



WRONGNESS, RESPONSIBILITY, AND CONSCIENTIOUS REFUSALS IN HEALTH CARE

ALIDA LIBERMAN

Keywords

conscientious objection, conscientious refusal, professional competency, Zubik v. Burwell, responsibility, moral wrongness, subjective

ABSTRACT

In this article, I address what kinds of claims are of the right kind to ground conscientious refusals. Specifically, I investigate what conceptions of moral responsibility and moral wrongness can be permissibly presumed by conscientious objectors. I argue that we must permit HCPs to come to their own subjective conclusions about what they take to be morally wrong and what they take themselves to be morally responsible for. However, these subjective assessments of wrongness and responsibility must be constrained in several important ways: they cannot involve empirical falsehoods, objectionably discriminatory attitudes, or unreasonable normative beliefs. I argue that the sources of these constraints are the basic epistemic, relational, and normative competencies needed to function as a minimally decent health-care professional. Finally, I consider practical implications for my framework, and argue that it shows us that the objection raised by the plaintiffs in Zubik v. Burwell is of the wrong sort.

INTRODUCTION

In recent years, conscientious refusals to provide certain kinds of health care—such as abortion, particular forms of contraception or assisted reproduction, and physician-assisted dying, among others—have been much discussed in both popular political debates and the academic literature. Health-care providers (hereafter HCPs) who make such refusals are generally seeking penalty-free exemptions to providing legal and medically appropriate services that they personally disagree with. Much of this discussion focuses on the extent to which we should accommodate conscientious refusals in health care, and on how to resolve conflicts between the conscience claims of HCPs and the rights of patients who would be harmed or inconvenienced by refusals of care. These are issues of great importance, both for developing our best philosophical understanding of conscientious refusal and for implementing a morally sound public policy. However, in this article I focus on a more foundational question, which has not been as thoroughly explored in the

literature: namely, what claims are of the right kind to ground conscientious refusals in the first place? In other words, what sorts of objections are potential candidates for permissible conscientious refusal?

It is widely acknowledged that refusing to perform a task or provide a service counts as an instance of *conscientious* refusal only if the objector is refusing because she takes acting to be *morally wrong* or religiously impermissible. Less frequently articulated explicitly—although widely presumed—is the fact that someone who conscientiously refuses to Φ must take herself to be *responsible* in some way for the moral wrong brought about by Φ ing.

In this article, I investigate what conceptions of moral responsibility and moral wrongness can be permissibly presumed by conscientious objectors. We must permit HCPs to come to their own conclusions about what they take to be morally wrong and what they take themselves to be responsible for. However, I argue that not just any belief about what actions are wrong or what responsibility connections exist can appropriately ground conscientious refusal; these beliefs cannot involve empirical

Address for correspondence: Alida Liberman, University of Indianapolis – Philosophy and Religion, 1400 East Hanna Avenue, Indianapolis, Indiana 46227. UDA. Tel: 317-788-4904.
Email: libermana@uindy.edu or alida.liberman@gmail.com

falsehoods, objectionably discriminatory attitudes, or unreasonable normative beliefs.

These first two constraints have been widely presumed in the literature, while the third has been overlooked. I offer a novel explanation of why all three constraints exist: they stem from the basic epistemic, relational, and normative competencies needed to function as minimally decent health-care professionals. While I focus my discussion on conscientious refusal among HCPs, we can adapt this framework to assess conscientious refusal in any profession.

Presuming a conception of wrongness and responsibility that does not violate any basic professional competencies is a necessary condition for a conscientious refusal being permissible, all-things-considered; it is not a sufficient condition. For determining whether a particular conscientious refusal is of the right kind will not settle the question of whether it is ultimately justified. A conscientious refusal can be of the right kind and yet fail to be justified overall, just as an epistemic reason can be of the right kind to support a belief in P yet fail to justify belief in P overall. For example, the fact that you saw Mr. Green skulking away with a knife is the right kind of reason to believe that Mr. Green killed Mr. Body. This is so even if you are not justified all-things-considered in believing that Mr. Green is the murderer, because you also saw Professor Plum running off with a heavy candlestick. But the fact that Mr. Green is a Scorpio and your horoscope tells you that Scorpios have something to hide today is not the right kind of reason to believe that Mr. Green committed the murder. Similarly, refusing to perform a tubal ligation at a patient's request because you believe that voluntary elective sterilization is morally wrong is the right kind of reason for conscientious refusal. This is so even if the refusal is not justified all-things-considered (say, because the patient lives in a remote area and is unable to receive the same service from another provider.) But refusing to perform a tubal ligation because the *Downton Abbey* finale is about to air and you don't want to miss it is not the right kind of reason for conscientious refusal.

A refusal that is of the right kind might be ruled out for independent moral reasons, and two refusals that are of the right kind might stem from fundamentally different moral viewpoints; determining whether an objection is of the right sort does not resolve all potential conflicts between incommensurable moral perspectives. Nor does it settle questions about the ultimate justification of these claims. But it is nevertheless a valuable undertaking. First, it makes the ultimate justificatory work easier; if a refusal does not meet the necessary condition I propose, we need not further investigate whether it is justified overall. Second, it enables us to easily identify real-world instances of conscientious refusal that do not meet even this minimal necessary condition, and therefore cannot

be justified all-things-considered. I argue that this is true of the *Zubik v. Burwell* case currently pending before the US Supreme Court, in which religiously-affiliated non-profits object to signing a waiver opting out of the contraception mandate required by the Affordable Care Act (ACA): the conception of moral responsibility the non-profits presume violates the normative competency required of minimally decent employers.

