1. Introduction

Sometimes medical professionals are asked to provide (or assist in providing) forms of medical treatment or medication to which they have a conscientious objection—that is, treatment or medication that they are opposed to providing on moral or religious grounds. In such cases, medical professionals face a difficult choice. If they decide to follow their consciences by refusing to provide the requested medical interventions, this has the potential to negatively affect patients as well as colleagues. For patients, these potential negative consequences include the inconvenience of seeking out alternative medical professionals who will provide the requested medical assistance, negative or unwanted health effects resulting from the delay, and a negative impact on one’s emotional or psychological state stemming from feeling judged by the conscientious objector. For the medical professional’s non-objecting co-workers, these potential negative consequences include the increased burden to pick up the slack in providing the forms of treatment and medication that their objecting colleagues refuse to provide. If, on the other hand, objecting medical professionals decide to violate their consciences by providing the requested assistance despite their beliefs that it is wrong for them to do so, this would be to compromise their moral integrity. Compromising one’s moral
integrity is a high personal cost to pay, one which also carries potential negative consequences for society on the whole.¹

Two questions arise here which are related but distinct. One question concerns the moral permissibility of these alternatives for the individual practitioner: When, if ever, is it morally permissible for medical professionals to refuse to provide (or assist in providing) forms of medical treatment or medication owing to their having a conscientious objection to doing so? The other question concerns the kinds of law and policy we should have in place to govern conscientious objection and conscientious refusal in health care: When, if ever, should medical professionals be permitted to refuse to provide (or assist in providing) forms of medical treatment or medication owing to their having a conscientious objection to doing so? My focus here will be on the second question, though some of what I will say can also be applied to debates surrounding the first question.²

The longstanding dominant view is that medical professionals should be permitted to refrain from providing (or assisting in providing) forms of medical treatment or medication owing to their having a conscientious objection to doing so.³

¹ For more on the personal value of moral integrity, as well as the benefit to society of having citizens who cultivate and protect their own moral integrity, see Myskja and Magelssen (2018).
² Note that, though related, these questions are distinct. There are actions (such as cheating on one’s spouse) that many people think are morally impermissible but should not be illegal, just as there are actions (such as riding a motorcycle without a helmet) that many people think are morally permissible but should not be permitted. Similarly, even if there is significant overlap between those who believe that conscientious refusal is morally permissible and those who think it ought to be permitted as a matter of law and policy, as well as between those who hold that conscientious refusal is morally impermissible and those maintaining that it ought to be prohibited as a matter of law and policy, one’s view on the moral permissibility question does not logically commit one to a corresponding position on the policy question.
treatment and medication when they have a conscientious objection to doing so in a broad range of cases. I will refer to this position as Broad Accommodationism. Unlike a position we might call Total Accommodationism, Broad Accommodationists hold that there may be some instances of conscientious refusal that should not be permitted, even though conscientious objections should be accommodated in the majority of cases. This is the official position of the American Medical Association, as well as numerous other professional medical associations. It is also the dominant position in most state legislatures, as evidenced by the fact that most states have laws on the books (often called “conscience clauses”) explicitly protecting medical professionals from termination, punishment, or other negative repercussions for conscientious refusal.

In recent years, a growing minority have been fervently advocating a sea change. In their view, which I will call Non-Accommodationism, medical professionals should never be permitted to refuse to provide (or assist in providing) particular medical interventions on the grounds that doing so conflicts with their personal moral or religious views. For instance, in a recent and widely-discussed paper in The New England Journal of Medicine, Ronit Stahl and Ezekiel Emanuel (2017) argue that health

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3 See Cantor and Baum (2004).
4 For example, few, if any, Broad Accommodationists would endorse allowing medical professionals to refuse to provide medical treatment to people of particular races or religions, even granting that those practitioners had a sincere conscientious objection to doing so. On other kinds of cases, such as whether conscientious objections to providing referrals ought to be accommodated, Broad Accommodationists might be more divided. On this last point, see Finegan (2019). Cf. Greenblum and Kasperbauer (2018).
care professionals who are unwilling to provide certain medical interventions that the medical profession has deemed legitimate “have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession” (1383).

My aim in this paper is to evaluate one of the main arguments offered for Non-Accommodationism. This argument focuses on the fact that medical professionals voluntarily chose to take on their professional roles. I will argue that this argument fails to provide us with good reason for rejecting Broad Accommodationism in favor of Non-Accommodationism.

2. The Argument from Voluntariness

One of the most commonly offered arguments for Non-Accommodationism focuses on the fact that, unlike conscripted soldiers, medical professionals volunteered for these positions, knowing what they involved. As Stahl and Emmanuel put it:

No one is forced to be a physician, nurse, pharmacist, or other health care professional or to choose a subspecialty within their larger field. It is a voluntary choice. By entering a health care profession, the person assumes a professional obligation to place the well-being and rights of patients at the center of professional practice. This obligation is not unlimited, but exemptions are reserved for cases in which there are substantial risks of permanent injury or death. (2017, 1382)
Let us grant that the general point about health care practitioners having voluntarily chosen to occupy their professional roles is correct.

