At the University of Notre Dame’s 2009 commencement, President Obama proposed to,

... honor the conscience of those who disagree with
abortion, and draft a sensible conscience clause, and make
sure that all of our health care policies are grounded in
clear ethics and sound science, as well as respect for the
equality of women (President Obama at Notre Dame

This paper takes up the President’s suggestion by addressing conscientious objection in
medicine. In what follows, this paper presents the principal features of a sensible clause while
elaborating upon the need to extend CO to include referral, a particularly controverted claim.

What is a sensible conscience clause? First, one needs to distinguish professional
conscientious objection in medicine from conscientious objection in employment more
generally. The former concerns those who have stood before (pro) others and said (fateri) what
they stand for. They have articulated and publicly stated an account of medical care that delimits
what they take to be within and without the practice to which they commit themselves. Most
importantly, this account includes their conceptions of themselves as medical practitioners, what
constitutes a patient (patiency), a disease, health, and medical therapy. Physicians, nurses, and
pharmacists are medical professionals. Ultrasound, radiology, and surgical technicians are not. A
sensible medical conscience clause bears on the former; CO in employment more generally
would address the latter, just as it would address the issue of, for example, Islamic taxi drivers
religiously-based objections to transporting passengers carrying alcohol.¹ Thus, what follows concerns professional conscientious objection in medicine.

This account understands a profession to have an independent character autonomous from what law permits and society accepts. While there is pluralism within professions concerning particulars, and, therefore, disputes within the professions concerning their self-conceptions, a profession and professionals, as such, always stand for something more than the efficient use of skill. Put most generally, this something more amounts to their view of the goods they seek and the bads they avoid, or, their ethic. With this distinction in mind, and noting that CO bears on otherwise legal patient requests, here follow the characteristics of a sensible conscience clause for medical professionals. After delineating CO, I will present the obligations attending it.

First, the professional objects based upon her professed account of medicine. Her account is public, promulgated, graspable by others, and scientifically-grounded. The objector must be

¹In Minneapolis, MN., approximately 2/3s of taxi-drivers are Islamic Somalis. According to certain Muslim clerics influential in Minneapolis, the Koran’s prohibition against drinking alcohol extends to transporting alcohol. While other clerics dispute this interpretation, some Muslim cab drivers at the Minneapolis airport refused to transport passengers openly carrying alcohol from the duty-free airport stores. In April of 2007, the Minnesota Airports Commissioners unanimously decided that a taxi driver must transport passengers with alcohol. If a driver were to refuse, his work license is to be suspended for thirty days; a subsequent refusal is to result in a two-year suspension. The policy was appealed to the Minnesota Court of Appeals which in September of 2008 ratified a lower court’s ruling that it was legitimate as the taxi drivers did not thereby suffer irreparable harm. Although not the topic of this paper, this seems like an unenlightened, unimaginative resolution of the dispute. Given that there were typically more taxis than customers at the airport and that problems arose fewer than a dozen times a month, a variety of resolutions presented themselves, including having non-objecting drivers jump the taxi-line when an objection arose. This, in conjunction with a policy that once a driver took a fare away from the airport he must bring the fare to her destination would have resolved the conflict. The latter rule would address cases – which did occur – of drivers stranding fares upon incidentally learning that they were transporting alcohol. (A passenger commented upon the wine he had purchased and the driver required him and his family to get out of the cab
capable of giving reasons accessible to others, in contrast to asserting an entirely personal stance. These reasons must refer to empirically grounded concepts of health, disease, the subject of both (a patient), the goals of medicine, its capabilities, and its boundaries. So, for example, an obstetrician who objects to circumcising a healthy newborn male may do so based upon his account of bodily integrity and the proper functioning of organs. For similar reasons, a nurse may object to being involved in a sterilization post-caesarian section. A pharmacist in Oregon or Washington might object to a terminally ill cancer patient’s legal request to fill a lethal prescription for PAS in terms of life not itself being a disease that pharmacology can cure. An anaesthesiologist might object to her participation in capital punishment by reference to her account of the very concept of a patient and of sickness. In doing so, each of these professionals offers a reason-based explanation available to others for objecting to the relevant request, not simply in terms of personal beliefs, but, rather, in terms of accessible, albeit controverted, answers to the central questions of medical practice. Those questions include: what is medicine? what is a patient? what is a disease? what is health? and what goals can and ought medicine serve?²