1. THE NEED FOR SUBJECTIVE CONSTRUALS

As already noted, in order to count as *conscientious* refusers HCPs must be refusing to act because they take acting to be morally wrong or religiously impermissible; you do not *conscientiously* refuse if you refuse to provide a medical service because doing so is illegal, or not financially beneficial to you, etc.¹ Conscientious refusers must also take themselves to be *morally responsible* for bringing about (or in some other way substantially contributing to the occurrence of) the action that they take to be wrong; our consciences cannot be violated by actions for which we are in no way responsible. This is common sense, and while it is not always explicitly or formally articulated in discussions, it is a widely presumed account of what conscientious refusal is.

Conscience can be protected only if people are allowed to determine for themselves which acts they take to be morally wrong and what they take themselves to be morally responsible for. Under most contemporary accounts, conscience is a subjective notion. A common view is that acting according to your conscience protects your moral integrity, which is typically understood as a form of inner unity.² Moral integrity can also be understood in other ways; for example, Carolyn McLeod defends a feminist relational account of integrity, according to which integrity is not about preserving one's inner unity at any cost, but about coming to the best moral

¹ I use "moral wrongness" to cover both non-religious moral refusals and specifically religious refusals. For further discussion of accommodating religious vs. moral refusals, see D. Weinstock. Conscientious Refusal and Health Professionals: Does Religion Make a Difference? *Bioethics* 2014; 28 (1): 8–15.

² For example, see M. Benjamin. 1995. Conscience. In *Encyclopedia of Bioethics*, ed. W. T. Reich. New York: Macmillan: 469; P. Benn. 2007. Conscience and Health Care Ethics. In *Principles of Health Care Ethics*, ed. R. Ashcroft et al. Hoboken, NJ: 345–350; J. Blustein. Doing What the Patient Orders: Maintaining Integrity in the Doctor-Patient Relationship. *Bioethics* 1993; 7 (4): 289–314; D. W. Brock. Conscientious Refusal by Physicians and Pharmacists: Who is Obligated to Do What, and Why? *Theor Med and Bioeth* 2008; 29 (3): 187–200; J. Childress. Conscience and Conscientious Actions in the Context of MCOs. *Kennedy Inst Ethics J* 1997; 7 (4): 403–411; and M. R. Wicclair. 2011. *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge: Cambridge University Press.

judgment you can, as informed by dialogue and relations with others.³ However we understand it, moral integrity is protected only if we allow agents to act in accordance with their moral commitments, whatever those commitments happen to be. For example, suppose I believe that it is morally wrong to drink a Budweiser in a craft beer bar with lots of amazing local brews on tap. Drinking a Bud will violate my moral integrity. It doesn't matter that drinking a mass-produced lager instead of an interesting local beer is not *in fact* morally wrong. Rather, what matters for assessing whether I have violated my own moral integrity is that *I take it to be* wrong.

The same is true for moral responsibility: integrity, understood as inner unity or in a feminist relational way, is protected only if we allow objectors to make their own determinations about what they are morally responsible for. For integrity is undermined when people act in self-betraying ways, and self-betrayal occurs if you take yourself to be responsible for actions that go against your fundamental commitments. For example, suppose I superstitiously take silly rhymes to heart, and believe that stepping on the cracks will break my mother's back. I violate my moral integrity if I step on the cracks anyway. Again, it doesn't matter that stepping on cracks in no way affects my mother's back; what matters is that *I believe* that it does. In short, conscientious refusal claims are of the right sort only when the objector *takes herself to be responsible* for an action *that she takes to be wrong*. However, I argue in the next section that there are important limits on these subjective assessments.

2. PROFESSIONAL COMPETENCY CONSTRAINTS

Conscientious refusals to provide care are professional decisions that greatly affect the public. Individual refusals can be burdensome for or harmful to patients even when other HCPs are available to provide care instead, and can create additional work for those HCPs who do not refuse.⁴ And widespread or systemic refusals

to provide certain services can lead to situations in which patients struggle to access those services, or are disincentivized from seeking them in the first place.⁵ Because the potential burdens on patients and other HCPs are so great, it is commonly assumed that minimally decent HCPs must make use of such refusals appropriately.

First, appropriate refusals must first be genuine or sincere, and employed only when necessary to prevent genuine violations of conscience; this is a widely acknowledged constraint, and is not my main focus at present.⁶ Rather, I am focusing primarily on the ways in which appropriate refusals must not run afoul of the valuable social roles professionals play. Professionals serve the public in a variety of ways. They receive extensive training, and sometimes official licensing, that enables them to provide important public goods and services, and they are in many cases the unique providers of such services. Professionals possess valuable knowledge and skills, and the public must rely on them, if not explicitly place their trust in them, to make good decisions on the basis of this knowledge and to employ these skills appropriately. This is particularly true of HCPs, who often function as the gatekeepers of essential medical services and technologies.

To fulfill these important social roles, professionals must generally be competent in several ways. First, they must have basic knowledge of their professional areas. Professionals who lack such knowledge will be unable to serve their societal functions; for example, an immigration lawyer who does not know the basics of immigration law will be unable to assist clients with attaining residency or citizenship. Call this an *epistemic competency*. Second, at least some types of professionals must have certain kinds of attitudes towards their clients if they are to perform their jobs minimally well. For example, a therapist who makes fun of patients to their faces will be unable to establish the patient/therapist trust that is essential for effective therapy. Call this a *relational competency*. Finally, because they have been endowed with special powers and privileges by society, professionals must not make their professional decisions irresponsibly or on

³ C. McLeod. 2011. Taking a Feminist Relational Perspective on Conscience. In *Being Relational: Reflections on Relational Theory and Health Law and Policy*, ed. J. Downie and J. Lewellyn. Vancouver: University of British Columbia Press.

