Special Section: Conscientious Objection in Healthcare: Problems and Perspectives

Tolerance, Professional Judgment, and the Discretionary Space of the Physician

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Abstract: Arguments against physicians' claims of a right to refuse to provide tests or treatments to patients based on conscientious objection often depend on two premises that are rarely made explicit. The first is that the protection of religious liberty (broadly construed) should be limited to freedom of worship, assembly, and belief. The second is that because professions are licensed by the state, any citizen who practices a licensed profession is required to provide all the goods and services determined by the profession to fall within the scope of practice of that professional specialty and permitted by the state, regardless of any personal religious, philosophical, or moral objection. In this article, I argue that these premises ought to be rejected, and therefore the arguments that depend on them ought also to be rejected. The first premise is incompatible with Locke's conception of tolerance, which recognizes that fundamental, self-identifying beliefs affect public as well as private acts and deserve a broad measure of tolerance. The second premise unduly (and unrealistically) narrows the discretionary space of professional practice to an extent that undermines the contributions professions ought to be permitted to make to the common good. Tolerance for conscientious objection in the public sphere of professional practice should not be unlimited, however, and the article proposes several commonsense, Lockean limits to tolerance for physician claims of conscientious objection.

Keywords: medical ethics; conscience; tolerance; professional practice; John Locke

Many commentators have forcefully rejected physician claims of a right to refuse to provide tests or treatments to patients based on conscientious objection to the use of these interventions.[1,2,3,4,5,6] In this article, I examine two premises that are not often explicitly articulated, but that underlie many arguments urging that physicians and other healthcare professionals have an obligation, on patient request, to provide any and all treatments that are not illegal and fall within the scope of practice approved by their professions. The first premise is that the constitutional protection of religious liberty (broadly construed) should be limited to freedom of worship, assembly, and belief. Some of those who reject physician appeals to conscientious objection seem to assume, at least implicitly if not explicitly, that any citizen who engages in the public provision of goods and services through any particular occupation or practice is morally required to provide all the goods and services that fall within the scope of what that occupation or practice provides, to whomever asks for them, regardless of personal religious, philosophical, or moral objection. They assume that this moral requirement should have the force of law, such that the only recourses that a conscientiously objecting citizen would have would either be to find another means of earning a living or to accept legal penalties. I will argue that this position is onerous and intolerant, would inhibit the flourishing of a truly pluralistic liberal democracy, and would afford citizens far less religious liberty than they would have under John Locke's view of what tolerance means and requires. The second suppressed premise is a special case of the first. Some of those who would press physicians to provide interventions to which they object morally seem to assume that because professions are

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licensed by the state, any citizen who practices a licensed profession is required to provide all the goods and services determined by the profession to fall within the scope of practice of that professional specialty and permitted by the state, regardless of any personal religious, philosophical, or moral objection. The only recourses a conscientiously objecting citizen would have would either be to find another means of earning a living or to accept legal penalties. I will argue that this premise undermines the concept of professional judgment, shrinks the discretionary space necessary to the practice of a profession, upsets the balance among professions, markets, and the state necessary to the flourishing of a truly pluralistic liberal democracy, and instantiates another version of the Lockean intolerance described in my objections to the first premise. Locke understood, and I agree, that there are reasonable limits to the scope of tolerance for conscientious objection, based on concern for the common good and the preservation of the order of the state. I therefore will outline reasonable limits to tolerance for such conscientious objection, while arguing that the common good and the preservation of the order of the state actually require that the scope of respect for conscientious objection should be broad, especially for professionals. Absent the ability to rely on one of these two unsupportable premises, objection to very broad respect for conscientious objection by clinicians loses its force.

Religious Liberty and the Notion of Tolerance

Most claims of conscientious objection in medicine have been based on claims of religious liberty, or at least on the liberty to exercise something very like a religion. Such claims turn crucially on the scope of the term "exercise." The First Amendment to the United States Constitution states, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." The use of the word "establishment" is relatively straightforward to understand, meaning that there can be no state religion. The rights to freedom of belief and worship and equal treatment under law regardless of one's religious beliefs were deemed crucial to the identity of the new nation, as many (if not most) of its citizens were former British colonists who had left their mother country precisely because they adhered to religions other than the established state religion: the Church of England.