Because a sensible conscience clause must be grounded in a professed account of medicine, it does not cover, for example, objecting to relieving a patient’s pain based on one’s religious belief in pain’s redemptive value or one’s experiential belief that pain builds character. It does not extend to an obstetrician who considers anaesthesia during labor objectionable based

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²Not that long ago, there was something approaching a monolithic profession of medicine roughly corresponding to the Hippocratic ethic; today, one finds numerous oaths, and, by implication, professions. For a study of the variety amongst oaths in all accredited U.S. allopathic and osteopathic medical schools as of 2000, see Kao and Parsi, Content Analyses of Oaths Administered at U.S. Medical Schools in 2000, Academic Medicine, 79:9, 882-87.
upon his religious conviction that Genesis’ 3:16, “in sorrow thou shalt bring forth children” requires that labor be redemptively painful. Nor does it encompass the profane belief in pain as character-building. Sensible objection requires that one’s grounds be both reason-based and medical. A religious belief in the redemptive value of pain is neither reason-based nor medical. Alternatively, a belief in pain as character-building may be reason-based, but not medical. Thus, such non-medical, non-reason-based convictions do not ground professional CO.

The exclusion of profane, non-medically based convictions does not significantly depart from current statutes concerning CO in medicine. However, ruling out exclusively religious convictions importantly differs from current federal conscientious objection statutes which explicitly mention religious beliefs as a basis for conscientious objection. (For example, the Church Amendment of 1973 refers to “religious beliefs or moral convictions” (42 USC §§ 300a-7)). Accordingly, it requires comment. A sensible conscience clause for medical professionals does not extend to every instance of conscientious objection that society may be willing to grant to individuals. As noted, an employee may have a claim to conscientious objection in employment just as a citizen may have one to military-service or other forms of governmentally-mandated action (such as, for example, requirements that U.S. school children pledge allegiance to the flag). These claims may be grounded in religion. These rights of objection extend to the employee as an employee in the context of employment, or to the citizen as a citizen in the context of citizenship. So also, the professional as professional has rights to conscientious objection in the professional context which may materially differ from those of the employee and those of the citizen. Most significantly, the professional’s actual profession (her view of health, sickness, patiency, and the purposes of medicine) grounds professional
conscientious objection.

As professions, medicine, law, and the clergy possess an autonomy, literally a self-lawed character. For example, the legal and clerical professions enjoy a virtually absolute degree of confidentiality not found elsewhere in social relations. (In this respect, the defeasible confidentiality in medicine differs from its counterparts in law and religion, thus indicating differences within the professions.) Professional conscientious objection in medicine is an instance of the autonomy of the professions from what is simply legal. Professional conscientious objection differs from religiously grounded objection by being reason-based, and, therefore, in principle, accessible to all. Exclusively to highlight religiously-based conscientious objection to the neglect of professional conscientious objection renders conscientious objection a strange and alien phenomenon to the non-religious. More importantly, to do so erroneously suggests that the professional has no positions concerning the ethics of her own practice. The venerable Hippocratic Oath indicates otherwise. Regardless of one’s judgement concerning the Oath, it points to a 2,400 year old autonomous profession, as does professional conscientious objection more generally. Accordingly, we must distinguish professional from religious conscientious objection.

