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PAPER

Conscientious objection in healthcare, referral and the military analogy

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ABSTRACT

An analogy is sometimes drawn between the proper treatment of conscientious objectors in healthcare and in military contexts. In this paper, I consider an aspect of this analogy that has not, to my knowledge, been considered in debates about conscientious objection in healthcare. In the USA and elsewhere, tribunals have been tasked with the responsibility of recommending particular forms of alternative service for conscientious objectors. Military conscripts who have a conscientious objection to active military service, and whose objections are deemed acceptable, are required either to serve the military in a non-combat role, or assigned some form of community service that does not contribute to the effectiveness of the military. I argue that consideration of the role that military tribunals have played in determining the appropriate form of alternative service for conscripts who are conscientious objectors can help us to understand how conscientious objectors in healthcare ought to be treated. Additionally, I show that it helps us to address the vexed issue of whether or not conscientious objectors who refuse to provide a service requested by a patient should be required to refer that patient to another healthcare professional.

INTRODUCTION

The idea of introducing tribunals to adjudicate over the legitimacy of conscientious refusals in healthcare has been explored in some detail in the recent bioethics literature (JA Hughes. Conscientious objection in healthcare: why tribunals might be the answer. *J Med Ethics*. forthcoming: doi:10.1136/medethics-2015-102970).[1–3] One motivation for this discussion is the suspicion that some appeals to conscientious objection are either not genuine, or are not based on sufficiently deeply held convictions to warrant refusal to provide legal, efficient and beneficial healthcare to patients.[4] A second motivation is a concern that appeals to conscientious objection in healthcare, which were almost unknown until the 1970s, are proliferating at such a rate that they may soon start limiting the ability of healthcare organisations to provide all the services required by patients.[5] This appears to be happening already in some places.[6] Many doctors and medical students seem to have acquired the view that they are entitled to conscientiously object to any and every aspect of healthcare; and that they do not have to justify their objection to anyone other than themselves.[7] Because, in many parts of the world, all healthcare professionals have to do, to authorise a conscientious refusal, is to sign a form declaring that they have a conscientious objection, the right to conscientious objection is 'unlimited in practice'.[8]

Tribunals have been used to adjudicate over the legitimacy of conscientious objections in many countries which have conscripted citizens to perform military service. In the USA, as a consequence of the 1970 Supreme Court decision *Welsh* v. *USA*, 398 US 333, conscientious objectors need to satisfy a tribunal that they have a sincere objection to war and that their objection is based on 'moral, ethical, or religious beliefs about what is right or wrong'.[9] If the conscientious objections of healthcare professionals were to be examined by tribunals, then, it can be reasonably expected, some would be rejected. Healthcare professionals have a *prima facie* duty to conduct legal, efficient and beneficial medical procedures and particular conscientious objections that were judged to be insincere, or not sufficiently deeply held, could also be judged to fail to outweigh this duty in importance (Hughes, forthcoming).

Here, I consider an aspect of the analogy between conscientious objection in healthcare and in military contexts that has not, to my knowledge, been considered in debates about conscientious objection in healthcare. In the USA and elsewhere, tribunals have been tasked with the responsibility of recommending particular forms of alternative service for conscientious objectors. A basic determination military tribunals have been asked to make is whether a particular conscript, who objects to active military service, and whose objection is accepted, should be required to serve the military in a non-combat role, or if that conscript should be allowed to forego all forms of military service and assigned some form of community service instead.[10 11]

Tribunal decisions about the nature of alternative service are guided by the indications of conscientious objectors to military service regarding the forms of alternative service that they are willing to accept. But these indications are not the only consideration that tribunals consider. Tribunal members question conscientious objectors extensively, in part to determine whether their objections are genuine, and also to clarify what those objections are. Unfortunately, conscripts who have conscientiously objected to military service have often not been able to state their position clearly and coherently.[12 13] Part of a tribunal's traditional role has been to rationally reconstruct these conscientious objections, to help determine how best to deal with them.

It is probably not obvious that consideration of the role that military tribunals have played in

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determining how conscientious objectors to active military service ought to be treated is relevant to the issue of conscientious objection in healthcare. To show that it is relevant I will need to say more about the decisions that military tribunals have been required to make, in the next section of the paper, before focusing on the analogy between the military context and healthcare in the following section. In the final section, I show how consideration of the treatment of conscientious objectors in the military sheds light on the vexed issue of whether or not conscientious objectors in healthcare should be required to refer patients to other healthcare professionals.

