



# A defense of conscientious objection: Why health is integral to the permissibility of medical refusals

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## Abstract

Schuklenk, Smalling, and Savulescu put forth four conditions that delineate when conscientious objection is impermissible. Roughly, they argue for the following claim: if some practice is legal, standard, expected of a profession, and in the patient's interest, then medical professionals cannot refuse to perform the practice. In this essay, I argue that these conditions are not jointly sufficient to deny medical professionals the ability to refuse to perform procedures that detract from a patient's health. They are insufficient to bar medical refusals to perform certain practices because, even when these conditions are met, non-health conducive practices would not be open to refusal by the physician. I provide an example of a non-health conducive practice female genital mutilation, which meets all of the proposed conditions but, intuitively, should be open to medical refusals. As a result, I conclude that the proposed conditions are insufficient to determine when conscientious objection is impermissible. I then offer an amendment to their position by suggesting that a practice, in addition to the other four conditions, must also be health conducive in order to remove the medical professional's ability to refuse to perform the practice.

## KEYWORDS

conscientious objection, female genital cutting, health, Schuklenk

## 1 | INTRODUCTION

Schuklenk, Smalling, and Savulescu put forth four conditions that delineate when conscientious objection is impermissible. In this paper, I argue that their proposed conditions to determine when refusing to perform a medical procedure is impermissible—that a practice must be legal, expected, standard care within the patient's interests—are insufficient for removing one's ability to conscientiously refuse to perform that procedure. Specifically, their proposed conditions are insufficient as they would not allow doctors to conscientiously object to practices that one would rightfully expect them to refuse to perform.

The paper proceeds as follows: first, I define and expand upon sufficient conditions given by Schuklenk, Smalling, and Savulescu that delineate when conscientious objection in medicine is impermissible. Second, I produce a case in which the conditions are insufficient to remove conscientious objection and in which it seems the doctor should be able to object to the procedure, specifically the practice of female genital cutting. As a result of my argument, I suggest that the addition of a pathocentric condition to my elaboration of Schuklenk, Smalling, and Savulescu's criteria is the best way to allow doctors to refuse to perform harmful practices such as female genital cutting. Accordingly, I propose a limited form of conscientious objection centered around health: if the sole purpose of a medical procedure is

to introduce a pathology, medical professionals should be permitted to refuse to reform the practice.

## 2 | THE ANTECEDENT CONDITIONS

According to one recent and influential proposal concerning conscientious objection by medical professionals,<sup>1</sup> liberal democracies must bar conscientious objection in tax payer funded, state run, medical monopolies according to the following conditional claim:

CCO: If a medical practice is legal, expected, standard care in the patient's interest, then medical professionals should not be allowed to conscientiously refuse to perform the procedure.

For shorthand, I will refer to the sufficient conditions—legal, expected, standard care in the patient's interest—as the antecedent conditions since they form the antecedent clause of this conditional claim about conscientious objection (CCO).<sup>2</sup> I take the consequent of the claim to amount to something like the following: employers and governments should make it a condition of employment in the medical field that professionals capitulate their ability to conscientiously refuse to perform a practice.<sup>3</sup> This paper argues that this consequent does not follow from the antecedent conditions.

Understanding how Schuklenk, Smalling, and Savulescu characterize these conditions is vital to demonstrating their insufficiency to bar conscientious objection from medical practice; I now turn to describing these conditions that are supposedly jointly sufficient. First, the practice must be legally permissible. They include this condition because, if it were not included, objectors could refuse to perform practices patients are legally entitled to, resulting in harm and inconvenience to patients. Schuklenk and Smalling<sup>4</sup> and Savulescu<sup>5</sup> argue that the existence of conscientious objection would result in a high “cost to patients hoping to access medical services that they are legally entitled to access.” Some such costs would include reduced access to legal care in remote, rural areas, which may have only a few physicians who can perform an abortion, euthanasia, sterilization, sex change, or provide contraception, all of whom object to the procedure,<sup>6</sup> thereby forcing the patient to travel in order to

see a physician that would be willing to perform the procedure.<sup>7</sup> The procedure must be legal, which is the first condition that must be met to remove conscientious objection.

Second, the practice must be expected; practices to which doctors should not be able to object are expected by the profession. Schuklenk and Smalling are concerned “with conscientious objectors who decided to join a particular profession (in this case medicine) voluntarily and who then wish to be exempt from providing services that are typically expected of that profession.”<sup>8</sup> For instance, abortion is a practice expected to be performed by doctors in Canada, the United States, and many other countries. The details of this condition are not spelled in detail by Schuklenk and Smalling. However, the following seems to be a charitable interpretation that will work for the present purposes: a medical practice is expected of a profession if and only if many or all of the members of that profession have sufficient medical knowledge to perform, or are trained to perform, that medical practice.

Third, the practice must be standard for a particular area of medicine. The previous requirement appeals to *expectations* of a profession, where I proposed a tentative definition of what expectation amounts to and which is compatible with Schuklenk and Smalling's use of the term. Conversely, whether or not a practice is standard is determined by the standing of that practice's *procedures*. The sort of practices that Schuklenk is concerned with are those that “fall within [a medical professional's scope of practice].”<sup>9</sup> They are, as he describes them, the practices that “are part and parcel of modern medical practice.”<sup>10</sup> He does not give any obvious definition for what this condition amounts to, but the following sufficient condition will suffice for the present purposes: some medical practice is standard if there exists a diagnostic and treatment process that a clinician should follow, according to predetermined guidelines for how and when these procedures should be done, for a certain type of patient, illness, or clinical circumstance.<sup>11</sup> This leaves the possibility open that objections are allowed to be raised against non-standard practices within a profession, but these are not typically the sorts of practices that are objected to.