"Exercise" is trickier. What does it mean to say that one is "exercising" a religion? Today this word is most often associated with workouts and gymnasia. But the first six definitions of the word in the *Oxford English Dictionary* hearken back to its dominant meaning in the eighteenth century, referring to "the state of giving practical effect to (a right)," "habitual or customary practice," "the fulfillment of duties," "the right or permission to celebrate the observances (of a religion)," and "practice for the sake of training or improvement, either bodily, mental, or spiritual."

Contemporary debates about the rights of conscience of medical practitioners and institutions in the United States, particularly those that are faith based, are highly dependent on differing views about what it means to exercise a religion, although the protagonists in these debates have not generally noted this explicitly nor have they explicitly examined what it means to tolerate the free exercise of a religion.

For example, in the initial rollout of the so-called "Contraceptive Mandate" of the Affordable Care Act, the Obama Administration stated that it had fully

respected religious freedom by providing a conscientious objection clause, allowing religious institutions to "opt out" of the requirement to provide healthcare insurance for all employees covering contraceptives (including some, such as mifepristone and intrauterine devices, that are widely agreed to act, at least in some instances, by inducing very early abortions). These regulations, however, defined a religious employer as one that "(1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization."[7] Although not explicitly described as such, this definition of a religious employer implies an understanding of the constitutionally protected right of free exercise of religion as limited to private belief and corporate worship. What counts as a religious institution is defined in an insular way, as if to say, "you're free to believe what you want to believe and free to act as you choose to act when you're with your fellow believers, but when you step out the door and become an actor in the public sphere you leave that freedom behind and your beliefs must be subordinated to the rule of the secular state." Similar views undergird the opinions of a number of US legal scholars who have written on this topic.[8,9]

This view of what a religion is and of what its free exercise means has provoked the ire of religiously affiliated institutions that explicitly undertake work in the wider society out of a sense of religious identity and mission (particularly charitable work among people of all faiths and of no faith). These institutions include religiously affiliated schools, shelters for the homeless, food pantries, hospitals, and more. What such a legal definition of a religious employer implies is that the meaning of the word "religion" is circumscribed by what happens in houses of worship and among adherents to a particular faith. Faith might inspire one to perform acts of charity, but as soon as one leaves the confines of church, synagogue, mosque, or temple to undertake such work, one is in the secular world, and the mores of the secular society, not one's religious convictions, ultimately define the content of that work and delineate the proper recipients of one's charitable dispositions.

This narrow view of the scope of the free exercise of religion is unprecedented in United States history. The view of religious tolerance enshrined in the First Amendment of the United States Constitution was profoundly influenced by the writings of John Locke, essays that were already a century old at that time.[10,11] Certainly the pressing public issues were different for Locke than they are for twenty-first century medicine. Locke's central concerns in his writings on religious toleration were that citizens not be killed, tortured, or imprisoned for their religious beliefs, and that wars, both civil and international, based on differences in religious conviction, should cease. But Locke also understood that a religion was not merely a set of beliefs and worship practices held in common by a voluntary group of citizens. Religions instruct their adherents on how they ought to behave in the world, and questions about religious tolerance must therefore address tolerance for the ethical precepts of religions as well as adherence to their creeds and worship practices.

Locke proposed a tripartite analysis.[12] First, he proposed that worship and belief be afforded almost complete tolerance by the state, a degree of liberty limited only by the proscription of acts of worship deemed abominations against natural law and the good of the state, such as infant sacrifice. Second, he thought acts that were absolutely destructive to human society ought to be universally forbidden and granted no tolerance, such as murder, fraud, or treason. Importantly however,

he noted a third category, of "practical principles or opinions by which men think themselves obliged to regulate their actions with one another."[13] Locke argued that such opinions and actions ought to be tolerated unless "apparently destructive to society."[14] Such acts and opinions ought to be tolerated, he argued, "because the conscience, or persuasion of the subject, cannot possibly be a measure by which the magistrate can, or ought to frame his laws, which ought to be suited to the good of all his subjects, not the persuasions of a part."[15] It is critical to note that Locke explicitly notes that this aspect of religion—religious teaching about one's activities in the world—deserves wide toleration, although Locke also thought that the breadth of toleration for this class of acts should not be as near absolute as that afforded to private religious beliefs and worship, inasmuch as these public acts have a greater and more direct impact on others. Still, the Lockean view seems to be that such beliefs and actions in the moral sphere ought to be tolerated, and differences in practices adjudicated by the free decisions of individuals through contractual or other arrangements, unless and until the common good or the preservation of the good order of the state would be threatened.

