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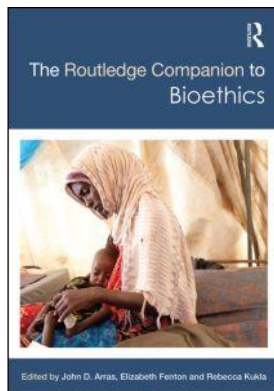

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Conscientious Refusal and Access To Abortion and Contraception

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Part VI

REPRODUCTION

Beginning-of-life decision-making represents a major field of contemporary bioethical interest. While it may be tempting to construe this area as primarily asking questions about abortion and contraception, the authors in this section reflect the variety of issues at stake with respect to reproduction. These topics, ranging from assisted reproductive technologies (ARTs) to population control to disability, demonstrate the complicated relationships between individuals and groups that pose some of the crucial ethical dilemmas in this literature.

As is evident from the previous section on autonomy and agency, the ideal of self-governance is immensely important not only for bioethics, but for Western social and political culture writ large. However, the reproductive domain inherently implicates multiple moral agents, including potential parents, families, gamete donors or surrogates, medical practitioners, members of social groups, as well as the new entity (or entities) being conceived (the moral status of which has been hotly contested). These relationships between individuals involved in the reproductive process raise questions about the extent to which one person's autonomy can or should be privileged in the face of countervailing interests, especially in such cases where moral obligations to others are far from clear.

Carolyn McLeod and Chloë FitzGerald speak to this very question when considering the legitimacy of conscientious refusal to provide reproductive health services, such as abortions or contraceptives. Because such services are legal in many jurisdictions, one might suppose that their citizens ought to have ready access to them if they so choose. However, many bioethicists agree that conscientious refusal is permissible in some cases on the ground that requiring medical professionals to provide services that contravene their deeply held moral convictions could be seen as a violation of individual autonomy. In reviewing the literature in support of conscientious refusal, McLeod and FitzGerald argue that even a restricted scope of refusal runs the risk of significantly interfering with women's reproductive autonomy, while relying on a construal of conscience that is difficult to defend. On their view, an adequate account of acceptable refusal must focus more on potential harms to patients, particularly when the implications of refusal have a disproportionate likelihood of harming women and thus have downstream consequences for justice.

While some women are faced with concerns about the availability of abortions or contraceptives, other women struggle to conceive, and so avail themselves of in vitro fertilization (IVF) or other ARTs to try to become pregnant. However, the production

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of embryos outside of the body raises questions about what ought to be done with the embryos that are not needed for reproductive objectives. Can such embryos legitimately be used for research without harming those who helped to produce them? Can scientists legitimately produce embryos solely for the purpose of research? Françoise Baylis considers the various claims regarding the moral status of embryos, and the harms that can accrue as a result of the overproduction of ova, for whatever purpose. Because of the increasing popularity of IVF and the need for scientific research on the early phases of human embryonic development, Baylis advocates for a nuanced view of embryo use that can support both reproductive and scientific aims.

The legitimacy of the scientific use of embryonic materials can be seen as a question stemming from broader considerations about the regulation of reproductive technology. No matter the ultimate consensus on experimentation, regulation regarding ARTs has powerful consequences, as laws regarding when and where ARTs can be used impact not only reproductive autonomy, but also help steer social norms of reproductive behaviors. Isabel Karpin takes as case studies the regulations of several nations governing ARTs, and suggests that the liberal legal notion of a bounded individual is intrinsically threatened by pregnancy, which muddles straightforward notions of where one body ends and another begins. Karpin proposes an understanding of the pregnant body as "not-one-but-not-two" in order to capture the relationality inherent in any conception of reproduction, and suggests that an understanding of autonomy as relational can be applied even to cases where the embryo exists outside of the human body. In so doing, she aims for an embodied, feminist analysis of reproductive regulation.

Reproduction as understood in this section involves not only biological reproduction (i.e., conception), but also social and ethical reproduction (for example, the ongoing process of raising and socializing children). An important element of this latter form of reproduction is assuring children's health, a role obligation typically seen as part and parcel of parenthood. Even while parents may rightly be supposed to have responsibility for the health of their children, Amy Mullin suggests that non-parental actors also have legitimate interests in ensuring the health of children in their communities. However, the standard of health cannot be too onerous, as all interests concerning the community must be weighed against others. Mullin uses the capability approach to argue for a right to minimally decent care for children, while illustrating that this standard cannot be met without support from both parents and the state. By identifying children as members of social communities with independent moral status, Mullin can be seen as expanding upon the notion of relationality introduced earlier in this section.

