

Are conscientious objectors morally obligated to refer?

Samuel Reis-Dennis ,¹ Abram L Brummett ²

Abstract In this paper, we argue that providers who conscientiously refuse to provide legal and professionally accepted medical care are not always morally required to refer their patients to willing providers. Indeed, we will argue that refusing to refer is morally admirable in certain instances. In making the case, we show that belief in a sweeping moral duty to refer depends on an implicit assumption that the procedures sanctioned by legal and professional norms are ethically permissible. Focusing on examples of female genital cutting, clitoridectomy and ‘normalizing’ surgery for children with intersex traits, we argue that this assumption is untenable and that providers are not morally required to refer when refusing to perform genuinely unethical procedures. The fact that acceptance of our thesis would force us to face the challenge of distinguishing between ethical and unethical medical practices is a virtue. This is the central task of medical ethics, and we must confront it rather than evade it.

INTRODUCTION

Suppose a physician refuses to perform a medical procedure that is professionally accepted and legal. Is he morally obligated to refer the patient to another doctor? In this paper, we will show that referral is not always morally required. Indeed, we will argue that refusing to refer is morally admirable in certain instances.ⁱ

We will suggest that the widespread intuition that providers are morally obligated to refer depends on substantive moral judgments that the medical interventions in question are ethically permissible. The referral intuition does not persist when the assumption that professional and legal standards are legitimate is undermined. To be clear, we will not claim that providers may refuse to refer if they *believe* a procedure to be unethical. (Presumably, nearly all objecting providers believe this about the procedures they object to.) Rather, we will argue that no one is morally obligated to facilitate *genuine* wrongdoing. The fact that this thesis raises the challenge of identifying genuine wrongdoing is a virtue. Making sound moral arguments for and against specific types of medical interventions is a central task of medical ethics.

THE STANDARD VIEW

Mark Wicclair has described three approaches to conscientious objection.¹ At one extreme, conscience absolutism asserts that conscientious objections should always be permitted. At the other extreme, the incompatibility thesis asserts that

ⁱWe use ‘moral’ and ‘ethical’ interchangeably in this paper.

conscientious objections should never be permitted. In the middle, compromise approaches offer criteria that conscientious objections must meet in order to be legitimate. Almost all compromise approaches to conscientious objection require refusing providers to refer their patients or facilitate transfers to willing providers.^{1–6} The referral requirement reflects acceptance of the slogan that a provider may ‘step away from, but not in between’ patients and professionally accepted medical interventions; it is part of an attempt to ensure that all patients have access to care while allowing providers to maintain their integrity.ⁱⁱ The referral requirement also expresses a belief in the value of tolerance in a morally diverse liberal society: patients get the care they require and demand; providers are not forced to forsake their ethical commitments.

The precise wordings of the requirement vary. The American Academy of Pediatrics claims physicians have a ‘moral obligation’ to refer²; the American College of Obstetrics and Gynecology³ and the American College of Physicians⁴ both state that providers have a ‘duty’ to refer; Mark Wicclair describes it as an ‘ethical constraint’¹; Jason Eberl writes that it ‘requires’ healthcare providers to refer⁵; Dan Brock writes that providers can object ‘only if’ they refer⁶; Julie Cantor and Ken Baum explain that providers ‘should follow the rule’ of referral⁷; Bernard Dickens calls non-referral ‘unethical’.⁸ It seems to us that according to the standard view, conscientiously objecting providers incur moral obligations to facilitate transfers to willing colleagues.

AGAINST THE MORAL OBLIGATION TO REFER

Suppose that in a society in which doctors are permitted to administer lethal injections, an anaesthesiologist is asked by his state government to administer such an injection to a condemned prisoner. And suppose, further, that the anaesthesiologist knows that the prisoner is innocent. The anaesthesiologist, rightly judging that it would be morally wrong to participate in the execution of an innocent man, refuses to administer the injection.

In response, the state asks him to recommend a colleague who would be willing to take his place. As it happens, the anaesthesiologist has a colleague whom he knows would be eager to step in. It seems to us that it would be morally permissible for the anaesthesiologist to refuse to make the referral. Such a referral would facilitate the execution of an innocent man.

ⁱⁱOther common criteria of compromise views include a requirement to disclose what options are legally and professionally available to patients, and a requirement that conscientious objections must not involve invidious discrimination.

