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Does Medicine Need to Accommodate Positive Conscientious Objections to Morally Self-Correct?

Eric J. Kim & Kyle Ferguson

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This invites hard questions about when, why, and how to vindicate conscientious provision, what shape exemptions might take, and how broadly they should sweep. The answers to these inform my longer law review article that develops, defends, and applies a conceptual framework for medical disobedience. Should protections be limited to job loss and tort liability, or cover criminal indictment too? Should they take shape in explicit, upfront permission via statute or common law? Or unspoken, back-end forgiveness via prosecutorial discretion or jury nullification? Should they sweep broadly, or be narrowly specified? The reproductive health context alone features a range of contested procedures: from sex selection, female genital cutting, and gag rules on informing patients about birth control and other family planning measures, to in vitro fertilization for same-sex couples, emergency contraception or sterilization for young, unmarried, or childless women, and advance directives that comatose women left to forgo life-sustaining treatment even if they are pregnant. Outside of reproductive health, examples I consider include opioid restrictions to manage chronic pain for non-cancer patients and state bans on conversion "therapy" for sexual orientation or gender identity.

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OPEN PEER COMMENTARIES

Does Medicine Need to Accommodate Positive Conscientious Objections to Morally Self-Correct?

Eric J. Kim and Kyle Ferguson

NYU Grossman School of Medicine

The controversy around the accommodation of conscientious objections (COs) in medicine persists, especially for such contentious services as abortions. COs are typically considered in their negative form—that is, when doctors *refuse* to perform a legal and medically indicated service for moral reasons. However, the recent attempts by several states to pass "heartbeat" bills (Lai 2019), which would prohibit the abortion of embryos with heartbeats, raise the question of whether positive COs should also be accommodated if some types of abortions are once again made illegal. By positive COs, we refer to doctors who *insist* on performing a medically indicated but illegal service for moral reasons.

In "Unjustified Asymmetry," Fritz (2021) observes that there has been little discussion about positive-CO accommodations and argues that the disparate treatments of negative and positive COs are unjustified. Indeed, Fritz claims, "whatever criteria justify protecting negative appeals to conscience regarding abortion also justify protecting positive appeals regarding abortion" (47). Fritz focuses on Wicclair's appeal to integrity argument: Refusals to perform abortions for

CONTACT Eric J. Kim erickim213@gmail.com NYU Grossman School of Medicine, New York, NY, USA

moral reasons should be accommodated because integrity is intrinsically valuable, and because its loss can lead to significant moral distress and deterioration of moral character (Wicclair 2011, 25–27). Fritz reasons that because providers may feel just as morally convicted to perform medically indicated abortions, their integrity may similarly be jeopardized by the prohibition of abortions. Moreover, he claims that any burdens that may arise from positive-CO accommodations would be no more than those arising from negative-CO accommodations. Thus, Fritz concludes, it is inconsistent to accommodate negative COs while prohibiting positive COs.

Wicclair's integrity-based justification of negative-CO accommodations is important and well known. However, Wicclair exhibits the same tendency as many others who offer reasons for accommodating COs in medicine—namely, framing the question and seeking its answer at the individual level. These bioethicists fixate on features like personal moral integrity, individual liberty, or private virtues, and they go on to argue that those person-sized goods are so significant that the profession must accommodate them.

We think they are looking in the wrong place. We believe the most compelling reasons to accommodate COs in medicine are found not at the level of individual objectors but rather at the level of whole systems. Under our view, CO accommodations are a system-level or institution-sized design feature that is necessary for preserving the profession's ability to morally self-correct. By protecting members who object to medicine's potentially unethical positions, policies, and practices, the profession remains reformable from within.

We limit justifiable accommodations to what we call Nature of Medicine COs (NoMCOs), in which doctors refuse to provide a service because they believe it is against the nature of medicine and its ethic such that no doctor *qua* doctor should provide it. For example, a doctor who refuses to perform abortions because she believes it is against the nature of medicine to end or assist in ending any human life would be performing a NoMCO. On the other hand, a doctor who refuses to perform abortions in virtue of her idiosyncratic moral beliefs (religious or otherwise) that she would either not *universalize to all doctors* or not commit herself to *qua doctor* is *not* making a NoMCO.