Relationality is salient for autonomy not only among individuals or between individuals and communities, but also between communities themselves. In an increasingly globalized world with variable laws and social mores, it is becoming more and more commonplace to see citizens of one country travel to another for reproductive services unavailable in their own jurisdictions. While such international movement can allow individuals to make reproductive decisions that would be impossible in their home countries, such "reproductive travel" can have problematic consequences. While this practice may enhance reproductive autonomy for would-be travelers, G.K.D. Crozier cautions that this enhancement is not available in an egalitarian way, and can lead to exploitation of foreign gamete providers as well as unacceptably permissive reproductive legislation. Crozier makes clear the intersection of reproductive travel with other bioethical concerns discussed throughout this volume, including medical tourism, the sale of biological materials, and the need to weigh concern for autonomy with justice and egalitarianism.

The international arena is salient for reproduction not only with respect to the kinds of pregnancies made possible by globalization, but also the overall quantity of pregnancies worldwide. Since 1959, the global population has more than doubled, while economic and industrial development has led to the unprecedented use of resources to support human life. This has led to widespread environmental concerns about the carrying capacity of the planet, and activist efforts to minimize rapid population expansion to a leveling-off point, where reproduction is no longer potentially perilous on a global scale. If limiting reproduction is imperative to saving the planet, this will undoubtedly have implications for justice, since fair policies must be articulated that determine who can reproduce and how often. Margaret P. Battin considers the impacts previously imposed regulations have had in the developing world, and suggests that family planning mandates, like those of India's vasectomy program and China's one-child policy, can have negative repercussions for autonomy by introducing state coercion into reproduction, which has been criticized on both feminist and religious grounds. However, the epistemological uncertainty underpinning any future projections about population results in Battin's thoughtful—yet measured—proposal to consider how we might address population concerns in an ideal world while still protecting reproductive rights.

Finally, Adrienne Asch and David Wasserman consider justice and population from a different vantage point; one that returns to the issues of ARTs discussed earlier in this section. While technologies like IVF have enabled otherwise infertile couples to conceive, other advancements in the technology of reproduction have generated means to avoid the reproduction of certain traits. Prenatal genetic testing has enabled couples to find out if their children will be (or will be likely to be) born with certain disabilities, which enables parents to decide whether they are willing to parent disabled children. Such a decision, Asch and Wasserman argue, is incompatible with a view that considers the lives of the disabled to be equally valuable or worthwhile compared with the lives of the able-bodied, and ignores many first-person accounts of the quality of life with a disability. While it might be supposed that the possibility of terminating an impaired pregnancy increases reproductive options, Asch and Wasserman point out that, in fact, biases against the disabled often lead to pressures that preclude the possibility of continuing an impaired pregnancy. They also consider such selection to be incompatible with a desirable ideal that parents "unconditionally welcome" their children, whatever they might be like, and obscures the fact that even able-bodied children may deviate from parental expectations. In this chapter, Asch and Wasserman argue that although selecting to have certain kinds of children might seem to empower parents, it can also serve to undermine the status of entire communities.

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CONSCIENTIOUS REFUSAL AND ACCESS TO ABORTION AND CONTRACEPTION

Carolyn McLeod and Chloë FitzGerald

Conscientious refusal in health care refers to refusals by health care professionals to provide (or not to provide) certain health care services. The most widely cited examples involve physicians and nurses who refuse to perform or assist with the performance of an abortion and pharmacists who refuse to dispense contraceptives. The topic of conscientious refusal in bioethics is closely tied to debates about access to abortion and contraception and about how we conceive of the role of health care professionals and their obligations to their patients.

Abortion and contraception raise issues of conscience among health care professionals because strong religious or moral beliefs that concern the legitimacy of these services are common. Prime examples are beliefs about the status of fetuses and embryos, women's reproductive freedom, and the purpose of procreation. There are opposing views on these issues that can polarize societies, despite the fact that abortion and contraception are legally available in most of the developed world and often covered by state-funded health provision.

Although conscientious refusals *to* provide abortions or contraception are more well known, conscientious refusals *not to* provide these services have also occurred. In other words, some health care professionals insist on offering abortion or contraceptive services even when they are prohibited, because not doing so violates their conscience. James Childress mentions the example of physicians who secretly provided information on contraception to couples in Connecticut when there was still an anti-contraceptive law in vigor, an action he calls "evasive noncompliance" (Childress 1985, 68–9; see also Harris 2012). Which professionals make conscientious refusals on an issue depends to some extent on the legal status quo. In the current situation, where abortion and contraception are typically legal and form part of the standard services provided by health care professionals, conscientious refusals that concern abortion or contraception will be refusals to provide (rather than not provide) services. We focus predominantly on these refusals.