¹Alden March Bioethics Institute, Albany Medical College, Albany, New York, USA

²Department of Foundational Medical Studies, Oakland University William Beaumont School of Medicine, Rochester, Michigan, USA

Correspondence to

Dr Samuel Reis-Dennis, Alden March Bioethics Institute, Albany Medical College, Albany, NY 12208, USA; reisdes@amc.edu

Received 30 October 2020
Accepted 14 May 2021



© Author(s) (or their employer(s)) 2021. No commercial re-use. See rights and permissions. Published by BMJ.

To cite: Reis-Dennis S, Brummett AL. *J Med Ethics* Epub ahead of print: [please include Day Month Year]. doi:10.1136/medethics-2020-107025

The killing would not happen by the anaesthesiologist's own hand, but he would be complicit. Even if he cannot stop it from going forward, he has no obligation to ensure that the process is smooth and efficient.

Just as it is wrong to knowingly violate the rights of others, it is wrong to facilitate such rights violations. Just as it is wrong to administer a lethal injection to an innocent man, it is wrong to intentionally enable such an injection. The assistance disrespects the prisoner's humanity—it represents a failure to take him seriously as a fellow human being whose life has value, whose interests matter and who has a right against being unjustly killed. In short, it is wrong for many of the same reasons killing an innocent man is wrong. Depending on the underlying motivations, one might even say that in making the referral, the physician would be using the prisoner as a mere means to his ends, which might include keeping his job and maintaining good professional relationships.

To be clear, the moral propriety of the physician's refusal to refer does not depend on his ability to successfully protect the prisoner from harm, but rather on the legitimacy of his interest in disassociating himself from wrongdoing. This is true in more standard medical contexts as well. Objections to referral, like objections to providing unethical treatment, allow providers to preserve their integrity. Concern for integrity—the congruence of one's life and action with one's deepest values and commitments—depends on the belief that one's own behaviour and character have, and ought to have, a special moral significance to one. An objecting provider often knows that his refusal will not prevent the procedure in question from going forward. His aim in stepping away is not primarily to stop wrongdoing but to avoid personally committing it, assisting in it or devoting time and energy to it. Just as significantly, the dissociation allows him to protest and denounce it—to credibly signal that he stands against it. In making referrals for procedures that are unethical, physicians personally *facilitate* wrongdoing by ensuring an efficient transfer to a willing provider. In referring, physicians deploy their knowledge and energy with the intention of aiding a patient (or patient's surrogate) in seeking medical treatment. The fact that the physician does not perform the procedure herself mitigates, but does not prevent, damage to her integrity.

The lethal injection example shows how referral can make a physician complicit in wrongdoing, but it has its limits. After all, the cases that compromise views address involve requests for medical rather than punitive intervention and come from patients or their families rather than the state. Crucially, such examples depend on the existence of therapeutic relationships between the doctors and patients in question, which serve as ethical foundations for rules and ideals that rightly shape physician behaviour. In what follows, we will consider three kinds of cases that occur against the backdrop of such relationships: one involving a social context in which an ethically impermissible procedure is legally and professionally accepted, one from recent American history and, finally, one that reflects an active debate in contemporary medicine.ⁱⁱⁱ

First, imagine that a parent asks a paediatric surgeon to perform a ritual female genital cutting (FGC) procedure on her daughter. And suppose, for the sake of argument, that this interaction occurs in the context of a country and a medical system that permits FGC. The surgeon knows that the intervention would cause her patient great suffering, permanently limit the patient's future ability to experience sexual pleasure, contribute to a system of patriarchal control over women's sexuality and violate the patient's right to a kind of sexual

self-determination. If, given all this, the surgeon asserted a conscientious objection to performing the procedure, would she be morally obligated to refer the patient to a willing provider? It seems to us that she would not. In fact, the refusal to refer would be morally admirable. The physician has no moral obligation to facilitate the cutting even though the procedure (1) is legally permissible, (2) is professionally accepted, and (3) has been requested in the context of a therapeutic relationship by a legitimate medical decision-maker on a patient's behalf.

Perhaps it will be objected that both execution of the innocent and FGC are *widely held* to be wrong, and that the ethical status of interventions more commonly discussed in the literature on conscientious objection (abortion and physician aid in dying, for instance) is less clear. In the absence of widespread agreement, our opponents might claim, conscientious refusers must always refer. The problem with this response is that the canonical view mandates referral when providers refuse to perform 'legal and professionally accepted' procedures, and legal and professional norms sometimes condone unethical conduct. In the USA, clitoridectomies were performed at the request of parents aiming to prevent their daughters from masturbating until the mid-20th century, for example.⁹ Even when these procedures were legal and professionally accepted, some doctors opposed them. Would it have been *morally wrong* for these doctors to refuse to refer these patients into harm's way?

