Special Section: Conscientious Objection in Healthcare: Problems and Perspectives

Conscientious Objection, Complicity in Wrongdoing, and a Not-So-Moderate Approach

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Abstract: This article analyzes the problem of complicity in wrongdoing in the case of healthcare practitioners (and in particular Roman Catholic ones) who refuse to perform abortions, but who are nonetheless required to facilitate abortions by informing their patients about this option and by referring them to a willing colleague. Although this solution is widely supported in the literature and is also widely represented in much legislation, the argument here is that it fails to both (1) safeguard the well-being of the patients, and (2) protect the moral integrity of healthcare practitioners. Finally, the article proposes a new solution to this problem that is based on a desirable ratio of conscientious objectors to non-conscientious objectors in a hospital or in a given geographic area.

Keywords: conscientious objection; abortion; complicity; cooperation in wrongdoing

In the medical context, conscientious objection can be defined as the refusal by a healthcare practitioner to perform a medical activity (which is safe, legal, and accepted by the scientific community) because of concerns about its moral permissibility.

Common examples of conscientious objection include refusals to perform an abortion and to write or fill a prescription for a "morning after" pill.[1] However, there are also healthcare practitioners who refuse, or would prefer to be allowed to refuse, to examine a patient of the opposite sex, to examine someone intoxicated with drugs or alcohol,[2] to perform a sterilization, to administer terminal sedation, or to participate in interventions aiming to change a patient's sex.

Although the range of practices that healthcare practitioners refuse to perform (or would like to object to) is quite wide, abortion is the practice that raises the largest number of conscientious objections. For example, in a country such as Italy with a long Roman Catholic tradition, 69.6 percent of gynecologists (the only practitioners allowed to perform abortions in that country) were conscientious objectors to abortion in 2012 (latest data available). And in some regions, the percentage of conscientious objectors was as high as 90.3 percent.[3]

The issue of cooperation in wrongdoing that is raised by the requirement to refer the patient to a willing physician cannot be separated from the issue of conscientious objection, because the refusal to be an accomplice in wrongdoing is one of the main reasons why healthcare practitioners are conscientious objectors. In this article, I discuss the problem of complicity in wrongdoing in the case of healthcare practitioners (and in particular Roman Catholic ones) who do not perform abortions, but who are nonetheless required to facilitate abortions by informing their patients about this option and by referring them to a willing colleague. Although this solution is widely supported by the literature and is also widely represented in legislations, I argue that it fails to both (1) safeguard the well-being of the patients and (2) protect the moral integrity of healthcare practitioners. I finally propose a new solution to this kind of conflict between patients and healthcare practitioners.

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Three Approaches to Conscientious Objection

The array of positions on the ethics of conscientious objection have been grouped by Mark Wicclair[4] as follows: the incompatibility thesis, conscience absolutism, and compromise positions (this last approach is called "the moderate view" by Robert Card[5]).

The Incompatibility Thesis

According to the *incompatibility thesis*, healthcare practitioners should perform all safe and legal treatments that a patient may consider beneficial and may request. In this view, the professional duties of healthcare practitioners are not compatible with a request for conscientious objection. In other words, healthcare practitioners should always perform any legal, safe, and beneficial (from the patient's perspective) treatment that a patient may request. Because this view is not commonly found in the literature or in legislations about abortion worldwide, it will not be discussed in detail here.

The Conscience Absolutism View

According to the *conscience absolutism view*, healthcare practitioners should be free to refuse to perform any activity that they consider immoral, including informing patients about therapeutic options and referring them to a willing colleague. This is the position shared by the Roman Catholic Church.

The Compromise (or Moderate) View

Finally, according to the *compromise (or moderate) view*, healthcare practitioners should be allowed to refuse to perform a safe and legal medical activity (that the patient considers beneficial) only under certain circumstances. In particular, healthcare practitioners should be required to always *inform* their patients about relevant therapeutic options and to *refer* them to a colleague who will provide treatment.[6,7]

Conscience Absolutism

In the majority of countries where abortion is not illegal, healthcare practitioners have the legal right to refuse to perform abortions (as well as related controversial procedures). However, healthcare practitioners who share the conscience absolutism view, as Roman Catholics are likely to do, claim the right not only to refuse to perform treatments that they consider unethical, but also not to cooperate with patients or be accomplices by helping patients to obtain treatments elsewhere that they are not willing to provide.

