Theor Med Bioeth (2008) 29:187–200
DOI 10.1007/s11017-008-9076-y

Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?

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Published online: 28 August 2008

Abstract Some medical services have long generated deep moral controversy within the medical profession as well as in broader society and have led to conscientious refusals by some physicians to provide those services to their patients. More recently, pharmacists in a number of states have refused on grounds of conscience to fill legal prescriptions for their customers. This paper assesses these controversies. First, I offer a brief account of the basis and limits of the claim to be free to act on one's conscience. Second, I sketch an account of the basis of the medical and pharmacy professions' responsibilities and the process by which they are specified and change over time. Third, I then set out and defend what I call the "conventional compromise" as a reasonable accommodation to conflicts between these professions' responsibilities and the moral integrity of their individual members. Finally, I take up and reject the complicity objection to the conventional compromise. Put together, this provides my answer to the question posed in the title of my paper: "Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?".

Keywords Conscience · Complicity · Ethics

Introduction

Some medical services have long generated deep moral controversy within the medical profession as well as in broader society and have led to conscientious refusals by some physicians to provide those services to their patients. Abortion is the most obvious and prominent example, but others include use of medicines such

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as growth hormone for enhancement rather than treatment, assisted reproductive services for unmarried couples, the HPV vaccine for young girls that some believe encourages early sexual behavior, terminal sedation for dying patients, and physician-assisted suicide in Oregon, where it is now legal. These examples have drawn widespread attention and moral controversy, but many other examples have drawn only more limited objections from physicians and consequently more limited public attention. More recently, pharmacists in a number of states have refused to fill legal prescriptions for customers, sometimes because they object to any use of the prescribed item, such as the contraceptive Plan B, sometimes because they object to particular kinds of customers using the prescribed item, such as unmarried couples or minors using Plan B, and sometimes for both sorts of reasons [1]; indeed, in one highly publicized case in Wisconsin a pharmacist not only refused to fill such a prescription, but also refused to return the prescription to the patient so she could have it filled elsewhere [2].

What is the right of conscience?

Both physicians and pharmacists have claimed a moral (and often legal) right of conscience to refuse to provide these services to which they have strong moral objections—I shall call this a claim to conscientious refusal, although most of the literature refers to it as conscientious objection [3]. At their core, the actions in question are refusals to perform a action or participate in a practice that is legal and professionally accepted but that the individual professional believes to be deeply immoral [4].

I want first to explore very briefly the nature of conscience being appealed to, and more specifically the claim of a right to act on it. Very roughly, I shall understand by "conscience" an individual's faculty for making moral judgments together with a commitment to acting on them. For many persons, their consciences are deeply informed by their religious beliefs and commitments, but there is no necessary connection between conscience and religion since many non-religious persons are equally possessed of moral commitments and consciences [5].

What is the epistemic status of the moral judgments that issue from our exercise of conscience; will the judgments be true, correct, or justified? Some commentators have thought that this will depend on the account of conscience that issues the judgments. Ryan Lawrence and Farr Curlin, for example, have distinguished a religious and a secular account of conscience [6]. In the religious account, exercise of our conscience is the way we come to know divine law, what God requires of us. But widespread and frequent disagreement on moral questions, even among members of the same religion, implies fallibility in people's exercise of conscience in making moral judgments about how they should act. Even if there is a divine law that is somehow accessed through conscience, when individuals disagree about its content they cannot all be correct or their judgments all be true. Even setting this difficulty aside, a justified claim to religious authority lacks authority for public policy in a secular democratic state, though I shall not argue this point here [7].

What is the epistemic status of moral judgments derived from the exercise of conscience on a secular account of conscience? Once again, deep and intractable disagreement among persons on a wide range of moral questions entails that all of their judgments cannot be true or correct. So in either the religious or secular understanding of conscience, the claim to act according to one's conscience cannot be based on a claim of the truth about what one's conscience tells one to do. A weaker claim about the judgments of conscience is that they are justified, acknowledging that this does not entail that they are true. In most accounts of epistemic justification, for either moral or empirical judgments, individual A could be justified in believing that actions of kind p are morally right and individual B justified in believing that they are morally wrong, though both of their beliefs cannot be true. But this means that even if A's judgment of conscience is justified, that is not sufficient to warrant imposing his view in public policy on B, who may be justified in holding an opposing view.