⁴ Different theorists disagree about the nature of the harm imposed—e.g. about whether pharmacists' refusing to provide emergency contraception is harmful or merely inconvenient. For an overview, see G. Wester. Conscientious Objection by Health Care Professionals. *Philos Compass* 2015; 10 (7): 427–437. For arguments that this is harmful, see C. McLeod. Harm or Mere Inconvenience? Denying Women Emergency Contraception. *Hypatia* 2010; 25 (1): 11–30; and P. J. Kelleher. Emergency Contraception and Conscientious Objection. *J Appl Philos* 2010; 27 (3): 290–304. For an argument that it is merely inconvenient, E. Fenton and L. Lomasky. Dispensing with Liberty: Conscientious Refusal and the 'Morning-After Pill.' *J Med Philos* 2005; 30 (6): 579–92.

⁵ For example, in Italy 70% of gynecologists conscientiously refuse to provide abortions (with rates as high as 93% in some provinces), thus greatly restricting access even though abortion is legal; see S. Kirchgaessner, P. Duncan, A. Nardelli, and D Robineau. Seven in 10 Italian Gynaecologists Refuse to Carry out Abortions. *The Guardian* (11 March 2016).

⁶ For example, see R. F. Card, Reasonability and Conscientious Objection in Medicine: A Reply to Marsh and an Elaboration of the Reason-Giving Requirement. *Bioethics* 2014; 28 (6): 320–326; L. Kantymir and C McLeod. Justification for Conscience Exemptions in Health Care. *Bioethics* 2014; 28 (1): 16–23; E. LaFollette and H. LaFollette. Private Conscience, Public Acts. *J Med Ethics* 2007; 33 (5): 249–254; C. Meyers and R. D. Woods. Conscientious Objection? Yes, But Make Sure It Is Genuine. *Am J Bioeth* 2007; 7 (6): 19–20. For an overview of this discussion, see Wester (*op. cit.* note 4).

unjustified grounds; for example, a teacher who assigned grades to students using a random number generator would not be a minimally decent teacher. Call this a *normative competency*. The particular content of these professional competencies will be determined by the role that the profession in question plays in a particular society, and by what attitudes, beliefs, and abilities are necessary for fulfilling that role.

To claim that all professionals must meet minimum competency standards is not to make the implausible demand that they all excel at what they do. But professionals cannot be downright incompetent, lest they fail to fulfill their public roles. Conscientious refusal claims cannot be grounded in conceptions of moral wrongness or moral responsibility that violate the basic epistemic, relational, or normative professional competencies necessary for fulfilling the valuable social role of an HCP.⁷

2.1. Does all conscientious refusal violate professional roles?

One might worry that adequately serving the public requires fulfilling one's professional role regardless of personal objections, and that conscientious refusals in health care should therefore never be permitted; maybe if someone objects to filling a birth control prescription,

⁷ This should not be confused with proposals that ground conscientious objection in professional obligations in other ways. For example, Lynch argues that the medical profession itself (rather than individual physicians) is obligated to ensure that its essential social role is adequately fulfilled; accordingly, she suggests an institutional solution to the problem of conscientious refusal, in which the profession creates a registry of physicians that enables patients to engage in "morals matching" to find physicians who are willing to provide certain services to them and screen out physicians who object to these services (H.F. Lynch. 2008. *Conflicts of Conscience in Health Care: An Institutional Compromise*. Cambridge, MA: MIT Press). Wicclair (*op. cit.* note 2) argues that HCPs are subject to a professional obligation to "respect patient dignity and refrain from discrimination, an obligation to promote patient health and well-being, and an obligation to respect patient autonomy" (p. 88). These obligations constrain permissible conscientious refusal by HCPs. Wicclair's argument involves making all-things-considered judgments balancing one's professional obligation to serve the needs and protect the rights of patients against one's personal moral preferences. I'm engaging in a project of a different sort: identifying what capacities individual professionals must possess if they are to do their work in a decent way, and claiming that conscientious refusals are of the wrong sort from the get-go if they run afoul of these capacities. Importantly, these assessments can come apart. For example, suppose a physician's refusal is grounded in a belief that betrays a lack of minimally decent professional judgment—say, a refusal to inform patients of cancer diagnoses because of a belief that this jinxes the patient and makes recovery unlikely—but the refusal would not burden, harm, or fail to respect the patient in any way, since the patient has no special relationship with the refusing physician, and an equally qualified physician at the same practice can inform the patient instead. This refusal would be of the wrong kind under my account, but would be permissible under Wicclair's account.

she shouldn't have become a pharmacist.⁸ However, most academics and public officials think that we should permit conscientious refusal in at least some cases, and I agree with them for several reasons. First, HCPs have often been asked to engage in deeply unethical practices—think of doctors required to forcibly sterilize those deemed mentally unfit in the first half of the 20th century in the United States⁹—and there may be cases in which HCPs are asked to engage in similarly abhorrent practices in the future. We want to let principled HCPs resist genuinely terrible practices from inside the profession; it would be better to have widespread refusal to engage in such practices than it would be to have those who opposed such practices refuse to become HCPs in the first place.

Second, there are cases in which someone becomes an HCP, and then years later some medical practice that she objects to which wasn't legal when she first entered the profession becomes legal.¹⁰ For example, physician-assisted dying (in limited circumstances) became legal in all Canadian provinces in June of 2016. Requiring physicians who object to this practice to either comply with the new law or quit their jobs is significantly more burdensome than requiring future Canadian HCPs to become physicians only if they are prepared to assist with dying.

Finally, as Gry Wester notes, many have argued that:

Not only do practitioners have an enormous responsibility, the lives and health of their patients in their hands, but the health care setting can be morally challenging and ripe with dilemmas. Moral sensitivity and competence are therefore important qualities for practitioners to do their job well. The ability to act on one's conscientious beliefs, and not merely unquestioningly follow rules, could play an important part in fostering a culture of moral reflection in our health care services.¹¹

If we categorically forbid conscientious refusal, we might hinder HCPs from properly developing and exercising their best moral judgment.