Consideration of this example shows that widespread *agreement* that a procedure is unethical is not required to show that the procedure is wrong and should be neither performed nor facilitated. When clitoridectomy was widely accepted, there was not a broad consensus against it. The explanation of a practice's wrongness, then, must come apart both from the prevailing legal and professional standards of the time and from the whims of public opinion. Rather, the ethics of medical interventions depend on their statuses as injustices, harms, expressions of disrespect, violations of legitimate professional ideals, and so on. Clitoridectomy to prevent masturbation, for example, is violation of the child patient's rights, and this would be true even if most people—and the medical profession—supported it.

Another lesson of this brief historical reflection is that our own standards may continue to permit, and even encourage, unethical conduct. We are arguing that if this is the case, then physicians have no moral obligation to help execute these indefensible interventions.

We are now in a position to consider a case of this kind: medical treatment of children born with atypical sex development, or intersex traits. At the time of this writing, surgery aiming to 'normalize' atypical genitalia is both legal and professionally accepted. Surgery is typically performed before patients are old enough to understand the procedures' possible implications, which can include scarring, incontinence and loss of sexual sensation. The 'corrective' process can also require repeated follow-up procedures and hormone treatments. To be clear, these interventions are not medically necessary; rather, they are 'social' procedures chosen by parents who hope that early surgery will allow their children to grow up looking (and feeling) 'normal'.

Human rights organisations, including the United Nations and Human Rights Watch, have publicly declared that these procedures constitute human rights violations, and therefore should not be among the options available to parents in paediatric decision-making. We agree. Paediatric patients have a right against having their gender, sexual and reproductive development irreversibly physically engineered for purely social reasons. Early surgery may drastically limit patients' experiences of sexual pleasure and their ability to reproduce. Necessarily, it irreversibly alters their sexual anatomy, conclusively preventing them from forging their own sexual

ⁱⁱⁱWe are grateful to an anonymous referee for prompting us to make this explicit.

identities, which in turn are deeply significant to their identities as persons.¹⁰ It is no surprise that intersex activists, including many adults who have undergone these procedures, have condemned such surgeries since the 1990s,¹¹ citing harrowing patient testimonials.¹²

Nevertheless, early intersex surgery remains a legal and professionally accepted practice. Are paediatricians who concur with major human rights organisations and conscientiously refuse to perform such surgeries obligated to facilitate them by making referrals? It seems to us as though the answer to that question depends crucially on the ethical status of these procedures. If these procedures are genuine *human rights violations*, then surely the fact that they are currently permitted by legal and professional norms does not imply that providers are morally obligated to facilitate them. This conclusion merely extends the logic we employed in our discussion of clitoridectomy: when that procedure was legally and professionally accepted, it was still a violation of human rights; providers who refused to perform or facilitate it acted admirably.

GOOD POLICY AND GOOD CONDUCT

It is worth explicitly distinguishing two aspects of the ethics of conscientious refusal. First, there is the question we have been concerned with up until this point: do providers have an ethical obligation to make referrals after conscientiously refusing to perform legal and professionally accepted procedures? We have argued that if those procedures are ethically indefensible, then providers have no such ethical obligation to refer.

The second aspect of the ethics of conscientious objection concerns questions about the optimal conscientious objection *policies* hospitals and governments might enact. We are not taking a position on whether medical institutions are justified in making rules mandating referral. While there may be good reasons to establish rules requiring referral, one can and should maintain a distinction between sensible institutional rules and individual ethical requirements. The doctor who refuses to perform the clitoridectomy or intersex surgery, for example, may violate a general (and perhaps defensible) hospital rule to refer. Nevertheless, she does nothing morally wrong. She has nothing to feel guilty or ashamed about.

This could not be said of all providers who refused to refer. Consider, for example, a doctor who refused to treat or refer patients of a specific race because she found people of that race disgusting. This would be a shameful attitude, and her refusal would be blameworthy.

The fundamental difference between the two cases is that the doctor's ethical judgments are correct in one case and incorrect in the other. The physician in the first case is ethically justified in refusing to refer the parent seeking to force a child to undergo a clitoridectomy to prevent her from masturbating. She is willing to accept punishment rather than participate in the violation of a child's rights. She flouts a hospital rule demanding she refer, but not a *moral* obligation. She does nothing morally wrong.