This view has been supported quite vigorously by many bioethicists. For example, James T. McHugh, in an article opposing President Bill Clinton's health reforms in the mid-1990s, stated that "Catholic teaching not only forbids obtaining or performing abortion, but also forbids cooperating in or enabling others to undergo abortion."[8]

Renée Mirkes explains that "in prenatal and perinatal care, instead of recommending or referring for abortion, the NPT physician[9] manages pregnancies,

including high-risk pregnancies and those involving chromosomal or genetic abnormalities, in a way that optimally promotes the best possible outcome for baby and mom."[10] It is not entirely clear what "recommending" means in this context, but it could mean that physicians do not disclose the option of abortion to their patients. In any case, they do not refer for abortion.

This view is shared also by Karen Brauer, President of Pharmacists for Life.[11] who claimed that, to a pharmacist, facilitating the referral of a client "is like saying: I don't kill people myself, but let me tell you about the guy down the street who does." Michael Bayles similarly argued that "If a physician sincerely believes abortion...is morally wrong he cannot consistently advise a patient where she may obtain one."[12]

In 2008, under the Bush administration in the United States, the absolutist approach inspired a new conscience rule, "Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law" (45 CFR § 88), which allowed all healthcare professionals to refuse not only to perform, but also to assist in the performance of those activities that they found morally wrong. In particular, healthcare practitioners were entitled to refuse "to participate in any activity with a reasonable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department funded entity" (45 CFR § 88.2). This meant that healthcare practitioners could refuse to perform activities such as "counseling, referral, training, and other arrangements for the procedure, health service or research activity" (45 CFR § 88.2).

Similarly, in another example, the Oregon law that regulates assisted suicide guarantees an absolute right to physicians who oppose the practice, allowing them to choose not to disclose this option to their patients.[13]

Conscience Absolutism and the Issue of Complicity in the Doctrine of the Roman Catholic Church

The Roman Catholic Church shares the absolutist approach to conscientious objection. For example, according to its teaching, healthcare practitioners should be allowed to refuse to perform any activity related to abortion or euthanasia.

The main reason why Roman Catholic healthcare practitioners (and probably conscientious objectors among healthcare practitioners in general) do not want to perform abortions is that, from their perspective, abortion is morally comparable to murder. The encyclical letter *Evangeliun Vitae* reads "[t]he moral gravity of procured abortion is apparent in all its truth if we recognize that we are dealing with murder."[14]

Complicity (or cooperation) in wrongdoing is defined by the Roman Catholic Church as the realization of an act that somehow helps another person to perform immoral activities, in which "somehow" can mean one of the following:

- by participating directly and voluntarily in the activities
- by ordering, advising, praising, or approving the activities
- by not disclosing or not hindering the activities when we have an obligation to do so
- by protecting evil-doers[15]

From a Roman Catholic perspective, all these activities are morally wrong. Whoever informs, refers, or somehow aids someone seeking an abortion is an accomplice in wrongdoing.

An example illustrates the Catholic/absolutist perspective on this issue. Suppose that Ethan asks Jacob to kidnap Oliver so that Ethan can torture him. What should Jacob do in such a situation? Quite obviously, Jacob should refuse to cooperate with Ethan in carrying out his plan. Now, suppose that Ethan asks Jacob to help him find a person (Adam), who can help him to kidnap Oliver, so that he can then torture him. What should Jacob do? Once again, it is clear that Jacob should refuse to be an accomplice, and not help Ethan find Adam.

The healthcare practitioner (Catholic or not) who is in a position to inform a woman about the option of having an abortion, or to refer her to a physician willing to provide an abortion, may find him- or herself in a situation similar to Jacob's in the abovementioned examples, thinking it is wrong to do what Ethan plans to do and refusing to cooperate with him. Although abortion is considered an ethically acceptable procedure by many, torture for the sake of sadism is supported by virtually no moral theory. I am not advocating a view in which abortion is comparable to torture. My example is only intended to highlight the fact that people do not want to be accomplices in something that *they consider* immoral and harmful, regardless of the degree of complicity for which they find themselves responsible. The Roman Catholic doctrine endorses this view about complicity and prescribes that healthcare practitioners abstain from providing help to a woman who wants to have an abortion; that is, a procedure that, according to doctrine, Catholic physicians should (and typically do) consider immoral.

