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The Paradox of Conscientious Objection and the Anemic Concept of ‘Conscience’: Downplaying the Role of Moral Integrity in Health Care

ABSTRACT. Conscientious objection in health care is a form of compromise whereby health care practitioners can refuse to take part in safe, legal, and beneficial medical procedures to which they have a moral opposition (for instance abortion). Arguments in defense of conscientious objection in medicine are usually based on the value of respect for the moral integrity of practitioners. I will show that philosophical arguments in defense of conscientious objection based on respect for such moral integrity are extremely weak and, if taken seriously, lead to consequences that we would not (and should not) accept. I then propose that the best philosophical argument that defenders of conscientious objection in medicine can consistently deploy is one that appeals to (some form of) either moral relativism or subjectivism. I suggest that, unless either moral relativism or subjectivism is a valid theory—which is exactly what many defenders of conscientious objection (as well as many others) do not think—the role of moral integrity and conscientious objection in health care should be significantly downplayed and left out of the range of ethically relevant considerations.

I. INTRODUCTION: COMPROMISE AND CONSCIENTIOUS OBJECTION

Medical ethics is a field of moral conflicts *par excellence*. Two phenomena combine to sharpen conflicts and make them more likely to occur. First, the widening of scientific and medical possibilities creates new areas of potential moral tension. Second, multiculturalism in scientifically and medically evolved societies fosters a plurality of (bio)ethical views (Macklin 1998).

At the public level, compromise is often presented as the most appropriate solution to settle conflicts on the most controversial issues, for example abortion or euthanasia (Engelhardt 2011; Huxtable 2007; Benn 2005). Compromise “occurs when disagreement is invoked as a reason to

accept a political position otherwise perceived to be morally inferior” (May 2005, 318). One instance of such compromise in the health care context is conscientious objection: by appealing to their “moral conscience,” health care practitioners claim the right to have their moral integrity respected and therefore not to perform or take part in certain activities that patients have the right to request. Thus, for example, the countries where abortion or medical help to die are legal usually have conscience clauses that allow practitioners to withdraw from activities directly or indirectly linked to such practices (KNMG 2011; Kidd and Nys 2002, Section 14; Task Force to Improve the Care of Terminally-Ill Oregonians 2008). Being granted by the law, conscientious objection, as I will intend the concept here, is different from “civil disobedience,” which is an act contrary to the law aimed at bringing about a change in public policies (Rawls 1971, 299; Raz 1979, 262–75; Wicclair 2011, 11–13). Only conscientious objection, but not civil disobedience, represents a form of compromise.

Failing to achieve this form of compromise when it comes to “issues of conscience” might be seen as contradicting reasonable pluralism. In this view, a principle of reciprocity (Rawls 2005, 48–50) prescribes us to grant health care practitioners the right to stick to their deeply held moral or religious beliefs, as long as (1) they grant the same right to anyone else (e.g., patients who ask for a controversial treatment or doctors who are willing to perform such treatments), and (2) their beliefs are not intolerant (Sulmasy 2008, 146; e.g., racist or sexist) and do not violate plausible requirements of social justice (Brock 2008; Sulmasy 2008).

Thus, for instance, by appealing to the idea of “reasonable pluralism” Piers Benn (2005) has argued that “when well-informed and well-intentioned people disagree about [issues of conscience], laws and institutions should not take extreme stances” (177–78).

But are there good arguments in support of this kind of compromise? As I will illustrate, the philosophical arguments usually deployed to justify protection of practitioners’ conscience are often based on the principles of “respect” for their moral integrity or tolerance, and then different authors attempt to put reasonable constraints to such respect. However, I will show (Sections II–IV) that these kinds of arguments are extremely weak and, if taken seriously, have either impractical or counterintuitive consequences. Therefore, contrary to the prevailing view, I will argue that it is not possible to defend conscientious objection in health care by simply appealing to the value of respect for moral integrity, because it is not possible to constrain such respect to prevent undesirable (and unacceptable) consequences.

I want to propose an alternative and more promising approach to the problem—one that questions the role of moral integrity in medical ethics and that takes a new perspective on the issue of conscientious objection. The key question we need to ask, and from which this different approach stems, is whether impartiality towards conflicting parties should refer to (1) the individuals involved in the conflict, in which case we should grant them equal rights and protections in the name of respect for moral integrity, regardless of what moral reasons they put forward (Pellegrino 1994, 58); or to (2) the different moral positions at stake, in which case we should base the acceptability of these positions on an unbiased and rational assessment of their plausibility (assuming this is possible).

Whereas most of the literature has endorsed the former, the possibility of basing conscientious objection on the second perspective has remained largely—though not completely (Davis 2008, 88; McLeod 2008; Clipsham 2012)—unexplored. Here I want not only to provide arguments in support of this second solution (Section V), but also, and more importantly, to push it a step further by showing that the best argument that defenders of compromise can consistently deploy is one that appeals to moral relativism (or, alternatively, to moral subjectivism; Sections V–VI). As a provisional, working definition, moral relativism (as well as moral subjectivism) is the theory according to which none of two or more conflicting moral perspectives on a certain issue (for instance abortion) is objectively better or worse than the other(s). I will refine this definition (as well as the definition of moral subjectivism) in Sections V and VI. However, whether or not moral relativism and/or subjectivism are defensible views is an issue beyond the scope of my article. My point is simply that only by defending (some form of) moral relativism or subjectivism is it possible to make a case for respecting health care practitioners' moral integrity and granting them a right to conscientious objection. This point is quite surprising, not only because moral relativism is exactly what many strenuous defenders of conscientious objection in health care (for example the Catholic Church) strenuously reject, but also because it shows the paradoxical nature of conscientious objection. The paradox lies in the fact that, as I will show in Section VI, the best argument available in defense of a right to conscientious objection in medicine is the same argument that reveals the undesirable and unacceptable aspects of conscientious objection.