ALTERNATIVE SERVICE

Military tribunals have to decide whether conscientious objectors to military service, whose objections are judged to be genuine, should be required to serve the military in a non-combat role, or required to perform community service. Their decisions are guided by the nature of the particular conscientious objection under consideration. Some conscientious objectors object to killing, but not to assisting the military, while others object to making any kind of contribution to war. In the past conscientious objectors who have objected to killing, but not to contributing to war, have typically been given non-combat duties within the military, or assigned forms of work that clearly aided the military, such as work in munitions factories. Conscientious objectors who objected to all forms of contribution to war have typically be assigned forms of community service that did not contribute to the effectiveness of the military.

Cynicism is sometimes expressed about conscientious objectors who object to killing, but do not object to assisting a military force in a non-combat role. Their reasoning can appear incoherent. By serving in a non-combat role they indirectly help others to be more effective killers. So, their actions causally contribute to killing. One quick response to the cynic is to point out that, like most people, conscientious objectors to military service are typically not trained in moral philosophy and they may not have considered this line of objection to their reasoning. Another response is to try and find underlying coherence in their reasoning. Some such conscientious objectors do not object to killing in general, but take the view that they could not kill. Their objection is not grounded on the generalisation that it is always wrong to kill, but on the moral intuition that it is wrong for them to kill.[14] Why do they not generalise from this intuition and conclude that it is wrong for anyone to kill? There might be many reasons. One plausible one is that they do not presume that they should make moral judgements on behalf of other people. They presume, instead, that each individual should be guided by their own conscience. They are aware that their non-combat service for the military will better enable combat personnel to kill, and so make them (partially) causally responsible for killing. But they do not feel that they are morally responsible for instances of killing where someone else, who is also guided by their own conscience, is doing the killing.[15]

As well as determining what exactly conscientious objectors were objecting to, military tribunals have needed to determine whether the stated beliefs of conscientious objectors constitute a stable basis for their conscientious objections. Any set of beliefs is liable to shift, but some—especially those that lack coherence—are particularly liable to shift. Someone whose beliefs were particularly liable to shift might switch from being a conscientious objector to being willing to serve as an active combatant, or from being a conscientious objector who was only willing to perform community service, to one who would be willing to serve the military in a non-combatant capacity. If a tribunal reached the view that the set of beliefs underpinning a conscientious objection lacked coherence and was, therefore, unstable then the best course of action might be to push the objector to face up to the lack of coherence in that set of beliefs, so as to encourage them to acquire a more stable set of beliefs.

Consider, for example, some cases mentioned by Field, of British conscientious objectors at the beginning of the Second World War, who objected to Britain's participation in war, on the grounds that all reasonable alternatives to war has not yet been exhausted. A few of them suggested that Britain ought to offer to cede sovereignty over some British colonies to Nazi Germany, in order to secure peace, before resorting to war.[16] One problem with this suggestion is that it appears to treat the citizens of the colonies that the conscientious objectors proposed to cede to Nazi Germany in a very callous way, as these citizens would, almost invariably, be worse off under Nazi rule than under British rule. A conscientious objector who based his objection on the failure of Britain to consider this option might well come to see that he was proposing to treat the citizens of the colonies under discussion very badly, and might then come to modify the conscientious objection in question. A second problem with the suggestion is that Nazi Germany would have been very unlikely to stick to the proposed peace deal, even in it could be struck. As the Second World War progressed this would have become increasingly apparent. It would have become glaringly apparent in June 1941 when Nazi Germany invaded the Soviet Union, violating the terms of the Molotov-Ribbentrop pact. As soon as it became apparent that there was no realistic prospect of Nazi Germany sticking to peace deals, a conscientious objection, based on the assumption that Germany could have been relied upon to honour a peace deal with Britain, would need to be modified.

THE ANALOGY

Is there a useful analogy in the context of conscientious objection in healthcare, to the distinction between those conscientious objectors to active military service who are willing to serve the military in non-combatant roles and those who are only willing to perform community service? I believe that there is. A doctor who conscientiously refuses to conduct an abortion, but who is happy to go on working for an organisation in which other doctors conduct abortions, is analogous to a conscript who refuses to kill but is willing to serve the military in non-combat roles. A doctor who refuses to work for an organisation that conducts abortions is analogous to the conscript who refuses to contribute to the military in any way and must be assigned some form of community service. Mutatis mutandis for other conscientious objectors and other subjects of conscientious objection in healthcare.