Finally, the procedure must be in the patient's interest. Being professional, argue Schuklenk and Smalling, includes “a promise... to serve the public good and to serve patient interests first and foremost.”<sup>12</sup> This aspect of CCO eliminates many practices that may be legal, expected, and standard examples of medical care but that are clearly not in the interest of the patient.

However, it is not quite clear in what sense Schuklenk and Smalling are using the term “interest.” There are at least two ways that they may be using the term. First, they may be using the word to refer to health—that which is objectively best for the patient's health

<sup>1</sup>Savulescu, J. (2006). Conscientious objection in medicine. *British Medical Journal*, 332, 294–297; Schuklenk, U. (2015). Conscientious objection in medicine: Private ideological convictions must not supersede public service obligations. *Bioethics*, 29(5), ii–iii; Schuklenk, U. (2019). Conscientious-based refusal of patient care in medicine: A consequentialist analysis. *Theoretical Medicine and Bioethics*, 40, 523–538; Schuklenk, U., & Savulescu, J. (2017). Doctors have no right to refuse medical assistance in dying, abortion or contraception. *Bioethics*, 31(3), 162–170; Schuklenk, U., & Smalling, R. (2017). Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of Medical Ethics*, 43, 234–240.

<sup>2</sup>The arguments of this paper center around secular, state-funded health care institutions. State-funded health institutions are extensions of the liberal democracy's government, and cannot have professionals imposing idiosyncratic moral/personal beliefs on patients.

<sup>3</sup>Schuklenk & Savulescu, op. cit. note 1, pp. 162–163.

<sup>4</sup>Schuklenk & Smalling, op. cit. note 1.

<sup>5</sup>Savulescu, op. cit. note 1, p. 295.

<sup>6</sup>Schuklenk & Smalling, op. cit. note 1, p. 237.

<sup>7</sup>Savulescu, op. cit. note 1, p. 295.

<sup>8</sup>Schuklenk & Smalling, op. cit. note 1, p. 234.

<sup>9</sup>Schuklenk (2019), op. cit. note 1, p. 527.

<sup>10</sup>Ibid: 536.

<sup>11</sup>I am grateful to an anonymous reviewer for suggesting this definition of a “standard of care” as it is used in the medical setting.

<sup>12</sup>Schuklenk & Smalling, op. cit. note 1, p. 238.



is within her interest. This use of the term requires a definition of health, one of the most prominent of which is a naturalistic definition. Boorse characterizes health in the following summary:

1. The *reference class* is a natural class of organisms of uniform functional design; specifically, an age group of a sex of a species.
2. A *normal function* of a part or process within members of the reference class is a statistically typical contribution by it to their individual survival (or) reproduction.
3. *Health* in a member of the reference class is normal functional ability: the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency.
4. A *disease* (later, pathological condition) is a type of internal state which impairs health, that is, reduces one or more functional abilities below typical efficiency.<sup>13</sup>

In short, health is the absence of pathological conditions, where a pathological condition is a suboptimal contribution of some part or process to one's survival and reproduction. From this naturalist definition of health, it is clear that Schuklenk and Smalling have not defined interest in terms of health. They argue that in Italy, where a majority of doctors refuse to perform abortions, "patient interests come clearly last."<sup>14</sup> Yet, aborting a child contributes to a suboptimal functioning of a part or process—reproductive organs and the birthing process—and is therefore considered a pathology. Schuklenk and Smalling thus assert that introducing a pathology into a patient can be within the patient's interest. If "in the patient's interest" refers to the optimization of health, where health is an absence of pathologies, then they are not defining interest in terms of health since an abortion, under this definition of health, is an introduction of a pathology.<sup>15</sup>

The second obvious way of using "interest" is in terms of what the individual desires or thinks is the best route to optimize her well-being. While desire and what one believes is in her best interest may coincide, they are not coextensive. For instance, a woman may want

to have a child after she has fallen in love with her child. Her desire to have the child is coupled with financial stability and a loyal partner to support her in raising a child. Her desire comes along with her interest; they seem indistinguishable in such a case. Yet, say the partner is not loyal and abandons the woman and their child. Say also that the woman now no longer has the financial support to pay for the child's needs. She is also enrolled as a full-time student at a university, must remain so in order to receive her scholarships, and does not believe she would have time to take care of a child and finish her education simultaneously. While she has fallen in love with the fetus and desires to raise him/her, she ultimately decides it is in her best interest to abort the fetus. Such a scenario seems plausible, so I do not take Schuklenk and Smalling to be using the term interest as equivalent to or coextensive with a patient's wants. Therefore, they seem to be using the term "interest" to delineate that which the patient deems is the best for her well-being, regardless of whether or not she finds her desires to align with what she concludes is best for her well-being.

One might also claim that having the abortion done will *objectively* result in a better life for the mother.<sup>16</sup> Say, for instance, that the mother does not just *believe* that her financial struggles will be mitigated if she receives the abortion, but also that this will in fact be the result of the procedure. In such a case, it may also be *objectively* in her interest to receive the abortion; there exists some benefit of receiving the procedure that sufficiently outweighs the alternative. A definition of interest inspired by Schuklenk and Smalling, then, might be given as follows: a patient is said to have an interest in having a medical procedure performed if and only if she *believes* obtaining the benefits of said procedure is the most efficacious way for her to pursue well-being or obtaining those benefits *actually* provides the best way for her to pursue her well-being.