My conclusion (Section VII) will be that even the best arguments available for respecting moral integrity and conscientious objection in the health care context would render conscience an obscure and problematic

concept, rather than a pillar of medical ethics—not least because moral relativism is in itself a problematic theory. In other words, the best argument in defense of conscientious objection might not be good enough. Discussing ethical relativism as a possible justification for conscientious objection in medicine, Mark Wicclair (2000) wrote that “conscientious objection would be an extremely anemic moral concept if its recognition were based exclusively on a lack of confidence in the validity of ethical standards” (210). I take an “anemic concept” to be a concept that does not allow us to make any progress in moral reasoning; for example, it would not allow us to draw any morally relevant distinction among different kinds of objections in order to determine which ones should be granted and which ones should not. My argument implies that conscience and “conscientious objection” are anemic moral concepts, at least when they are used in the attempt to solve moral conflicts in health care. As a consequence, I suggest that we should downplay the role of conscience and of “moral integrity” in medical ethics and leave them out of any moral assessment of decision-making in the clinical and medical context.

II. RESPECT FOR MORAL INTEGRITY

The category of health care practitioners includes physicians, nurses, and pharmacists. All these professionals might object to providing a variety of safe, beneficial, and legal medical services. A practitioner might base the objection on the idea that a certain service is not “safe” or “beneficial” from a medical point of view; this can happen, for instance, when a physician has reasons to believe that the patient who asks to have medical treatments withdrawn is underestimating the chances of her life being significantly prolonged by the treatment or her suffering being significantly alleviated. In such cases, the objection does not qualify as “conscientious” objection.

In other cases, however, the objection that a certain practice, such as abortion or euthanasia, is not “safe” or “beneficial” can be based on views grounded in metaphysical claims (for instance the view that the foetus is a person with a soul), religious beliefs (for instance the view that God commands us not to kill any human life), or ethical stances (for instance the view that the duty of a health care practitioner, or of any person, is to heal and save life and not to bring about death). When these objections express core moral beliefs (Wicclair 2011, 4–5) of the practitioner, they qualify as proper “conscientious objections.”

The most common conscientious objections are those against abortion, against medical help to die, and against filling prescriptions for contraceptives (Swarz 2006, 272). Defenders of conscientious objection in the health care context most commonly invoke philosophical arguments that make a direct appeal to tolerance (Sulmasy 2008) and to respect for moral integrity and autonomy of practitioners (Wicclair 2000; 2011; Brock 2008). “Moral integrity” refers to the sphere of one’s core, self-identifying values that are central to the notion of “conscience” (Wicclair 2011, 4–5; Sulmasy 2008, 138). The importance that many authors attach to moral integrity and moral conscience cannot be overstated; according to Murphy and Genuis (2013), for instance, “to force people to do something they believe to be wrong is always an assault on their personal dignity and essential humanity.” On this basis, they claim that the law should generally protect “preservative freedom of conscience,” i.e., freedom not to do what one believes to be wrong.

In spite of such overemphatic words, some cases of conscientious objection seem to be particularly problematic and seem to suggest that there might be a case for “assaulting” one’s “essential humanity.” For instance, a physician might refuse palliative care as part of withholding or withdrawing treatment, because she believes that, in the name of the sanctity of human life, life-prolonging treatments should be provided instead. A recent survey has shown that nearly half of the medical students in the UK believe that doctors should be entitled to object to any procedure; physicians might even object to treating patients of the opposite sex on religious grounds, as 36% of Muslim medical students in the UK do in principle, and as 7.8% of them would do in practice (Strickland 2012). If we think that conscientious objection should be accepted in the “common cases” (i.e., cases in which it is commonly accepted) of abortion or medical help to die, it is hard to tell what distinguishes the “common cases” from the uncommon ones and to set clear limits to the range of procedures doctors can legitimately object to. One might think that the principles of tolerance and of social justice mentioned above would be sufficient to draw the relevant distinctions. But the issue is not so simple. For instance, it is not obvious that a doctor unwilling to inspect a person of the opposite sex is intolerant or violates social justice (no more than a doctor refusing to provide abortion does), at least as long as the principle appealed to does not target exclusively women or exclusively men (but only any person who happens not to be of the same sex of the doctor, whichever it is).

On the other hand, patients can request unconventional treatments from doctors. For example, someone affected by Body Integrity Identity Disorder or “apotemnophilia”—i.e., “a body dysmorphic disorder in which the patient feels incomplete with four limbs” (Savulescu 2007, 18)—might ask to have healthy limbs amputated. Would “compromise” require that at least some doctors be available to grant the request? If so, there might be no limit to what doctors (or at least some of them) should in principle be required to do. Apart from amputating healthy limbs, we can think of such practices as euthanasia on convicted prisoners who ask for it, female genital cutting (where legal), penile subincisions (a traditional practice among some Aboriginal Australians), and so on.

The problem is due to the difficulty of striking a balance between respect for “moral integrity” and professional or even social duties of practitioners. Despite unwarranted claims to the contrary (Magelssen 2012), it is a matter of fact that many people do have bad self-identifying values. Also for this reason, some restrictions on the notion of respect for conscience and for moral integrity are usually proposed. In particular, many would expect that these restrictions grant practitioners the right to object to practices like abortion or assisted suicide, i.e., rights which, as Wicclair says, “few would deny” (2000, 207); at the same time, we would be inclined to think that the restrictions should not allow practitioners to make the situation of the patients or of colleagues too burdensome, or to refuse the normal services that one might expect from them (for instance providing antibiotics or vaccines). The problem is that, as I will show in the next sections, any criteria proposed for limiting freedom of conscience fall short of providing a satisfactory account of why certain forms of conscientious objection—for instance to abortion—should be accepted and certain others—for instance to inspecting patients of the opposite sex—should not.