Because the professed account of medicine must be empirically grounded, new information and technological changes influence it. It is scientifically grounded, not ideologically based. Accordingly, unlike ideology, discoveries can change it. So, for example, to consider one currently debated issue of conscience, some find emergency contraception (EC, or

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3 From the legality of an intervention one may not conclude that a professional must acquiesce to a patient’s request for it. For the criteria in terms of which one determines legality – to take Rawls’ proposed “liberty compatible with an equal liberty for all”, or Mill’s “greatest good for the greatest number”, or Locke’s “enough and as good” – have little to no bearing on the
the morning after pill, Levonorgestrel) morally problematic. They do so because they believe it to have at least two mechanisms of operation by which it prevents pregnancy: first, a contraceptive agency by which it prevents ovulation and, thereby, fertilization of an ovum, and, second, an abortifacient mechanism by which it prevents the fertilized ovum from implanting in the uterus. All acknowledge the contraceptive mechanism. Similarly, all parties acknowledge that there is no evidence that EC affects a blastocyst attached to the uterus. Dispute and some ambiguity attends the second, putatively abortifacient mechanism. If it were to be established that the currently favored EC (Levonorgestrel) had no abortifacient mechanism, or if an alternative pill were developed that acted solely as a contraceptive, then one who finds abortion professionally objectionable (while not objecting to contraception) could with a clear conscience prescribe, fill, or administer it.\(^4\) Whatever the case concerning this example, professional CO must be evidence-based.

Second, the professional objects to a requested intervention, not to the requestor. So, for example, a fertility doctor who provides IVF cannot object to the request of a lesbian insofar as she is a lesbian; nor may he object to a single woman’s request based upon his belief that a child is best raised by a mother and a father. Rather, if he does not object to IVF in terms of his account of medical practice, he must provide it to all otherwise medically qualified patients.\(^5\)


\(^5\) See, for example, California Supreme Court case *North Coast Women’s Care Medical Group, Inc., v. Superior Court*, case # S142892. A lesbian woman had sought and received fertility treatment. While her doctors had no objections to prescribing medication to facilitate fertility nor to referring her to a non-objecting physician, the doctors did object to performing intrauterine
Objection cannot employ any non-medical reference to the one who makes the request. Rather, it solely considers the act requested. Medicine bandages the wounds of the wounded, regardless of creed, character, race, gender, sexual orientation, innocence, or guilt. Similarly, CO excludes scrutiny of the one to whose request one objects.6

Third, CO extends from individuals to institutions. For institutions organically arise out of the association of individuals who often share a professed account of medicine. As Thoreau notes, “It is truly enough said, that a corporation has no conscience; but a corporation of conscientious men is a corporation with a conscience” (original emphasis).7 To prohibit the extension of CO to corporations or institutions is to thereby prohibit citizens from associating conscientiously. So, just as a pharmacist may object to filling a prescription for PAS, so also may a pharmacy. Indeed, in the case of small pharmacies, the pharmacy is often the pharmacist.

Fourth, and this point closely follows upon that just made, the extension of CO to individuals in principle amounts to an extension of CO to the entire profession. For one professional after another may legitimately exercise CO to include the entire membership of the

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6 As noted by the Supreme Court of California (in the preceding footnote) and, separately, by Wesley Smith in Pulling the Plug on the Conscience Clause, First Things December 2009.
profession. Simply because the law endorses the use of a medical technology does not insure, nor, more importantly – given the profession’s autonomy from the law – ought it insure that medical professionals themselves agree with that use of their abilities.

This will understandably be a much controverted claim, especially given legitimate concerns about access to interventions in rural areas where one typically finds fewer practitioners. Moreover, as some note, given that the medical professions enjoy monopoly-like control over the controverted procedures and technologies, ought one grant CO to the profession itself (that is, allow CO in principle to extend to all members)?

In light of this monopoly-like control some who would grant CO to individuals would deny it both to institutions and to the profession in its entirety. However, as noted, because professionals constitute a profession and individuals by association compose institutions, CO cannot be limited to individuals. For to do so disregards the individual’s associative nature. Nonetheless, those who attend to the exclusive command the medical professions enjoy over the relevant matters make a good point. Medical professions and institutions cannot, on the one hand, exert sole control over technologies and, on the other, enjoy CO concerning those interventions that have been legalized. Thus, just as legislatures and voters may legalize the use of medical technologies in manners rejected by the medical profession, so may they legalize others to employ those interventions. Indeed, the medical professions ought not to impede, and, as much as is consistent with their professional ethic, ought to endorse non-medical personnel being permitted to employ the relevant legalized technologies and interventions.