It would seem that this Lockean view would not merely encompass toleration for conscientious objection by individual clinicians, but also by not-for-profit institutions that act out the moral imperatives of their religion to do good work in the world for any and all persons in need, and not merely their own co-religionists. It seems obvious that it would be better for the flourishing of a pluralistic liberal democracy that such organizations should serve not only their co-religionists, but everyone in need of the service they are motivated (out of adherence to their own faith) to provide. Narrowing the scope of what a religion means in order for its moral views to be tolerated would force those organizations to discriminate, on the basis of religion, among those they serve, in effect forcing them to discriminate in order to be eligible for tolerance. Therefore, the view that a religion can be tolerated only if it only serves its own seems to do violence to the very notion of religious tolerance.

Moreover, the scope of this tolerance of religious liberty can be readily extended to any set of deeply held, fundamental, self-identifying moral commitments. Such commitments are often, as in certain forms of humanism, religion-like in character. Atheism also ought to be tolerated under the rubric of religious liberty. It can be argued that tolerance for atheism is a necessary condition for true respect for religious liberty, because true religious liberty would necessarily entail the freedom not to believe.

Importantly, this Lockean view of tolerance would not permit just any individual's disagreement about the morality of the service denied him or her by the conscientious objector to trump the objector's conscience. One would need to argue that the denial of the service is "destructive of society." That is a fairly high bar. Inconvenience for a small number of persons would not seem to count. However, Locke was certainly also right that the breadth of tolerance for conscientious objection in the arena of public action should be narrower than that of tolerance for belief and worship. One needs to spell out just what constitutes an act or a refraining from action that is destructive of society and therefore defines the Lockean limit of tolerance for conscientious action and conscientious objection in the public sphere. I will return to that question later in this article.

Epistemic Moral Humility: Why Tolerance Does Not Imply Moral Relativism or Subjectivism

Locke also provides a ready answer for those who claim that tolerance for differing religious and moral views implies moral relativism or subjectivism.[16] Locke notes that there is no point in having convictions, particularly religious ones, unless one believes them to be true. As he puts it "every Church is Orthodox to itself."[17] However, one can hold that belief and also affirm, without contradiction, that one is not infallible; that one can be mistaken in one's convictions, and unable to persuade others that one's convictions are true. This is not relativism or subjectivism. This is epistemic moral humility, and it is the true root of tolerance. Locke writes, "For however the magistrate be persuaded in himself of the reasonableness or absurdity, necessity or unlawfulness of any of [these practical opinions], and is possibly in the right, yet whilst he acknowledges himself not infallible, he ought to regard them in making of his laws, no other than as things indifferent, except only as being enjoined, tolerated, or forbidden, they carry with them the civil good and welfare of the people."[18]

In other words, one person might think that abortion is immoral and another might think that it is morally permissible. Both ought humbly to acknowledge the fallibility of their positions and their inability to persuade each other of the truth of these positions, but this need not mean that one must conclude that neither position is true or that moral truth is subjective. Each can be persuaded that his or her position is universally correct and that the other person's position is wrong. That makes moral argument meaningful. There would be no point in arguing were one to hold that there can be no correct answer to the question being debated. Tolerance springs from humility: the honest acknowledgment that one's moral judgments are fallible. The question then shifts to deciding which policy regarding the disputed idea best advances the civil good and welfare of the people, a question to which the answer any society gives also will be fallible. Consequently, that society ought to be broadly tolerant of the diversity of views its citizens hold on the disputed matter, unless that view is "destructive of society."