III. BALANCING THE BURDENS

One form of compromise usually proposed is that respect for moral integrity be given a prominent role in medical ethics, provided that it does not pose an excessive burden on the patients or customers. A burden is “excessive,” presumably, when it outweighs the burden on the practitioner of acting against her deeply held moral beliefs. There are different possible interpretations of this general principle. According to Sulmasy, for example, conscientious objection is important and we should generally accept it in the name of tolerance, but not if it entails “substantial risk of

serious illness, injury or death” for those who suffer the consequences of the conscientious objection (Sulmasy 2008, 146). So tolerance, although playing the prominent role in Sulmasy’s view, needs to be restricted through what seems to be a form of cost/benefit analysis, where the “costs” are represented by illness, injury, and death, and the “benefits” by the fact of having one’s moral integrity respected and of receiving timely and adequate medical assistance. The so-called “conventional compromise” (Brock 2008) is another proposed solution, according to which we should allow practitioners to object as long as they facilitate the transfer of the patient to the willing practitioner, so as to fulfil the requirements of what John Davis has called an “ethics of quitting” (Davis 2008, 75). The *Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life* provide an example of such solution: they state that institutions should accommodate requests by practitioners to withdraw from certain activities provided that the professional maintains “his or her duty of care by assisting in the orderly transfer of the patient to another professional” (Berlinger, Jennings, and Wolf 2013, 17).

At a first glance, these seem to be the most reasonable solutions. The patient/customer receives the service requested without suffering any serious harm, while the practitioner has her conscience respected and the practitioners willing to provide the service do not experience any additional distress. I will call these kinds of proposals “cost/benefit solutions,” as they are based on a favorable cost/benefit analysis in terms of harm to the parties involved. Another way to put the same idea is the one suggested by John Davis, according to whom “a doctor may refuse a patient’s request provided the refusal leaves the patient no worse off than the patient would have been had the patient never met that doctor in the first place” (Davis 2008, 76). So if everyone is as well off as possible, why should we reject the “cost/benefit solution”? I offer here two reasons for why we should.

The first reason is that we should apply the same considerations to any kind of conscientious objection a practitioner might put forward. So, for example, if a doctor refuses to inspect a patient of the opposed sex, we should accept this conscientious objection as long as (a) another doctor is available to perform the inspection; (b) the objecting doctor facilitates the transfer (whatever this is taken to mean) to a doctor willing to perform the inspection; and (c) the patient does not suffer any significant psychological distress and/or physical harm (determining what counts as “significant” turns on the issue of how broadly the concept of “cost” should be interpreted). While such a scenario may intuitively appear undesirable, it

might be that upon further reflection this turns out to be the best solution. That is, we might just have to accept that any practitioner can object to any medical procedure, as long as other people are willing to do the job and no one suffers significant harm. Admittedly, this kind of solution might also appeal to opponents of conscientious objection in medicine (Savulescu 2006, 296). I will call this the “extended cost/benefit solution,” as consistency requires that this solution be extended to any procedure a practitioner might object to. I am going to show, however, that the other reason against the cost/benefit solution is sufficient to reject this thesis.

The second reason against the “cost/benefit” solution is that it might be impossible to put it in practice. This is because it is impossible to know whether the patient has actually been left “no worse off than he would have been had he never met that doctor in the first place.” Even a doctor refusing to perform an abortion and referring the patient to a willing colleague may be imposing a too high level of psychological distress on a woman; for example, it might exacerbate her sense of guilt, especially if she sees the refusal by the first doctor as a form of moral condemnation of her. There is no empirical ground for claiming that the burden of such psychological distress is lesser than the burden practitioners have to carry for acting against their deeply held moral beliefs.

It is worth noting that the same problem arises if we look at the level of moral distress experienced by the doctor. For example, it could be claimed that even informing a patient or providing a referral represents an unacceptable level of complicity in wrongdoing (Charo 2005). Awareness of such ethical implications might therefore have psychological repercussions on referring doctors who oppose, say, abortion. These repercussions would then be part of the “costs” that must be taken into account. Robert Card has argued that *if* one defends the right of pharmacists to conscientiously object to dispensing emergency contraception, then “allowing another willing pharmacist to do so” might not be seen as ethically different (Card 2007, 9). This position is held, for instance, by the Roman Catholic Church with respect to abortion: since, in the Roman Catholic view, a practitioner ought not to perform a wrong activity like an abortion, it follows that she ought not to be accomplice in wrongdoing by facilitating the abortion in any other way (Pellegrino 2000; McHugh 1994). The main problem, here, is that in both examples the claims are perfectly reasonable and consistent with the ideals of reciprocal respect, tolerance, and social justice: their supporters can consistently respect other practitioners who are available to provide the service, as long as these other willing practitioners (a)

respect the colleagues who object and (b) do not expect these colleagues to refer or even inform the patients. Nonetheless, this scenario would be highly undesirable. By not facilitating the transfer, a doctor might prevent patients from accessing basic beneficial services, or make this access difficult, thereby acting against the basic rights and interests of a patient. For why should (a) and (b) apply to things which “very few would deny,” such as the alleged right to object to abortion, but not to, say, an objection against inspecting patients of the opposite sex? Any of these practices might impose a high psychological cost on the practitioner, depending on how deeply held the beliefs motivating the conscientious objection are; and any of these practices might be forbidden by a certain moral or religious code, or at least the practitioner might believe that they are. There is no ground for claiming that the beliefs against abortion or euthanasia are *necessarily* more deeply held or self-identifying than those against, say, inspecting women by male doctors.