Moreover, whether one's moral judgments issuing from the exercise of one's conscience are even justified depends on how an individual's conscience operates. If someone's exercise of conscience simply consists in seeing what "feels right," or what brings a feeling of "repugnance," or what seems right directly consulting her unexamined intuitions, or what some "authority" says is right, no claim that judgments arrived at in these ways are even justified is warranted. A claim of justification requires some process in which reasons have been offered and considered, that the judgment is made in at least reasonably favorable conditions for judging as opposed to conditions known frequently to lead to mistakes, and so forth; I shall say that justification requires that the judgments have survived a critical screening process [8].

Moral integrity—what should be the limits to its protection?

If what our conscience tells us would be morally right or wrong to do need not be true, correct, or in some cases even justified, what is the moral basis for the claim that individuals ought never to act against their conscience, or that they have a right, and so ought to be free to act as their conscience dictates? As Mark Wicclair has correctly argued (in my view), these claims must be grounded in the importance of individuals' moral integrity [9]. Deeply held and important moral judgments of conscience constitute the central bases of individuals' moral integrity; they define who, at least morally speaking, the individual is, what she stands for, what is the central moral core of her character. Maintaining her moral integrity then requires that she not violate her moral commitments and gives others reason to respect her doing so, not because those commitments must be true or justified, but because the maintenance of moral integrity is an important value, central to one's status as a moral person. Individuals value maintaining their own moral integrity, and this gives them in turn a reason to value and respect the moral integrity of others. But it is of fundamental importance that the value of respecting other people's moral integrity, and so leaving them free to act in accord with their conscience, can conflict with other important values that will sometimes be more important than and

override respecting their moral integrity. Let me illustrate this with two examples that may initially seem unrealistic, but whose implications will extend to more realistic and common cases.

Dr. A has deeply held religious and moral beliefs that the mixing of the races is wrong. In particular, he believes that white doctors should treat white patients and that black patients should be treated by black doctors; he refuses to accept black patients in his practice. Dr. A is a renal specialist and spends two days a week in a hospital renal clinic seeing patients with end stage renal disease and here too he refuses to see black patients.

Dr. B is an emergency medicine physician who has long been on staff in the Emergency Department of a large urban hospital. She recently converted to the Jehovah's Witness religion and now believes that transfusing a patient would threaten the patient's salvation and constitute a grave act of disobedience to God. As a result, she now refuses on grounds of conscience to transfuse any patients in the ER in which she works.

Assume that there is no reason to doubt that Dr. A's and Dr. B's beliefs are sincerely and deeply held. They each seek to exercise their right of conscience and so refuse, respectively, to treat black patients or to transfuse patients. How should others—for example, their hospitals, their colleagues, their professional societies, and the state that licenses them—respond to their conscientious refusal? In the case of Dr. A, while he has wide freedom to decide whom to accept as patients in his private practice, most would argue that he is not free to discriminate on grounds of race. A social consensus (not to say unanimity) exists in the United States that racial discrimination in access to services like health care is unethical, and this is reflected in the law as well. Most people would consider Dr. A unjustly prejudiced, despite his offering a moral or religious defense of his position. Dr. A's belief does not deserve respect, even if his moral integrity does. Public policy holds that social justice requires prohibiting this form of discrimination and that if Dr. A's moral beliefs and integrity are in conflict with this policy, they and not the policy must give way. It is worth noting also that public policy recognizes a public/private distinction here; Dr. A is entitled to invite only whites to parties at his home, even if he is not permitted to make the same distinction in his medical practice. In his role as a doctor, he provides a service properly regulated by the state and its anti-discrimination laws. This case illustrates that being free to act on one's conscience in the protection of one's moral integrity is not an absolute ethical bar to others, in particular the state, coercing individuals to act contrary to their conscience.

