BOOK REVIEW (Submitted Version)

***CONSCIENTIOUS OBJECTION IN HEALTH CARE: AN ETHICAL ANALYSIS.* BY MARK WICCLAIR. CAMBRIDGE: CAMBRIDGE UNIVERSITY PRESS, 2011.**

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Should medical professionals be permitted to conscientiously object to providing legal, standard health services? Mark Wicclair's latest book is dedicated to addressing this difficult question. He criticizes views which are either overly permissive or restrictive of objections, and defends a compromise approach that allows for some conscientious objections within specified ethical constraints. I will analyze Wicclair's book from a feminist perspective, and argue that his view perpetuates unfair harms to women in conscientious refusals.

In the first chapter, Wicclair argues that conscientious refusals are worth protecting at least to some degree because of their connection to moral integrity. Conscientious refusals are based on core moral beliefs, and to act contrary to one's deepest convictions threatens moral integrity and can result in a loss of self-respect. This impact makes it undesirable to require health care professionals to act against their conscience. The first chapter lays the groundwork for Wicclair's rejection of views about conscientious refusals that are overly restrictive: since refusals are worth protecting, they cannot simply be banned from the health care context.

The stated purpose of chapter two is to introduce three approaches to conscientious objection in health care: conscience absolutism, the incompatibility thesis, and compromise. Wicclair briefly outlines these views: according to conscience absolutism, health care professionals should be exempted from performing any action that goes against the dictates of their conscience, including giving information and referrals. The incompatibility view claims

that all objections by medical professionals are contrary to their professional obligations and should be denied. Last, a compromise approach states that conscientious refusals can be compatible with professional obligations as long as the refusals meet specified ethical constraints. However, the chapter is misleadingly titled, as Wicclair spends most of his time examining various accounts of professional obligations rather than explaining any of the three views in detail. He argues that a compromise approach to refusals is more compatible with common accounts of professional obligations than the absolutist or incompatibility views.

For example, consider the essentialist view of medicine according to which professional obligations follow from the inherent healing nature of medicine. Conscience absolutism would not respect professional obligations to promote healing, since it would allow exemptions even when doing so would impede healing. The opposite view—that conscientious refusals are always incompatible with professional duties—is also problematic. A health care worker can be committed to healing and still not provide *all* healing-related services, and also, not every health care service (such as emergency birth control) unambiguously promotes healing. Wicclair argues that conscience-based objections are neither ruled out nor supported wholesale by (among others) the essentialist view of professional obligations; rather, whether or not a conscientious refusal is compatible with these obligations is context-dependent. Since context is important, Wicclair proposes that a compromise approach—one that uses a set of ethical constraints to limit the exercise of conscience in the health care context—is best. The extensive discussion of the various accounts of professional obligations is a rather round-about way of introducing his own version of a compromise approach, and repeats Wicclair's previous work.[1]

The third chapter is the heart of the book, where Wicclair defends his compromise

approach to conscientious objections in health care. He identifies three core professional obligations toward patients common to medicine, nursing and pharmacy: the obligation to respect patient dignity and refrain from discrimination, to promote patient health and well-being, and to respect patient autonomy. Since no one is required to enter or remain in any particular health care profession, these core obligations do not require anyone to act against their conscience; rather, they provide guidelines for career choices within the medical profession. Furthermore, Wicclair claims that these obligations justify five ethical limitations on the exercise of conscience: regarding 1) discrimination, 2) patient harms and burdens, 3) disclosing options, 4) referral and/or facilitating a transfer, and 5) advance notification. Wicclair clarifies that the constraint on harm is really on *excessive* harm, and that while there is no sharp line separating harms and burdens which are excessive from those which are not, it would be wrong to assume that harms and burdens cannot be excessive when they are the result of the exercise of conscience. Such an assumption would entail conscience absolutism, and Wicclair argues that excessive harm to patients can and does outweigh claims to conscience in many cases.

Wicclair insists that excessive harms to patients place justifiable limits on conscientious refusals even in the most controversial cases. For example, he claims that a physician's refusal to perform a life-saving abortion when there is no other physician available imposes an excessive harm or burden on the patient, and violates the professional obligation to promote patient well-being (100). Similarly, a refusal to disclose information about emergency contraception to a rape victim may expose her to further excessive harm (potentially bearing the child of her rapist), violate respect for her autonomy by limiting her choices, and threaten her well-being (101, 104). According to Wicclair these types of refusals should not be permitted because they contravene

professional obligations and the ethical guidelines for conduct which these obligations entail. While Wicclair's examples in this chapter demonstrate admirable sensitivity to the degree of harm which conscientious refusals often impose on patients, much more needs to be said about what counts as excessive harm in order for his compromise approach to offer any clear guidance in adjudicating refusals.

