perform the procedure.” Perhaps their idea is that objectors are only justified in their actions if they find reasonable alternatives for their patients. *If* that is true, then objectors have to do more than prove genuineness. But whether it is true is unclear, because Meyers and

In requiring that objectors prove genuineness, Meyers and Woods are suggesting that they give reasons of a certain sort for their objection. These are motivating reasons as opposed to normative reasons. Motivating reasons explain what causes an agent to act as she did. They are not normative, because they have no power to motivate others to act in the same way. Normative reasons have such power—over rational agents—because they are “*as a matter of fact* good reasons for action.”¹⁹

Turning to an evaluation of Meyers and Woods’ position: as a response to a particular problem—a lack of genuineness among some conscientious objectors—their contribution is important. They refer to a case involving a public hospital in California that was legally responsible for providing first- and

Woods leave open *who* should explore reasonable alternatives for the patient. It may be that employers or the profession have this job, in which case objectors only have to prove the genuineness of their objection.

¹⁹ C. Miller. Motivation in Agents. *Nous* 2008; 42(2): 222-266: 224, his emphasis. Meyers and Woods indicate at one point that the reasons they are looking for from objectors are “shared reasons for action,” that is, normative reasons (*op. cit.* note 2, 1996, p. 117; quoting L. Winner. 1986. *The Whale and the Reactor: A Search for Limits in an Age of High Technology*. Chicago, IL: University of Chicago Press: 159). Yet this suggestion does not fit with the rest of their article, in particular, with the criteria they offer for evaluating objections, which say nothing about whether the beliefs motivating objections could be shared by rational agents.

second-trimester abortions to women who were either imprisoned in the county jail or were not competent to make medical decisions for themselves.²⁰ The hospital could not find within its ranks a physician who was qualified or willing to perform the abortions. All Ob/Gyn physicians appealed to California's conscience clause, which protected refusals to provide abortion services by health care workers who declared in writing that they held "a moral, ethical, or religious objection" to abortion. Each of the physicians made the relevant declaration even though some of them objected to abortion mainly on economic grounds (e.g. abortion services are "typically not lucrative") or on aesthetic grounds (e.g. second-trimester abortions are "frankly ugly").²¹ Conscience was not obviously driving them to object; but the conscience clause did not require them to prove that conscience was their motive. This case clearly illustrates the value of having physicians and other health care professionals show that they are genuine when they appeal to *conscience* clauses.

Although Meyers and Woods's main point is valuable, the process they recommend for having objectors prove that they deserve a conscience exemption would produce some seriously problematic exemptions. The sorts of cases we have in mind are those in which empirical beliefs grounding the objection are baseless, moral or religious beliefs grounding it are discriminatory, or the harm the objector would experience if he had to perform the relevant service is not greater or is only marginally worse than what his

²⁰ *Op. cit.* note 2, 1996, p. 115.

²¹ *Ibid.*: 118.

prospective patients would suffer if he did not perform it. Let us consider each of these possibilities in turn.

First, what if the objection rests on an empirical claim that is baseless? In other words, there is no evidence to back it up; the scientific community would reject it or has done so already? Consider a hypothetical case of a physician who refuses to give children the MMR (Measles, Mumps, and Rubella) vaccine on the grounds that there is a proven link between the vaccine and autism. The physician insists on this fact even after the *British Medical Journal* declares that research that supported it was fraudulent.²² She, the physician, could prove that her conscientious objection is genuine, simply by showing that she fervently believes that the MMR vaccine is dangerous to children. Moreover, any review board that evaluates her objection could reasonably conclude that the harm to her of having to violate her conscience is greater than any harm children or their parents would suffer as a direct result of her objection, especially if they could obtain the vaccine at a different clinic and would probably not be dissuaded from doing so by the physician. It seems that Meyers and Woods would have to agree with the physician being excused from having to offer the MMR vaccine. But surely this is a problematic result.