Tolerance, Professional Judgment, and the Physician's Discretionary Space

The "get another job" argument contends that although wide tolerance for conscientious action might generally be appropriate regarding action in the public sphere, physicians have a moral and legal duty to perform, upon patient request, any service that is legally permitted and within the scope of practice of their specialty.[19,20,21,22] Advocates of this position argue that the state authorizes physicians to perform such services through licensure, and that patients, as citizens of the state, have a right to demand such services of them. Refusal to do so interferes with the rights of patients to access these services, unethically prioritizing physicians' "personal" values over their "professional" duty to serve patients. If one is licensed by the state to drive a cab and hired to work as a cabbie, so the argument goes, one cannot refuse to drive the cab because of a conscientious objection to its combustion engine's contribution to global warming.[23]

This line of argument is not only in itself intolerant, it also falters because of deep misunderstandings of the notion of a profession, the nature of professional reasoning and judgment, and the proper place of professions in a pluralistic liberal democracy.

The first source of potential confusion that might give rise to such an argument concerns the use of the word "profession." If the term "profession" is to have any meaning at all, it cannot be synonymous with the word "occupation."[24] A sort of fuzzy-minded egalitarianism has led many to use the words synonymously, fearful that any difference between the two words might imply exclusion and elitism. The marking of differences, however, is necessary to meaning. Words must refer to some things and not to others or all words would be meaningless. This does not imply elitism. Driving a cab does not fall within the set of activities to which the word "profession" refers. It is a good, noble, and important occupation, but it is not a profession.

People earn a living through practicing professions, but the professions, properly speaking, have certain elements in common that differentiate them from other ways of earning a living. The traditional medieval professions of law, medicine, and divinity are the paradigm instances of the use of the word.[25] First, all professions require a complex and highly specialized fund of knowledge that is at once abstract and practical and generally requires extensive advanced education.[26,27,28] This is certainly true of medicine.

The work of professions is complex, involving multiple different kinds of decisions and potential tasks, depending on the precise circumstances of the one who seeks professional help. One who hails a cab needs a ride, and what cabbies do is to provide them with rides. A patient with abdominal pain may need a cholecystectomy or an appendectomy or a laxative or a proton pump inhibitor or any of a very large number of other possible interventions that clinical judgment concludes are "indicated."

Professions also all require a special moral orientation toward service, even to the point of at least some effacement of self-interest in favor of the needs of those the profession serves.[29,30,31,32] Professionals are held to a higher standard of ethics than ordinary citizens. A shoe salesperson, for example, has no moral obligation to tell you that your shoes are ugly if you are willing to pay for them. By contrast, a physician has a moral obligation not to provide unnecessary medical services, such as a CT scan for a muscle tension headache, even if the patient requests it and the physician could make money providing it. The fact that some individual professionals fail to live up such professional norms is not evidence that there are no such norms. In fact, our negative judgments about those who violate such norms implies that we do hold these higher moral expectations.

The work of a profession is to make particular judgments about particular individuals in particular situations, applying the specialized knowledge of the profession, in conformity with its moral norms, for the service of those individuals.[33,34,35] Professional judgments are not merely instrumental. They are not oriented primarily toward the satisfaction of the preferences of clients or customers, but toward the realization of goods internal to the profession's practice.[36] Morality and specialized knowledge are thus woven into each and every decision professionals make on behalf of those they serve. In medicine, the concept of an indication for treatment points in this direction. One offers treatments that are "indicated" in the sense that they are oriented toward the health of the patient. The consent of the patient is required in order to proceed, and patient preferences might shape the treatment choices that a surgeon ultimately makes, but patient preferences are not indications. The removal of a patient's external pinnae might be indicated in the treatment of a horrible cancer, for example, and such an operation could be

undertaken with the patient's fully informed consent. But a patient's preference to have this same operation performed in order to look like Vincent van Gough would not be considered a medical indication.