In addition to obligations to patients, Wicclair argues that obligations to employers as well as to colleagues of one's own and other professions warrant additional limitations on the exercise of conscience. In particular, they warrant constraints on imposing an excessive burden and the requirement to give advance notification (when possible) of one's conscientious objections. Failure to give an employer advance notification of known objections is a justifiable reason not to grant accommodation, since unexpected refusals can jeopardize patient access to services as well as cost an employer clients and income. Similarly, when accommodating refusals places excessive burdens on other professionals, such as requiring them to routinely take on more than a fair share of the workload, accommodation may be justifiably denied.

In chapter four, Wicclair considers whether institutions may also be able to object to providing services on grounds of conscience. Again, the answer is context-dependent and responsive to professional obligations to prevent harm to patients, promote patient health, and respect patient autonomy. These obligations set limits to refusals to provide things such as medically necessary abortions and emergency contraception to rape victims by placing patient health and well-being ahead of institutional moral integrity. Wicclair claims that even Catholic hospitals which prohibit abortion are obligated to provide an abortion in emergency circumstances when a referral and/or transfer is not feasible (165-167). Institutions are also held

to the same standards as objecting individuals in terms of disclosing relevant medical information when it goes against their conscience to do so.

Chapter five extends the discussion of permissible refusals to students and residents, who he argues are likewise limited by obligations particular to their stage of training. Limits to exemptions derive from five competing values and interests: established core educational requirements, "local" core curricula, non-discrimination, impact on patients, and impact on substitutes and supervisors.

Wicclair devotes the final chapter to a consideration of conscience clauses[2], and argues that they either offer too little or too much protection for conscience. States in the U.S. with overly broad conscience clauses legalize an absolutist approach to refusals, and thus offer too much protection by allowing professionals to neglect their obligations to patients. Conscience clauses can also offer too little protection for conscience-based claims, especially when they prevent a health care professional from providing a service. Lack of protection of conscience in this case prevents a health care worker from fulfilling what they consider to be their obligation to the patient, and may be unjustified. Wicclair concludes that both positive and negative appeals to conscience are worth protecting when they respect the ethical limitations that follow from health professional's obligations.

Considering that women's health care services are often the subject of objections, from a feminist perspective Wicclair offers a much-needed voice of moderation regarding permissible refusals. First, his reminder that entering the health care field is *voluntary* and thus that the professional obligations attaching to this role do not force anyone to go against their conscience cannot be emphasized enough (91). Objectors are not the victims of a morally bankrupt health

care industry; rather, they are professionals who knew the risks beforehand and still chose their field. The services most commonly objected to (abortion, emergency contraception, medically provided nutrition and hydration) are neither novel nor unusual; rather they are part of standard care and have been so for some time. Health care workers with moral objections to these services could avoid the risk of compromising their moral integrity by choosing another field or speciality. To knowingly choose a speciality in which you anticipate regularly denying certain members of the community (such as women) legal, standard health care services arguably demonstrates disregard for patient well-being and one's professional obligations.

Second, Wicclair's claim that harm to patients plays an important role in determining the permissibility of objections rightly emphasizes the potential impact of objections on patients. Too often, the focus in discussions of conscience-based objections is on the harm done to an objector in acting against her conscience (McLeod 2010). Yet when both objectors and patients stand to suffer, it is unfair to focus primarily on the harm done to the objector, particularly given the fiduciary relationship between health care professionals and patients. Patients entrust professionals with their well-being, and the dependence relationship between them is asymmetrical. This suggests that harms to patients deserve more emphasis than the harm of offending the conscience of health care professionals.

However, despite Wicclair's laudable efforts to make harms to patients central in limiting refusals, his view nonetheless perpetuates unfair harms and burdens to women. I offer two lines of evidence in support of my claim. First, Wicclair's view of discrimination potentially obscures discriminatory treatment of women in conscience-based refusals. To begin with, nowhere in his discussion of discrimination does he consider that women as a group may be discriminated

against in common cases of refusals. Instead, his examples of gender discrimination are primarily of gay, lesbian, or transgendered individuals (95), and the one example of discrimination against women is an uncommon case of a male medical student's objection to performing examinations on women based on beliefs about their inherent unworthiness or uncleanliness (196). This makes it seem as if discrimination against women in the context of refusals is rather rare. However, I want to raise the possibility that it may be more common than is typically acknowledged in the mainstream bioethical literature on conscientious refusals. The fact that it is most often *women* who are refused medical goods and services should at least make us ask: are there discriminatory beliefs about women at work in refusals?

If so, Wicclair's definition of discrimination will make it difficult to detect these beliefs. He distinguishes between refusals predicated on the belief that a particular *good or service* is unethical versus the belief that serving specific *classes of patients* is unethical, and claims that it is the latter type of refusal which may be unjustly discriminatory (92-94). However, in the case of women this distinction is often blurred. Only women ask for many of the goods and services most commonly objected to: only women can get (and thus ask for) abortions, and only women currently use emergency or other contraceptives. While objectors can claim that their refusals to provide certain reproductive goods or services would hold regardless of who asked for them, in reality women as a class of people bear the brunt of most refusals around reproductive health care. This means that if there *are* discriminatory attitudes toward women that underlie some refusals, then Wicclair's focus on discrimination toward classes of people may obscure them. It seems prudent to inquire about potentially discriminatory beliefs when refusals to provide goods or services routinely target a particular group of people.