The point here is that empirical beliefs that ground a health care professional's objection need to be defensible. To be sure, such a stance goes against the tradition of evaluating only whether conscientious objectors are

²² F. Godlee *et al.* Wakefield's article linking MMR vaccine and autism was fraudulent. *BMJ* 2011; 342: c7452.

sincere in their objection and not whether the grounds for their objection are reasonable.²³ However, there are important values other than respect for conscience at stake when deciding whether to permit conscientious objections in health care, and these values encourage the critical assessment of empirical claims made by objectors. The competing value of professionalism does so in particular. Implicit in the notion of being a professional is that one “possesses the necessary knowledge” to fulfill one’s role.²⁴ Conscientious objectors cannot insist that as health care professionals, they receive conscience protection when technical ignorance rather than knowledge informs their conscience.

Second, Meyers and Woods would have to allow that conscientious objections are justified when they are grounded in moral or religious beliefs that are discriminatory (i.e. sexist, racist, or homophobic). Surely, objectors who have beliefs of this sort could prove genuineness. But this simply shows that proving genuineness alone could not establish a legitimate need for conscience protection. There is widespread agreement, and rightly so, that discriminatory refusals do not deserve protection.²⁵

²³ A. Gewirth. 1974. Reasons and Conscience: The Claims of the Selective Conscientious Objector. In *Philosophy, Morality, and International Affairs*. V. Held *et al*, eds. New York: Oxford UP: 93-4.

²⁴ E. D. Pellegrino. Toward a Reconstruction of Medical Morality. *AJOB* 2006; 6(2): 65-71: 67.

²⁵ The idea here is that these refusals are intolerable. But one might insist that some non-discriminatory refusals are intolerable as well (e.g. a refusal by a

Last, what about cases where the harm that the genuine objector would suffer if she had to go against her conscience was not greater or was only marginally worse than the harm her prospective patients would face if she did not honour their requests? The suggestion in Meyers and Woods's argument that the harm to the objector in abortion cases will always be greater is not obviously true (although a sympathetic reading of their work could allow them some exceptions, such as when the woman's life is at risk). Moreover, to assume that the harm to the objector only has to be greater—and so could just be marginally worse—is misleading, for it implies that the objector and patient are equally responsible for the moral conflict they are in. In reality, the objector bears more responsibility than the patient, because she, the objector, did not have to choose to be a health care professional or to choose the specialty she is in. The voluntary aspect of being a health care professional suggests that conscientious objection is not justified if patients would suffer substantial harm. Objectors ought to have to prove not only that the harm of them violating their conscience would be great, but also that harm to patients would be minimal or

physician to perform blood transfusions because people sacrifice their eternal soul when they have blood transfusions). Thus, to focus exclusively on discriminatory refusals is problematic. We agree with this criticism, but have found it difficult to flesh out a broader category of intolerable refusals (vs. merely discriminatory ones). We leave this task for another time not only because we believe it is complicated, but also because we want to highlight the problem of leaving room for discriminatory refusals.

would simply not occur. We develop this idea in more detail below.

At this point, we hope to have said enough to convince the reader that justification for conscience exemptions in health care must involve more than proving genuineness. Health care professionals' voluntary role as professionals and their duty not to discriminate against patients, among other duties, makes the justification for these exemptions more complicated than Meyers and Woods suggest that it is.

3. Proving Reasonableness: Card

What about describing the necessary justification as proving the reasonableness of one's beliefs rather than their genuineness? Card makes this suggestion: the "beliefs on which conscientious objection is based must be reasonable and should be subject to evaluation in terms of their justifiability."²⁶ On this view, objectors must show not merely that they passionately hold the relevant beliefs, but that they hold them for good reasons. In short, they must prove that they have normative reasons for their refusal: reasons that others should accept.

Card develops his view in response to pharmacists refusing to provide women with emergency contraception (EC). He argues, in short, that because of their role-related responsibilities and the great harm their refusals can cause patients, objecting pharmacists ought to have to provide "justifying reasons" for their objection to EC.²⁷ Card thinks that none of the reasons they could have for objecting are justifiable, for it is not reasonable to assume either that EC is

²⁶ *Op. cit.* note 1, p. 13.