2.2. Epistemic competency

Minimally decent professionals must adhere to whatever standards for belief are required for competency in their

⁸ Savulescu and Schuklenk argue that "doctors must put patients' interests ahead of their own integrity ... If this leads to feelings of guilty remorse or them dropping out of the profession, so be it." See J. Savulescu and U. Schuklenk. Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion, or Contraception. *Bioethics* 2016; 31 (1): 358–364.

⁹ For example, see P. R. Reilly. 1991. *The Surgical Solution: A History of Involuntary Sterilization in the United States*. Baltimore: Johns Hopkins University Press.

¹⁰ See Wester (*op. cit.* note 4).

¹¹ *Ibid.*: 429; see also Lynch (*op. cit.* note 8); Weinstock (*op. cit.* note 1); and Wicclair (*op. cit.* note 2).

particular areas. This varies from one profession to another. For example, professional academic philosophers must follow basic norms of logic in their writing and teaching. There are other areas—say, abstract art—in which the ability to follow logical norms is not essential for minimal professional competency. In health care, understanding and responding appropriately to empirical evidence is essential.¹² Medical practice involves understanding how the body and mind work, diagnosing the ways in which they fail to function well, and helping them function better. These goals cannot be achieved if one's professional decisions are grounded in empirically false beliefs; for example, a doctor who falsely believes that vaccines cause autism will be unable to adequately care for public health.

In order to meet the epistemic norms required of minimally decent medical professionals, the conscientious refusal claims of HCPs must be properly grounded in empirical evidence. It is widely assumed that the moral wrongness claims that ground conscientious refusals cannot be based in factual errors. My appeal to epistemic competency constraints explains why this is the case: factual errors are not appropriate grounds for conscientious refusal by HCPs *because* they inhibit HCPs performing their fulfilling their professional roles in minimally decent ways. For example, suppose a pharmacist believes that terminating an established pregnancy is morally wrong, and falsely believes that emergency contraception (EC) functions like mifepristone and terminates established pregnancies, rather than using the same mechanism as standard oral contraceptives.¹³ On the basis of this false belief, the pharmacist conscientiously objects to providing EC. This is not a conscientious refusal of the right sort, and my view tells us why: because it violates the basic epistemic competency required of minimally decent HCPs.

The same is true of HCPs who object to the use of IUDs and EC because they believe for religious reasons that pregnancy begins with fertilization, and that these methods regularly prevent implantation of a fertilized egg into the uterine wall and thereby function as abortifacients. This is contrary to the scientific and legal definition of pregnancy, which is implantation; there is also no scientific evidence that hormonal IUDs or EC ever

prevent implantation, and evidence that the copper IUD can do so only in rare cases.¹⁴

Nor can the responsibility claims that ground conscientious refusals be based in empirical falsehoods. Suppose a physician falsely believes that giving young girls the HPV vaccine will cause them to have sex at an earlier age than girls who do not receive the vaccine. This physician is morally opposed to sexual activity among pre-teens, and believes that administering the HPV vaccine will make him personally responsible for higher rates of such activity. This is not a conscientious refusal of the right kind. Although there can be reasonable disagreement about whether it is good for adolescents to engage in sexual activity, minimally competent physicians cannot base their professional decisions in empirically false beliefs about the effects of the HPV vaccine.¹⁵

2.3. Relational competency

Minimally decent professionals must also relate to their clients in appropriate ways. What counts as appropriate depends on the profession in question and the social role the profession serves, and will be determined by whatever attitudes are in fact needed to fulfill the role that the profession plays in a particular society. For example, it would be appropriate for a modeling agency to discuss the physical appearance of their employees with potential clients, because the social role of modeling agencies is finding people with certain physical traits to model clothing. It would not be appropriate for a temporary staffing agency to discuss the physical appearance of their employees with their clients, because physical traits are irrelevant for fulfilling temporary staffing needs. Most

¹⁴ See ACOG. June 12, 2014. Facts Are Important: Emergency Contraception (EC) and Intrauterine Devices (IUDs) are Not Abortifacients. <http://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/FactsAreImportantEC.pdf> [Accessed 4 Nov 2016]. The plaintiffs in the 2014 *Burwell v. Hobby Lobby et al.* Supreme Court case based their conscientious refusal to provide their female employees with IUDs or EC as required by the ACA's contraception mandate on the same scientifically flawed reasoning. However, they are not HCPs but rather the owners of a closely-held corporation, objecting in their capacity as employers. Presumably, employers generally need not believe in established medical facts in order to perform their roles minimally well—though as I will argue in Section 4 below, their refusal to provide contraceptive coverage violates the normative competencies of employers in other ways. For a comprehensive analysis of whether the conscientious refusal in *Hobby Lobby* is justified overall, see P. West-Oram and A. Buyx. Conscientious Objection in Healthcare Provision: A New Dimension. *Bioethics* 2016; 30 (5): 336–343.

¹⁵ A number of studies have established that girls who receive the HPV vaccine do not have higher rates of sexual activity than do girls who do not; for example, see L. M. Smith, J. S. Kaufman, E. C. Strumpf, and L. Lèvesque. Effect of Human Papillomavirus (HPV) Vaccination on Clinical Indicators of Sexual Behaviour Among Adolescent Girls: The Ontario Grade 8 HPV Vaccine Cohort Study. *CMAJ* 2015; 187 (2): E74–E81.

¹² For discussion of the prohibition on empirical falsehoods, see ACOG Committee Opinion No 385. The Limits of Conscientious Refusal in Reproductive Medicine. *Obstet Gynecol* 2007; 110: 1203–8; Card (*op. cit.* note 6); Kantymir and McLeod (*op. cit.* note 6); LaFollette and LaFollette (*op. cit.* note 6); and Weinstock (*ibid.*).