Here is what Flexner has to say:

> …the real characteristic of the activity is the thinking process; a free, resourceful and unhampered intelligence applied to problems and seeking to understand them—that is in the first instance characteristic of a profession. Wherever intelligence plays thus freely, the responsibility of the practitioner is at once large and personal. The problems to be dealt with are complicated; the facilities at hand, more or less abundant and various; the agent—physician, engineer, or preacher—exercises a very large discretion as to what he shall do. He is not under orders; though the work be team work rather than individual work, his responsibility is not less complete and not less personal. This quality of responsibility follows from the fact that professions are intellectual in character; for in all intellectual operations the thinker takes upon himself a risk. If then intellectuality with consequent personal responsibility be regarded as one criterion of a profession, no merely instrumental or mechanical activity can fairly lay claim to professional rank; for the human mind does not, in instrumental or mechanical activities, enjoy the requisite freedom of scope or carry the requisite burden of personal responsibility.[37]

Because of these moral and intellectual differences between professions and other occupations, individual practitioners of a profession are granted wide latitude in their decisions about what to do on behalf of those that they serve.[38,39,40] Pellegrino has called this, for the profession of medicine, "the physician's discretionary space."[41] Society has an interest in promoting good medicine, and, therefore, society has an interest in granting physicians the wide discretionary space that is required to make medical practice excellent. All algorithms are ultimately only guidelines. Medicine may be scientifically informed, but medical practice is ultimately an art and not a science.

Professionals sometimes choose to limit the scope of their practices, and a well-ordered society gives its professionals such discretionary space. A surgeon may choose, for example, to specialize in endocrine surgery. This decision may sometimes be motivated only by a matter of intellectual interest and/or personal aesthetic taste. It might be motivated by a moral commitment to improving the lot of patients with such disorders because of memories from childhood of a thyroid operation gone wrong in a loved one. The state ought not to require every surgeon to perform every operation for which he or she was trained or could be trained. Therefore, the premise that state licensure requires clinicians to perform any and every requested service that the profession deems potentially medically indicated seems mistaken. Professional licensure is permissive, not proscriptive. Professional licensees are *permitted* to perform interventions covered under the scope of their practice, not required to perform all of them. Such discretionary space redounds to the good of society, permitting such developments as specialization. In well-ordered societies, the state does not demand that licensed professionals do everything covered by licensure.

Moreover, sometimes physicians refuse to perform interventions that fall within the scope of their own chosen practice parameters. As with other professional

judgments, these professionals should be afforded wide discretionary space in making such judgments, which are driven by complex admixtures of technical and moral considerations. For example, if a thoracic surgeon is consulted about whether to operate on a patient with an acute dissection of a thoracic aortic aneurysm, the family may ask for the operation, saying that it represents the patient's best hope of survival. The surgeon, however, may judge that although it might be technically possible to do so, that surgeon's moral commitments to beneficence and non-maleficence lead him or her to conclude that the patient is likely to die more quickly as a result of the surgery, and that he or she does not wish to undertake responsibility for that risk, even acknowledging that the patient's only chance of survival might be surgery. Another surgeon, however, might disagree and undertake the operation. Such discretion ought not to be limited to such dramatic decisions. Clinical judgment and discretionary variability are ubiquitous. For example, a patient may ask a physician for antifungal medicine to treat a deformed toenail. One physician might say, "Not until I've done a culture and proven that it is a fungal infection. I would not want you to have a side effect from the medicine for no good reason." Another might say, "Sure. It is most likely a fungal infection, and culture is expensive and can yield false negatives," and write a prescription without performing a culture. It would not seem wise for society to impose uniformity on all such decisions. The quest for uniformity would be both unwise and unrealistic.

Such judgments will vary, inevitably. There will not be a randomized controlled trial to provide data for each and every decision that clinicians must make. There are 69,823 codes in the latest version of the United States Clinical Modification of the International Statistical Classification of Diseases and Related Health Problems (ICD 10), and a myriad presentations, circumstances, and comorbid conditions for each individual affected by each of these conditions.[42] The decisions that clinicians must make about each case are inextricably both medical and moral. No reasonable society would demand, in each case, were the physician to disagree with the patient over the correct course of medical action, that the physician must always do as the patient demanded or lose licensure. Reason demands that professionals be granted wide discretionary space.