²⁷ *Op. cit.* note 3, 2011, p. 62.

anything other than a form of contraception or that contraception is somehow immoral.²⁸ Thus, according to Card, even if they tried, objectors could not prove their reasonableness and should not be excused from having to dispense EC.

Card's model is an improvement over that of Meyers and Woods. It narrows the overly broad scope of permissible refusals that we get in Meyers and Woods by ruling out objections grounded in the sort of beliefs discussed above: empirical beliefs that are baseless and moral or religious beliefs that are discriminatory. Conscientious objections motivated by such beliefs could not be reasonable.

Nonetheless, Card's model, like that of Meyers and Woods, is flawed. Jason Marsh rightly complains that Card fails to describe what he means by reasonableness or justifiability.²⁹ We think he has to mean, at least, that the beliefs motivating the objection are as likely or more likely to be true than beliefs that support the service the objector finds offensive. (So, for example, the burden for the anti-abortionist would be to prove that a pro-life stance on abortion is as plausible or more plausible than a pro-choice one. If it is as plausible, then the objector could rightly insist that he cannot be obligated to ignore his pro-life views.) We argue that, so understood, Proving Reasonableness is too restrictive. It would result in some problematic *denials of exemption* based on conscience. At the same time, it could produce some

²⁸ *Op. cit.* note 1, p. 10.

²⁹ Marsh, *op. cit.* note 12.

problematic *exemptions* based on conscience, making it too permissive (though not as permissive as Proving Genuineness). Let us explain.

To see why Card's model is too restrictive, consider cases in which the objector cannot prove reasonableness, but the objection is genuine and grounded neither in empirical beliefs that are baseless nor in moral or religious beliefs that are discriminatory. Further, the objector can promise that she will be respectful toward patients who request the relevant service and that they will get ready access to it elsewhere. An example would be an objection to most abortions on grounds that the fetus is a person, where the objector can and will provide referrals for abortion in a morally appropriate manner.³⁰ We think to prohibit objections of this sort would be to fail to take conscience seriously enough. Because Card would have us prohibit them (assuming that the objectors could not prove reasonableness), we should reject Card's model. He would oppose conscience exemptions in such cases, even though the exemptions would not harm patients.

To see how Card's model could be too permissive while at the same time being too restrictive, consider that a lack of fairness in adjudicating reasonableness would probably produce some problematic exemptions and problematic denials of exemption based on conscience. Some review panels will not assess reasonableness fairly, that is, without unfairly privileging certain

³⁰ On why it is important that referrals be respectful, see C. McLeod. Harm or Mere Inconvenience? Denying Women Emergency Contraception. *Hypatia* 2010; 25(1): 11-30.

moral views.³¹ We have this worry, in particular, about the evaluation of refusals grounded neither in empirical beliefs that are baseless nor in moral or religious beliefs that are discriminatory. Consider a belief (or set of beliefs) that arguably falls into neither of these categories: abortion is immoral because fetuses are persons. There is profound disagreement in many societies about the morality of abortion. We assume, given such disagreement, that evaluations of the reasonableness of conscientious objections to abortion will vary among review panels, with some deeming these objections reasonable and others not. Those that favour extreme anti-abortion views, for example, will do so unjustifiably. They will issue morally problematic exemptions to the duty of health care professionals to participate in (or at least not prevent) abortions.

Notice that unfairness in adjudicating the normativity of reasons for or against abortion could also produce morally problematic *denials* of exemption to one's duty: that is, if the duty extends to all abortions, including, for example, sex-selective ones. A physician who refuses to perform sex-selective abortions in a society that condones or encourages sex selection (e.g. China or the US) may fail to prove the reasonableness of his position to a panel of review. We think the denial of an exemption to him would unfairly privilege this society's view about sex selection.