There are two major problems with relying on this point to argue for Non-Accommodationism. The first problem with this kind of argument is that, even assuming that the point about voluntariness is correct, it’s not at all obvious how we are supposed to get from that claim to the conclusion that medical professionals should not be permitted to refuse to provide (or assist in providing) certain forms medical treatment or medication. It is not an immediate inference, logically speaking. For the argument to be valid, this claim will need to be joined with another premise. It is precisely at this point that the argument runs into difficulty.

To illustrate the problem, consider the following principle, as an example of the kind of bridging premise that is needed:

(V) If a person voluntarily takes on a job while knowing that doing this job involves performing a certain task, then that person should not be permitted to refuse to perform that task on the grounds that doing so conflicts with their moral or religious views.

As stated, such a principle is ambiguous, as there are different ways of understanding what it is for a job to involve performing a certain task. One rather broad way to understand what it is for a job to involve performing a certain task is merely for it to be the case that some people with that job sometimes perform that task in the course of
doing that job. Understanding the claim in this way would yield the following disambiguated version of (V).

(V*) If a person voluntarily takes a job while knowing that some people who have that job perform a certain task in the course of doing that job, then that person should not be permitted to refuse to perform that task on the grounds that doing so conflicts with their moral or religious views.

If accepted, V* would certainly be capable of supporting the non-accommodationist conclusion that doctors, nurses, pharmacists, and other health care practitioners should not be permitted to refuse to provide (or assist in providing) medical services and medications provided by other similar practitioners, such as abortions and all manner of contraceptives (to name just two particularly salient examples).

The trouble with V*, however, is that it is totally implausible. The overly broad interpretation of what it is for a job to involve performing a certain task renders it vulnerable to numerous counterexamples. Consider, for instance, a person who voluntarily joins a police department while knowing that some police officers in that department sometimes coerce confessions and plant evidence in the course of doing their job. V* implies that such a person should not be permitted to refuse to participate in coercing confessions and planting evidence on the grounds that doing so conflicts
with their moral or religious views. Similarly, consider a person who becomes a journalist while knowing that some other journalists have intentionally distorted the facts, ignored evidence, and repeated false information in the course of doing their job. V* implies that such a person should not be permitted to refuse (or protected from negative repercussions for refusing) to participate in these activities on the grounds that they believe it would be morally wrong for them to do so.

One way to avoid these problematic implications is to rely on a narrower understanding of what it is for a job to involve performing a certain task. One narrower way of understanding this is for a task to be an essential part of doing a job. Interpreting the claim in this way would yield the following version of (V):

(V**) If a person voluntarily takes a job while knowing that performing a certain task is an essential part of doing that job, then that person should not be permitted to refuse to perform that task on the grounds that it conflicts with their moral or religious views.

On the face of it, V** looks to be considerably more plausible than V*. Unlike V*, V** does have the infelicitous implication that police officers should be required to participate in coercing confessions and planting evidence, nor does it imply that journalists should be required to intentionally distort the facts, ignore evidence, and repeat false information. The problem here, however, is that it is not at all obvious that

5 One who worries that such activities are illegal can simply imagine it occurring at a time and place where it was not.
it will be useful in mounting an argument for non-accommodationism, and so cannot
do the work set out for it. Many of the tasks to which various health care professionals
have a conscientious objection are not obviously essential to their job. Indeed, some of
these practices—including some of the most salient examples, such as abortion—were
not even legal or professionally approved until relatively recently. It would be rather
startling to claim that these practices are now not only legitimate medical practices but
essential to the practice of medicine (even in particular subspecialties). It seems rather
implausible, for example, to maintain that providing (or assisting in providing) abortion
is an essential part of obstetrics and gynecology—especially given that there are so many
obstetricians and gynecologists who go their entire career without participating in these
procedures. The same goes for prescribing life-ending medication and participating in
physician-assisted suicide for those working in geriatrics. Thus, neither V* nor V** seem
promising candidates for bridging the gap in this argument for Non-
Accommodationism.

There is a second problem with the argument from voluntariness for the claim
that conscientious objections among health care practitioners should not be
accommodated by permitting conscientious refusal. This problem stems from the fact
that Broad Accommodationism is not a new proposal; it is longstanding policy. Why is
that important? When those who are currently doctors, nurses, and pharmacists
voluntarily chose to take on their professional roles, they did so with the explicit
understanding that conscientious objection would be accommodated and they would not be required to provide (or assist in providing) medical interventions that conflicted with their personal moral and religious views. So, it’s no good arguing that conscientious refusal on the part of health care practitioners should not be permitted because they voluntary took these positions and they knew what they were getting into. Indeed, they did! They were getting into a field that explicitly allowed for conscientious refusal. Okay, so much for the argument from voluntariness.

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6 There are some limited qualifications to this, of course. See n. 4.
Works Cited