The Compromise View: A Critical Analysis

According to the compromise view, or moderate approach, healthcare practitioners who make a conscientious objection are entitled to refuse to perform a certain treatment (e.g., to perform abortions) but not to refuse to refer patients to a willing physician or to inform them about relevant therapeutic options, abortion among them. The compromise view is commonly seen as striking the right balance between the needs of patients and physicians. The main argument in support of this approach is that, by refusing to perform an abortion, physicians put themselves out of the chain of events leading to the abortion; at the same time, they fulfill their professional duties, which include ensuring that a patient obtains the medical service she needs, by either referring her directly to a willing colleague or by indirectly by suggesting a willing physician who will perform the procedure.

Therefore, for example, J. Cantor and K. Baum argue that the moderate approach allows healthcare practitioners to keep their hands clean: "[a] referral may also represent a break in causation between the pharmacist and distributing emergency contraception, a separation that the objecting pharmacist presumably seeks."[16]

Dan Brock provides a different justification for the compromise view. He argues that complicity comes in different degrees, depending on the kind of activity a healthcare practitioner performs. For Brock, although informing and referring (contrary to what Cantor and Baum suggest) do not represent a break in causation

between the healthcare practitioners and the activity that they consider immoral, the degree of complicity is significantly lower than the degree of complicity of healthcare practitioners who actually perform the abortion.

According to Brock, it is true that informing a patient about the availability of a certain therapy can play an important role in her decision of whether or not to undergo a treatment; but if the physicians do not encourage her to use it or do not refer her to a willing colleague, then the degree of their complicity is minimal. If, instead, physicians make their moral objections clear, but refer the patient to a willing colleague, their degree of complicity is greater. Brock does recognize that someone informing a patient about an available therapy is an accomplice, but he argues that this person is less of an accomplice than someone else who directly refers a patient to a willing colleague. In both cases, complicity is significantly lower than in the case of a physician who performs the abortion.

On the basis of these different degrees of complicity, Brock argues that healthcare practitioners who want to make a conscientious objection should be allowed to do so only if they respect the conditions stated in the "conventional compromise." Accordingly, the physician (and the pharmacist) are obligated to inform and refer the patient, and they are justified in objecting only if their refusal does not impose an unreasonable burden on the patient.

Brock seems to attribute an *intrinsic* degree of complicity to different activities, suggesting that referring always implies a greater degree of complicity than informing and a lesser degree than performing an abortion. However, the assumption that complicity is an intrinsic property of an activity can be challenged. Specifically, differences in circumstances ought to be taken into account when assessing the degree of complicity related to a certain activity. Whether or not performing an abortion involves more or less complicity than referring a patient depends not only on the nature of the act, but also on the situation in which the act is performed. In a hospital where all the physicians are willing to perform abortions, the individual physician is less of an accomplice in wrongdoing than that physician's counterpart who works in a hospital where that physician is the only one performing abortions. The reason is that in the first scenario, the patient has access to an abortion even if one of the physicians refuses to perform it, which means that each physician has a less decisive role in the chain of events that brings the woman to having the abortion. However, in the second scenario, the refusal of the particular physician makes a decisive difference, because if the physician objects, the woman will not be able to have an abortion at that hospital. Given the fact that reality is much more fluid than in these two scenarios, and that the number of physicians willing to perform abortions in a certain hospital may vary, it would be very difficult to assess the degree of complicity of each physician at any given time.

This is not the only reason why Brock's proposal (and the moderate view in general) provides a "weak" solution to the problem, especially when it comes to Roman Catholic physicians. Even if it would be technically possible to assess degrees of complicity of a certain activity, the Roman Catholic physician would still feel like, and be, an accomplice, according to the Catholic doctrine (but also independently of it, as the example of Ethan, Jacob, and Jack shows), regardless of the actual degree of complicity. The problem, especially in the Catholic view, is not to assess *to what extent* someone contributes to an immoral activity, but rather whether he or she *in any way* contributes to this activity.