These four conditions are supposedly sufficient to bar conscientious objection. That is, employers and governments should make it a condition of employment in the field that medical professionals surrender their ability to conscientiously refuse to perform a practice.<sup>17</sup> Provided each condition is fulfilled, there should be no option for a doctor to object to providing whatever medical services that they are trained to provide to patients. In cases such as abortion, euthanasia, sex change, and so forth, these conditions deliver the results desired by Schuklenk, Smalling, and Savulescu; physicians should not be able to refuse to perform legal, expected, standard medical procedures that are in the interest of the patient.

### 3 | FEMALE GENITAL CUTTING AND THE ANTECEDENT CONDITIONS

Schuklenk argues that "doctors are first and foremost providers of healthcare services. Society has every right to determine what kinds of services they ought to deliver."<sup>18</sup> Regardless of culture, as long as

<sup>13</sup>Boorse, C. (1977). Health as a theoretical concept. *Philosophy of Science*, 44(4), 542–573; Boorse, C. (2014). A second rebuttal on health. *Journal of Medicine and Philosophy*, 39, 683–724.

<sup>14</sup>Schuklenk & Smalling, op. cit. note 1, p. 238.

<sup>15</sup>One might wonder why health here should be characterized by a naturalistic definition. To see why I chose this conception of health to define a patient's interest in the present context, one must consider the main alternative. The main competitor to a naturalistic definition would be a constructivist account of health. Under some such accounts, for example, Cooper, R. (2002). Disease. *Studies in History and Philosophy of Biological and Biomedical Sciences*, 33, 263–282, one should think of the badness of "diseases in a way analogous to... weeds. A plant is only a weed if it is not wanted." Thus, at the very least, disease is partially constituted by whether or not one views the disease as bad (see also: Wakefield, J. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist*, 47(3), 373–388. Cooper (ibid: 274) suggests that one who suffers from schizophrenia may find her condition desirable, and it would therefore not be considered a disease. In other words, it may be in her interest to have the condition. Thus, if one were to define interest in terms of a constructivist definition of health, her definition would become circular. One can define health by appealing to the interests of individuals. Such a suggestion is not circular. However, it would become circular if one were then to define interests in terms of health, since health presupposes a definition of interest on a constructivist account. Thus, the most plausible definition of interest used here by Schuklenk and Smalling should be put in terms of well-being, not health. This is not to suggest that they cannot simultaneously endorse a constructivist view of health, but only that they cannot define interests in terms of a constructivist definition of health.

<sup>16</sup>I am grateful to Peter Vallentyne and Philip Robbins for pressing me on this point.

<sup>17</sup>Schuklenk & Savulescu, op. cit. note 1, pp. 162–163.

<sup>18</sup>Schuklenk (2015), op. cit. note 1, p. iii.

these four antecedent conditions are met, refusing to perform a specific medical practice should not be an option for medical professionals. It is clear that Schuklenk and Smalling's objection to conscientious refusals is meant to evolve with and be applicable to different cultures as well as cultural shifts within a particular society: "it is important to recognize that medical practice is also a cultural practice that changes over time."<sup>19</sup>

The basic argument that follows will utilize the idea, which advocates of CCO take to be an advantage of its antecedent conditions, that medical practice changes as societies do. What proponents of CCO take for granted is the fact that societies might change, or may have existed previously, that allow for seemingly objectionable practices which fulfill all of CCO's antecedent conditions. If medical professionals were to be denied conscientious objection in every case where these conditions are fulfilled, it is possible for a society to exist in which all conditions are fulfilled but where medical professionals would not have the right to refuse to perform harmful cultural practices.

An example of a seemingly objectionable practice that fulfills all of CCO's antecedent conditions is the extremely prevalent practice of female genital cutting (FGC)<sup>20</sup> in large portions of Africa. FGC is a cultural practice in which parts of the vulva are removed or reduced. There are three main types of FGC that are performed:

Type 1, Clitoridectomy, involves prepuce with or without excision of part or all of the clitoris; Type 2, excision, removes the prepuce and clitoris together with partial or total excision of the labia minora; Type 3, infibulation, removes part or all of the external genitalia and stitches/narrows the vaginal opening.<sup>21</sup>

I assume that any satisfactory analysis that attempts to remove conscientious objection from the medical profession must permit medical professionals the ability to refuse to perform FGC. Further, I take this desideratum as a baseline assumption because of the rightfully overwhelming worldwide call to ban the practice. In a joint statement, the World Health Organization, United Nations Children's Emergency Fund, and eight other international organizations denounced the practice as a violation of human rights that is extremely dangerous to women's health.<sup>22</sup> The statement notes that the practice "is painful and traumatic. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences."<sup>23</sup> This practice brings about adverse health effects for mothers and their children. Long term consequences for the mother include, but are not limited to, "chronic pain, infections, and

decreased sexual enjoyment;" the statement also notes an estimation that between approximately one to two children out of every 100 die as a consequence of FGM.<sup>24</sup> Although I cannot thoroughly examine the multitude of negative health consequences, it will suffice for the purposes of this paper to note that the negative health consequences are a major reason why these international organizations have fought to ban the practice.<sup>25</sup> As a result, I propose the following desideratum for any analysis that purports to remove conscientious objection from the medical practice:

Desideratum: Any analysis of conscientious objection in medicine—purporting to delineate conditions that, once fulfilled, deny the medical professional the ability to refuse to perform a medical practice—must permit a medical professional to refuse to perform FGC.

In the remainder of this section, I demonstrate that the jointly sufficient conditions to remove conscientious objection proposed by Schuklenk, Smalling, and Savulescu would not allow medical professionals to refuse to perform FGC. Their proposal does not meet the outlined desideratum. In the following section, I suggest a failure to meet this desideratum requires a rejection or revision of their position. I now turn to demonstrating how FGC can meet their proposed sufficient conditions.