Because these professional judgments are both technical and moral in all cases, it seems even more important to respect and protect a wide discretionary space for physicians regarding ethically controversial interventions. Precisely because there can be no a priori legislation of each and every medical decision, society has a deep interest in cultivating practitioners of conscience. This is in the interest of patients. Just as it is important to allow general surgeons the discretionary space to decide, conscientiously, which operations they will train themselves to perform and to decide when they think an operation is indicated in a particular case, so too, gynecologists should be permitted to decide, conscientiously, whether to be trained to perform abortions and whether (for those who have been trained) an abortion is indicated for sex selection or other controversial reasons. The vast majority of gynecologists do not perform abortions, whether for matters of personal moral objection or distaste. The state ought not to require all gynecologists to perform abortions, or all family physicians to prescribe birth control, or all pediatricians to provide growth hormone on demand.

A pluralistic, liberal democratic society needs to foster the independence of its professions if it is to flourish. To the extent that markets, the academy, the press, religions, other private associations, and the professions all thrive as

vibrant institutions, independent of the government and the other institutions, each can keep the other from becoming too dominant and each can independently (and all collectively) contribute to the common good. Democracies go awry when there is too much power concentrated in the hands of one, such as markets, or the government, or a particular religion. Independent professions play a key role in maintaining a healthy, pluralistic democracy. Physicians, for example, should be agents neither of the market nor of the state. Patients suffer when physicians become agents of the market, selling their services at the highest price the market will bear, negligent of the moral commitment of the profession to relegate self-interest before the ideal of service. Patients also suffer when physicians become agents of the state, which can eventuate in ethical atrocities, such as physician participation in torture or the psychiatric institutionalization of political dissidents. Because of the complex nature of the moral and medical decisions that professionals must face, society has an abiding interest in fostering an independent professional culture that attends to conscientious practice, and an interest in respecting the consequently wide discretionary space that must be afforded to individual practitioners.

Therefore, general Lockean considerations of tolerance for citizens' differing moral and religious views (including differences in practices based on those views), and considerations of the value of an independent but conscientious profession in contributing to the flourishing of a pluralistic, liberal, democracy, converge on the wisdom of tolerating conscientious objections by healthcare professionals, particularly regarding interventions widely thought to be morally controversial. Those who argue that tolerance is limited to freedom of worship and belief, but precludes actions in the public sphere, hold a narrow and intolerant view of tolerance, incompatible with a broadly Lockean view. Those who hold that professionals must supply upon request any and every service for which they are licensed by the state hold a distorted view of what a profession is, what a professional does, and the role of professions in a pluralistic, liberal democratic society. Absent one of these misguided premises, the argument against physician conscientious objection to the provision of morally controversial services falls apart.

What Are the Limits of Tolerance of Professional Action in a Pluralistic Liberal Democracy?

As noted, Locke argued that certain actions, such as treason, ought never to be tolerated; that freedom of worship and personal belief should be afforded almost absolute tolerance; and that public actions motivated by deep personal moral and religious views ought to be afforded wide, but not absolute, tolerance. Lockean tolerance circumscribes the wide sphere of conscientious public action by forbidding only acts that are "destructive of society," which are further specified as being destructive of the common good and/or the good order of the state. Locke's state was a monarchy, and his examples concerned the power of the monarch. What might those limits look like in a contemporary, pluralistic liberal democracy?

I have argued elsewhere that there are three questions to be asked when deciding whether a conscientious public act ought not to be tolerated, because it would truly be destructive of society.[43] An "act" is taken here to include both motor actions and intentional refrainings from action.

Does the Act for Which a Claim of Conscientious Objection Is Made Undermine or Contradict the Principle of Tolerance Itself?

It would be unjust for a person to ask for tolerance for an intolerant practice. A moral system that tolerated intolerance would be internally inconsistent. This, I think, establishes one firm boundary for tolerance.

One way to operationalize this difference between respect-worthy conscientious objection and intolerance would be to distinguish between an individual's moral objection to a class of actions versus his or her objection to a class of persons. The former ought to be afforded a wide berth of tolerance. The latter would be intolerant, and thereby would forfeit any claim to tolerance.

There are several useful questions to ask in order to probe the motives for the objection and to determine whether it represents a respect-worthy form of conscientious objection or is an instance of intolerance that cannot lay claim to tolerance. First, one should ask whether the objection is to the act itself that the clinician is asked to perform or to an act that the patient will perform, but that the clinician judges would make him or her complicit in patient behavior that he or she considers morally wrong.