Consider a case requiring physician- and nurse-complicity in capital punishment in the

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8On the issue of monopoly and its bearing on conscientious objection, see Fenton and Lomasky Dispensing with Liberty: Conscientious Refusal and the “Morning-After Pill”, Journal of
State of North Carolina.\textsuperscript{9} The Supreme Court of North Carolina recently ruled that the North Carolina Medical Board, which licenses physicians in the state, cannot restrict physician-participation in capital punishment to the physician being physically present at an execution. Rather, in opposition to the Medical Board’s (on the face of things, principled and balanced) stance, the legislature can, as it does in N.C.G.S. §§ 15-190, require that a physician, “monitor the essential body functions of the condemned inmate and notify the Warden immediately upon his or her determination that the inmate shows signs of undue pain or suffering.”\textsuperscript{10} It could come about that all physicians object to this participation in capital punishment (as it could develop that all nurses and pharmacists also object). Indeed, in arriving at its stance, the Medical Board noted that, “physician participation in capital punishment is a departure from the ethics of the medical profession.”\textsuperscript{11} Additionally, the Medical Board cited the American Medical Association’s Code of Medical Ethics section 2.06 which distinguishes the personal opinion of the medical practitioner concerning the morality of the death penalty from the ethic of a member of a profession, “dedicated to preserving life when there is hope of doing so.”\textsuperscript{12} Given the exclusive control physicians, nurses, and pharmacists have been legally granted by licensure over the relevant procedures and drugs, the state legislature that mandates the use of medical technologies in capital punishment must also, to protect CO and to insure accessibility to the legalized intervention, extend authority over the relevant technologies and drugs to others not belonging to the medical professions. Thus, the State of North Carolina, for example, ought to

\textsuperscript{9} The North Carolina Supreme Court issued a judgement in the case in May of 2009, \textit{North Carolina Department of Correction v. North Carolina Medical Board}.
\textsuperscript{10} \textit{Ibid.}, quoting the law.
\textsuperscript{11} \textit{Ibid.}, N.C. Medical Board’s Position Statement of January 2007, as quoted in majority’s opinion, p.5.
revisit the exclusive control of medical professionals over the relevant technologies. Clearly, one needs alternatives. The same holds for whatever other uses of medicine legislatures legalize.\textsuperscript{13}

Fourth, CO is a two-way street. That is, CO protects both those who regard certain patient-requests as objectionable and those who consider providing the requested medical intervention to be legitimate or even required. One finds this admirable feature in the Church Amendment of 1973 which prevents discrimination against both those who perform abortions and sterilizations and those who refuse to do so. A conscience clause recognizes that there are competing professed accounts of medicine and controverted interventions. As a two-way street, the conscience clause acknowledges the legitimacy of conscience at the level of institutions, while preventing institutions and individuals from discriminating against those whose consciences differ. So, for example, a Catholic hospital that objects to the performance of abortions or sterilizations on its premisses may not deny privileges to an obstetrician who does so elsewhere. CO considers one’s own conduct, not that of another. While the Catholic hospital might prefer to have unanimity on this controverted matter amongst those who practice within it, it must extend to others the very protection afforded to it and to those practitioners sharing its account of medicine.

