

## CONSCIENTIOUS OBJECTION IN HEALTHCARE: PROBLEMS AND PERSPECTIVES

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Conscientious objection in healthcare is the refusal by healthcare professionals (HCPs) to provide certain medical services on the basis of moral or religious beliefs. Conscience clauses in legislations regulating abortion and medical assistance to die typically exempt doctors from providing these services on conscience grounds. Conscientious objection often consists in a refusal to perform a certain medical activity, e.g. a refusal by a Catholic doctor to perform an abortion. However, some conscientious objectors claim a right to refuse to inform a patient about a certain therapeutic option and some others might refuse to refer a patient to a colleague for a medical procedure they find morally objectionable.

It is not surprising that, in the last few decades, the issue of health professionals' conscientious objection has become a central topic of discussion in medical ethics. Since the range of medical options available has significantly expanded (and is continuing to expand), moral conflicts in healthcare are increasingly more common. For example, new gene-editing techniques, such as CRISPR/Cas9, which hold promise for correcting genetic abnormalities at the embryonic stage, might be available in the medium term. It is likely that many HCPs will find these techniques morally objectionable.

Technological progress advances at fast pace, and at the same time Western societies become increasingly more pluralistic, multicultural and multireligious. As a consequence, the landscape of healthcare professionals' moral views becomes highly varied. Refusals to provide some basic medical service by doctors with certain religious backgrounds – such as the possible objection of some Muslim doctors to medically inspecting patients of the opposite sex - are likely to further sharpen moral conflicts in healthcare delivery.

Conscientious objection raises both practical and philosophical problems. For example, on the practical side, too many doctors objecting to a certain medical service might make patient's access to that service difficult, if not impossible. On

the philosophical side, the problem is that of finding an ethical principle that can justify conscientious objection in the case of individuals who voluntarily choose to enter a profession but don't want to perform some of the activities which are considered quite central to their role (e.g. a gynaecologist who refuses to perform abortions).

The practical and the philosophical dimension of conscientious objection are closely related. It is tempting to allow a doctor to conscientiously object to abortion as long as there is an efficient referral system in place that guarantees that women can easily obtain the service from another doctor; however, this practical solution raises several other questions: should conscientious objection be granted only to a certain number of doctors? If so, is exclusion of certain doctors from conscience exemptions a form of discrimination? And should doctors be allowed to object to any practice, or only to practices that contravene some religious views? Should the same right be extended to other professions, or is it a prerogative of the medical profession? Answering these questions requires answering more fundamental questions at the philosophical level: is a right to conscientious objection grounded in some fundamental civil right, such as freedom of religion? Can pluralism about value or respect for autonomy justify conscientious objection in cases where individuals freely choose their profession? Is there something special about medicine that makes it different from other professions when it comes to protecting individual conscience?

These and other questions will be addressed in the papers of this special issue of the *Cambridge Quarterly of Healthcare Ethics*, which gathers contributions from some of the most important bioethicists and philosophers worldwide. The papers here collected address both the practical and the philosophical dimension of the problem of conscientious objection in healthcare. A wide range of positions will be presented, criticized and defended from philosophical, ethical, and legal perspectives.

Some of the articles defend a right to conscientious objection. In particular, Mark Wicclair appeals to the value of (a certain conception of) moral integrity as the main reason for granting HCPs' requests for conscience accommodation. Both Daniel Sulmasy and Roger Trigg defend a right to conscientious objection by appealing to values such as tolerance and pluralism and by emphasizing the importance of respecting individual conscience in democratic societies.

The paper by Hugh LaFollette and the one co-authored by Christian Munthe and Morten Nielsen both present arguments against an ethical and a legal right to conscientious objection in healthcare. These arguments are based on the consideration that by voluntarily entering a certain profession, individuals take up a commitment to acting in accordance with professional values and, in the case of medicine, with professional duties towards patients. On the basis of the Kantian understanding of conscience, Jeanette Kennett also argues that appeals to conscience do not warrant exemptions from fulfilling professional duties.

Yet other authors make the right to conscientious objection contingent upon HCPs' objections satisfactorily meeting some basic requirements. In particular, according to Robert Card, conscientious objection should be granted as long as the moral view it expresses meets a certain standard of reasonableness. Steve Clarke argues that a HCP advancing conscientious objection needs to demonstrate that the view she holds is either reasonable or that it is sincerely held, depending on which of two distinct philosophical conceptions of conscience we adopt.

Some authors defend practical solutions that do not depend on principled justifications of conscientious objection. Through an analysis of the theory of complicity in wrongdoing, Francesca Minerva argues that compromise solutions based on referral systems fail to protect both the conscience of HCPs and patients' interests; as an alternative, she proposes a solution based on an optimal ratio of objecting and non-objecting doctors in a given geographical area. Aaron Ancell and Walter Sinnott-Armstrong argue in their paper that, at least within private health systems, doctors should be allowed to conscientiously object to providing certain services, as long as clinics pay for any extra cost patients would incur when they have to request the service elsewhere (for example, at more expensive clinics or at clinics that are far away).

Finally, some of the papers address conscientious objection in some specific medical contexts. Dominic Wilkinson addresses the issue of conscientious objection in intensive care units; he argues that doctors' most appropriate stance is what he calls "conscientious non-objection": in his view, a good doctor should not object to practices that are legal and professionally accepted, even if they conflict with their personal moral values. Thomas Douglas focuses instead on the question whether HCPs should be allowed to object to treating sexual dysfunction in the case of sex offenders; he argues that, whatever answer we give, this case is not significantly different from more common cases of conscientious objection, and in particular conscientious objection to abortion.

Overall, this special issue will offer a comprehensive overview of the current bioethical debate on conscientious objection in healthcare. In doing so, it serves three main purposes. First, it presents the state of the art of the debate by giving a detailed analysis, defence, or criticism of the current positions, thus representing an ideal introduction for those who approach the issue of conscientious objection for the first time. Second, it proposes some practical solutions to the problem of conscientious objection in healthcare, thus offering suggestions to policy makers and more in general to those interested in the regulation of conscientious objection at the legislative level. Third, it offers insights about fundamental philosophical and ethical aspects of the conscientious objection debate, thus providing the starting point for future discussion of conscientious objection as applied to the new medical options and the new moral conflicts that are likely to characterize healthcare delivery in the coming years.

Most of the papers here published were presented at a conference on "Conscience and conscientious objection in healthcare", which was held at the

University of Oxford on 23-24 November 2015, hosted by the Uehiro Centre for Practical Ethics at the University of Oxford and the Centre for Applied Philosophy and Public Ethics at Charles Sturt University, with the generous support of the Uehiro Centre for Practical Ethics and an Australian Research Council Discovery Grant (DP 150102068). Each of the papers has been externally peer-reviewed, as well as internally reviewed by the two guest editors and by the chief editor of the *Cambridge Quarterly of Healthcare Ethics*, whom we would like to thank for the opportunity to publish the papers as well as for her expert editorial guidance.

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