In the first section, we provide more details on the nature of conscientious refusal in health care and discuss how refusal impinges on access to abortion and contraception. We approach the considerable, while qualified, support for this phenomenon by bioethicists

in the second section. We express worries in the third section about certain aspects of this support and the view of conscience on which much of it is based. Finally, the fourth section explores the implications of alternative conceptions of conscience—those that we have each proposed elsewhere—for the bioethics education of health care professionals. Our focus here is on education about patient access to abortion and contraception. Our general position on conscientious refusal, which informs our discussion throughout, is that accommodation for conscience in health care can be appropriate. But such a policy must be grounded in a more nuanced view about conscience than what we tend to see in the bioethics literature; and it must take seriously the political nature of conscientious refusals and their likely impact on women's access to abortion and contraception.

Conscientious Refusal: The Phenomenon and Its Impact

The phenomenon of conscientious refusal by health care professionals is complicated by the variety of kinds of services that the refusals can target and by how the phenomenon differs from paradigm cases of conscientious objection. We cover these issues first and then turn to what is known about the impact of conscientious refusals on access by patients to abortion and contraceptive services.

Depending on the kind of professional involved (doctor, nurse, or pharmacist), conscientious refusal that concerns abortion or contraception can be a refusal to do the following: Perform an abortion; prescribe or dispense contraception, emergency or otherwise; prescribe or dispense contraception to a particular group (e.g., unmarried women); refer a patient to another professional for abortion or contraceptive services; provide information on abortion or contraception; train to perform abortions and related procedures; stock contraception (i.e., in one's pharmacy); or simply participate in any way in the provision of these services. Conscientious refusal can therefore target a range of services, from providing patients with a particular service to offering them information about it.

However, conscientious refusal is directed not only at a certain health care service (or set of services), but also at the expectation that the relevant professional will provide the required service. This expectation comes from professional norms or policies, or from legal rules. Normally, the objector does not refuse a direct order by an authority to meet the relevant expectation; and in this way, conscientious objection in health care differs from the tradition of conscientious objection by pacifists to comply with the military draft. What many objectors in health care refuse to do is accede to a request by a patient, who may hold an expectation of care, but who neither issues an order nor has authority over the objector. As a result, relevant authorities (e.g., the health care professional's college or professional association) will not know about an objector's refusal unless the patient complains about it or the objector makes her objection public. To be sure, some conscientious objectors in health care are like pacifist objectors in that they refuse to comply with a direct order by an authority (e.g., an order by a physician to a nurse); however, many enjoy too much autonomy in their practice for that to be true.

Conscientious refusals in health care can go unnoticed not only by authorities, but also by patients themselves, particularly if health care professionals are not clear about why they will not fulfill patients' requests. Thus, because of how very private they can be, the frequency of conscientious refusals in health care is unknown. However, their impact on others can be substantial. Unlike a citizen refusing the military draft whose action has at most a statistical effect on the numbers fighting for a nation, a conscientious refusal in

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health care typically has direct effects on patients, some of which can be severe (e.g., unwanted pregnancy). Moreover, when conscientious refusals in health care target abortion or contraceptive services, women are disproportionately affected.

Although the numbers of conscientious refusals by health professionals are difficult to measure, they seem to be significant enough to create serious obstacles to access to abortion or contraception in some places. In the United States, for example, the political and legal prominence of the issue (many health care professionals in the U.S. have a legal right to conscientious refusal; Charo 2007; Downie 2012; Dykes 2002) and the media attention it attracts (Dale 2004; Editorial 2007; Stein 2006, 2008, 2012) suggest that the frequency of conscientious refusals is quite high. The issue is growing in political importance in other countries, including Canada (Downie and Nassar 2008; Rodgers and Downie 2006), the U.K. (Deans 2013; Laurance 2007), Spain (Sánchez Esparza 2012), South Africa (van Bogaert 2002), and Italy (Palma 2012). There have been reports in some of these countries of serious restrictions, even "black-outs," to abortion access because of conscientious refusals. (See Cannold 1994 for an example from Australia.) The potential for conscientious refusals to limit access to abortion severely is a reality in some parts of the world.

Conscientious refusal in health care is intimately tied to the political and moral debate about abortion, especially in the U.S. There, the right of health care professionals to issue such refusals was not a topic of serious debate until the Supreme Court decriminalized certain kinds of abortion in *Roe v. Wade* (Stein 2012). Nonetheless, some bioethicists approach the issue as though it had little to no connection to the politics of abortion. We criticize this tendency in the next section.