If the objection is directly to a class of medical actions that the clinician is asked to perform, then the genuine conscientious objector ought to refrain from performing actions of that class for all persons (regardless of race, religion, gender, or sexual orientation) in order to be judged eligible for tolerance. For example, were one to refuse, conscientiously, to assist patients with suicide, and one were to refuse this for all patients, one's objection could be construed as an objection to the class of action and not to the person, and, therefore, other things being equal, ought to be tolerated. By contrast, were one to refuse to perform rectal examinations for gay men, while being willing to perform this examination for all other patients, then, barring some other explanation, such a refusal would seem intolerant and would forfeit a claim to tolerance.

Were the action to which the clinician objects a patient behavior (or the behavior of some third party involving the patient), the category of ethical analysis would change to an analysis of the clinician's degree of complicity in that behavior. The objecting clinician would need to justify his or her refusal to perform the requested medical action by claiming that the act would make him or her complicit in the behavior that the clinician considers morally objectionable. For such a refusal to be justifiable, the medical act he or she refused to perform for the patient would need (1) to be relevant to the objectionable behavior, (2) to meet criteria for moral complicity, and (3) to be consistently applied to all cases of performing the medical act for all patients who would be involved in the morally objectionable behavior. For example, were one to refuse to certify that a civil prisoner was medically fit for a form of legal "enhanced interrogation" that one considered to be torture, one would need to claim that one's objection was to this form of interrogation for all prisoners, and assert that the act of medical certification was relevant to the conducting of this form of interrogation and that certification was a form of complicity in the act that one considered to be an immoral form of torture. Barring other considerations, it would seem that this objection ought to be tolerated. By contrast, one ought not to tolerate the objection of a physician who refused to treat the strep throat of a Jehovah's Witness because of disagreement with the practices of that religion regarding blood transfusion, but who was willing to treat a strep throat in other persons engaging in moral wrongdoing or medically unrecommended

practices, such as tax cheaters, stock market manipulators, alcoholics, crack pushers, and narcissists. The intervention being withheld has nothing to do with the behavior that the clinician claims is morally wrong, and, therefore, the objection should be judged prejudicial and not tolerated.

Does the Act Entail a Substantial Risk of Serious Illness, Injury, or Death for Those Who Do Not Share the Belief that Is Said to Justify the Practice?

Acts that entail a high risk of serious harm to others would seem to be "destructive of society" and, therefore, undeserving of tolerance. By contrast, it would not seem that inconvenience to a small number of particular individuals would rise to the level of compelling the conscience of another, because it would not seem to meet the threshold of being destructive of society. In a medical context, a serious risk of injury or death could constitute grounds to compel conscience. Therefore, needing to travel a long distance to obtain a medical service would not seem sufficient to override tolerance. Were a patient facing imminent death, however, the moral analysis seems different. Every effort must be made both to protect the patient and to minimize any potential compromise of the physician's values, but patients who need life-saving treatment should receive it. For example, in a true life and death circumstance, were a physician morally opposed not only to performing but also, as a rule, even to facilitating an action (say an abortion), arrangements ought to be made for the action to be performed by others as a compromise.

Fortunately, in medicine, such cases are extremely rare. Those who oppose granting physicians wide conscience rights often need to go to great lengths to find actual cases in which solutions that accommodated the needs and convictions of all parties were not possible. Such cases are so rare that although there is documentation that women do die (extremely uncommonly) from legal abortions,[44] there have been no documented cases of women dying in the United States, over the more than four decades since abortion became legal, because of lack of access to the procedure as a consequence of conscientious objection by physicians. This suggests that conscientious objection to abortion is less dangerous than abortion itself. Those who advance such arguments are, therefore, forced to rely on fictional, hypothetical cases, or must rely on an overly broad construal of harm, such as by the claim that if 70% of the gynecologists in a country oppose abortion this itself represents a harmful inconvenience. Such arguments are specious. A far smaller fraction of gynecologists in most nations perform in vitro fertilization. One does not consider this state of affairs a "harm" to infertile women who need to expend some extra effort to find specialists rather than seeing their neighborhood physicians to obtain advanced fertility services. Locke had trust that the general reasonableness of the people would prevail as long as they were prevented from using force against one another. People tend to be able to find ways to figure things out and get along with each other when they come to a moral impasse, even if they disagree, without the need to pass laws governing each possible source of disagreement.