Another reason why it might be practically difficult—if not impossible—to implement the “cost/benefit solution” has to do with the number of practitioners who might in principle object to the same practice in any geographical area. It is a matter of fact that, where the percentage of doctors who refuse to perform certain activities is too high, access to the service by patients/customers is practically jeopardized. Take the case of a Catholic country like Italy, for example. According to the last data released by the Italian Ministry of Health, 69% of Italian gynaecologists conscientiously object to performing abortions; in some areas of the country (in particular in southern Italy) the percentage is above 85% (Italian Ministry of Health 2012, Table 28). Clearly, this situation significantly impacts the actual opportunities women have to access safe abortion. It is noteworthy that the same document by the Italian government reports a constant decrease in the number of abortions in Italy in recent years. These two sets of data could be interpreted in many ways, including enthusiastic accounts of how policies and subsidizations for families encourage women to continue pregnancies. One plausible explanation, though, is that in Italy it is practically difficult, when not impossible, to have access to (legal and safe) abortion because of the high rates of conscientious objectors (Minerva 2014).

This situation is only one example of the potential consequences of an approach based on respect for the moral integrity of practitioners. One might think that a cost/benefit solution like that proposed by Sulmasy would prevent such scenarios. That is, it is at least plausible to say that in Italy the “cost” on women who seek for abortions is too high, and such

consideration might seem sufficient to constrain respect for practitioners' conscience. However, even leaving aside the difficulties with interpersonal comparisons of psychological costs between practitioners and patients, a further problem arises in this case. Whether or not a conscientious objection becomes too burdensome for women does not depend solely on the personal choice of the practitioner who objects, but also (and often to a greater extent) on the analogous choices of the colleagues working in the same hospital, city, or region. In this case the restriction that we would need to apply is that only a certain number of practitioners can object in a certain area (Fenton and Lomaski 2005, 588; Minerva 2014). Though this solution might be advisable for merely pragmatic reasons in some cases (for instance doctors who are forced to do something they strongly oppose might not have the motivation necessary to do a good, or even safe job), it has at least two major shortcomings (leaving aside the fact that many upholders of conscientious objection would not accept that some practitioners are forced to act against their deeply held moral beliefs just because the right has already been granted to others).

The first major shortcoming is that the idea that someone cannot object if there are already too many conscientious objectors is discriminatory. This is because the criterion used for deciding who is entitled to object and who is not is morally irrelevant. We can suppose, for example, that senior practitioners would be more likely to be granted the right to object. Younger practitioners would therefore be able to object only if their older colleagues have not already taken up positions assigned to conscientious objectors. But age or years of activity cannot be morally relevant criteria in this case. Otherwise, the notion of "right" would be jeopardized. Indeed, we would have to talk not of a right to conscientious objection, but of a *privilege* that is granted only to some people. The principles of tolerance and respect for moral integrity would be not just constrained, but actually violated if a limitation on who can be respected or tolerated is posed on the basis of morally irrelevant factors.

The second major shortcoming is that, if the concern is about not imposing too high a "cost" on patients/customers, then we should extend it to all the activities physicians might be asked to perform. So there would have to be a minimum number of physicians performing not only abortions, but also female genital cutting (where legal), amputation of healthy limbs, and all those other services doctors are likely to be unwilling to provide. In areas where there are not enough willing practitioners, we would be obliged to force some practitioners to undertake procedures

they might have (even good) reasons to object to. And we would have the same problem of deciding which criterion, if any, should be used for picking those practitioners who would be required to act against their moral views. Absent a non-arbitrary criterion, respect and tolerance would be violated, rather than just restricted.

IV. MEDICINE'S CORE VALUES

Another option available for restricting respect for moral integrity of healthcare practitioners is the solution proposed by, among others, Wicclair (2000; 2011) and Swarz (2006). The idea is that we should respect the practitioner's moral integrity because of the value of moral integrity itself and of self-respect (Wicclair 2011, 25–31), but only insofar as the refusal to perform certain activities does not contradict medicine's core values and the “generally accepted professional standards of practice applicable to their profession” (Swarz 2006, 277). This principle would ensure that health care practitioners' moral conscience is warranted neither “too little” nor “too much protection” (Wicclair 2011, 203–30). Thus, for instance, Wicclair (2000) says that

taking account of the profession's core values when determining how much moral weight to ascribe to appeals to conscience can be defended by appealing once again to the objective of promoting the moral integrity of the medical profession. (223)

Among medicine's core values that can justify the refusal to perform a certain activity, Wicclair lists life, health, well-being, and justice (216–17). Though the proposal looks appealing, there are at least four decisive objections.

Objection 1: We Need Ranks of Values, Not Just Values

The first thing to notice is that, as Wicclair himself recognizes, relevant medical and ethical guidelines such as those issued by the British Medical Association, the American Thoracic Society, and the Hastings Center endorse the “prevailing view”—which also has strong legal and constitutional protection in many countries—that patients have a right to refuse medical treatments (Wicclair 2000, 208). So among the core values in medicine, patients' autonomy is, to say the least, an important one. The fact that the same medical guidelines also recognize conscientious objection to, for example, withholding medical treatments upon a patient's autonomous request might be seen as a sign of the internal inconsistency

of such guidelines, rather than a reasonable attempt to strike a balance between the interests of patients and the moral integrity of practitioners. The aforementioned example of conscientious objection to abortion in Italy shows that only contingently upon certain circumstances (i.e., when conscientious objectors are not numerous) can a balance between these two kinds of interests be struck. However, there is nothing in a principled attempt to strike a balance between patients' autonomy and practitioners' moral integrity that prevents a similar scenario from coming about. In order to overcome the problem, medical guidelines should provide not just values that conscientious objectors can appeal to, but ranks of values, to each of which a conscientious objector can legitimately appeal to only if, in those particular circumstances, the value in question is not at odds with some other value ranked higher. Wicclair himself is aware of this problem, and he actually attempts to suggest a possible ranking; for example, he says that it is "uncontroversial" that "preventing death is generally more important than protecting confidentiality," and that "autonomy and consent are more important than medical progress and research" (Wicclair 2000, 221–27). But this is of no help. This ranking is uncontroversial only in the sense that it does not apply to the most controversial cases. We might ask, for example, whether preventing death is generally more important than protecting not just confidentiality, but the autonomy of a patient who asks to be euthanized.