Support for Conscientious Refusal in Health Care

There is broad support in the bioethics literature for the claim that health care professionals have a right (or at least should be permitted) to refuse conscientiously to provide services; however, this support is not unqualified. In this section, we outline the different qualifications that bioethicists defend to this right. We also discuss the method that some of them use to defend their moderate endorsement of conscientious refusals.

The majority of bioethicists who have commented on conscientious refusal take a moderate stance: That is, one that permits refusal but at the same time restricts it. The limitations on refusal that bioethicists defend concern the kinds of refusals that health care professionals can make, when they can make them (e.g., not in emergencies), and possibly how they do so (Benjamin 1995; Blustein 1993; Brock 2008; Card 2011; Charo 2007; Childress 1997; Deans 2013; Fenton and Lomasky 2005; LaFollette and LaFollette 2007; Lynch 2008; McLeod 2010; Meyers and Woods 2007; Wicclair 2000, 2011). Julian Savulescu is somewhat unusual in his extreme view that health care professionals (he focuses on physicians) have no right to conscientious objection, although they could permissibly make objections that do not compromise "the quality, efficiency, or equitable delivery of a service" (2006: 296; see also Kelleher 2010 and Kolers 2014). According to Savulescu (2006: 296), physicians are responsible for providing all "legal and beneficial care," and their conscience should not interfere with them doing so.

Different limitations on what is permitted distinguish different versions of the moderate position on conscientious refusal in health care. The following is a non-exhaustive list of moderate views that appear in the literature. A conscientious refusal is permissible if and only if:

- The objector is willing to make a timely referral to a professional who will perform the relevant service (Cantor and Baum 2004; Charo 2007).
- The objector is able to show that her objection is genuine—that it stems from a sincerely held moral or religious belief (Benjamin 1995; Lynch 2008; Meyers and Woods 1996).
- The refusal respects the "core values" of the profession (Deans 2013; Wicclair 2000, 2011).
- The objector has registered her refusal with her licensing board, which is an institution that should be charged with ensuring that patients get the services they need (Lynch 2008).
- The objector works in an area in which the patient could easily get the service somewhere else close by (Fenton and Lomasky 2005).

Most authors also argue that to be morally permissible, a conscientious refusal cannot be explicitly discriminate against a minority social group (e.g., be racist), nor can it occur in an emergency situation.

Most of the above restrictions do not preclude health care professionals from refusing in many contexts to perform abortions or to prescribe or dispense contraception. More generally, many bioethicists have taken positions that, while qualified, do not prevent them from endorsing or allowing much conscientious refusal in health care. Overall, support among bioethicists for conscientious refusal is considerable. We point this out, not because we believe that conscientious refusal should be banned necessarily, but because we worry about the implications that such support has for women's freedom to access abortion or contraception. As noted above, conscientious refusals can have a substantial negative impact on women's ability to obtain these services.

Granted, support from bioethicists tends to be weaker for pharmacists who object to emergency contraception (EC), compared with physicians who refuse to perform abortions. Pharmacists who object to EC often do so because they believe that EC is an abortifacient and is, as a consequence, morally wrong. Such refusals by pharmacists are typically grounded in empirical beliefs about the mechanisms of action of EC that are questionable at best, which helps to explain why bioethicists have little sympathy for them. In general, refusals to prescribe EC are heavily criticized in the literature (e.g., Card 2011; Greenberger and Vogelstein 2005; Kelleher 2010).

In defending moderate positions on conscientious refusal, bioethicists often employ extreme examples unrelated to abortion and contraception that most of us, regardless of our views on abortion, would agree are highly morally desirable or morally undesirable. Bioethicists use the former type—the morally desirable refusal—to help motivate the view that conscience is worth protecting among health care professionals. For instance, if a physician who was working under the Nazi regime in Germany conscientiously refused to be involved in the killing of Jews, he would reveal the kind of conscience most of us would want to protect in health care (McLeod 2008: 37).

Bioethicists use cases at the opposite extreme—that is, refusals that almost anyone would consider morally abhorrent—to show that limits on conscientious refusal in health care are essential, even when the refusals are based on sincere moral convictions. Mark Wicclair (2000: 216) invents the example of a physician who has a deeply held moral belief that pain is a sign of a moral flaw and therefore should be endured. This physician conscientiously refuses to prescribe medication for pain. Dan Brock (2008: 190) imagines a white physician who sincerely believes that racial mixing is morally

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wrong and thus conscientiously refuses to treat black patients. Both of these examples are of conscientious refusals that are clearly unacceptable. Because of cases like them, conscientious refusal, or protection for it, cannot be unlimited in health care.