¹³ 37% of pharmacists surveyed in South Dakota did not know how EC worked, with 19% incorrectly believing it functioned like mifepristone. See K. K. Van Riper and W. L. Hellerstedt. Emergency Contraceptive Pills: Dispensing Practices, Knowledge and Attitudes of South Dakota Pharmacists. *Perspect Sex Reprod Health* 2005; 37 (1): 19–24.

professionals who serve the public—including HCPs—fail to be minimally competent if they harbor racist, sexist, homophobic, or other objectionably discriminatory attitudes towards their clients.¹⁶

This is in part for instrumental reasons. Effectively caring for the well-being of individuals and maintaining public health requires being fair, objective, and respectful; most HCPs who harbor invidiously prejudicial attitudes and assumptions towards patients will be unlikely to provide them with adequate care. For example, some physicians are biased against fat patients in a way that leads them to make unjustified presumptions about the patient's habits and health, and to fail to offer treatments that would likely be offered to a thinner patient (e.g. recommending that fat patients suffering from treatable conditions unrelated to their weight lose weight as a solution.) HCPs with discriminatory attitudes also erode public trust in the medical professions, and can disincentivize the members of vulnerable minorities who are the victims of discrimination from seeking health care again in the future.¹⁷ Discriminatory attitudes among HCPs are also intrinsically problematic. Discriminating on the basis of race, religion, sex, gender, sexuality, body size, etc. is independently impermissible, and it is especially bad to engage in such behavior from a position of power and authority like that held by many HCPs.

It is widely accepted that the claims about moral wrongness used to ground conscientious refusal cannot be based in unfair or invidious discrimination. As with the previous constraint, an appeal to professional relational competency demands explains why this is the case: HCPs who harbor overtly discriminatory attitudes towards their patients are unable to fulfill their professional roles in minimally decent ways. For example, suppose

a physician believes for purely homophobic reasons that sex between men is morally wrong. Accordingly, she is willing to prescribe Viagra for heterosexual men suffering from erectile dysfunction, but refuses to prescribe Viagra for homosexual men suffering from the same condition. This refusal is not of the right sort, for it betrays a discriminatory and disrespectful attitude that fails to exhibit the relational competency needed for minimally decent care.

Likewise, the conception of responsibility that grounds a conscientious refusal claim cannot be motivated by prejudice or unjust discrimination. For example, suppose another physician believes that women tend to blindly follow the suggestions of their doctors instead of making informed decisions for themselves, and that this makes him as a doctor responsible for the medical decisions made by his female patients. He does not harbor such assumptions about his male patients, and believes that they are fully responsible for their own medical decisions. This physician believes that it is morally wrong for people to choose to have do-not-resuscitate orders. He gives his male patients full information about the high risks and low success rates of resuscitation, and trusts them to make whatever choice they think best, assuming that he is absolved of moral responsibility if they choose a DNR. But he refuses to discuss this with his female patients, believing that he will be personally responsible if they choose a DNR. This is not a responsibility assessment of the right sort to ground conscientious refusal. For it is objectionably discriminatory for the doctor to think that he is primarily responsible for the free choices of his female patients while his male patients are responsible for their own decisions. This is a sexist undervaluing of the agency of his female patients that will likely lead to worse health outcomes for them, and is incompatible with the relational competency required of minimally decent physicians.

2.4. Normative Competency

Minimally decent HCPs must also make their professional decisions in responsible ways. Responsible decision-making is important for any agent. But responsible decision-making is especially important for HCPs, who advise—and sometimes act as surrogate decision-makers for—patients about topics that can be of literal life or death importance. Society has entrusted HCPs with certain powers and privileges on the assumption that they will use of these powers and privileges responsibly.

Making decisions responsibly requires following an acceptable decision-making procedure. We can be fairly permissive about what moral decision-making procedures are acceptable. Methods of moral reasoning differ; some people focus primarily on consequences, while others focus on intentions, or rights and duties, or virtues. And

¹⁶ For discussion of the prohibition on discriminatory attitudes, see ACOG (*op. cit.* note 13); Brock (*op. cit.* note 2); Card (*op. cit.* note 6); LaFollette and LaFollette (*op. cit.* note 6); and Wicclair (*op. cit.* note 2).

¹⁷ For example, a meta-analysis found that “experiences of or expectations for poor treatment may cause stress and avoidance of care, mistrust of doctors and poor adherence among patients with obesity. Stigma can reduce the quality of care for patients with obesity” (S.M. Phelan, D.J. Burgess, M.W. Yeazel, W.L. Hellerstedt, J.M. Griffin, and M. van Ryn. Impact of Weight Bias and Stigma on Quality of Care and Outcomes for Patients with Obesity. *Obes Rev* 2015; 16 (4): 319–326, p. 319). For patient anecdotes about weight discrimination by HCPs leading to ineffective treatment, see V. Tovar, “Fat Patients Endure Humiliation, Misdiagnoses, and Neglect.” 2013. Available at: <http://www.virgietovar.com/special-report-fat-patients-medical-care.html> [Last accessed 4 November 2016]. Studies have also shown that Black Americans tend to be less trusting of the healthcare system, which leads to worse overall healthcare outcomes for Blacks than for their White counterparts. The source of this distrust is due, in part, to histories of racism and discriminatory attitudes among medical professionals and institutions. See L. E. Boulware, L. A. Cooper, L. E. Ratner, T. A. LaVeist, and N. R. Powe. Race and Trust in the Health Care System. *Public Health Rep* 2003; 118 (4): 358–365.

some professionals will be better moral reasoners than others. But there are clear cases of unacceptable moral decision-making that we cannot permit; a doctor who flipped a coin to decide whether to remove a comatose patient from life support would not be normatively competent.