First, this practice meets the legality condition. The medicalized version of this procedure was, not long ago, legal, expected to be made available by medical persons, and standard practices in many African countries. In most countries in Africa, the practice was, until recently, *legal*, and it remains legal in some countries.<sup>26</sup>

Second, this practice is both expected and standard. While it may be a less common type of work that a physician might have to perform, the procedure was very much expected up until recently, evidenced by a 2018 study that found 26% of those previously cut had the procedure performed by a healthcare professional.<sup>27</sup> Another 2018 study shows that medically trained persons are performing this procedure in many countries; the highest rates of medicalization are found in Egypt and Sudan.<sup>28</sup> As early as 1995, Guinea, Kenya, Nigeria, and Egypt have had a very large number of circumcision procedures performed by doctors or trained nurses, with over 60% of the procedures in Egypt performed by medically trained

<sup>19</sup>Ibid: 11.

<sup>20</sup>Notice, this does not mean that severe negative health consequences are the *only* reason why the practice should be banned. The statement also notes sexist motivations of the practice, thereby providing another reason for its eradication.

<sup>21</sup>There is a growing consensus in parts of Africa that this practice should be eradicated, (see: Mandara, M. U. (2000). *Female genital cutting in Nigeria: Views of Nigerian doctors on the medicalization debate*. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 95–107). Lynne Rienner.

<sup>22</sup>28 Too Many. (2018). *The law and FGM: An overview of 28 African countries*, p. 44. <https://www.28toomany.org/Law>. The organization 28 Too Many describes itself as "an international research organization created to end female genital mutilation (FGM) in the 28 African countries where it is practiced and in other countries across the world where members of those communities have migrated."

<sup>23</sup>Kimani, S., & Shell-Duncan, B. (2018). Medicalized female genital mutilation/cutting: Contentious practices and persistent debates. *Current Sexual Health Reports*, 10(1), 25–34.

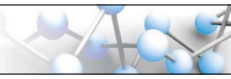
<sup>19</sup>Schuklenk & Smalling, op. cit. note 1, p. 239.

<sup>20</sup>The practice is also referred to as female circumcision or female genital mutilation.

<sup>21</sup>Skaine, R. (2005). *Female genital mutilation: Legal, cultural, and medical issues*. McFarland and Company, p. 8.

<sup>22</sup>OHCHR, UNAIDS, UNECA UNDP, & UNFPA UNESCO. (2008). *Eliminating female genital mutilation. An interagency statement*. WHO.

<sup>23</sup>Ibid: 1.



persons.<sup>29</sup> In Sudan, 67% of the procedures were performed by medical persons.<sup>30</sup>

This procedure, then, was expected and was *standard* as well. In 1994, Egypt “enacted a policy requiring that FGM/C be performed by a trained medical professional.”<sup>31</sup> The Egyptian Ministry of Health mandated that one day a week be set aside specifically to perform the FGC.<sup>32</sup> The practice was a standard practice: there were guidelines that outlined how the practice should be performed in a medical setting. This policy has been reversed, but the point remains that the practice was commonly performed by medical professionals.

Finally, this practice is very plausibly in the *interest* of the women receiving the care. Recall that Schuklenk and Smalling seem to claim that a patient is said to have an interest in having a medical procedure performed if and only if she *believes* obtaining the benefits of said procedure are the most efficacious way for her to pursue well-being or obtaining those benefits *actually* provide the best way for her to pursue her well-being. One woman notes the obviousness of the fact that having been cut is a necessary prerequisite to marriage:

In Sudan... most of the young ladies get married early, maybe twelve or fourteen. Then they have to be ready before she gets married, because you will never hear that there is some lady that got married first and did surgery later.<sup>33</sup>

Marriage in many cultures that practice FGC is the best way for women to gain “land and security.”<sup>34</sup> In Guinea-Bissau, for instance, the practice is a prerequisite for marriage because it is seen as a moving, or “rite of passage,” into womanhood.<sup>35</sup> This is perhaps why widows also pursue the procedure later in life if they choose to remarry.<sup>36</sup> It is also done for aesthetic reasons. One woman notes

that “we say that [type 3 FGC] is good because after it is done the girl's genital area becomes very beautiful and smooth.”<sup>37</sup>

This brief survey is not meant to be an in-depth exploration of the motivation for the practice's perpetuation. Rather, it is to show that this practice *just* is part of the cultural identity of women in these countries. By cultural identity I mean one's feeling of belonging to a group based on nationality, religion, agreeance with and consent to societal norms, and familial or societal lineage or heritage. It is “controlled, organized, and encouraged primarily by women.”<sup>38</sup> An instance of the cultural importance of the practice can be seen by a poll of Somali-Canadian women. These women “reported being excited before the event, looking forward to it and feeling special afterward... they do it for themselves to feel clean, more beautiful, and pure.”<sup>39</sup>

All aforementioned social benefits are certainly desirable in those cultures. While some or many young women may not *want* the procedure, it can certainly still be said that it is in their *interest*—at least in the sense used by Schuklenk and Smalling; many reasonably feel it is the best decision for their overall well-being within the particular cultural contexts in which they live. Many may deem it an important way to achieve success, gain respect, and be included in the culture to which they belong. In one study conducted, more than one-third of a survey of 909 girls reported that they were glad they were circumcised.<sup>40</sup> The majority of young women in Egypt, Sudan, and Mali supported the continuation of FGC in a 2004 survey.<sup>41</sup> The surgery, therefore, can certainly be said to be in the interest of the patient.