It is worthwhile considering extreme examples of conscientious refusal that are removed from the debate over access to abortion and contraception; they can allow one to develop a universal analysis of conscientious refusal and can also provide clues about the moral dimensions of refusals to provide abortion and contraceptive services. However, too much focus on these cases and not enough on those that involve abortion, contraception, or the like (e.g., sterilization) is problematic for two reasons. First, it leaves us with theories that do not say enough about whether or when the latter are morally justified, given what is special about *them*: For instance, the significant impact they can have on women's reproductive freedom. Second, it simply misrepresents the phenomenon of conscientious refusal in health care (at least within the U.S.), which arose in the midst of heated debate about abortion and is still embedded to some degree in this political context. Conscientious refusal is tied—in health care, not in the military—generally speaking with right-wing political agendas and opposition to them, particularly agendas that favor the traditional family and women's place within it. Portraying the phenomenon as though it either did not have this connection or was politically neutral is misleading.

Further Criticisms of the Literature

We see at least two additional problems with the literature on conscientious refusal: It is often too one-sided, focusing more on the potential harm to conscientious objectors if forced to violate their conscience than on the consequences for patients if they do not have access to treatment; and much of the literature is grounded in a view about conscience that is unpersuasive. Let us discuss each of these issues in turn.

McLeod (2010) highlights an instance of the first problem when she argues that bioethicists have failed to think clearly about the negative consequences women (or girls) are likely to face when conscientious objectors deny them access to EC. In her view, these consequences amount to more than mere inconvenience, which is how some bioethicists assess them (e.g., Fenton and Lomasky 2005). It is more likely that women will be harmed rather than merely inconvenienced by a conscientious refusal of EC, according to McLeod, even when they could get the drug at another pharmacy close by. She explains how in circumstances where the drug is widely available, conscientious refusals to provide EC can still interfere with women's interests: More specifically with "their autonomy in obtaining EC . . . their moral identity (as a good or fine person), and [their] sense of security" (i.e., security in knowing that their society respects their ability to decide what happens to their own bodies) (2010: 19, 20). Women's reproductive autonomy is at stake because a refusal can be so emotionally difficult that a woman stops trying to get EC and decides to take her chances with getting pregnant (see also Kelleher 2010: 302). Such outcomes are dependent, according to McLeod, on the socio-political context in which conscientious objections to EC occur. Currently this context is one in which negative social stereotypes influence what it means for women to request EC and for someone to deny such requests on moral grounds. The relevant stereotypes include "that women who are sexually promiscuous are of low character—they are 'sluts' or 'whores'—and [that] women, more so than men, who have unprotected sex are 'irresponsible' or 'careless'" (McLeod 2010: 18, citing Stubblefield 1996).

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Because of this oppressive social context, women tend already to be vulnerable when they seek EC. Their social position puts them at serious risk of harm when pharmacists or other health care professionals refuse them access to EC. Even if a woman who has this experience manages to continue her search for the drug and obtain it from another pharmacy, the refusal at the first pharmacy can be damaging to her (e.g., to her bodily security). Moreover, regardless of how the refusal is made, it can be harmful. The pharmacist could be as kind and caring as possible when stating his moral objection and yet still make the woman feel horrible, in part because one can only do so much to deflect the negative social meanings of one's actions.

Overall, McLeod's argument reminds us that bioethicists need to probe in detail what the effects of conscientious objections to abortion and contraception are on women *within* the societies in which they live: That is, societies that are sexist, racist, and in other ways morally non-ideal. If McLeod is correct about what these consequences are like, then the feminist struggle to ensure that women have access to abortion and contraception continues even where these services are legal *and* readily available, so long as there is some conscientious refusal.

The second problem we see with the literature on conscientious refusal is that it tends to rely on a particular understanding of conscience and why conscience is worth protecting that is flawed. What McLeod calls the "dominant view" of conscience in bioethics is explicitly defended by Martin Benjamin, Jeffrey Blustein, James Childress, and Mark Wicclair (McLeod 2012: 161–81; Benjamin 1995; Blustein 1993; Childress 1979, 1997; Wicclair 2000, 2006). These authors associate the value of conscience (or of listening to one's conscience) with having moral integrity, and in turn, define moral integrity in terms of psychological unity, or more specifically, unity between one's moral principles and commitments and one's actions. The violation of integrity, so understood, is harmful, according to this view.

We see three problems with the conception of conscience just described:

1. It prioritizes the preservation of psychological unity over the development of an individual's moral values.
2. It provides no incentive for an agent to rethink her moral values, encouraging a view of conscience as fixed.
3. It focuses exclusively on the explicit attitudes of conscientious objectors, neglecting the implicit attitudes that can also influence their behavior and thus lead them to violate their conscience.