Making professional decisions responsibly also requires having reasonable beliefs about your normative connections to the world, including about what actions are wrong and what you are morally responsible for.¹⁸ A conception of moral wrongness or responsibility is unreasonable if it is arbitrary, or there are no principled reasons to hold it. For example, it would be reasonable to believe that a military commander shares responsibility for the bad actions of those in her command; they act under her orders, after all. But it would not be reasonable to believe that the mayor of a town shares responsibility for the bad actions of all of the residents of the town; mayors do not usually have a strong enough influence over the actions of their constituents to make them morally responsible for those actions.

A conception of moral wrongness or responsibility is also unreasonable if analogous cases have implausible results. For example, it's reasonable to think that someone who knowingly drives a getaway car from a bank robbery is at least partially responsible for the robbery; equally plausible claims about responsibility can be made for agents in relevantly similar scenarios. But it would not be reasonable to think that a taxi driver who unknowingly transported a passenger to a bank that the passenger then robs is partially responsible for the robbery. In general, it is not plausible to claim that taxi

drivers are always responsible for the actions that they unwittingly enable by transporting passengers.

Decisions by HCPs that are based in unreasonable conceptions of moral wrongness or responsibility are problematic because they are likely to lead to bad results for patients. For example, a doctor who arbitrarily believed that it was morally wrong to use contraceptives on weekdays but not on weekends would not be able to function as a good advice-giver or surrogate decision-maker. Nor would a pharmacist who implausibly believed that she was morally responsible only for actions taken after 2:00 PM. HCPs who base their professional decisions on unreasonable normative assumptions engage in behavior that unnecessarily risks bad results for someone else. Moreover, even if such behavior does not lead to a bad outcome in a particular case, actively risking (or being negligent about risking) harm displays a lack of proper respect for and moral consideration for the people you might harm.

While other theorists have noted the way in which the moral wrongness conceptions that ground conscientious refusal cannot be empirically false or objectionably discriminatory, they have not explicitly highlighted the way in which moral wrongness conceptions must be normatively reasonable, as well. For example, suppose a surgeon sincerely believes that anything that disgusts her is morally wrong. She is disgusted by the thought of transplanting an organ from an old person into the body of a young person. So she conscientiously objects to performing organ transplants when the donor is old and the recipient is young, even if the transplant is medically appropriate. This is not a conscientious refusal claim of the right sort. Even though there is no widespread agreement about which actions are morally wrong, there is widespread agreement about which sorts of considerations are relevant for determining moral wrongness (e.g. harming people, violating rights, etc.) and which are not (e.g. emotions like fear or disgust, brute preferences, etc.) The surgeon's claim is grounded in an untenable conception of moral wrongness, and therefore fails to display the normative competency required of minimally decent HCPs.

The conception of responsibility that grounds a conscientious refusal claim must be reasonable, as well. For example, suppose another surgeon believes that saving someone's life makes him responsible for whatever actions the person goes on to do. Because of this, he refuses to perform life-saving surgery on a patient who works as a lobbyist for political causes he takes to be unethical. This conscientious refusal is of the wrong sort, for the responsibility connection it presumes is unreasonable. The connection between the surgeon's saving the lobbyist's life and the lobbyist advocating for bad political causes is far too tenuous to ground moral responsibility. It delivers implausible implications in analogous

¹⁸ R. F. Card defends an account of the permissibility of conscientious refusal in terms of reasonability, arguing that "medical professionals seeking a conscientious exemption must provide reasons in support of their objection and allow those reasons to be subject to evaluation... the objection must have a reasonable basis in order to successfully ground an exemption" (*op. cit.* note 6, p. 320). Although we are both concerned in some way with reasonability, my proposal differs from Card's in several ways. First, we address different analyses: I am narrowly assessing whether an objector's conceptions of wrongness and responsibility are reasonable, while Card is assessing the holistic reasonability of refusals overall. Second, an objection counts as reasonable in Card's sense if it "(1) is understandable by others and (2) avoids arbitrariness such as that which infects sexism or racism" (In Defence of Medical Tribunals and the Reasonability Standard for Conscientious Objection in Medicine. *J Med Ethics* 2016; 42 (2): 73 – 75, p. 74). While I too claim that a reasonable conception of wrongness or responsibility cannot be arbitrary, I am not concerned with public understandability or justifiability, and I also argue that it must have plausible implications in analogous cases, which is a constraint Card does not address. Third, Card does not ground all of his constraints on reasonability specifically in professional competencies in the way that I do. Finally, Card's proposal is primarily focused on requiring objectors to defend their positions, while I do not demand that objectors explicitly articulate or publicly defend the reasons for which they act.

cases; surely not every person who saves a life is morally responsible for everything the person who was saved goes on to do.

This account of normative competencies is flexible enough to explain what sorts of conscientious refusal are appropriate not only in health care professions, but in *any* profession. All one must do is figure out what role the professional plays and what competencies are necessary to attain that role; if the conscientious refusal violates those competencies, it is of the wrong sort. For example, consider the competencies needed to fulfill the professional role of a scientific researcher. Like HCPs, researchers must refrain from believing obvious empirical falsehoods; a researcher who objected to performing an experiment on bacteria because she believes that the bacteria feel pain would not be making a conscientious objection of the right kind. Researchers also have relational competency standards governing their interactions with other researchers; an American researcher who objected to collaborating with a Chinese lab for xenophobic reasons would be unable to adequately fulfill the role of researcher in a globalized world. Finally, researchers must also have reasonable beliefs about what sorts of research practices are immoral and about what their work makes them responsible for; a researcher who refuses to work on a cure for a certain disease because a brutal dictator suffers from this disease and she doesn't want to do anything that might save the dictator's life would not be making a conscientious objection of the right kind. We can run this same sort of analysis for any professional role that might involve conscientious objection; below, I consider conscientious refusal by employers.