## 4 | THE INSUFFICIENCY OF THE ANTECEDENT CONDITIONS

Yet, even though all four conditions are fulfilled, it seems reasonable to refuse to perform medical procedures if the sole physical outcome of which is the introduction of a pathology. Imagine a 15-year-old<sup>42</sup> girl who goes with her parents to have a medical version of FGC. She understands that cultural significance of the practice and wants to undergo the procedure. She also understands that many in her culture see it as a prerequisite for marriage; she embraces the tradition of FGC. She wants to be able to marry and believes this will identify her as entering womanhood within the particular culture of which she is a part. She may associate the practice with purity and

<sup>29</sup>Skaine, op. cit. note 21, p. 13. The median age at which the procedure is performed on girls in these countries—except Nigeria, where the median age was 0—ranges from 7 to 13 (Ibid: 14–15). This is not a definite age range, as FGC “is performed at varying age groups, from the first week of life, during infancy, before puberty, before the first childbirth and other periods in the woman's life” (Odukogbe, A. A., Afolabi, B. B., Bello, O. O., & Adeyanju, A. S. (2017). Female genital mutilation/cutting in Africa. *Translational Andrology and Urology*, 6(2), 138–148). It was estimated that 97% of Egypt's population has undergone some form of FGC, whereas it was estimated that about 50% of women in Kenya and Nigeria experience this procedure. Shell-Duncan, B., & Hernlund, Y. (2000).

Female “circumcision” in Africa: Dimensions of the practice and debates. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female “circumcision” in Africa: Culture, controversy, and change* (pp. 9–12). Lynne Rienner.

<sup>30</sup>Kimani & Shell-Duncan, op. cit. note 28.

<sup>31</sup>Refaat, A. (2009). Medicalization of female genital cutting in Egypt. *East Mediterranean Health Journal*, 15(6), 1379–1388; Shell-Duncan, B., Njue, C., & Moore, Z. (2017). The medicalization of female genital mutilation/cutting: What do the data reveal? In *Evidence to end FGM/C: Research to help women thrive*, i–29. Population Council.

<sup>32</sup>Refaat, Ibid: p. 1385.

<sup>33</sup>Skaine, op. cit. note 21, p. 15.

<sup>34</sup>Ibid: 17–18. See also: Odukogbe et al., op. cit. note 29, p. 141.

<sup>35</sup>Johnson, M. (2000). Becoming a Muslim, becoming a person: Female “circumcision”, religious identity, and personhood in Guinea-Bissau. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female “circumcision” in Africa: Culture, controversy, and change* (pp. 215–233). Lynne Rienner, p. 218; Balk, D. (2000). To marry and bear children? The demographic consequences of infibulation in Sudan. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female “circumcision” in Africa: Culture, controversy, and change* (pp. 55–71). Lynne Rienner.

<sup>36</sup>Balk, Ibid: 56.

<sup>37</sup>Abusharaf, R. M. (2001). Virtuous cuts: Female genital mutilation in African ontology. *Differences: A Journal of Feminist Cultural Studies*, 12, 123–124.

<sup>38</sup>Johnson, op. cit. note 35, p. 217.

<sup>39</sup>Einstein, G. (2008). From body to brain: Considering the neurobiological effects of female genital cutting. *Perspectives in Biology and Medicine*, 51(1), 89–90.

<sup>40</sup>Orubuloye, I. O., Caldwell, P., & Caldwell, J. (2000). Female “circumcision” among the Yoruba of southwestern Nigeria: The beginning of change. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female “circumcision” in Africa: Culture, controversy, and change* (pp. 73–94). Lynne Rienner, p. 89.

<sup>41</sup>Skaine, op. cit. note 21, p. 42.

<sup>42</sup>If age is a reason to protest at this point in my argument, just imagine a woman who is older. In the United States, for instance, the Female Genital Mutilation Act of 1996 left open the possibility for FGC to be performed on women at least 18 years old.

beauty. Not long ago this was legal, expected, and standard medical care, and the procedure in many cases would include the patient's interest. The doctor explains to her the risks of the procedure, and that some people experience complications related to the surgery.<sup>43</sup> She still assents to the surgery because she deems the benefits of the surgery far outweigh the risks. Under CCO, the doctors could not object to performing this procedure. But such a conclusion seems to go against commonsense intuition that the doctor should be able to refuse to perform this practice.

The analysis proposed by Schuklenk, Smalling, and Savulescu does not meet the aforementioned desideratum. In other words, their conditions are not sufficient to remove conscientious objection because their analysis entails that medical professionals would not be able to refuse to perform this practice. While there may be others, the greatest absurdity entailed by CCO is the inability of physicians to refuse to perform practices that introduce a pathology into the patient with no health benefits whatsoever. Say one embraces the supposedly sufficient antecedent conditions of Schuklenk, Smalling, and Savulescu. Such a view by itself would allow FGC to continue without the ability of doctors to refuse to perform such a practice. It is for this reason that CCO is insufficient and the antecedent conditions, therefore, should not be used as a gauge to determine when conscientious objection is permissible. The options left for proponents of CCO is to either accept the unpalatable consequences of the view as it stands or attempt to make revisions to avoid the undesirable conclusions.

## 5 | REVISED CONDITIONS

There seems an effective revision: include a clause that bars conscientious objections for procedures that are intended to maximize or preserve the health of the patient. Like the other conditions, if this new condition was not met, then medical professionals could refuse to perform the procedure. In other words, the addition of such a clause would allow that any pathology introducing procedures, such as FGC, are open to conscientious objection. A revision of CCO might be:

RCCO: If a medical practice is legal, expected, *health preserving*, standard care in the patient's interest, then medical professionals should not be allowed to conscientiously refuse to perform the procedure.