Objection 2: Overly Conservative Nature of the Proposal

Surely, it is an uncontroversial fact that medical professionals themselves support the view that doctors can legitimately refuse to euthanize patients. But appealing to this fact just begs the relevant moral question about what values *should* prevail. The normative and the factual aspect are here mixed up in the concept of "uncontroversial values of medicine." This overlapping of factual and normative considerations accounts for the second objection to this proposal, namely that it is overly conservative. It prevents medicine from keeping up with the moral and scientific progress society is undergoing. An example of such moral progress is the idea that, contrary to what most people used to believe until some decades ago, it is not an absolute truth that doctors' first commitment should be that of preserving life. Considering the possibility that medical technologies nowadays offer to keep someone alive in conditions that are not compatible with one's conception of a good or flourishing life (think of the relatively new medical categories of "[permanent] vegetative state" or "minimally

conscious state”), liberal societies have generally acknowledged that autonomy over one’s body and health is a more fundamental value than respect for life *per se*. But considering the encoded values of medicine as the moral criteria for the acceptance of conscientious objection prevents society and medicine from putting moral progress into practice.

Wicclair says that the refusal to provide pain medication to a terminally ill patient as part of withdrawing treatment out of the belief that pain is a just punishment for some moral flaw is unacceptable because the belief is not linked to any value of medicine. On the other hand, he thinks that the same decision made out of the belief that the patient should instead be treated with life-prolonging measures is acceptable because it is based on a core value of medicine, namely preserving life. In both cases the practitioner’s claim to have her moral integrity respected is assessed against the patient’s autonomous request to be treated only with sedatives. But only in the second case does Wicclair think that there is an obligation to respect the practitioner’s moral integrity. Therefore, the actual value here at stake is not respect for moral integrity—which is claimed in both cases—but preserving life, which is present only in the second case and which, as a matter of fact, is one of the core values of medicine. The factual consideration that preserving life is a core value of medicine is mixed up with the normative claim that preserving life is a valid reason for overcoming a patient’s autonomy.

But this just shows that such an approach prevents medicine from reflecting upon its own profound values, and in particular from giving the appropriate weight to patients’ autonomy. If the encoded values were to be used as the ultimate criterion to solve cases of moral conflict, such values might never be found to be wrong or in need of updating. Indeed, the reasons for questioning a right to conscientious objection might turn out to be the same reasons for questioning the underlying values of medicine.

To be fair, Wicclair does engage with a similar objection when he says that using the generally accepted values within the medical profession “does not constitute an uncritical endorsement of those values.” Rather, he says, “from the fact that there is a reason for not obligating physicians to act in a certain way, it does not follow that physicians are not obligated to act in that way.” For example, he continues, “there may be sufficient overriding reasons to warrant imposing an obligation . . . if a transfer to another physician is infeasible or if a patient’s interests trump the physician’s integrity interests” (2000, 224).

It is far from clear, however, how this example would demonstrate that Wicclair's solution does not represent an uncritical endorsement of the values of the medical profession. At best, it shows that such endorsement is not absolute (but there is hardly anything absolute in ethics). Besides, the example is question begging. Whether or not a patient's interests are morally more relevant than the practitioner's interest in having his moral integrity respected is exactly what the appeal to the values of medicine was supposed to tell us. But Wicclair is now saying that whether the appeal to medicine's core values is a conclusive consideration depends on whether the patient's interests are morally more relevant than the practitioner's interests. So it seems we have only two options: either we find an independent criterion, different from the appeal to medicine's values, to assess whether, for example, a woman's interest in not suffering the psychological burden of a referral trumps a doctor's interest in not being an accomplice in what he perceives as immoral conduct; or we stick with the fundamental values of medicine, which does represent, contrary to what Wicclair says, "an uncritical endorsement of those values."

Objection 3: Inaccessibility of Propositional Attitudes

The example of two doctors who, for different reasons, refuse to provide pain medication (as part of treatment-withdrawing procedures) to a terminally ill patient also underpins a third objection to the idea that the core values of medicine are a valid criterion to limit respect for moral integrity. The problem here is that the assessment of an objective situation is replaced by the assessment of a subjective, propositional attitude (e.g., the attitude of *believing* that a certain practice is wrong). This is problematic because there is no evidence for telling whether a conscientious objection to the same practice is based on the core values of medicine or on some other kind of personal belief. How do we know whether the conscientious objection is based on the belief that life-prolonging treatments should be provided instead, or on the belief that the patient deserves to suffer so as to expiate his or her sins? There is no access to the intimate sphere of an agent's personal beliefs and motivations.

Robert Card (2007) has suggested that

the establishment of conscientious objector status with respect to certain activities would be a step forward by requiring that medical professionals state succinctly their reasons for refusing to serve and be open to these reasons being evaluated as part of institutional practice. (13)

The requirement of stating one's reasons for objecting is necessary for the view that conscientious objection should be allowed only when grounded on the core values of medicine. However, practitioners could always "state succinctly" a reason that reflects some core medical values, whether or not it is their actual reason for objecting. For example, the New Zealand doctor who recently refused to provide a woman with contraceptive pills because he believed that she had not done her "reproductive duty" yet (*New Zealand Herald* 2013) could easily have stated instead that the use of contraceptive pills violates the principle of promoting life, which certainly is a core value of medicine. And the same belief could be put forward as a reason not to perform an abortion.