The first concern lies with what the dominant view takes to be wrong with denying professionals the right to conscientious refusal. The idea is that if a health care professional cannot abide by her conscience, she loses psychological unity (i.e., integrity). And this is bad for two reasons: Unity is part of what constitutes a good life (Blustein 1993; Benjamin 1995: 470); and desire to repair "inner division" is an admirable characteristic of persons (Blustein 1993: 297).

However, it is not clear that the function and value of conscience lie in protecting psychological unity. Obeying one's conscience and going against the grain of social norms under considerable social pressure can make people feel less, rather than more, psychologically unified. McLeod describes an example (based on the real case of Lois Jenson) of a woman who listens to her conscience telling her to stand up for herself and press charges in the face of debilitating sexual harassment at work. Because the woman

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receives little support in her endeavor and instead faces a worsening situation and mounting social pressure, she begins to doubt that she has done the right thing in listening to her conscience. She loses confidence in her perspective and starts to loathe herself. In sum, she loses rather than gains psychological unity as a result of listening to her conscience (McLeod 2012).

McLeod's feminist relational perspective on conscience and consequent consideration of scenarios in which the protagonist is part of an oppressed group help to highlight the disunity that conscience can bring. However, the point can be made even if we limit ourselves to more traditional examples of powerful men in positions of privilege. Literature, film, and popular myth are replete with examples of heroes who struggle with their conscience. Moreover, obeying conscience is often depicted in these narratives as a process that makes one feel *less* psychologically unified. For instance, the Thomas More of the 1966 film, *A Man for All Seasons*, remains true to his religious and moral values and refuses to swear the oath required by law because it challenges the Pope's power; yet he doubts and struggles with himself in the process, particularly in the face of the suffering his decision inflicts on those dear to him. Granted, he might enjoy some psychological unity when he finally faces execution for his beliefs, at which point he appears to be at peace with himself. But even assuming that is true, obtaining such unity was not More's aim in following his conscience, nor does it capture what we value most in his actions. Rather, we appreciate the fact that he struggles to work out what he values and to do the right thing by his own lights. On this view, conscience is valuable precisely because it prevents us from blindly following whatever the social norms of the day dictate and encourages us to make our own moral choices (McLeod 2012; FitzGerald 2014).

A second and related problem with the dominant view about conscience in bioethics is that its insistence on psychological unity does not encourage rethinking the values that one upholds through one's conscience; instead it tends to present conscience as the reinforcement of a fixed set of values. For example, Mark Wicclair (2000: 214) refers to the "core ethical values" involved in conscience that are "integral" to a person's "self-conception or identity," as if these values did not change over time. Although Wicclair and other proponents of the dominant view do not explicitly say that conscience involves a fixed set of values, we suspect that this idea is lurking behind their conceptions of conscience and it is evident in the way that they discuss examples. There is rarely mention of the possibility of an individual's conscience developing and changing, nor of cases where the voice of one's conscience is in fact a recalcitrant emotion stemming from past values that one has disowned. For instance, a theatre-goer raised in a strict Puritan household may experience pangs of guilt when going to the theatre as an adult, even if he completely rejects the Puritan values of his upbringing (example originally from John Rawls 1972: 482; employed in the context of recalcitrant emotions by Brady 2007: 274). Psychologically complex cases such as these highlight the dangers of conceiving of conscience as the reinforcement of fixed values.

The notion that the values of conscience are fixed goes hand-in-hand with the idea that conscience protects psychological unity. Once one has a set of values that are unified, whatever those values might be, conscience will continue to reinforce them in order to preserve psychological unity, if that is the correct function of conscience. But there is no incentive here for the agent to change her values or rethink her conscience. This outcome is deeply problematic because there may be values influencing a person's conscience that she no longer endorses and perhaps has never endorsed.

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The final problem is that the prevailing view ignores implicit attitudes, which may influence objectors' explicit attitudes about the services they find offensive. There is a wealth of empirical evidence showing that much of our behavior is influenced by implicit attitudes that are not under our direct rational control and that may even conflict with our explicit attitudes (Jost et al. 2009; Nosek and Riskind 2012). The Harvard Implicit Association Test (IAT) is widely used by social psychologists to measure implicit attitudes. Subjects are asked to match negatively and positively valenced words with, for example, black faces and white faces, at such a speed that conscious reflection is not involved in the task. Most white subjects and many black subjects who are tested connect negatively valenced words with black faces more quickly than they do with white faces. This is taken as an indication of an implicit, non-conscious association between negative evaluations and black people, amounting to a pro-white bias. Most who are found to exemplify an implicit pro-white bias hold explicit anti-racist views and are thus horrified to learn about their implicit attitudes. Biases related to a variety of factors, such as gender, socio-economic status, ethnicity, age, nationality, and sexual orientation have been tested in populations from all over the world and their widespread presence confirmed (Jost et al. 2009).