If this new clause, combined with the others, is sufficient to remove conscientious refusals, medical care must be beneficial to the health of the patient. To allow doctors to refuse to perform FGC, it will be most effective to adopt the notion of health defined as an absence of pathological conditions, where a pathology is the sub-optimal contribution of a part or process to survival and

reproduction.<sup>44</sup> Roughly, then, the health preservation clause should be understood as preventing, removing, or mitigating pathologies, so as to achieve normal function of parts or processes for the purpose of survival and reproduction.

The addition of this health preservation clause can answer a great deal of claims against conscientious objection that it leads to "a Pandora's box of idiosyncratic, bigoted, discriminatory medicine."<sup>45</sup> RCCO does not allow for unprincipled and arbitrary religious conscientious objection. Neither the female Muslim doctor who refuses to see a man naked or learn about sexually transmitted diseases, nor the Jehovah Witness surgeon who will not use blood transfusions, and so forth, can conscientiously object, since the purpose of bodily examinations and blood transfusions is health preservation.<sup>46</sup> In short, practices performed with the goal of preventing, removing, or mitigating pathologies, where pathology is understood according to a naturalistic definition of health and disease, are not subject to conscientious objection. In this sense, RCCO is a rejection of conscientious objection understood as arbitrary refusals based on personal beliefs.<sup>47</sup> On the other hand, RCCO provides a principled way for doctors to refuse to perform practices that have no health serving function whatsoever. RCCO, then, is a non-arbitrary, patho-centric version of conscientious objection.

RCCO certainly provides ground for medical professionals to refuse to perform practices such as FGC, since FGC introduces a pathology without any purpose of preserving health. FGC fails to fulfill all the conditions of RCCO, and medical professionals, therefore, can refuse to perform the practice. This seems to render the desirable results, since it is intuitively plausible that FGC should be a practice that doctors can refuse to perform.

However, upon adoption of RCCO, those who want to remove conscientious objection, such as Savulescu, Schuklenk, and Smalling, must then allow medical professionals the right to refuse to perform practices that induce a pathology without the purpose of preserving health. Such practices would include abortion, euthanasia, sterilization, sex change,<sup>48</sup> providing contraception, and so forth. These procedures are detracting from the individual's ability to survive and reproduce. In other words, since these practices bring about the suboptimal function of a biological part or process, they would not meet all conditions of RCCO, and would, therefore, be vulnerable to conscientious refusals. It would not be sufficient, under RCCO, to only meet the first four conditions but ignore that of health preservation since they are jointly sufficient.

Without adding the condition of health preservation to CCO, Savulescu, Schuklenk, and Smalling have no grounds, other than arbitrary personal preference, to allow medical professionals to object

<sup>44</sup>Boorse, op. cit. note 13.

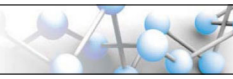
<sup>45</sup>Savulescu, op. cit. note 1.

<sup>46</sup>Schuklenk & Savulescu, op. cit. note 1, p. 165; Hershenov, D. (2021). Conscientious objection or an internal morality of medicine? *Christian Bioethics*, 27(1), 104–121. See also: Zolf, B. (2019). No conscientious objection without normative justification: Against conscientious objection in medicine. *Bioethics*, 33, 146–153.

<sup>47</sup>Schuklenk & Smalling, op. cit. note 1, pp. 235–236; Schuklenk & Savulescu, op. cit. note 1.

<sup>48</sup>Unless changing one's sex is the treatment of a pathology.

<sup>43</sup>Imagine she is having a type 2 procedure done, where it is much less likely immediate and future medical complications will result from the surgery.



to some strictly pathology inducing procedures (abortion, euthanasia, etc.) and not others (FGC). In other words, given two strictly pathology inducing procedures, for example, abortion and FGC, there is no principled reason under CCO to allow medical professionals to refuse to perform the latter and not the former. Further, if health preservation is not an added condition to remove conscientious objection, then practices such as FGC can exist without any medical professionals in secular institutions being able to refuse to perform the procedure. It is for this reason that any revision of CCO cannot fail to include the health preservation condition.

## 6 | OTHER ACCOUNTS OF CONSCIENTIOUS OBJECTION

In this section, I aim to briefly review other accounts that argue for the protection of conscientious objection and suggest how RCCO might inform those analyses. I sketch how the present analysis informs two plausible motivations for the protection of conscientious objection: motivations based on the moral integrity of the medical professional and motivations based on an internal morality of medicine.

First, consider accounts that argue that conscientious objection should be preserved in order to protect the moral integrity of the medical professional. Accounts such as Wicclair's<sup>49</sup> and Brock's<sup>50</sup> argue that conscientious refusals should not always supersede patient requests, but fall short of offering a clear set of conditions under which conscientious refusals should no longer be accommodated.<sup>51</sup> RCCO advances these moral integrity accounts by taking a specific value in medicine, health, and argues that this value, conjoined with other conditions, is sufficient to block conscientious refusals because it would allow medical professionals to refuse to perform practices that are strictly pathology producing (e.g., abortion and FGC) and deny medical professionals the ability to refuse to perform practices that prevent, mitigate, or remove pathologies (e.g., vaccines and blood transfusions). Thus, RCCO does allow for a protection of the medical professional's moral integrity advocated for by Wicclair and Brock, but in a clear and principled way—my account provides a clear set of conditions that delineate when conscientious objection is no longer permissible. In particular, conscientious refusals cannot be

accommodated when clinicians refuse to perform a practice that prevents, mitigates, or removes pathologies.