One way out of this problem could be to modify the requirement so that, in order to be acceptable, conscientious objection should be consistent with medicine's core values, *regardless of what the actual reason behind the conscientious objection is*. But this proposal is also problematic. Firstly, it would not avoid the objection about the overly conservative and question-begging nature of the proposal. Secondly, it would not prevent the occurrence of a problematic scenario like the one in Italy. Thirdly, and perhaps most importantly, it is not clear why medical values should be overriding when they conflict with needs and expectations of patients and customers. This leads me to the fourth objection.

Objection 4: Why Should Medical Values Be Overriding?

In the case of medicine, the ethical values of the profession have been decided, endorsed, and written down in the form of deontological codes by the professionals themselves. So practitioners have come to acquire a particular status within societies "as professionals" with their own moral code, rather than as citizens among other equal citizens. But this is problematic, because one's moral duties as a citizen are predominant over one's duties as a professional: duties as citizen at least include the duty to perform all the activities that other fellow citizens can reasonably expect from someone *as a certain type of professional*. And what citizens can "reasonably" expect from a certain type of professional includes, at the very least, providing those safe, legal, and beneficial services that those professionals can exclusively provide (such as, for instance, safe abortions). As Julian Savulescu (2006) put it, "to be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system" (295).

These are not requirements that practitioners can decide by themselves whether or not to adopt, without any consideration of their role in society and of the constraints such a role poses on them; these requirements derive from what society expects from practitioners of that particular professional category with that particular social role. If medicine really is a moral enterprise, as Wicclair says, then these requirements posed by society should represent its more fundamental values.

It is interesting at this point to see how Carolyn McLeod has further qualified the appeal to medicine's values. According to her, "physicians cannot make conscientious objections in their practices that violate established norms of the profession that are morally justified" (2008, 38). The last part of the sentence introduces a caveat that, as I am going to argue, is of the utmost relevance for anyone who wants to make an argument either for or against respecting moral integrity and the conscience of health care practitioners.

V. CONSCIENTIOUS OBJECTION AND MORAL RELATIVISM

So far, I have shown that a compromise based solely on the idea of respect for moral integrity and on limitations posed on such respect fails to provide a satisfactory account of whether, when, and why conscientious objection in the health care context should be accepted. Is there any other way to approach the problem?

One hint is provided by the question raised by Kimberley Brownlee, namely:

When a person *mistakenly* believes that a law or directive is morally wrong, should her refusal to adhere to it be regarded as an exercise of a moral right of conscientious disobedience? And, if so, what implications does this have for how her act should be viewed by the law? (2012, 535)

The word "mistakenly" here is worth focussing on. I take the word "mistakenly" in the broad sense to encompass both mistakes about matters of fact (e.g., believing that emergency contraception is abortifacient when in fact it is not) and errors in moral reasoning, such as for example grounding one's moral view in unwarranted metaphysical assumptions (e.g., about God or the existence of a soul, etc.). In the context of conscientious objection in the health care system, this translates into the question of whether the right to object depends on:

(1) the fact that practitioners have the right to object "even if they are objectively in error" (Murphy and Genus 2013), being the right

grounded in political values such as tolerance or respect (which means that impartiality should be directed towards individuals as citizens of a liberal democracy); or

(2) the fact that the claim of the one who objects is morally justifiable, so that the right to object should not be granted to those who hold mistaken beliefs and/or morally unjustified views (which means that impartiality should be the attitude towards the different moral positions to be assessed).

As seen in Sections II–IV, most of the literature has endorsed the first option. Here, I want to propose an argument in favor of the second.

When it comes to moral integrity and moral conscience, the notion of “compromise” requires that we respect what we perceive as morally wrong or bad conduct so as to protect the moral integrity of someone, regardless of what we think is moral or immoral. The subjective aspect is worth considering: the pronoun “we” refers here to any member of a liberal society who might be requested to grant others the right to act according to their different moral views. For instance, it might refer to those who morally approve of abortion but are nonetheless required by the notion of “compromise” to accept that practitioners have the right not to take part in abortions; and it could refer to practitioners who morally object to abortion but are nonetheless required to accept the fact that patients have the right to have an abortion and that some colleagues would provide it. It is important to note that the problem here is the philosophical one of what arguments can justify such compromise, and not the psychological issue of what can motivate people to accept it. So the problem becomes how to *justify* the passage from the personal sphere of individual values (e.g., “I think abortion is wrong”) to the impersonal, impartial perspective that should govern the liberal approach (e.g., “I ought to respect those who think abortion is permissible and who act accordingly”). As shown above, respect for others’ moral integrity cannot by itself *justify* compromise in the case of conscientious objection in the health care context (although, from a psychological perspective, being a respectful person can *motivate* someone to look for a compromise). The alternative and more promising justification is provided by the idea that no objective ground exists to show others that our moral view is better justified than a rival one.

Objective validity of reasons, if such a thing exists, is a relevant issue when it comes to solving conflicts at the public level *that cannot be solved by appealing to the value of respect*. In such cases, it is essential that a moral stance believed by someone to be better than rival ones—for instance the view that abortion is permissible—can be *publicly* shown to be so in

order to be proposed as a stance that should prevail (not only in theory but also in practice) over a conflicting one—for instance over the view of a doctor who believes that abortion is impermissible. A necessary, although possibly not sufficient, condition for meeting this publicity requirement is that there exists an objective ground—i.e., something that everybody can in principle recognize—for the claim that a certain view is better justified than a rival one.

To deny that such an objective ground exists, and so to deny that a moral view can be publicly shown to be better than another, is to endorse (a certain form of) either moral relativism or moral subjectivism. To be sure, the difference between the two theories is relevant in many respects, both from a metaethical and a normative perspective. However, relativism and subjectivism can be taken as relevantly similar for the present purposes. What matters here is not so much the difference between their positive claims (i.e., that morality is either relative or subjective), but their shared negative claim that no objective ethical standard exists. The discussion here will focus on moral relativism because, as most of the examples provided so far show, most of the times the moral values appealed to by conscientious objectors are grounded in either cultural or religious backgrounds (as is often the case, for instance, with moral views against abortion or against inspecting patients of the opposite sex). However, it is worth pointing out that a similar argument can be made by relying on moral subjectivism.