Are There Objective Parameters to Assess the Permissibility of Complicity?

It has been suggested that, although it may be difficult to assess degrees of complicity, it should still be possible to distinguish permissible and impermissible types of complicity in wrongdoing.

For example, Edmund Pellegrino states:

> [o]ne way to assess the moral status of a particular act of cooperation is by estimating its moral distance from actual or potential harm to the person the physician attends. This "distance" is measured in moral terms by the degree to which the participant shares the intention to do harm, the moral status of the act in question, the seriousness of the harm done, and the extent to which the participant's actions are necessary to, and/or causal of, the harm and the proportionality of harm to benefit[17]

Although Pellegrino acknowledges that there is no precise formula to measure the moral status of a particular act of cooperation, he adds that "[w]hen the participant does not share the harmful intent, the act itself is good or morally neutral, the participant's actions are not necessary or causal but only remotely facilitative, and the good is proportionate, cooperation could be justified."[18]

However, the healthcare practitioner who informs and refers a patient *has* a causal relationship with the outcome, and he or she is performing a necessary act insofar as the patient would find it extremely difficult, or even impossible, to be informed and find a physician willing to perform the abortion. Moreover, the good of the outcome, in this case helping the patient, is not proportionate to the wrong of the action (killing the fetus); therefore, for this healthcare practitioner, it is never appropriate to perform the abortion.

Pellegrino's view is based on the view of the Catholic Church, according to which there is an important difference between formal and material cooperation, and between direct material and indirect material cooperation.

According to the Catholic Church, *formal cooperation in wrongdoing* is never morally permissible. All acts that constitute direct participation against innocent human lives, or indicate approval of an immoral activity, represent acts of formal cooperation. Such acts of cooperation cannot be justified by appealing either to the duty to respect other people's freedom or to the fact that the law requires one to be an accomplice.[19]

Direct material cooperation implies that the accomplice performs an evil act even if not sharing the intention of the person wanting the help. *Indirect material cooperation,* instead, implies that the accomplice is not aware of the evil intentions of the person he or she is helping.[20]

Daniel Sulmasy makes a similar point: "[t]he first judgment to be made is whether one shares in the intent of the one who is doing wrong. This is called 'formal' cooperation, and a well-formed conscience always ought to judge that such cooperation is morally wrong."[21]

According to Sulmasy, there are some circumstances under which *material* cooperation in wrongdoing can be justified, and they all seem to be cases of indirect material cooperation. According to Sulmasy, the further a person is from the final outcome, the more he or she is justified in being an accomplice. Or, similarly, the less the material cooperation is necessary to bring about the final outcome, the more someone is justified in being an accomplice.

In summary, although some forms of cooperation in wrongdoing are morally permissible, the conditions under which cooperation in wrongdoing is morally acceptable do not apply in the case of a healthcare practitioner who facilitates an abortion (by either informing and referring). Pellegrino's and Sulmasy's approaches are consistent with the perspective of the Roman Catholic Church and, therefore, with that of a committed Catholic physician. Moreover, such consistency of views on cooperation in wrongdoing could also explain the position of those non-Catholic practitioners who consider abortion immoral and who do not want to be accomplices in wrongdoing.

Should Physicians Be Allowed to Refuse to Facilitate Activities that They Find Immoral?

In the previous paragraphs, I have argued that the moderate approach fails to protect Roman Catholic healthcare practitioners' moral integrity and conscience. From their perspective, it is essential not to cooperate in wrongdoing, including not informing and not referring patients about medical procedures that the Roman Catholic Church considers immoral.

However, there are good reasons to think that the moderate approach fails to adequately protect the patients' best interest as well because, *as a matter of fact*, in many cases physicians would not provide information, referral, or an emergency abortion even if the moderate approach would require them to do so. Three cases recently discussed at the European Court of Human Rights seem to support this claim.

