Editorial for JME special issue on conscientious objection

Conscientious objection was barely mentioned in debates about the ethics of healthcare provision before the 1970s. [1] The conscientious objections that attracted public and academic attention were those of conscripts who objected to participation in military forces, and of parents who objected to the vaccination of their children. All of this was changed by the 1973, US Supreme Court decision *Roe v. Wade*, which established a constitutional right to abortion in the US. Shortly after this decision the American Medical Association's (AMA) House of Delegates, the peak policy making body within the AMA, adopted a resolution that sought to protect hospital employees from having to contribute to the provision of abortion if they felt that doing so was immoral. The resolution was adopted in response to a specific controversial court decision, but the language employed in it was broad in scope. House of Delegates Health Policy 5.995 contained a conscience clause stating that: 'Neither physician, hospital, nor other hospital personnel shall be required to perform any act violative of personally held moral principles.[2]

Debates about the proper scope of the right to conscientious objection in healthcare have been a mainstay of bioethical discussion ever since *Roe v. Wade*. Two recent legal cases with controversial outcomes have added new complications to these debates. In *Doogan* (2015) the UK Supreme Court determined that two senior midwives who objected to abortion were, nevertheless, obliged to provide administrative and supervisory assistance to other healthcare professionals who were providing abortions. In *Burwell v. Hobby Lobby et al*. (2014), the US Supreme Court determined that a for-profit organization can be considered a person for legal purposes, and so entitled to freedom of conscience. Hobby Lobby were able to exercise this freedom to acquire an exemption to a requirement (under the US Affordable Care Act) that they cover the cost of particular contraceptive services, through insurance schemes, for their female employees.[3]

Contributors to this issue push debates about conscientious objection in healthcare in a number of directions. Oderberg argues that the issue of cooperation in immoral action is at the heart of the controversies that have followed on from both *Doogan* and *Hobby Lobby et*

al. He suggests that courts need a set of principles to determine when cooperation in wrongdoing occurs and, so, when individuals are complicit in wrongdoing. He also outlines a theory of cooperation in immoral action, built around the traditional Catholic doctrine of double effect. Two responses to Oderberg, due to Vacek and to Stammers, are included in the issue, as well as a reply from Oderberg. Cowley discusses issues of complicity in wrongdoing, which arise when a general practitioner who has a conscientious objection to abortion is asked to authorise an abortion. Cowley defends the status quo in the UK, under which GPs are entitled to refuse to authorise abortion, but also required to refer patients to a provider who is willing to authorise abortion.

Under the status quo in the UK, the US and elsewhere, healthcare professionals effectively determine whether their own conscientious objections are genuine. Hughes argues that determinations of the genuineness of conscientious objections in healthcare should be made by tribunals, as is the norm in military contexts. Clarke pushes the military analogy further and argues that, as well as determining whether conscientious objections are legitimate, tribunals should determine how conscientious objectors should be dealt with. Card is also concerned about the legitimacy of conscientious objections. He argues that evaluations of conscientious objections should turn on reason giving. Wilkinson examines conscientious objection in the context of decisions about resource allocation. Minerva considers cases of doctors who conscientiously object to providing cosmetic treatments.

Schuklenk and Smalling argue that medical professionals in liberal democracies should not be entitled to avoid providing any of the services that are within the scope of their profession's practice, even if they hold conscientious objections. Their argument is provocative and four responses to it are included in this issue, due to Maclure and Dumont, Symons, Glick and Jotkowitz, and Lyus, along with a reply from Schuklenk and Smalling. Munthe discusses the Swedish approach to conscientious objection in public healthcare. Sweden is a country in which individual health care professionals have no recognized right of conscientious refusal. However, the 'Swedish solution' may be under threat, due to legal cases that are before the European Court of Human Rights. Adenitire argues that British Medical Association's policy on conscientious objection should be revised so that it aligns

with recent human rights developments that have been driven, in large part, by decisions of the European Court of Human Rights.

References

[1] Wicclair, MR. *Conscientious Objection in Healthcare: An Ethical Analysis*. Cambridge, Cambridge University Press, 2011, 14.
[2] Wicclair MR 2011, 16.
[3] West-Oam, P. and Buyx, A. Conscientious Objection in Healthcare Provision: A New Dimension. *Bioethics*, 30, 5, 336-343.