\textsuperscript{12}\textit{Ibid.}, as quoted in majority’s opinion, p.6.
\textsuperscript{13}In the North Carolina case, the trial court, at the request of the Department of Corrections, declared that, “executions are not medical procedures.” The North Carolina Supreme Court appears to agree with this declaration. The logic of the position being that, if executions are not medical procedures, then when the law requires medical doctors actively to participate in them, the relevant medical boards have no jurisdiction. For, or so this line of thinking proceeds, the physicians do not, thereby, act in a professional capacity. What ought one make of such a tortured and tortuous line of reasoning? One possible implication would be that the Department of Corrections and a majority of justices of the N.C. Supreme Court recognize the autonomy of the medical professions in their very attempt to suborn it. For our purposes, if a legislature wants to use medical expertise for a purpose medical professionals do not share, the legislature does well to make alternative provisions in light of that fact.
Fifth, CO encompasses more than simply not performing the controverted intervention, yet less than all things that enable the patient to achieve his request. Working out the boundaries of CO may be the most difficult task in reaching some political consensus concerning what a sensible conscience clause looks like. Most importantly, CO encompasses referrals. Because many would permit professionals to object to performing the controverted interventions while requiring referral, this merits greater consideration.  

In order to discuss the extension of CO to referral, a number of distinctions are in order. First, we must distinguish two cases; namely, that of a patient with whom the professional has no pre-existing relationship and that of the patient with whom there is a relationship prior to the controverted request. Second, we must distinguish the act of referral from what we may call full disclosure. By full disclosure, I refer to the need fully to inform the patient of the legally and medically available interventions that other professionals have to offer. In my discussion of the obligations attending CO, I will attend to the obligation of the objecting professional fully to discuss alternative options with the patient. Referral and full disclosure differ. The objector need not refer while he must disclose. Putting this distinction aside for the moment, let us consider the issue of referral with respect to the two aforementioned cases. 

Before considering these two cases, why consider referral objectionable? Given that professionals refer for those interventions they do not perform, it is, at least on the face of things, natural to suppose that an objecting professional would refer. For, just as the internist refers 

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14See, for example, Asch, Two Cheers for Conscience Exceptions, The Hastings Center Report, 2006, 36:6, 11-12.  
15As I employ the phrase, a pre-existing relationship requires an encounter between professional and patient. The more such encounters, the more significant the relationship, and the more reliance the patient has upon the physician. Simply having an appointment or calling in a prescription to one rather than another pharmacy does not establish a pre-existing relationship.
ingrown toenails to a podiatrist, so also would the objecting practitioner refer for PAS.

Moreover, the internist would refer in both cases for the same reason; namely, because he does not perform the requested procedure. This understandable (yet, ultimately, mistaken view) proposes that referral ought to occur if one does not perform the relevant act, regardless of the basis for one’s not doing that act. This view fails to note, however, that by referring one endorses the relevant act. The internist referring to the podiatrist thereby approves of and, indeed, recommends the podiatrist’s act to the patient. In the case of objection, since one does not consider the relevant request to be consonant with one’s professed account of health, sickness, and the ends, capabilities, and limits of medicine, one could not consistently refer the patient to another. For to do so would be to contradict one’s very objection to the request in the first place.

A professional ethic cannot coherently regard some act as out of bounds while referring to another professional for the performance of that act. While a patient might be gratified by an objecting professional’s referral, he would be rightly puzzled by such a view of an ethical principle. For those who apprehend the concept of a restrictive ethical principle understand it as prohibiting both one’s own performance of the act and one’s promotion of another’s doing of the act.\textsuperscript{16} Thus, from the very nature of allegiance to an ethical principle, CO extends to referral.\textsuperscript{17}

\textsuperscript{16}For a comparable view, see Bayles, \textit{A Problem of Clean Hands: Refusal to Provide Professional Services, Social Theory and Practice}, 1979, 5:2, 165-181. Bayles notes, “The argument against referring ... appears consequentialist. ... The consequentialism involved is inescapable in morality, for it is the ‘consequentialism’ of claiming that it is better that wrongful conduct not occur, that one ought not to assist in it, ... The arguments are drawn from the inescapable consequentialism of having moral principles.” Bayles, 168.