In general, deciding whether objectors should receive exemptions based on whether they can provide normative reasons for their refusal could create

³¹ Wicclair, *op. cit.* note 6.

substantial unfairness.³² Giving objectors an opportunity to present normative reasons for their views is important nonetheless, as we describe below. We turn now to a stance on justification for conscientious objection in health care that we prefer and that follows clearly from the criticisms we have raised of Card, and of Meyers and Woods.

4. Proving reasonableness or genuineness plus: Kantymir & McLeod

We think health care professionals who have a conscientious objection should have two options for defending their objection: prove *either* 1) that it is reasonable, in particular by showing that what grounds the objection is as likely or more likely to be true than what grounds the standard of care for patients, *or* 2) that it is genuine, *plus* that it satisfies certain criteria. For option 2), the criteria are as follows: patients will still get the care they need in a respectful and timely fashion, any empirical beliefs on which the objection rests are not baseless, and the moral or religious beliefs on which it rests are not discriminatory.

To get clear on our position, consider how it would apply to the case of

³² We accept that this potential exists in evaluating not just the *reasonableness* but also the *genuineness* of objections. However, we believe that the problem is more serious with the former. Simply put, determining whether people's views are justifiable is generally less straightforward than determining whether they are genuinely committed to those views. To decide the latter, we can often just look to their behaviour to see whether it is consistent with the relevant commitments.

a pharmacist who refuses to dispense EC. The pharmacist would first choose whether he wants to attempt to prove reasonableness (as understood above). If he does so³³ and he succeeds, then the review panel would give him license to object conscientiously to EC (and especially if the panel decides that the beliefs grounding this objection are more likely to be true than beliefs that support EC, then it might also lobby government or pharmacists' groups to oppose EC). If the pharmacist does not succeed or does not want to prove reasonableness, then he will have to demonstrate that his objection is genuine, *plus* that the following are true: 1) patients would still have timely access to EC and would be treated respectfully while being directed to pharmacists who dispense it; 2) there is some evidence in favour of the beliefs about EC that underlie the objection; and 3) the relevant moral or religious beliefs are not discriminatory. This last criterion requires that the pharmacist not be motivated by, for example, the sexist belief that women are obligated *as women* to ensure that they and their sexual partners use protection, and thus that women who request EC are irresponsible and do not deserve it as a result. If the pharmacist can show that he is genuine and can satisfy the above three criteria, then he will succeed in

³³ Note that in doing so, he might lose the status of “conscientious objector” if conscientious objections typically are not aimed at communicating to others that the relevant duty or norm is misguided. Instead, his actions might qualify as civil disobedience. See K. Brownlee. 2009. Civil Disobedience. *Stanford Encyclopedia of Philosophy*. Ed. E. Zalta. <http://plato.stanford.edu/entries/civil-disobedience/> [Accessed 21 February 2013].

proving “genuineness plus.” And the review panel would then have to excuse him from having to dispense EC.

Our reasons for accepting the above model are evident in our analyses of Card and of Meyers and Woods. Even so, let us summarize them. First, the invitation to objectors to prove reasonableness makes it possible for us to learn from their refusals and also for objectors to pursue a goal they might have in objecting: to convince us that some change in health care practice is needed.³⁴ Conscientious objectors can help to expose morally weak or corrupt norms in health care. Yet for that to happen, a forum needs to exist for them to defend the reasonableness of their objections. It is only fitting that this opportunity be the one in which they try to justify their refusal to fulfill the duty that morally offends them.

Second, our model supports the duties that objectors have to their patients, which is the aim, in particular, of the “plus” part of genuineness plus. For instance, requiring objectors to ensure that patients can still get respectful and timely treatment promotes duties of patient care. Insisting that any empirical claims underlying their objections have some scientific basis to them supports standards of knowledge appropriate to their role and the trust that patients have in them as professionals. Finally, requiring that relevant moral or religious beliefs are not discriminatory prevents objectors from subjecting patients to oppressive treatment under the guise of religious or moral freedom.

³⁴ Granted, this outcome is unlikely if the objector’s beliefs are fundamentally different from our own.