Doctors who refuse to work for public health services that conduct abortions and will only work in private practice, or for private clinics in which abortions are not offered, are conscientious objectors. They may not seem like conscientious objectors because, after finding work that is consistent with the dictates of their conscience, they are not called upon to conscientiously refuse to perform particular acts. However, their choice of employer is guided by their conscience, and by objections they have to making an indirect causal contribution to the conduct of a particular class of acts that they find objectionable. So they are, in a very real sense, conscientious objectors. Sometimes, it is suggested that all conscientious objectors to the provision of any type of safe, legal and effective medical treatment, offered in public healthcare organisations, should go and work in the private sector. Ian Kennedy is someone who has expressed this view.[17]

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My assumption that doctors who conscientiously refuse to conduct abortions, but who work for organisations in which other doctors conduct abortions, make indirect causal contributions to the conduct of abortions might be disputed by some. However, it seems hard to refute. In most such organisations patients seeking abortions are not turned away, but are booked in to have abortions, which are then conducted by other doctors. The same number of abortions is conducted by these organisations regardless of whether or not some of the doctors working for them conscientiously object to conducting abortions. By conducting operations other than abortions, the conscientiously objecting doctor relieves the doctors who are willing to conduct abortions of some of their other responsibilities. She thereby frees up their time, enabling them to conduct scheduled abortions. So, she makes an indirect casual contribution to the conduct of abortion.

If tribunals were to be introduced, to adjudicate over the acceptability of conscientious objections in healthcare, then they could be asked to make two sorts of decisions: a decision about whether particular conscientious objections are acceptable or not, and a decision about how best to deal with conscientious objectors. Some conscientious objectors are best dealt with by allowing them to make other contributions within the organisation that they work for and some are best dealt with by helping them to leave the organisation in which they have been working, to find employment that is consistent with the demands of their conscience. A doctor who objects to conducting abortions, and also objects to making an indirect causal contribution to abortion, but who currently works for an organisation in which abortions are conducted, should be helped to find work with a different organisation, where abortions are not conducted. The objections of a doctor who conscientiously refuses to conduct abortions, but who has no objection to making an indirect causal contribution to the conduct of abortion are best dealt with by finding that doctor other duties to perform, within the current organisation that she is employed in.

A tribunal should question conscientious objectors extensively so as to establish whether the reasoning that underpins their objection is stable or not. A doctor who has a conscientious objection to conducting abortions, but who assures a tribunal that she does not object to working in the same organisation as other doctors who conduct abortions, should be asked to explain why she does not object to working in the same organisation as other doctors who conduct acts that she conscientiously refuses to conduct. Some doctors who refuse to conduct abortions, but who say that they are happy for other doctors whom they work with to conduct abortions, may not have given due thought to the issue. Once they are confronted with the challenge of explaining why it is not objectionable to them to make an indirect causal contribution to abortion, the beliefs underpinning their conscientious objection may begin to shift. If they settle on the view that they cannot work, conscientiously, in an organisation in which abortion is conducted, then the best outcome for all parties is that doctor be offered assistance to find work with an organisation that does not conduct abortions. Mutatis mutandis for all healthcare workers and all other forms of conscientious refusal.

REFERRAL

In many institutions and jurisdictions healthcare professionals who conscientiously refuse to perform a particular procedure are expected to refer a patient, who requests that procedure, to another healthcare professional who is willing to perform it. The expectation is controversial because it causally implicates conscientious objectors with the very act that they conscientiously refuse to provide. If I am convinced that abortion is morally wrong, then by referring a patient to a willing abortion provider I knowingly enable an act to occur that I consider wrong. Surely I bear some causal responsibility for its occurrence.