Another way of putting the point is that the mere existence of a general institutional rule mandating referral does not settle the question of whether one is *morally obligated* to follow that rule in a given case. And this is true even if the rule is reasonable. Suppose that the physician who was asked to perform the clitoridectomy approached a close confidant and explained her situation as follows: 'I know I will be punished if I refuse to refer the patient to another pediatric surgeon, but, if I do refer the patient, I will be playing a role in her being violated and harmed. I am considering accepting the punishment and refusing to refer.' The confidant may advise the doctor to refer—perhaps the punishment will be more than the physician can bear, for example. It would be unfounded, however, for the friend to insist that the doctor is *morally obligated* to assist in the harmful violation of her patient. The suggestion that she is not morally

obligated to perform the procedure, but that refusing to facilitate it would be morally wrong, would be misguided.

The fundamental moral problem in cases of this kind is not the existence of institutional rules mandating referral in general, but rather the specific professional and legal standards that permit unethical medical procedures. Such corrupt standards create conditions in which following institutional rules requiring referral would force doctors to facilitate wrongdoing and help to cause unnecessary harm.

The fact that such institutional requirements to refer may exist for a moral reason, for example, to express a commitment to providing access to care, may seem to complicate the analysis.^{iv} Don't we have a moral obligation, one might wonder, to conform our conduct to sensible rules that exist for good moral reasons? We may have such an obligation, but it is defeasible. It does not apply when following the rules would force one to violate another person or to be complicit in such a violation. We believe that this principle enjoys broad acceptance in a range of cases: one may be obligated, in general, to register for military service during wartime, but not if such service would involve systematic commission of war crimes; one may be obligated, in general, to pay one's taxes, but not if those taxes would fund an explicit policy of ethnic cleansing.

TELLING RIGHT FROM WRONG

Our thesis raises an obvious question: which medical procedures are unethical? This, however, is nothing to be embarrassed about. Indeed, answering this question—by making good arguments for and against various medical practices—is the task of clinical ethics. Insofar as we attempt to adjudicate the ethics of referral independently of the morality of specific medical procedures, we fail to do justice to considered judgments about cases (including those we have discussed here), and fail to meet our responsibilities as ethicists to make and defend substantive claims about the moral propriety of specific standards and practices.

Our position is not to be confused with the view that physicians are not obligated to facilitate treatment that they *believe* to be unethical. Such a position would imply that no one is ever wrong in his refusal to refer, and this is false. It is wrong to prevent patients from accessing ethically justifiable care. But it is *not* wrong to refuse to facilitate genuinely unethical interventions.

At this point, some readers may cry out in frustration: 'But who's to say that some procedures are ethical and others are unethical? How do we know? Who decides?' This is the task of ethics. It is an ongoing collective responsibility we must face. 'Who's to say what is right and wrong?', when voiced as a sceptical challenge to which there can be no answer, is a response that amounts to an abandonment of the ethical project. It is an abdication of our duty as ethicists and practitioners to make *good arguments* for and against the interventions in question, to sharpen our moral vision and help others do the same, and to articulate good reasons for our moral claims.

Here, we have relied on the concept of a violation of rights in arguing that providers are not obligated to facilitate certain medical procedures. Nothing we have said implies, however, that other kinds of considerations could not justify a refusal to refer. One could argue that a legally and professionally accepted medical intervention is incompatible with legitimate medical goals or ideals, for example, or that providing a particular form of treatment would be harmful or unjust.^v Evaluating specific medical procedures in these ways is a

^{iv}Of course, it is an empirical question whether such rules actually ensure access to care. We do not address that question here. We are thankful to an anonymous referee for suggesting this clarification.

^vWe are grateful to an anonymous referee for encouraging us to make this clearer.

core ambition of our field. We are arguing that refusals to refer must be judged in the light of such evaluations.

Such hope for the ethical project should not be confused with a commitment to the idea that ethical truths have a timeless metaphysical status. Our arguments are consistent with that position, but also with less metaphysically ambitious views according to which ethics is grounded in foundational social principles, values or commitments that admit of no further justification. The claim that some medical procedures are unethical is mainstream. It is widely accepted by ethicists and by the public. Indeed, no one would seriously engage in discussions about medical ethics if he rejected it.