Third, our model would produce, in total, fewer problematic exemptions and denials of exemption than the models of either Meyers/Woods or Card. There would be fewer problematic exemptions than with Meyers and Woods's model because of the plus part of genuineness plus. There would be fewer problematic denials of exemption than with Card's model because objectors who cannot prove reasonableness but who can prove genuineness plus should get an exemption, which we have argued is as things should be. The reason for not being able to prove reasonableness could be that the objection is simply unreasonable or that the review panel would not judge it fairly.

Notice that unfortunately, our model would not necessarily create fewer problematic exemptions, as opposed to denials of exemption, compared with Card's model. Some objectors will succeed in proving reasonableness even though their objections are not reasonable, because some review panels will evaluate some objections poorly, with the result that exemptions based on reasonableness occur without good reason. Below, we suggest a way to minimize this problem, which fortunately exists for us no more than it does for Card.

To sum up, we think the standard for justifying conscientious objections in health care needs to be more strict than what Meyers and Woods recommend, but less strict than what Card proposes. Objectors should have to prove genuineness plus rather than mere genuineness. Alternatively, they could prove reasonableness; however, they should not have to do so. We hope that the need for and merit of our view is clear.

5. Imperfections and Conclusion

No model for the justification of conscience exemptions in health care will be perfect. Nonetheless, we feel that we can minimize the imperfections in our own view by taking certain criticisms of it seriously, two in particular.

First, as noted above, our model will not produce fewer problematic exemptions than Card's because it still relies upon the adjudication of putatively normative reasons, which can be unreliable. As a result, objectors could succeed in proving reasonableness even though their objections are not reasonable. For example, the pro-life health care professional whose objection is reviewed by a panel that is predominantly pro-life will probably be excused from having to provide abortion services on the grounds that abortions are immoral, which is (arguably) false, at least about most abortions.

To respond to this first criticism, we would like to propose that an appeals process be set up so that poor decisions of review boards could be overturned. An appeal should be open not only to objectors, but also to their colleagues, to their prospective patients, or really to any interested party. For example, Planned Parenthood could appeal when an objector succeeds in proving the reasonableness of a pro-life objection to abortion. Although introducing such a measure would not eliminate bad exemptions of this sort, it could surely minimize them.

Second, we do not provide standards for judging which moral or religious beliefs are discriminatory. But review panels may differ in which

beliefs they deem to be discriminatory, which will generate unfairness.³⁵

In response, giving review panels some guidance on what they should count as discriminatory would be appropriate. A handbook on discrimination that outlines the different ways in which sexism, racism, and the like can manifest themselves should be helpful for this purpose. The goal in arming review panels with such material would be to make the review process less imperfect than it would otherwise be. In particular, evaluations of the plus part of genuineness plus would be more reliable.

In summary, there will inevitably be some unfairness in deciding, in practice, what counts as a justified conscientious objection. However, by fine-tuning our model of justification, we believe that we have come closer to creating a fair process than our counterparts in the literature do.

To conclude, insofar as conscientious objectors in health care ought to justify their objections (in our view, they ought to do so), the justification should take the form of proving either reasonableness or genuineness plus. A

³⁵ Ultimately they may decide differently, for example, about whether the “Christian pharmacist who refuses to fill birth control prescriptions differs only in degree and not in kind from the Talibanesque taxi driver who refuses to serve women who are unaccompanied by their male relatives” (E. Anderson. 2005. So you want to live in a free society? (5): Common property, common carriers, and the case of the conscientious objecting pharmacist. *Left2Right*. Available at: http://left2right.typepad.com/main/2005/08/so_you_want_to_.html)

[Accessed 21 February 2013]).

refusal should not have to be reasonable for the objector to receive some conscience protection. Thus, Card's view is too restrictive. At the same time, not every refusal that is genuine warrants an exemption. Thus, Meyers and Woods' view is too permissive. We have proposed a middle-ground position that accords, by comparison, greater respect to the conscience of health care professionals and to the dignity and health of their patients.

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