Different definitions of moral relativism could be provided, depending on whether we consider the normative, the semantic, the epistemic, or the ontological aspect of moral claims (Tännsjö 2007). However, the aspect they all have in common is the idea that “there exists more than one truth about some moral cases” (Tännsjö 2007, 124; where “more than one truth” does not necessarily mean “one truth for any different moral position”). The core idea can also be formulated by saying that *at least some* moral claims that conflict with one another can be right or wrong only with respect to a certain cultural background or agreement (Harman 1975, 4), but not objectively and independently. Because of this relation to an agreement (whether explicit or implicit, for instance in the form of a cultural heritage), not only does moral relativism *justify* the view that my moral beliefs can be wrong and others’ can be right, depending on the cultural framework adopted; more importantly, it also provides the *valid* reason to put in practice the respect for others’ moral views that conflict with mine. Such valid reason is that those views are neither less nor more justified than mine on objective ground, i.e., a

ground that can be publicly shown to be true or false, valid or not valid. Applied to a case where “very few would deny” that there is a right to conscientious objection, e.g., abortion, this equivalence would be a valid reason for neither forcing the practitioner to perform the procedure, nor forcing the patient to withdraw the request, which she would be entitled to lodge to some other practitioner. In other words, only by denying that the view that abortion is permissible is *objectively* superior (or inferior) to the opposed view can someone convincingly defend a “compromise” that cannot be otherwise defended by appeals to respect or tolerance, and whereby both the requests for abortion and the conscientious objections to it are respected.

That only moral relativism can *justify* the compromise represented by conscientious objection does not exclude, of course, that people might choose to respect others’ views (including conscientious objections) without endorsing moral relativism. Surveys have shown (Christian Medical Association 2009) that even the stunning majority of pro-choice people in the US think that practitioners should have the right to conscientious objection to abortion. Some of them would think so out of the belief that we should respect others’ moral conscience; this approach, however, is subject to the same criticism presented in Sections II–IV. Some others would grant conscientious objection despite their own personal belief that abortion is permissible because they see such things as abortion or euthanasia as merely a matter of different cultural perspectives or of personal choice. But this compromise approach can be morally and philosophically *justified* only if what is “seen as” merely a matter of cultural perspective or personal choice actually “is” merely a matter of cultural perspective or personal choice; in other words, if some form of either moral relativism or of moral subjectivism is true.

VI. MEETING SOME OBJECTIONS

There is one quite obvious objection, or at least observation, that can be raised at this point. If only moral relativism or subjectivism can justify respect for moral integrity, and if moral relativism and subjectivism entail that different views can be equally justified, then moral relativism and subjectivism could also justify respect for moral integrity in cases where few would acknowledge it, such as objections to inspecting patients of the opposite sex or to providing blood transfusions or vaccination. But it would be absurd to claim that a doctor can refuse to vaccinate a child for personal moral reasons. Moral relativism and subjectivism would not

provide better justifications than the direct appeal to respect does, as the same objections could be raised against them.

A first reply is that this observation might not represent an objection to my argument, but just to the idea of “conscientious objection” or of “moral integrity.” The observation might be a sound consideration to the effect that any possible justification for respecting moral integrity, including moral relativism and subjectivism, would render conscientious objection problematic; any possible justification would support the idea that allowing conscientious objection to abortion is not morally different from allowing conscientious objection to inspecting people of the opposite sex or to anything else (providing vaccinations, antibiotics, etc.). I am ready to accept this claim as a valid objection not only to moral relativism and subjectivism, but also to the right to have one’s moral integrity respected. If the best arguments for respecting moral integrity in the medical context are not good enough, it simply means moral integrity should be left out of the relevant considerations in decision-making in the medical context. These counterintuitive consequences of moral relativism would make the defense of conscientious objection in medicine a paradox, because the best argument that can be deployed to defend conscientious objection is also the argument that, through a *reductio ad absurdum*, renders it unacceptable.

If one wanted to give moral relativism—and consequently “moral integrity”—a second chance, however, there is a possible way round the objection. This way might better accommodate intuitions about the permissibility of conscientious objection to abortion and euthanasia and its impermissibility in cases like not inspecting people of the opposite sex or providing vaccinations. As noted above, moral relativism is not necessarily the same as the idea that *any* moral stance is as valid as *any* other, or that *all* moral stances should be equally respected. A moral relativist need not accept what Bernard Williams (1993) called “vulgar relativism” (20–25). Some forms of relativism are consistent with the idea that some systems of morality, or some agreements, are better than others (Harman 1975, 4). For the purpose of my argument, it suffices to say that moral relativism implies that *at least some* moral stances (for example that abortion is permissible) can be as valid as some other conflicting moral stances (for example that abortion is impermissible), without necessarily committing to the idea that this extends to *any* possible moral stance (Foot 2003; for example that inspecting a person of the opposite sex is impermissible). Even moral relativism can put some constraints on the normative consequences of the metaethical thesis that moral claims are valid only relative to a

certain cultural background. For example, according to Wong's pluralistic relativism, such constraints are represented by the fact that a moral system must be functional to successfully coordinate the individuals of a given group (2006, in particular Chapter 2). So if two different moral systems equally succeed at this, and if they entail conflicting moral views on, say, abortion, then moral relativism would entail that they are equally justified. But this does not mean that they necessarily are on an equal footing with a moral system entailing that inspecting people of the opposite sex is wrong. Whether or not they are, and whether relativism can put constraints on the range of acceptable moral systems, are questions beyond the scope of this essay, as is the more general question of whether (some form of) moral relativism is true. What I intend to point out is simply that, *if* moral relativism were false, then we would know that some moral views can be morally better than others because they can be justified through evidence and public reasons. This would provide a criterion for deciding which of the conflicting moral positions should prevail *in case of conflict*.