\textsuperscript{17}Notably, this is one of the ways in which an ethical principle can differ from a religious obligation. Consider a few religious observations. On certain days Catholics, for example, do not eat meat. Yet this religious duty does not prevent them from selling, providing, preparing, recommending, and in general promoting the eating of meat by others who do not share their religion. Similarly, on the Sabbath, observant Jews refrain from certain activities. This religious commitment does not prevent them, however, from accepting the performance of such acts on
In light of this, return to the above-mentioned two cases. For the extension of conscientious objection to referral in the two cases differs. If no pre-existing relationship exists, the professional need not refer for the above-noted reasons. However, if the professional has a pre-existing relationship, he does have an obligation to insure that his patients are aware of his stance. If he has failed in this respect and an existing patient reasonably assumes him to be willing, the professional has an obligation to refer if the patient so insists. For, absent notification to the contrary, the patient has the reasonable belief that the professional will perform or refer for the requested act. Moreover, the patient has justifiably developed reliance upon the professional. Were the professional not to refer, he would thereby violate the patient’s honest dependance to which he contributed by not adequately communicating his objection. Accordingly, as will be noted subsequently, professionals must scrupulously inform relevant parties of their positions lest they create obligations based upon others’ reasonable reliance upon them. With the above exception in mind, an objector need not refer.

CO, however, does not extend to non-professional, logistical tasks such as the forwarding of medical records, or the return of a prescription from a pharmacy. (Absent reliance, however, a
pharmacist need not call another pharmacy and communicate the contents of a prescription.) In an instance of CO, but for the loss of time and the opportunity costs, the patient emerges no worse off from the interaction with the objecting professional. (Needless to note, the patient incurs no charges for the refusal.)

Yet, some who have recourse to CO might object, is not to acquiesce in the forwarding of medical records, the release of prescriptions, and fully to disclose legal and medically accepted options provided by other practitioners tantamount to a referral or to moral complicity in the satisfaction of the requested intervention? By so limiting CO has not what has been given with one hand been taken away by the other? No. For performing an intervention, referring to another to do the same, filling a prescription, or communicating the contents of the same to another so that it may be filled intimately involves one in the relevant matter. One thereby acts with the purpose of insuring the performance of the act. The achievement of the disputed goal shapes and informs one’s own act. Accordingly, one thereby becomes an accomplice to the act to which one objects. For example, a referral must be to one capable and willing to acquiesce to the contested request. That desiderata structures one’s act of referral and, thereby, violates a well-formed conscience. Transferring medical records or returning a prescription does not, however, so deeply implicate one in the objectionable act. One need not thereby intend or deliberate about how to achieve the wrong to which one objects. The objectionable act itself does not shape and determine those acts which incidentally advance its achievement. While such acts make it easier for the patient to satisfy his request, they have only a modest determination to that goal. Moreover, they are not necessary to insure its success. For example, if prior to the CO, the patient incurred an insurance co-payment, one would reimburse the same. It is immaterial to CO the case such as how burdensome referral is to the patient and how elective is the intervention.
that the patient can use that same co-payment to procure the relevant request elsewhere. Absent the return of the co-payment, or return of a prescription, or transfer of medical records, the patient could still secure the controverted intervention. In any case, CO does not extend to preventing the patient from achieving what he seeks. Rather, it insures that the professional need not violate her profession of medicine in her practice. To transfer a medical record, or to return a prescription, or to disclose legal options that other professionals offer is not, thereby, to violate a well-formed conscience. Thus, a professional may not invoke professional CO for such matters.

Sixth, CO extends to practitioners and to those becoming practitioners. In terms of their chosen profession, students may object to learning medical interventions they regard as incompatible with it. As yet to be professed and as one still learning the relevant profession, the student must insure that she has a proper understanding of her chosen vocation and that her account has sufficient bases in reason and in medicine. She does well to recognize the plurality of views concerning what amounts to medical practice. Moreover, the aspiring medical professional ought to confirm the soundness of her view of medicine and its implications by seeking out experienced practitioners and reflecting upon her views in the light of their practice.