1) *R.R. v. Poland* (no. 27617/04).[22] In Poland, a woman was denied *timely* access to genetic tests although an ultrasound had revealed that the fetus she was carrying was most likely affected by a severe genetic disease. When the fetus was finally diagnosed with Turner Syndrome (a chromosomal abnormality in which all or part of one of the X chromosomes is missing or altered) it was too late to have access to a legal abortion. As a consequence, her daughter was born with the genetic abnormality and the woman claimed that raising the ill daughter affected the well-being of her family.
2) *Tysiąc v. Poland* (no. 5410/03).[23] A woman with severe myopia was denied a therapeutic abortion, although physicians had warned her that the pregnancy could cause blindness. Soon after her daughter was born, the woman became legally blind.
3) *Z. v. Poland* (no. 46132/08).[24] A woman affected by ulcerative colitis was denied a colonoscopy because her physician was concerned about the risk of harming the fetus. The woman died after a miscarriage.

These cases appear to support the claim that healthcare practitioners who are not comfortable with performing abortions, or other medical activities that could have the side effect of killing or damaging the fetus, sometimes fail to provide women with the medical assistance to which they are entitled (by law) in a public health system, and that the compromise view requires physicians to provide. In some cases, forcing healthcare practitioners to facilitate abortions even when they would prefer to be exempted from this duty can harm patients.

In countries such as Italy, where the percentage of conscientious objectors to abortion is extremely high, many women have begun traveling abroad to obtain

an abortion, and some have turned to self-induced abortion through prostaglandin. The Italian Ministry of Health officially reports that 20,000 back street abortions were performed in the country in 2008 (latest data available); however, a more realistic estimate is that approximately 40,000 to 50,000 back street abortions are performed every year. This estimate is based on the fact that over the last 30 years, the number of miscarriages in Italy increased considerably, from 55, 000 in the 1980s to approximately 80,000 in the past few years. It has been suggested that this phenomenon occurs because Italian women are having more back street abortions that often result in hemorrhaging, thus forcing them to go to the hospital for what is officially recorded as a "miscarriage."[25]

It appears, therefore, that the compromise approach damages patients when: (1) physicians do not want to inform or refer them, putting in place stratagems to avoid doing what they would be required to do under the compromise approach; and (2) the percentage of conscientious objectors in a certain hospital or geographic area is so high that women are forced to go abroad to obtain the service, or, even worse, undergo back street abortions.

A New Proposal

Thus far, I have argued that the moderate approach cannot be considered an ideal solution to strike a balance between the interests and preferences of patients and those of healthcare practitioners.

In geographical areas where only a few physicians are conscientious objectors, conscientious objection might be permissible because it does not cause delays or inefficiencies, or harm to the patients. On the other hand, conscientious objection is not permissible in areas where the majority of physicians are conscientious objectors and delays and inefficiencies are unavoidable. The number of conscientious objectors in a certain geographic area or in a certain hospital ought to be regulated in such a way that the patient is not negatively affected by the healthcare practitioners' refusal. This means that conscientious objection is acceptable only if another healthcare practitioner is readily available to perform the activity that his or her colleague refuses to perform, so that the patient can always obtain the treatment she needs without any noticeable delay. In a hospital, or in a geographic area where there is, for example, one conscientious objector and nine physicians willing to perform the activity that the conscientious objector does not want to perform, patients will not be denied the treatment and will not suffer from any significant delay.[26] But in a hospital (or in a geographic area) where the reverse situation applies (nine objectors vs. one non-objector) patients will probably need to wait longer in order to get their treatment, and they will even risk being denied the treatment if too many people require the same treatment at the same time.

A ratio of one objector to nine non-objectors seems to be acceptable, whereas the reverse may cause delays in the care of patients, inefficiency, and economic and psychological burdens on patients, as well as serious health consequences for them. Empirical research needs to be conducted to assess the acceptable ratio of objectors to non-objectors in an area of a certain size, and until there are enough data, it will be difficult to draft adequate policies. Regardless, it seems safe to say that in any hospital or in any given geographic area, at least the majority of physicians should *not* be conscientious objectors. However, at the same time, in order to truly protect physicians' conscience (including their conscientious beliefs about

complicity) and patients' rights, the physicians who are entitled to object should not be required to facilitate the abortion in any way. Contrary to what the moderate approach prescribes, they should not be required to inform or refer patients and, therefore, become their accomplices.