Another possible objection to my argument is the consideration that, as a matter of fact, the right to conscientious objection to abortion is often claimed by those who believe that abortion is wrong and out of the conviction that this is an objective truth, and not out of the belief that the pro-abortion and anti-abortion arguments are on equal footing. Thus, for instance, the Catholic Church bases the defense of the right to conscientious objection on the assumption that "abortion and euthanasia are . . . crimes which no human law can claim to legitimize" (John Paul II 1995, par. 73). However, such a firm belief in objective grounds would justify not the compromise represented by conscientious objection, but civil disobedience aimed at changing an unjust and wrong law (which, as mentioned in the introduction, is not a form of compromise). And in fact, the Catholic Church's position on the right (and indeed the duty) to object to abortion and euthanasia by medical personnel is not based on the notion of respect for everyone's conscience, but rather on the biblical claim that the law of God is superior to the law of men (1995, par. 73) This implies that Catholics, if they want to be consistent with the prescriptions of their religion, should not support those laws that are at odds with the law of God.

Someone might think—and this is a third possible objection—that the relevant theory here is not relativism, but moral uncertainty. In general terms, the idea is that there is uncertainty around the moral status of some medical options, and for this reason precaution should be applied

(Selgelid 2001; 2012). In the case of conscientious objection to abortion, for example, precaution might imply that, since we cannot decide whether or not a foetus has a moral right to life, we should leave practitioners the right to object so as not to risk to force them to do something that might be revealed to be a serious moral flaw. This precaution might be advisable in some cases, but it is important to keep this approach distinct from that of moral relativism. Unlike moral relativism, uncertainty does not mean that an issue cannot be decided *in principle*, but only that the evidence available is at the moment not strong enough. Nonetheless, when uncertain, we know what evidence and reasons we would need in order to decide the issue (Giubilini and Minerva 2012, 52–55), and therefore we should do our best to seek them. There is no guarantee of success, but this does not mean that we should not look for valid arguments and convincing evidence, rather than accept a priori the idea that all positions are on equal footing. The normative consequences of moral uncertainty might well be the same as those of moral relativism, but only *as long as a significant degree of uncertainty remains*, which need not be forever. Besides, if we wanted to defend the right to conscientious objection by appealing to moral uncertainty, we would need to clarify where the burden of proof lies in each controversy. This would require setting some precise rules for the arguing game (for instance one might expect that the burden of proof is on the person who makes a positive claim—for example about the existence of a soul in foetuses—rather than on the person who does not accept that claim).

A fourth possible objection to my argument can be raised by recalling Thomas Nagel's point that "unless there is some way of applying from an impersonal standpoint the distinction between my believing something and its being true, an appeal to its truth is equivalent to an appeal to my belief in its truth" (Nagel 1987, 231). In this view, looking for an objective ground to solve conflicts of conscience would be a non-starter, because the claim "some moral views are objectively better than some others" is epistemologically equivalent to "I think some moral views are better than some others." But this equivalence holds only within the framework of moral subjectivism, according to which "X is true" is epistemologically and pragmatically (besides semantically) equivalent to "X is believed by someone to be true." Unless we accept this equivalence, there is no necessary overlapping of what is true and what is believed to be true.

VII. CONCLUSIONS

In this essay I have argued that respect for moral integrity of health care practitioners cannot morally justify conscientious objection in medical practice. Since such respect cannot be absolute, we would need to put some constraints on it in order to determine in which circumstances practitioners can legitimately refuse to perform certain activities or to provide certain services. However, I have shown that none of the proposed solutions—namely not putting at risk the health or the life of patients, not imposing an excessive burden on patients, referring patients to willing doctors, complying with medicine’s core values, asking practitioners to clearly state the reasons for their objection—are acceptable. I have defended instead the alternative view that the only justification for the compromise represented by conscientious objection in health care would be one based on an endorsement of either moral relativism or moral subjectivism. My conclusion implies that this compromise cannot be defended unless we accept (1) a metaethical view (either moral relativism or subjectivism) that many defenders of conscientious objection—as well as many others—would not accept, and (2) the idea that the most common cases of conscientious objection, for instance to abortion, might not be morally different from less common cases, for instance objecting to inspecting people of the opposite sex, which, once again, many defenders of conscientious objection—as well as many others—would probably not accept. Both conditions would therefore make defense of conscientious objection on grounds of moral integrity at odds with principles and norms that the defenders of conscientious objection—as well as many others—are not willing to give up.

Only if either moral relativism or moral subjectivism were true would there be a strong moral case for looking for a compromise to accommodate all the parties involved as much as possible (which also includes respecting practitioners’ moral integrity). But in this case compromise would be sought not because (a) compromise and respect for moral integrity are always good solutions in themselves (I have shown in Sections II–IV that they are not), but because (b) there would exist no criteria to determine which of the conflicting views has the credentials to prevail. Though the practical conclusion would be the same (seeking for a compromise, i.e., allowing conscientious objection with some restriction), it is important to distinguish the two different types of justification for it. While (a) justifies the search for a compromise as something valuable in itself, (b) simply means that we do not have any other choice but *surrendering* to compromise.

My argument also raises questions about the meaning of moral “conscience” itself and about its moral weight. Appealing to the idea of conscience entails appealing to a private sphere that requires each individual to provide justifications only to herself, not to anyone else. This clashes with the requirements of publicity and openness of discussion that are needed to settle conflicts at the public level. Moreover, this does not allow for any moral progress, as a conscientious objector is not urged to question his position and to submit it to a public, rational scrutiny.

Unless we assume that either moral relativism or subjectivism is true, we should discourage people from relying on their “conscience” or on their “moral integrity” when it comes to making decisions in the health care context.

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