We suspect that some readers will fear that any interrogation of the referral requirement will empower providers to inappropriately withhold services from patients. But this fear, while perhaps warranted, is not a legitimate reason to reject our arguments. The thesis that one is not morally obligated to follow unjust laws provides a useful analogy. That idea might make a misguided opponent of laws against, say, insider trading, feel empowered to break them, but it would not justify his behaviour. The problem here is with the lawbreaker's false moral view, not with the (true) claim that we are not morally required to obey unjust laws.

Our aim in writing this paper is not to embolden reactionaries but rather to explore the ethics of referral in a way that goes beyond discussion of legal and institutional norms. This interest in the *moral* status of referral is not merely academic. Many of life's deepest questions are inescapably ethical. We cannot make sense of what we owe to others, what others owe to us or even how we ought to feel about our relationships and behaviour, without an understanding of our ethical duties and ideals. 'How can I become a better person?' 'Do I owe her an apology?' 'Am I justified being angry in response to what he's done?' 'Should I feel guilty about this?' In answering these questions, we shape our self-conceptions and our actions. Legal and institutional norms will not settle them.

The widespread acceptance and internalisation of the standard compromise position distorts and even forecloses inquiry into many of these important ethical questions. Rejecting it would force participants in the healthcare system to rethink the relationship between conscientious objection and ethical reasoning. Rather than encouraging an individualistic conception of objection, according to which refusal is entirely personal and readily obscured by speedy referral, our approach encourages practitioners, students and hospital policymakers to think of refusals to refer as ethical claims evaluable against the backdrop of standards and ideals justifiable to all. Along these lines, rejection of the standard view may even change the self-understandings of refusing physicians. On the one hand, their colleagues and employers may think twice before criticising them for their failure to refer; on the other hand, objectors would be open to moral criticism based on the reasons for their objections. Indeed, they may feel, or actually be, compelled to defend their refusals in

general terms rather than taking refuge in personal commitments that others could never be expected to share.

To review: we have argued that a sweeping moral requirement for conscientious objectors to refer depends on an implicit assumption that the procedures sanctioned by legal and professional norms are ethically permissible. Focusing on examples of FGC, clitoridectomy and 'normalizing' surgery for children with intersex traits, we have argued that this assumption is untenable and that providers are not morally required to refer when refusing to perform genuinely unethical procedures. The fact that acceptance of our thesis would force us to face the challenge of distinguishing between morally defensible and indefensible medical practices is a virtue. This is the central task of medical ethics, and we must confront it rather than evade it.

Acknowledgements We are grateful to Elizabeth Reis, Matthew Dennis, Pamela Reis, Vida Yao and three anonymous referees for their feedback on earlier versions of the paper.

Contributors Both authors wrote and revised the manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement There are no data in this work.

ORCID iDs

Samuel Reis-Dennis <http://orcid.org/0000-0002-5417-8002>

Abram L Brummett <http://orcid.org/0000-0003-0511-574X>

REFERENCES

1. Wicclair MR. Conscientious objection in health care: an ethical analysis. Cambridge University Press; 2011.
2. Committee on Bioethics. Policy statement--Physician refusal to provide information or treatment on the basis of claims of conscience. *Pediatrics* 2009;124(6):1689-93.
3. American College of Obstetricians and Gynecologists. ACOG Committee opinion no. 385 November 2007: the limits of conscientious refusal in reproductive medicine. *Obstet Gynecol* 2007;110(5):1203-8.
4. Snyder L, Bledsoe TA. American College of physicians ethics manual: seventh edition. *Ann Intern Med* 2019;170:51-32.
5. Eberl JT. Protecting reasonable conscientious refusals in health care. *Theor Med Bioeth* 2019;40(6):565-81.
6. Brock DW. Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theor Med Bioeth* 2008;29(3):187-200.
7. Cantor J, Baum K. The limits of conscientious objection--may pharmacists refuse to fill prescriptions for emergency contraception? *N Engl J Med* 2004;351(19):2008-12.
8. Dickens BM. Unethical protection of conscience: defending the powerful against the weak. *Virtual Mentor* 2009;11(9):725-9.
9. Rodriguez SB. *Female circumcision and clitoridectomy in the United States: a history of medical treatment*. Boydell & Brewer, 2014.
10. Reis-Dennis S, Reis E. The irrelevance of data to the ethics of infant intersex surgery. *Journal of Pediatric Ethics* In Press.
11. Davis G. *Contesting intersex: the dubious diagnosis*. Vol 10. NYU Press, 2015.
12. Davis G. Normalizing intersex: the transformative power of stories. *Narrat Inq Bioeth* 2015;5(2):87-9.