Following the "ratio" solution, patients would easily have access to the best care available, and conscientious objectors would not be forced to do anything they conscientiously refuse to do. Of course, this implies that a healthcare practitioner who is a conscientious objector could have a job only in those hospitals or areas where there is a place for people who object to performing a particular activity (e.g., abortion) and all the activities that are related to it, because there are enough physicians who *are* willing to perform that activity. Once placed in the right hospital, these physicians would no longer be involved in activities that they consider immoral. Conscientious objectors would not meet the patients who need the treatment that they are not willing to provide. An informative sign could be placed on the physicians' doors, explaining that they are conscientious objectors and that they will not inform/refer patients who want an abortion (or other treatments that physicians are allowed to refuse according to conscience clauses in the country where they work). Alternatively, hospitals could have a board at the entrance with the names of all the physicians working on their premises, and a "conscientious objector to practice X" warning next to the name of conscientious objectors. An additional option would be for the staff in the reception area to provide new patients with information about practices that may be subject to conscientious objection, so that the patients could decide whether to see a conscientious objector or not.

Regardless of the practical solutions each hospital would implement, the patient should always be aware of the fact that a particular healthcare practitioner would not explore all the possible therapeutic options with her. If the patient chooses a conscientious objector because, for example, she happens to share the same (religious) values that her healthcare practitioner holds, then there is no reason for her to seek another physician. But if the patient prefers to deal with a healthcare practitioner who will not withhold any piece of information from her, then she should be given the opportunity to immediately see another physician.

Conclusions

I began this article by introducing three main approaches to the issue of conscientious objection on the part of healthcare practitioners. I argued that the moderate approach, usually considered to strike a balance between the needs of patients and healthcare practitioners, cannot be considered a satisfactory solution to the problem of conscientious objection in medicine because it does not give due consideration to the argument regarding complicity in wrongdoing. I challenged Brock's view that there are intrinsic degrees of culpability or moral responsibility in each activity of informing, referring, or performing related to conscientious objection, and I have maintained that degrees of complicity depend on circumstances rather than on the activity itself.

I have argued that it is not possible to protect a healthcare practitioner's moral integrity through conscience clauses that do not force them into practicing an abortion but that still require them to refer or to inform the patient.

However, the majority of conscience clauses in Western legislations allow the physician to refuse to perform abortions, but not to refuse to inform the patient

about therapeutic options or to refer to willing colleagues, hence these conscience clauses fail to protect (at least some) physicians' consciences and moral integrity.

On the other hand, allowing healthcare practitioners to refuse to inform and/or refer a patient would seriously damage the efficiency of the health system, sometimes even putting at risk the health or the life of patients. Especially when it comes to information, it can be dangerous for a patient not to be informed about all the available therapeutic options.

Brock's solution, and the moderate view in general, could theoretically work in a situation in which (1) degrees of complicity in relation to circumstances could be assessed once and for all; and (2) the physician would consider it moral to be an accomplice at least up to a certain degree. However, there is no formula to calculate degrees of complicity in different circumstances once and for all, because circumstances change continuously, depending on the number of physicians in a certain area and on the availability of each physician to inform, refer, or perform.

Moreover, to some physicians, especially to Roman Catholic ones, even a minimum degree of complicity would represent a serious violation of their moral integrity. However, the efficiency of the health system and the well-being of the patients would be put at risk if healthcare practitioners were simply allowed to object to some forms of cooperation in what they view as wrongdoing. This is a solution that can hardly solve the clash of values between patients and physicians that arises in cases of conscientious objection.

To solve the problems presented by the moderate view, and to maximize the preference satisfaction of both healthcare practitioners and patients, I have suggested the two following solutions:

1) A ratio of objectors to non-objectors should always be respected, and conscientious objectors should not be allowed to practice in areas where there are few healthcare practitioners practicing.
2) In areas where many physicians can perform a certain treatment and the ratio of objectors to non-objectors is respected, patients should be aware of the fact that conscientious objectors would withhold some information from them about possible therapeutic options on moral or religious grounds. The patient should immediately be given the opportunity to see a non-objecting healthcare practitioners in the same hospital or in the same geographic area.
3) More research should be undertaken to assess the ideal ratio of objectors to non-objectors and, therefore, to understand what percentage of conscientious objectors is necessary to avoid any relevant delay in the delivery of abortion (or any other health service protected by conscience clauses) in a certain public hospital or geographic area.

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