Sometimes defenders of the view that there is a duty to refer argue that to allow healthcare professionals to do otherwise is to impede patients from obtaining the safe, legal and effective healthcare they are entitled to, and that amounts to a violation of the duties of healthcare professionals.[18] This line of argument only succeeds if it is accepted that the duty to ensure that safe, legal and effective healthcare is provided outweighs the duty that a conscientious objector has to avoid conducting acts that are inconsistent with the demands of her conscience. But it is not clear how to weigh these two duties against one another, so it is not clear that the line of argument succeeds. Sometimes, though, the widespread view that conscientious objectors should make referrals is presented as a political compromise rather than a principled position. Conscientious objectors are allowed to opt out of performing abortions and other conscientiously objectionable procedures, provided that they make referrals, so as to enable the medical system to continue to function as it would have, had there not been any conscientious objections. But this is a compromise that many conscientious objectors are loathe to accept.[19]

As has already been argued, there are two different forms of conscientious objection in healthcare, analogous to the two different forms of conscientious objection distinguished in military contexts. Appreciation of the differences between the two sheds light, I think, on whether and when it is reasonable to ask a healthcare professional to make a referral, when a patient requests a procedure that is incompatible with the demands of her conscience.

Consider first the case of a doctor who conscientiously objects to abortion and cannot reconcile working in an organisation in which abortions are conducted with the demands of her conscience; and who goes and finds employment with an organisation that does not provide abortions. If a patient asks this doctor to refer her to another doctor, at another organisation, who is willing to provide an abortion, then that patient is asking her to take on an additional moral burden. The doctor's conscience would not allow her to be complicit in the provision of abortion, which is why she chose not to work for an organisation that provides abortions. So, it seems morally onerous to now require her to refer patients to abortion providers, thereby making her complicit in the provision of abortions. All things being equal, this doctor should not be expected to make referrals.

Now consider a doctor who conscientiously objects to abortion, but whose conscience allows her to continue to work for a healthcare service in which other doctors conduct abortions. It is entirely reasonable to expect such a doctor to make referrals. What might be objectionable about being asked to make referrals, is that it can seem, to a conscientiously objecting doctor, to make her indirectly causally responsible for abortions being conducted. However, as has already been argued, merely by continuing to work where she has been working she already makes herself indirectly causally responsible for such acts taking place. By conducting other operations that need to be conducted, she frees up the time of other doctors, enabling them to conduct scheduled abortions. So, asking her to make referrals is not saddling her with any additional moral burden.

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A possible objection to the above line of reasoning might be to argue that referral looks like a much more direct form of assistance than conducting other activities in the workplace and thereby enabling the time of other healthcare professionals to be freed up to conduct scheduled abortions. When a doctor refers a patient to another doctor, who is willing to conduct an abortion, she thereby enables an abortion to be conducted. She is only one step removed from actually conducting an abortion herself. When a doctor, who conscientiously objects to abortion, conducts a different type of operation, thereby freeing up the time of a colleague, who then has more time to conduct scheduled abortions, she is not usually enabling any particular abortion. It might be held that the directness of the causal connection between the conscientious objector and the act objected to makes moral difference. If this reasoning is sound, then perhaps there is a case for allowing a conscientiously objecting healthcare professional to continue to work for an organisation that conducts an activity that she conscientiously objects to, and also allowing her to refuse to refer patients who request that procedure.

Referrals can be more or less direct.[20 21] What is known as a direct referral involves taking active steps to ensure that a patient receives a required form of healthcare from an available, competent healthcare professional. An indirect referral might simply involve providing a patient with contact information for a service providing organisation. When a healthcare professional makes an indirect referral she is far more than one step removed from the procedure that she conscientiously objects to. So, it appears that the aforementioned line of objection could only succeed as an objection to requiring conscientiously objecting healthcare professionals to make direct referrals. But perhaps we need not give in to this line of objection at all. A doctor who provides a direct referral to a patient requesting an abortion is more causally responsible for an abortion taking place than is a doctor who makes an indirect referral; and she is also more causally responsible for an abortion taking place than she would be if she had conducted a different procedure and thereby freed up the time of another doctor, who then conducted an abortion. But what needs to be established is increased moral responsibility, not increased causal responsibility. There is a lack of agreement in the contemporary philosophical literature about whether or not increases in degrees of causal responsibility straightforwardly lead to increases in degrees of moral responsibility.[22 23] Because of this lack of expert agreement, we are not obliged to accept the assumption that increases in the directness of referral equate to increases in moral responsibility. But this appears to be the assumption that our objector is making. Unless we are given good reason to accept that assumption, then it is hard to see why we should try to accommodate the line of objection.

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