I now turn to how the previous arguments inform a class of views that motivate conscientious objection by appealing to an internal morality of medicine. Two very different approaches to this idea have been recently applied to conscientious objection: an internal morality of medicine that is pathocentric<sup>52</sup> and an internal morality of medicine that is cooperatively constructed by medical professionals and patients.<sup>53</sup>

Take first the pathocentric view of the internal morality of medicine. The health preservation clause in RCCO closely resembles a pathocentric view of medicine, such as that outlined by Boorse<sup>54</sup> and Hershenov.<sup>55</sup> The pathocentric view of medicine, in essence, claims that the goal of medicine is health preservation.<sup>56</sup> The previous arguments might support this account of medicine. If medicine is pathocentric, then medical professionals should be able to object to performing procedures that are not health preserving. They can refuse, qua medical professional, to perform pathology inducing procedures.<sup>57</sup> In other words, if medicine is pathocentric, clinicians can refuse to perform tasks that are not health preserving since health preservation is the nature of their profession. That a pathocentric account of medicine quite naturally accounts for the desideratum is a mark in its favor. As a result, the present analysis lends *prima facie* support to a pathocentric view of medicine.

Conversely, Ben-Moshe proposes an account of the internal morality of medicine that is constructed by the medical professional as well as the patient. His proposal begins with the claim that the goal of medicine is to "benefit patients in need of *prima facie* medical treatment and care."<sup>58</sup> However, he does not provide a detailed explanation of what he means by "benefit." His clearest statement of what is meant by "benefit" is as follows: "Since there is no *a priori* reason to limit what constitutes patient benefit, it should include both patients' medical good and their perception of the good."<sup>59</sup> This account is vague. If by "patients'... perception of the good" Ben-Moshe means that which is in the patient's interest—understood in the sense I've attributed to Schuklenk, Smalling, and Savulescu—then his view may be vulnerable to the same critique I have presented in this paper.

<sup>49</sup>Wicclair, M. (2000). Conscientious objection in medicine. *Bioethics*, 14(3), 205–227.

<sup>50</sup>Brock, D. (2008). Conscientious refusal by physicians and pharmacists: Who is obligated to do what, and why? *Theoretical Medicine and Bioethics*, 29, 187–200.

<sup>51</sup>For instance, both accounts note that certain values in medicine might outweigh the value of the medical professional who wishes to protect her moral integrity by refusing to perform the practice (Wicclair, op. cit. note 49, pp. 222–224; Brock, *Ibid*: 189–191). However, in many cases, neither accounts can claim when, once certain conditions are met, conscientious objection is no longer permissible. Wicclair's account claims that some values in medicine outweigh others, but does not provide a principled way of ranking these values, which makes his account difficult to apply. Similarly, Brock's account advances the "conventional compromise," a list of conditions aimed at determining which situations must be met in order for conscientious objection to occur. These conditions, however, are merely *necessary* conditions for the permission of conscientious objection. More must be added to delineate a sufficient condition for the permission of conscientious objection. As a result, his account, in many cases, cannot determine if conscientious objection is permitted.

<sup>52</sup>Hershenov, op. cit. note 46.

<sup>53</sup>Ben-Moshe, N. (2017). The internal morality of medicine: A constructivist approach. *Synthese*, 196, 4449–4467; Ben-Moshe, N. (2019). Might there be a medical conscience? *Bioethics*, 33, 835–841.

<sup>54</sup>Boorse, C. (2016). Goals of medicine. In É. Giroux (Ed.), *Naturalism in the philosophy of health: Issues and implications* (pp. 145–175). Springer Press. Although Boorse presents this view, he does not endorse it.

<sup>55</sup>Hershenov, op. cit. note 46.

<sup>56</sup>However, health preservation and a pathocentric view of medicine may not be coextensive, so it is not necessary that I adopt a pathocentric view of medicine here for the arguments of this paper to be effective. For instance, even if health preservation is defined as the prevention, removal, or mitigation of pathologies, it does not follow that medicine must be pathocentric. In other words, it might not be the goal of medicine to preserve health, even though preserving health requires the prevention, removal, or mitigation of pathologies.

<sup>57</sup>Hershenov, op. cit. note 46.

<sup>58</sup>Ben-Moshe. (2017), op. cit. note 53, p. 4458.

<sup>59</sup>*Ibid*: 4462.

Assuming this is what he means by “patients’... perception of the good,” whether or not my critique applies to his view depends on what he means by “medical good.” If by “medical good” he means what I have called health preservation, then it is not clear how his constructivist account determines whether or not conscientious objection is permissible when the “medical good” and patient interest conflict. If, on the other hand, by “medical good” he means something along the lines of Cooper’s<sup>60</sup> constructivist account of health, then his view is subject to the same critique I have brought against Schuklenk, Smalling, and Savulescu. On something like Cooper’s account of health, whether or not a condition is a pathology is partially constituted by the person’s perceiving it as a pathology. As a result, if by “medical good” he means health as understood by a constructivist view of health, then there would be no principled reason for medical professionals to be able to refuse to perform FGC on patients who do not view it as a pathology. As it stands, if the latter interpretation of “medical good” is a reasonable representation of his view, then his account cannot meet the desideratum with which I began. As a result, my analysis would suggest that a pathocentric view of the internal morality of medicine is preferable to Ben-Moshe’s account.

These brief considerations are not meant to claim definitive support of other motivations for conscientious objection. The point of this section, rather, was to examine how my analysis *might* be used to support other motivations for conscientious refusals that are already present in the literature.