Our position is based on what we call the Reform Argument (Kim and Ferguson, forthcoming). Here is a distilled version:

1. The medical profession should be epistemically humble and self-critical about potentially unethical policies so that it can morally self-correct when necessary.
2. NoMCOs criticize potentially unethical policies in an appropriately universalizable manner and from the relevant perspective.
3. Policymakers give the greatest consideration to those who are most directly impacted by their decisions—in this case, patients and *active doctors in the relevant specialties*.
4. Without NoMCO accommodations, objecting doctors would likely switch specialties or leave the profession altogether.
5. Without NoMCO accommodations, policymakers would give less consideration to objections to current policies. [3, 4]
6. Therefore, the medical profession should accommodate NoMCOs to preserve its ability to morally self-correct. [1, 2, 5]

The Reform Argument departs from traditional defenses of CO accommodations because of its system-level approach. It is therefore worthwhile to consider how our argument might apply to positive COs and whether Fritz is correct about the allegedly unjustified asymmetry between negative- and positive-CO accommodations.

It does seem that positive COs can meet the NoMCO criteria, for a doctor can reasonably judge that an action, despite its illegality, is one that *any* doctor *qua* doctor should perform. But according to the Reform Argument, NoMCO status is necessary but not sufficient for warranted accommodation. What is missing is a story about how positive-CO accommodations contribute to reformability.

A key feature of the Reform Argument is that negative-CO accommodations are *necessary* to maintain the medical profession's reformability: A medical profession that fails to accommodate NoMCOs is thereby less able to morally self-correct. Just as science achieves its status as a "self-correcting enterprise" by making any of its claims revisable (Sellars 1963, 170), and just as social and intellectual progress remain possible by protecting freedom of expression and ensuring the right conditions of discussion (Mill 1859), medicine's capacity for moral self-correction requires the accommodation of NoMCOs. But does this also, as Fritz would suggest, apply to positive COs? Would positive-CO accommodations also be *necessary* to preserving reformability?

Consider what would happen if positive-CO accommodations were not in place. Some doctors would continue to provide the illegal service in question when medically indicated and requested by a competent patient. Those objectors would be punished for their illicit activity; consequences would range from a financial fee or professional censure to the revoking of their medical licenses or even imprisonment. The more severe punishments would remove those objectors from the medical profession, and even the less severe punishments might push some of those objectors to switch specialties or to leave the profession altogether. Thus, the objectors might lose standing and receive less consideration from policymakers as per the Reform Argument. From this perspective, the medical profession may need to accommodate positive COs to preserve reformability.

What of the doctors who wish to provide the illegal service but ultimately decide to obey the law? Doctors who find abortions morally repulsive can avoid moral injury and burnout by leaving their specialty—and thereby avoid performing abortions—but those who feel that distress due to the *inability* to perform abortions would be no better off if they were to leave their specialty. Thus, while Wicclair's individual integrity-based defense would apply to such objectors, the Reform Argument does not justify accommodating their COs.

So, the Reform Argument might justify positive-CO accommodations for the sake of protecting objectors who would be willing to perform the service even illicitly. However, it does not apply to those objectors who would obey the law and refrain from providing the illegal service since their moral injury and burnout would not undermine the profession's ability to morally self-correct. Thus, the Reform Argument justifies positive-CO accommodations to a lesser extent than negative-CO accommodations. So, *pace* Fritz, at least some asymmetry is justified.

However, it might be that a more thoroughgoing asymmetry is justified from another perspective. As Fritz has framed the issue, CO in medicine is fundamentally a question about the law—namely, conscience clauses in legislation. But an alternative framing focuses on the medical profession rather than the state. From this perspective, the central question is: Should the medical profession accommodate its members who conscientiously deviate from its norms? Here, the answer is not to be found in how lawmakers or voters force the profession's hands, but rather in how the profession decides to govern itself. The Reform Argument maintains that the profession should design itself—not that the society should govern the profession—in such a way that preserves its capacity for moral self-correction. From this perspective, negative-CO accommodations are something the profession can autonomously decide and implement, but positive-CO accommodations are not. The profession cannot determine whether the state will enforce its laws (namely, the laws one breaks when performing an act of positive CO); it lacks the power and authority to unilaterally accommodate positive COs. Thus, the asymmetry is absolute and not arbitrarily so.

This is not to say that positive COs are morally worse than negative COs, which would, as Fritz observes, beg the question. Rather, it is to say that the profession is a community within a community, and not all communities are alike. Fritz writes, "it is important to emphasize that granting exemptions for HCPs with conscience-based objections is itself a community-level decision. *As a community*, we decide …" (55). We agree. But the issue changes shape depending on which community perspective one adopts. From within the medical-profession community, positive-CO accommodations are off limits even though negative-CO accommodations are on the table. So, even if Fritz is right that the asymmetry is unjustified from the external point of view, the asymmetry is inevitable from within.

ORCID

Eric J. Kim http://orcid.org/0000-0001-8032-2090
Kyle Ferguson http://orcid.org/0000-0001-9285-4975

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