Finally, a sensible conscience clause does not take an ad hoc approach to objection by singling out specific currently and widely recognized controverted interventions such as abortion and physician-assisted suicide. Rather, it attempts to establish an acknowledged forum for the exercise of conscience in an increasingly pluralistic milieu. Thus, such a clause would differ from the currently existing federal clauses. For these current federal laws almost exclusively

20 Of course, co-payments, prescriptions, and medical records often legally and morally belong to the patient.
21 The Church Amendment of 1973, 42 USC §§ 300a-7; the Coats/Snowe amendment of 1996, 42 USC §§ 238n; and the Hyde-Weldon law, part of the Labor, Health and Human Services, and
refer to abortion.\textsuperscript{22}

A number of reasons recommend not so limiting protections of conscience to specific interventions. First, by itself not singling out any one controverted matter, the clause treats all parties equally. All recognize that they may have recourse to the exception made for conscience, if not now, perhaps at some future date. It does not require an overly active imagination, extensive reading of \textit{Antigone}, or that one become a scholar of Anne Hutchinson’s trial to conjure up conditions in which a majority regards as legitimate some intervention one considers abhorrent.\textsuperscript{23} Consider, for example, the aforementioned case from North Carolina of legislatively mandated physician- and nurse-participation in administering capital punishment, or the prospect of military physicians being asked to participate in torture, or the mundane request that a pediatrician or obstetrician circumcise a healthy infant male so that he “fits in” or “looks like dad.” In light of such cases, many can realize that they have need of and, thereby, can welcome a CO clause. Second, by not singling out any debated issue, the CO clause itself avoids unnecessary controversy. The heat surrounding discussions of conscience derives entirely from that associated with abortion. The important debate concerning abortion ought to be entirely distinct from that concerning conscience. To confuse the two equates to thinking that the

\footnotesize{\textsuperscript{22}The Church Amendment also refers to sterilization; one section of it – 300a-7(c)2 – addresses non-discrimination in federally funded research towards those who perform or refuse to perform “any lawful health service or research activity”.

\textsuperscript{23}Or, the converse: one regards as obligatory something the majority considers heinous. For the purposes of this paper, medical CO concerns objections to acts one regards as violating one’s profession of medicine (not prohibitions concerning medical acts one regards as obligatory – a positive obligation to act). The latter might include the authorities – due to fear of losing a practitioner in low supply during a plague – forbidding a physician from treating a patient suffering from a highly contagious potentially lethal disease. Such cases are not the concern of this paper, nor do they typify actual cases of medical CO. They do, however, belong to the topic; a complete treatment would address them. I am inclined to think that the lineaments of CO}
legitimacy of a Quaker’s recourse to conscientious objection depends upon the legitimacy of the specific war in which he would otherwise serve. To the contrary, the reason for extending to him a right of objection has nothing at all to do with the justice or injustice of any particular war. Rather, it has to do entirely with the relation between the individual and a legitimate state. Enlightened individuals who regard war as legitimate realize that the state might demand other acts of them to which they object. Thus, they realize that they might have recourse to CO just as the Quaker does. So also, distinguishing CO in medicine from any one controverted issue allows those who regard the profession as something more than a technique for the provision of legally permitted acts to see the need for CO. For the need arises simply from the autonomy of the profession from the political and social fora in which it operates. Third, by not limiting the clause to any one intervention, one makes room for responses to unforeseen developments (e.g., new technologies) and less widely yet still controverted matters (e.g., routine infant male circumcision or the provision of what one regards as futile interventions). Fourth, and finally, all of the above aspects of a general conscience clause strengthen the inherent fairness of such a clause and, thereby, the political case to be made for it. For people can see that while they may enjoy liberty in their invocation of conscience, they may also incur costs when others with whom they differ invoke conscience in refusing an intervention they request. So, for example, those who oppose abortion may realize that a non-specific conscience clause which does not require them to perform or refer for abortion will also enable physicians who regard futile care to object to its provision. Moreover, once legislated, it will be less likely to suffer the constant tug of war fought over intervention-specific clauses. It will come to be seen, as it ought to be, as part of the nature of medicine as an autonomous profession(s) with its own ethic(s).

concerning positive obligations do differ from those regarding refraining from acting.
The above represent the outlines of a sensible clause that respects claims to CO. Associated with rights are obligations. What duties accompany conscientious objection? To sum up what follows: the obligations to the patient remain unchanged, but for the denial of the contested request.