Importantly, these biases have been shown to influence behavior outside the laboratory (Jost et al. 2009; Nosek and Riskind 2012). Researchers have recently investigated implicit biases among health care professionals and shown how they affect patient care. A landmark study of this kind indicated a negative correlation between the level of implicit pro-white bias exhibited by white physicians and the probability that they would recommend an effective treatment option (thrombolysis) to a black patient (Green et al. 2007). Another study showed that clinicians with higher levels of implicit pro-white bias, compared with those with lower levels, delivered a poorer quality of care and clinical communication to black patients (Cooper et al. 2012). (For further studies, see Sabin and Greenwald 2012; von Hippel et al. 2008.) The results of this research are disturbing because they prove that even if a physician is explicitly and sincerely committed to being non-prejudiced towards her patients, she may still harbor implicit biases and give poor treatment to marginalized patients as a result.

Underlying the dominant view of conscience is the problematic assumption that only explicit beliefs influence behavior and are thus relevant to conscience. This view presents conscience as a mode of consciousness that examines whether past or future behavior accords with an individual's moral values, yet only mentions actions that an agent plans explicitly (Benjamin 1995; Blustein 1993; Childress 1979, 1997; Wicclair 2000, 2006). However, we know that implicit attitudes also influence behavior, behavior that can contravene an agent's values without her awareness. We know, for example, that some physicians unwittingly go against values they cherish by treating black patients differently from white patients.

Consider that a conscientious objector to abortion or contraception could genuinely believe that he objects to the service for non-sexist reasons; but he actually harbors implicit biases against women that influence his desire to object. Some feminists have worried that sexism lies behind some conscientious objection (e.g., Anderson 2005). The data on implicit bias operating under the radar of conscious thought makes this a more likely phenomenon. Of course, just because beliefs are explicit does not mean that they are a better justification for conscientious objection; but an objector is at least able to cite the explicit beliefs that lead him to object and to hold them up to scrutiny. The worry is that implicit attitudes of which he is unaware (and would not endorse if he were

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aware of them) could be influencing a health care professional's decision to conscientiously object. We argue that important work on implicit attitudes and their contribution to decisions and behavior needs to be acknowledged and integrated into a realistic conception of conscience.

In this section, we have made two broad claims. First, the support by bioethicists for conscientious refusal in health care tends to focus too much on the potential harm to objectors and fails to appreciate the seriousness of the consequences these refusals may have for patients, particularly when they concern female patients' access to abortion and contraception. The remedy for this problem is fairly obvious: Bioethicists need to consider the socio-political context in which refusals take place and supplement their theorizing with data from the terrain that reveal the effects refusals have on access to abortion and contraception. Second, there are three main flaws in the dominant view of conscience that informs much of the discussion in bioethics about the moral permissibility of conscientious refusals. In the final section, we briefly discuss the implications for health professional education of a revised conception of conscience—one that we believe is immune to the three worries we have raised with the dominant view.

Promoting a "Well-Functioning Conscience" Through Health Professional Education

Given the impact that conscientious refusal has on access to abortion and contraception, it is reasonable to ask health care professionals for something in return for the right to conscientiously refuse services. In our view, this something should be participation in educational workshops that encourage the development of "a well-functioning conscience" (a concept we explain below) and promote understanding of the ethics of abortion, contraception, and conscientious refusal.

Our discussion in the previous section indicated that there is more involved in having a well-functioning conscience than the bioethics literature suggests. On our view, a well-functioning conscience is one that effectively flags occasions where an individual is behaving, has behaved, or is about to behave in a way that goes against her moral commitments, whether this behavior is the result of an explicitly planned action or of implicit attitudes (FitzGerald 2014). People with a well-functioning conscience have an awareness of their implicit biases and work to mitigate or avoid manifesting them, especially biases that conflict with their explicit moral or religious views. They will also revise their explicit attitudes when given good reason to do so and in response to inconsistencies internal to them and between them and their behavior. Such individuals will not maintain psychological unity at all costs and thus their conscience is not fixed; rather, it is open to revision based on what the individual endorses. The work of cultivating such a conscience is best done with the help and input of others rather than in isolation (FitzGerald 2014; McLeod 2012). Others can help us to see when implicit attitudes shape our behavior, when we have good reason to revise our commitments, and when our commitments and behavior are inconsistent. At least some of this work could be done with colleagues in a workshop setting and simply through encouraging professionals to reflect on their behavior.

On our view, health care professionals whose conscience is well-functioning with respect to the issues of abortion and contraception should have some understanding of how conscientious refusals to provide these services can affect women. This will involve having some sense of why these services are important to women who seek them out.