## 7 | POSSIBLE CHALLENGES AND FURTHER RESEARCH

In this section, I briefly consider two objections that might be raised against RCCO. First, I address an objection to my contention that health preservation is pathocentric instead of constructivist; specifically, I propose that, in order to meet the desideratum, health cannot be construed in constructivist terms. Second, I address the concern that mental health considerations might result in the inability of medical professionals to refuse to perform pathology inducing procedures if such procedures in fact prevent, mitigate, or remove greater mental illness.

First, a constructivist view of health would not allow medical professionals to refuse to perform the practice; it would, therefore, not meet the desideratum. A constructivist account of health, such as that of Cooper<sup>61</sup> or Wakefield,<sup>62</sup> would not allow medical professionals to refuse to perform FGC since, if the patient does not judge the procedure as producing a pathological condition, it would not count as a pathology. Therefore, conscientious objection would not be permissible in many cases of FGC because it would meet all the conditions of RCCO. Having met all conditions of RCCO, it would follow that the medical professionals would not be permitted to

refuse to perform the practice. Thus, if this additional condition is to secure a medical professional’s ability to refuse to perform practices like FGC, then health cannot be defined according to a constructivist account.

This same argument applies if one were to develop a constructivist account of health as *culturally relative*. A culture-relative conception of health would presumably resemble a constructivist view of health, such as Cooper’s view. A culture-relative definition of health would then be partially constituted by whether or not the *culture* viewed a condition as pathological. However, if health in RCCO were construed as culture-relative in this sense, then RCCO would not meet the desideratum. Using a culture-relative understanding of health, RCCO would essentially read:

RCCO\*: If a medical practice is legal, expected, standard care in the patient’s interest—*where a particular culture does not view that medical practice as inducing a pathology*—then medical professionals should not be allowed to conscientiously refuse to perform the procedure.

In many cultures, FGC may not be viewed as pathological. As a result, even if all the conditions of RCCO\* are met, medical professionals would not be able to refuse to perform FGC if the culture does not view the procedure as pathological. A culturally-relative understanding of health would not provide a principled reason to allow the physician to refuse to perform FGC. As such, a culturally-relative understanding of health does not meet the desideratum; medical professionals would not be able to refuse to perform FGC. Further argumentation would be needed to show that a constructivist account could in fact meet the desideratum.

A second challenge claims that RCCO might not allow medical professionals to refuse to perform other pathology inducing procedures, such as abortion and sex changes, if a great increase in mental health would result from these procedures. Some practices, analyzed as pathological by a naturalistic definition of health, seem to possibly improve *mental* health. Take, for instance, a case of abortion in which a mother would undergo some mental illness if she were to bring her pregnancy to term. Whether or not an abortion in this case would count as preventing, mitigating, or removing a pathology depends, according to the naturalistic definition of health I adopt in this paper, entirely on whether or not bringing the pregnancy to term affects a part or process that, in turn, provides a substantial suboptimal contribution to survival and reproduction.<sup>63</sup> On the surface, this does not seem to be the case in many elective abortions; that is, having an abortion generally does not restore well-functioning of biological parts or processes.<sup>64</sup>

However, there may be cases in which bringing the pregnancy to term results in a substantial suboptimal contribution of a *mental* part or process to the mother’s ability to survive and reproduce. In that

<sup>60</sup>Cooper, op. cit. note 15.

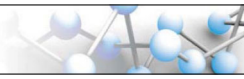
<sup>61</sup>Ibid.

<sup>62</sup>Wakefield, op. cit. note 15.

<sup>63</sup>Boorse. (2014), op. cit. note 13, pp. 686–687.

<sup>64</sup>Unless, of course, the mother’s life is in danger if she brings the pregnancy to term.





case, medical professionals may be obliged to perform pathology inducing procedures because the health condition of RCCO might be met. One could possibly settle this issue by a comparative evaluation: one could determine which condition—bringing the pregnancy to term or terminating the pregnancy, for instance—would be most detrimental to the mother's ability to survive and reproduce. Medical professionals often induce a pathology on the condition that it prevents, mitigates, or removes a greater pathology—for example, chemotherapy, limb amputation, abortions where the mother's life is in danger, and so forth—and the introduction of a pathology in such cases is health preserving. Thus, only in cases in which terminating the pregnancy is much *less* detrimental, relative to alternative options, to the mother's ability to survive and reproduce would abortion count as health conducive. It is beyond the scope of this paper to demonstrate when this comparative evaluation determines which abortions, sex changes, or the like are health conducive with respect to mental health concerns. *Prima facie*, the majority of elective abortions would not in fact prevent, mitigate, or remove a condition that severely hinders an individual's ability to survive and reproduce. At best, given my analysis, such considerations would rule out conscientious refusals for a minority of abortion cases in which inducing a pathology (e.g., abortion, sex changes, etc.) is clearly less detrimental to the ability of the individual to survive and reproduce than the alternatives. It would take much argumentation in future research to establish when such cases occur.

## 8 | CONCLUSION

A pathocentric clause seems the best way to allow doctors to object to pathology inducing practices such as FGC while refusing doctors the ability to abstain from practices that center around health preservation. Intuitively, FGC is a practice that, at the very least, medical professionals should have the ability to refuse to perform. The addition of a pathocentric condition in RCCO is

necessary to avoid the implausible implication that governments and employers should make it a condition of employment that medical professionals have no ability to refuse to perform FGC. Practices whose only physical outcome is to introduce a pathology are the practices that doctors should be allowed to refuse to perform. Ignoring health preservation as an integral part of medical practice would allow for FGC to continue and other practices like it to form, and this seems reason enough to reject the proposed sufficiency of the conditions outlined in CCO for the removal of conscientious objection.

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### CONFLICT OF INTEREST

The author declares no conflict of interest.

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