Is The Act an Action or a Refraining From Action?

As a general rule, substantially greater moral justification should be required to compel someone to perform an action in the name of tolerance than should be required to compel someone to refrain from an action in the name of tolerance.

It is more onerous to compel someone to do something he or she considers to be morally wrong, than to compel someone not to do something he or she considers a moral duty. It would seem to require a greater degree of harm to the common good or the well-ordered functioning of the state to compel people to perform public actions contrary to conscience than to require them to refrain from public acts that they feel conscientiously motivated to perform. For example, it would seem consistent with the notion of tolerance to prohibit physicians from proselytizing patients in the setting of the physician–patient relationship. One can compel a citizen to refrain from an act that represents an abuse of power that, if unchecked, might threaten the common good, no matter how zealous the clinician might be to save the patient's soul. No one should object to prohibiting physicians using the physician–patient relationship as a pretext for proselytizing patients.

Far more moral justification should be required, however, to compel the performance of an action that an individual finds conscientiously objectionable. Majority rule would not suffice in a truly pluralistic, liberal democracy. Suppose, for example, that 50.1% of the population of a country were to adopt a form of Islamic belief that included support for female circumcision. Suppose that that nation's highest court were to find that its constitution guaranteed a right to female circumcision, although not finding constitutional grounds to compel the minority to perform this procedure on themselves or on their children. Ought such a society therefore to demand that the conscientiously objecting individual physicians that it licenses perform that procedure, simply because that society has determined that there is a legal right to have it performed? Or ought that society to compel conscientiously objecting physicians to refer those who seek this procedure to clinicians who would be willing to do so? This seems beyond what a truly pluralistic liberal democracy ought to require of its citizens. The fact that someone might have a right to a procedure does not require that everyone capable of performing the procedure must provide it to her on demand.

Compelling citizens to do something that they think is wrong would surely seem to require much more justification than forbidding them from doing something that they think is morally praiseworthy. It would, therefore, seem that tolerant societies would set a very high threshold for compelling the performance of a practice in violation of conscience. Conscientious refraining from actions when such restraint does not risk illness, injury, or death, would not seem to rise to the level of being sufficient grounds for compelling conscience.

Conclusions

Inasmuch as a plurality of views about the nature, purposes, and goals of medicine is becoming more common, one can expect that disagreements about what tests and treatments a physician ought to order will also become more common. Patients will disagree with their physicians (and physicians will disagree with one another) about the goals of medicine and about what constitutes a technically correct and morally good intervention. One can hope for better clarity and collective personal and societal agreement; however, for the foreseeable future, there will be substantial disagreement at the edges. Is medicine about promoting and maintaining the biological flourishing of human beings as members of the human natural kind, or is it a technological service to be used by individuals as they see fit for any purpose they subjectively choose? Should normal-statured children be given growth

hormone to make them taller? Should sex-selection abortions be permitted? Are drugs indicated for cognitive enhancement? Should euthanasia be legalized? The more of these issues we confront, the more important it will become for society to maintain its respect for the physician's discretionary space and for general conditions of tolerance to prevail. Jan Hoogland and Henk Jochemsen have argued that these considerations demand what they call "an ethics of restraint."[45] Fortunately, the main bulk of medical interventions still retain a broad consensus. Patients will continue to seek treatment for myocardial infarctions and diabetes and pneumonia, and physicians will continue to provide treatments to which all agree. Because of this, it makes little sense to demand that physicians provide all treatments or find another job. In the vast majority of cases, there will be no moral disagreement. In the rare instances in which disagreements occur, patients can generally find alternative sources of care from practitioners who will provide what they want. Under these conditions, our view of conscientious objection in healthcare ought to be guided by a spirit of Lockean tolerance, informed by a reasonable understanding of what a profession is and of the proper role of the healing professions in a well-ordered society.

Notes

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