Specifically, what do these obligations entail? First, following from the very meaning of professing – and to develop a point previously mooted – full disclosure imposes the obligation to promulgate to the relevant parties one’s conscientious objection. This includes one’s prospective and current patients, colleagues, employers, and relevant institutions (e.g., hospitals and insurance companies). With respect to patients, this bears on informed consent and patient autonomy. Considering the recent legalization of PAS in the State of Washington, absent an internist’s noting his objection to PAS, a current or prospective patient might mistakenly assume that her doctor would agree to her request of PAS at some future date. Were he to inform her of his objection to so doing, she would have the opportunity to make alternative arrangements, perhaps developing a physician-patient relationship with a doctor whose views are more consonant with hers. Moreover, by promulgating one’s CO status, one avoids the previously noted problem of a moral dilemma resulting from a patient’s reasonable reliance which would require referral.

Second, CO status obliges the relevant professional to explain her reasons for her objection to those patients who request further information. That is, conscientious objection itself involves its own version of full disclosure based upon a patient’s informed consent. This does not mean that the patient must consent to the practitioner’s objection. Rather, it means that the patient is due the offer of an explanation. This does not, however, amount to the professional’s
having a right to pontificate concerning the relevant matter. Rather, the interested patient ought to receive some answer to the question as to why the professional objects. Certainly, not all patients will be interested to know why; those who are not ought not to be treated as captive audiences while those who do ought to receive a considerate and considered answer. In discussion of one’s CO, full disclosure requires that one note the controverted nature of the matter concerning which one objects. One must bring to the patient’s attention that not all medical professionals agree with one’s own view. As noted, if no previous relationship exists, this does not require referral. It does, however, require that one puts one’s own account of medicine into the larger context that includes other, disagreeing professionals, in virtue of which disagreement one resorts to conscientious objection. The interested patient ought to emerge having a sense both of one’s grounds for objecting and of the pluralism found in medicine regarding the controverted matter. This constitutes the analogue of informed consent for non-controverted medical care. A professional would have failed in this respect were a patient to emerge from the interaction thinking that the medical profession as a whole rejected the requested intervention.24

Third, CO status bears exclusively on the patient’s contested request; it does not relate to the other care the physician, nurse, or pharmacist provides for the patient. If a relationship exists with the patient, then the obligation of non-abandonment mandates that prior to alternative arrangements being in place for the controverted intervention, the physician, nurse, or pharmacist must provide care to which she does not object. So, for example, the internist who CO to her terminally ill patient’s considered request for PAS does not thereby abdicate her responsibility to

24If a patient does not wish to discuss one’s CO, a professional still must insure that the patient leave the clinical encounter realizing the legality of the requested intervention and that other
care for that patient otherwise until the patient finds an alternative physician.

Fourth, CO status requires the continued maintenance of confidentiality, particularly with respect to the fact that the professional objects to something the patient requests. For example, a woman who requests emergency contraception at the counter of an objecting pharmacist does not thereby forfeit any of her claims regarding discretion and confidentiality concerning that very communication with the pharmacist. Indeed, because such situations are fraught with potential for embarrassment and the untoward interest of others, the professional must strenuously and scrupulously protect the patient’s privacy specifically concerning the patient’s request and the practitioner’s conscientious objection.

Finally, as earlier noted, while CO status does not require referral to a third party who will abide by the patient’s request, it does require transfer of relevant documents, returning a prescription, and, more generally, acts which, while they may result in the act to which one objects, do not require one to aim at that act.