My account also matters for real-world cases in two ways. First, it shows us that we need not settle substantive normative debates to determine whether a conscientious refusal claim is of the right sort; all we need to do is determine whether the normative presumptions being made are in accordance with the basic normative competencies required of the kind of professional in question. Second, it illustrates how certain real-world conceptions of responsibility violate normative competencies, and establishes that any conscientious refusal claims grounded in them are of the wrong sort.

3. IMPLICATIONS

There is sometimes reasonable disagreement about whether a conscientious objector's Φ ing in fact makes her morally responsible for bringing about some allegedly wrong act X. When this is so, it satisfies minimum professional normative competencies to believe that Φ ing makes one responsible for X, or to believe that Φ ing does not make one responsible for X. In such cases, we

should defer to the objector's own beliefs about whether Φ ing makes her responsible for X.

For example, there is a great deal of controversy over whether conscientious objectors should be required to give referrals for health-care services to which they object.¹⁹ Many people assume that referrals always make you objectionably complicit in wrongdoing; for example, the president of the organization Pharmacists for Life has stated that writing a referral for prescription for a drug one believed to be immoral would be 'like saying, "I don't kill people myself but let me tell you about the guy down the street who does".'²⁰ This is a coherent position; it is reasonable to think that your referral makes you complicit in murder, especially if the referral is a but-for cause of the killing (i.e. the killing could not have happened had you not made the referral.)

It is also coherent to believe that making a referral does not always make you complicit. For example, suppose a vegetarian works as a hotel concierge. A hotel guest asks for a recommendation to a steakhouse. She declines to give the guest a recommendation, but instead refers the guest to the hotel's other concierge, who will be willing to make a recommendation. Granted, the vegetarian concierge in some way enables the guest to eat meat. But whether the killing of animals for the sake of meat-eating occurs depends on multiple further actions taken by the guest that have nothing to do with her, such as whether the guest gets the recommendation from the other concierge, whether he actually visits the steakhouse, and whether he orders meat if so. The connection between the concierge's referral and the guest's meat-eating seems too distant to sensibly ground a conscientious refusal.

Maybe HCPs who object to contraception and make referrals are like the person who makes a murder referral, and are culpably responsible for enabling patients to prevent conception. Or maybe they are like the vegetarian concierge; after all, whether conception is prevented depends on multiple actions taken by the patient that have nothing to do with the referring HCP, such as whether the patient fills the prescription, and whether she uses the medication for contraceptive purposes or for another reason (e.g. to treat acne or endometriosis.)

¹⁹ For arguments in favor of a referral requirement as a compromise, see Brock (*op. cit.* note 2); J. Cantor and K. Baum. The Limits of Conscientious Objection – May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception? *N Engl J Med* 2004; 351 (19): 2008–2012; and Wicclair (*op. cit.* note 2). For arguments that a referral requirement fails to fully respect the objector's conscience and is not an adequate compromise, see R. F. Card. Conscientious Objection and Emergency Contraception. *Am J Bioeth* 2007; 7 (6): 8–14; Kantymir and McLeod (*op. cit.* note 6); and Kelleher (*op. cit.* note 4).

²⁰ R. Stein. 2005. Pharmacists' Rights at the Front of New Debate. *Washington Post* March 28: A01.

Because either view is compatible with minimal professional competencies, the objector's claim will be of the right sort so long as *she believes* that writing a referral makes her morally responsible for the allegedly wrong action. (Of course, it might be the case that a refusal is required all-things-considered anyway, because it is the only way to satisfy the patient's right to adequate care.)

3.1. *Zubik v. Burwell*

Understanding what conceptions of moral responsibility can be presumed by appropriate conscientious refusals sheds light on a current controversy about religious accommodation in the United States. Under current ACA rules, most private health insurance plans are required to cover free contraceptive services for their female employees. As part of a political compromise, religious employers as defined by the Internal Revenue Code (primarily of houses of worship) are exempt from this mandate, and their health plans do not have to provide any contraceptive coverage whatsoever.

Religiously-affiliated non-profits (including the Little Sisters of the Poor, who run elder-care facilities) receive an accommodation of a different sort. They are required to fill out a simple form (EBSA Form 700) stating that they object to providing contraception. The form requires the organization to certify that it 'has a religious objection to providing coverage for some or all of any contraceptive services that would otherwise be required to be covered.' The organization must submit the form to its health insurance issuer, who will then directly pay for contraception for the organization's female employees, at no cost to the employees or the organization.²¹

A number of religiously-affiliated organizations have filed lawsuits objecting to this method of exemption. Together, they are being heard before the Supreme Court in a consolidated case as *Zubik v. Burwell*.²² The plaintiffs believe completing Form 700 makes them complicit in providing contraception, and that completing the form violates their conscience and thereby restricts their

religious liberty, in violation of the Religious Freedom Restoration Act (RFRA). A class action complaint filed by the Beckett Fund, who represent the Little Sisters, states in part:

The Little Sisters Homes cannot pay for such benefits. They cannot provide paperwork that will trigger such benefits. They cannot designate another party to provide such benefits...as a matter of religious faith, the Little Sisters Homes may not participate in any way in the government's program to provide access to these services....Class Action Plaintiffs' religious convictions equally forbid them from contracting with an insurance company that will provide free coverage for, or access to, contraception, sterilization, abortifacients, and related education and counseling.²³

However, closer inspection reveals that the Little Sisters' objection relies on an implausible understanding of the responsibility connection between filling out Form 700 and the provision of contraception. Unlike most of the cases we have been discussing, the conscientious objectors in question are not HCPs, but employers. Employers are subject to their own particular competency standards. Minimally decent employers must follow the law. They must compensate their employees in whatever way they have agreed to. And they must have control over only the work-relevant portions of their employees' lives. What counts as work-relevant will vary from one field to another; it would be an overstep for a fast-food corporation to restrict what their cashiers say about them on social media, but would not be an overstep for a politician to restrict what her staffers say on social media about her campaign. To avoid overstepping these boundaries, employers must ground their policies in normatively reasonable assumptions. If employers make unreasonable assumptions about what employee actions they are responsible for, they risk abusing this power and over-extending their control over their employees.