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Assuming this view is correct, ethics education for health professionals that covers abortion and contraception could help health care professionals improve the functioning of their conscience. This is not to say that those health care professionals who conscientiously object to abortion or contraception necessarily have badly functioning consciences, only to argue that any right to have one's conscience protected should be accompanied by a duty to ensure the cultivation of a well-functioning conscience.

In terms of training health care professionals to develop a well- (or better-) functioning conscience with respect to abortion and contraception, educators could employ the existing method of reflective practice. Reflective practice encourages health professionals to reflect critically on their professional experience and learn from this reflection; it helps them to integrate professional values with their personal beliefs; and it promotes self-awareness (Mann et al. 2007: 596). The practice involves teaching methods such as small group discussions, keeping private journals or portfolios, and developing a relationship with a mentor, which are all well suited to approaching sensitive and delicate topics. In one educational intervention, organizers held workshops for medical students that involved role-plays on conscientious refusal in reproductive health care. Students' responses indicated that the workshops were helpful for them, allowing them time to reflect on their own views, become more comfortable discussing them, and consider how to communicate a refusal to a patient (Lupi et al. 2009).

To target the specific threat that implicit attitudes pose to the well-functioning of a health professional's conscience, workshops designed to raise awareness of the dangers of implicit bias could be combined with reflective practice methods. Jeff Stone and Gordon Moskowitz (2011) provide recommendations on how to create such workshops. Organizers could invite health professionals to test their own implicit biases with tools such as the IAT, although the tests should be carried out in a supportive environment and the results should remain strictly confidential. The IAT in particular should be seen as a teaching tool rather than an exam that one must pass. Workshops could include methods of identifying implicit biases, along with advice on how to mitigate these biases or avoid their manifestation. Of course, great care should be taken with the way in which advice is proffered because there is a danger of provoking hostile and counterproductive reactions. Which techniques are most likely to be successful at reducing the manifestation of implicit bias remains a somewhat open question; empirical research in this area is at a very early stage and caution is needed. For instance, there is mixed evidence on whether intentional control has positive or negative effects on the manifestation of implicit stereotypes (Payne and Stewart 2008: 1333). However, indirect methods of control seem more effective, and there is evidence that the following in particular may be helpful: Focusing on one's past failures in the area of bias/discrimination before an encounter and thus activating the goal of "being egalitarian" (Moskowitz and Li 2011); holding in mind counter-stereotypical exemplars, such as a successful black person (Blair 2002: 248–9); and mentally rehearsing "implementation intentions," tied to specific environmental cues, such as "When I see a black person, I will think 'successful'" (Payne and Stewart 2008).

There is some indication that health professionals would welcome learning more about implicit attitudes. In the study cited in the previous section in which physicians with pro-white implicit bias tended to suggest thrombolysis less often as a treatment for black patients, 75 percent of the participants said that taking the IAT is a worthwhile experience for physicians, and 76 percent agreed with the statement that learning more about unconscious biases could improve the quality of their patient care (Green et al.

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2007: 1235). This evidence shows at least that health professionals would not necessarily be hostile to learning about the influence that implicit attitudes may have on their practice.

Concluding Remarks

In summary, conscientious refusal in health care is closely connected to political and moral debates over abortion and contraception. It can, and in some places does, have a significant impact on access to these services. The majority of bioethicists support the ability of health professionals to conscientiously refuse to provide abortion or contraceptive services within certain limits; most of them restrict permissible refusals to those that are not based on discriminatory beliefs, that do not occur in an emergency situation, and that satisfy other criteria as well. Such views tend not to preclude much conscientious refusal, however. On the whole, the bioethics literature is quite supportive of conscientious refusal in health care.

We have objected to the bioethics literature on conscientious refusal because, in general, it focuses too much on harm to health care professionals and too little on harm to patients, and because much of it employs a conception of conscience that is problematic. Although we agree that health care professionals should probably be able to make conscientious refusals in some circumstances, we also think that they should be duty-bound to cultivate a well-functioning conscience. We have outlined a revised conception of conscience that explains what a well-functioning conscience would look like and that has implications for the ethics education of health care professionals. Our recommendations for education included using reflective practice that is centered on the specific topics of abortion, contraception, and conscientious refusal, and that encourages health care professionals to maintain or develop a well-functioning conscience. Specific training in implicit attitudes is also vital, in our opinion, to ensure that these professionals are aware of the danger of behaving in ways that are contrary to their explicit beliefs.

Related Topics

Chapter 28, "Regulating Reproduction: A Bioethical Approach," Isabel Karpin

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