So is there any reason to think that women are discriminated against with conscientious refusals? One could speculate that given the history of patriarchy, if the situation was reversed and only men could use contraceptives or conceive, many refusals around reproductive health would never occur. Such thought-experiments are not necessary to make a weaker claim: given that women have historically been (and continue to be) subject to sexist, oppressive views including being treated as sexual objects and the property of their male partners, it is not unlikely that these views continue to be expressed in refusals around reproductive health.

For example, a refusal to dispense oral or emergency contraceptives could be based on the sexist view that sexually active unmarried women (but not men) are immoral. On Wicclair's view, such discriminatory attitudes may easily go unrecognized as long as objectors can claim that their issue is with contraception and not with women's sexuality; that refusals to dispense contraception are always suffered by women will be considered incidental. More nuanced accounts of discrimination, such as Adrian Piper's "second-order" view, explain why we ought to be wary when refusals always target the same group: the discriminator's real reason for refusing service (the belief that sexually active women are immoral) may be hidden behind the stated reason (contraception is immoral).[3] Sophia Moreau's view about discrimination likewise challenges Wicclair's account. Moreau argues that discrimination occurs whenever our freedom to decide the essential details of our lives is constrained by extraneous traits such as gender.[4] Reproductive autonomy is an essential detail of life for women in particular, and given historical constraints on this autonomy resulting from patriarchy, discussions about discrimination should be broadened to consider whether refusals unfairly threaten women's deliberative freedoms. The fact that it is women who so often get refused reproductive health care services seems more than

incidental, and Wicclair's view does not adequately consider the possibility of discrimination toward women in this context nor does it properly guard against it.

Second, even if refusals are not predicated on discriminatory views, Wicclair's view results in unfair harms and burdens to women. He claims that objections by health care professionals are limited by the ethical constraint to prevent excessive patient harms and burdens. Yet on his account objectors are only obligated to provide some goods or services such as abortions on an emergency basis, for example when a pregnant woman's life is in danger and the possibility of transfer to another physician is impossible. This is because according to Wicclair, a procedure must be not only medically necessary but an emergency in order for the harm to women to be great enough to override objections (162-167). Limiting compliance with legal procedures such as abortions to such drastic circumstances unfairly minimizes the harm done to women. Being denied abortion services when there are no alternate providers imposes the burden of unwanted pregnancy, exposes women to potential physical and emotional harms[5], and significantly reduces autonomy[6], regardless of whether or not the situation is an emergency. Being denied access to emergency contraception, even if it is readily available at a nearby pharmacy, can also harm women by reinforcing in their minds oppressive sexist stigmas such as the view that women who request emergency contraceptives are "sluts" or are irresponsible.[7] Wicclair's hesitancy to claim that denying a rape victim emergency contraception constitutes an excessive harm, stating that such a case may fall into a "gray zone" between excessive and permissible harms, demonstrates that his definition of "excessive" is insensitive to the harms many women experience (101). To require that women have to be facing imminent death or have been recently raped in order for their harms to be great enough to warrant overriding objector's

claims of conscience is to unfairly privilege the objector's conscience and impose unfair burdens on women.

In conclusion, Wicclair does not live up to his claim at the beginning of the book that a refusal is compatible with professional obligations only if it does not present an excessive impediment to a patient's timely and convenient access to a good or service (xi). Women in particular seem required to endure life-threatening and socially ostracizing impediments in order for claims of conscience to be overridden, with the result that their access (especially) to reproductive goods and services is often neither timely nor convenient.

Notes

1. See Wicclair 2008.

2. Conscience clauses are legal rules and regulations which protect the exercise of conscience at either the state or federal level. For example, the U.S. federal Church Amendment protects conscience-based refusals around abortion and sterilization (Wicclair 2011, 203).

3. Piper 1990, 289-290.

4. Moreau 2010, 147.

5. For example, pregnancy endangers the life of women with certain health conditions, while for others it may represent a ‘‘period of risk’’ for physical abuse by husbands or partners (McLeod 2010, 23).

6. For example, unwanted pregnancy may ruin the future plans of many women, particularly those who know they could not go through the intimacy of gestation and then give their child up for adoption (McLeod 2010, 23).

7. Carolyn McLeod has argued along these lines, claiming that being denied emergency contraception even when readily available elsewhere does more than merely inconvenience women: it harms them. She notes that studies reveal sexist stigma associated with obtaining emergency contraceptives for women, such as stereotypes of women as sexually promiscuous and of low moral character, and that women may think negatively of themselves when refused because they have internalized such stigma. This means that the subjective impact of the disrespectful views behind refusals can be quite severe (2010:18,19).

References

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Biography

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