Provision of no-cost contraception is *independently* legally mandated by the ACA; it's going to happen anyway, whether religiously-affiliated non-profits like it or not. As Judge Richard Posner notes in a ruling from the 7th Circuit Court against the University of Notre Dame:

The delivery of a copy of the form to [insurance company] Meritain reminds it of an obligation that the *law*, not the university, imposes on it—the obligation to pick up the ball if Notre Dame decides, as is its right, to drop it... Meritain must provide the

²¹ As of July 2015, the organization may opt to directly notify the Department of Health and Human Services of their objection; the Department then informs the insurer. For more information, see Center for Consumer Information and Insurance Oversight. June 28 2013. Women's Preventive Services Coverage and Non-Profit Religious Organizations. <https://www.cms.gov/CCHIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02-012013.html> [Accessed 4 Nov 2016].

²² In 2014, the Supreme Court ruled in *Burwell v. Hobby Lobby* that closely-held for-profit corporations whose owners object to contraception on religious grounds are entitled to the same exemption to the contraception mandate as are religiously-affiliated non-profits, as this is a less burdensome means of fulfilling a compelling state interest. *Zubik v. Burwell* essentially addresses whether this sort of exemption can still be considered overly burdensome. For updates about the status of the *Zubik v. Burwell* case, see SCOTUSblog. *Zubik v. Burwell*. <http://www.scotusblog.com/case-files/cases/zubik-v-burwell/> [Accessed 4 Nov 2016].

²³ p. 37 – 38; 25; see <http://www.becketfund.org/wp-content/uploads/2013/09/Little-Sisters-of-the-Poor-and-Christian-Brothers-v.-Sebelius.pdf>

services no matter what; signing the form simply shifts the financial burden from the university to the government, as desired by the university.²⁴

Religiously affiliated non-profits are not the ones who authorize the insurance company to provide contraception to their employees. Rather, federal law authorizes insurance companies to do this. Filing Form 700 triggers an existing mechanism; it informs the insurance company that they have to step in because the organization refuses to. And triggering a pre-existing mechanism does not plausibly make you complicit in the independent operation of that mechanism. This lacks the right causal connection to ground responsibility, and we would get implausible results in analogous cases if we assumed that this sort of connection could ground responsibility.²⁵

For example, suppose a school district mandates that all students receive comprehensive sex education. One of several health teachers at the school objects to providing comprehensive sex ed. The district requires her to fill out a form notifying them of her objection, so they can send in a substitute teacher instead. The teacher isn't responsible for the provision of sex ed: this happens *in spite of* rather than *because of* her objection. The same is true in *Zubik v. Burwell*.

Nor can filing Form 700 plausibly be construed as *contracting for* the provision of contraceptives in the way that the Beckett Fund legal brief suggests. Generally, A contracts for X only when X is something that A chooses to pursue, and that is not already destined to occur. The Little Sisters of the Poor et al. are not in this scenario. The Little Sisters' registering an objection triggers the provision of services, but is not the *source* of them. Accordingly, it is unreasonable to think that their

objection makes the Little Sisters responsible for the provision of contraception. The Little Sisters' claim is incompatible with the normative competency required of minimally decent employers, and is therefore of the wrong sort to ground conscientious refusal.

Ultimately, the competency-based approach I have proposed shows us that we can grant conscientious objectors a lot of leeway in determining what actions they take to be wrong and what they take themselves to be responsible for. But we cannot grant them complete leeway, for these conceptions must be in accordance with the epistemic, relational, and normative competencies required of minimally decent professionals. A proper understanding of normative competencies is especially important, as it can help us see why the conscientious refusal claim in *Zubik v. Burwell* is not of the right sort.

Acknowledgements

I wish to sincerely thank Meredith McFadden, Carolyn McLeod, Emma Ryman, and two anonymous *Bioethics* referees for extremely helpful discussion of this article. Thanks also to audiences at the University of Texas – San Antonio, the 2016 meeting of the Canadian Society for the Study of Practical Ethics, and the 2016 Rocky Mountain Ethics Congress for valuable feedback. Most of the work on this article was completed while I was a postdoctoral fellow at the Rotman Institute of Philosophy at Western University; thanks are also due to the informal audience of Western postdocs and graduate students who helped me prepare for these presentations.

Alida Liberman is a philosopher specializing in normative and applied ethics. She received her PhD from the University of Southern California, and is currently an assistant professor of philosophy at the University of Indianapolis. An earlier version, presented as a paper, was awarded the Young Ethicist Prize at the 2016 Rocky Mountain Ethics Congress.

²⁴ p. 17; https://www.au.org/files/legal_docs/2015-05-19%20Notre%20-Dame%20II.pdf

²⁵ What matters is not that there is a multi-step causal chain, but that the connection between signing form 700 and employees' use of contraception is not causal in the right way: it merely triggers an existing and independent mechanism. Contra Del Bò, I assume that a responsibility connection that is distant but directly causal could be of the right sort to ground conscientious refusal (C. Del Bò. Conscientious Objection and the Morning-After Pill. *J Appl Philos* 2012; 29: 133–145, p. 139); see also West-Oram and Buyx (*op. cit.* note 14, p. 341) for discussion of direct vs. tenuous causal chains.