Dr. B should also not be permitted to follow her conscience in the protection of her moral integrity but for somewhat different reasons. Just as with Dr. A, most people find the basis for Dr. B's religious belief about transfusion to be incredible. That belief may now deeply define her identity, however, and if she were a patient refusing a transfusion for herself it would have to be respected even at the cost of her life. To her doctor we should then say, "Your professional obligation to save life must give way to your patient's autonomy to decide about her treatment." We might go on to explain to her doctor that his professional obligation is not, without qualification, to save life, but rather to use his medical skills to benefit his patient, consistent with respecting his patient's autonomy and right to give or withhold

consent to any treatment. But Dr. B is not a patient—she is an emergency room physician attending to patients who present there needing care. So we should say to Dr. B, "Transfusing patients when that is medically indicated is a central part of your role and responsibilities as an emergency physician. You freely chose that role knowing that this responsibility is an important part of it. If after doing so you have now adopted religious beliefs which prohibit you from carrying out this responsibility without violating your personal and moral integrity, then you must leave that role and the hospital would be justified in firing you if you do not. You must find a new role, for example in psychiatry within medicine, or outside of medicine, whose central responsibilities do not conflict with your moral or religious commitments, and so do not require you to violate your integrity."

Should the hospital instead have to seek to accommodate Dr. B's new belief about transfusions, for example by permitting her to withdraw from a patient's care whenever a transfusion was required and have another physician take over the patient's care? I believe that such accommodation would be beyond what is reasonably required, or even acceptable, because it would risk significant harm to patients to have their care transferred in this way under emergency conditions. Compare this with Dr. B's colleague, Dr. C, whose religious commitments and personal integrity prohibit her from working on Saturdays. Working on Saturdays is not a central part of the professional role or responsibilities of an emergency physician and so it would be reasonable for the hospital to, and even to have to, arrange Dr. C's work schedule to accommodate her religious commitments.

I shall have more to say later about the problem of how to distinguish which beliefs and commitments central to an individual's moral integrity others should accommodate, if possible, and which they need or should not. But these three cases make at least this much clear—first, society can legitimately enforce requirements of social justice that require persons to act in a way that may violate their moral integrity, and can legitimately use coercive measures to enforce its judgment; and, second, society or a particular profession can likewise legitimately decide that a specific social or professional role may require actions that might violate a particular individual's integrity, and so can in turn exclude individuals from that role who are unwilling to perform those actions.

Does this mean that Dr. A or B should act against conscience and do what he or she thinks is wrong? No. It does mean that society can sometimes legitimately use coercive measures, if necessary, that interfere with one of its members acting without interference on his conscience. It means that society could legitimately require its members to act in a way that some of them *believe* to be wrong. No absolute moral claim or right to act on one's conscience without interference from others is sustainable.

The profession's responsibilities

For reasons of space, I am going to take up the responsibilities of the professions of medicine and pharmacy together, except when they need to be distinguished for purposes of my discussion. What are the responsibilities of these two professions to

the society that licenses them and to the individual members of society that they serve? Of course, in one respect their responsibilities differ because the medical profession provides medical services and the pharmacy profession provides pharmaceutical services. But in other respects the nature and source of their responsibilities and obligations are similar. In the most general terms, each profession has a responsibility to provide to the public a competent level of services—medical or pharmaceutical—and to monitor its individual members to assure that they do so (this latter is a part of the self-regulation that professions typically claim). This level of services should include all legal and beneficial medical interventions sought by patients (assuming patients can pay for them—I want to set that issue aside because it is not central to my discussion here). And it should include all legal and licensed drugs to patients with valid prescriptions for them. Each profession is also responsible for following other legal norms, such as not discriminating on the basis of race, gender, ethnic origin, and other comparable conditions.

The origin and basis of these responsibilities has several sources that I do not have the space to explore at all fully here. One is that the profession, through various professional societies, has voluntarily accepted them, through, for example, their professional codes of practice, codes of ethics, and other practice standards adopted by the profession. Of course, responsibilities voluntarily assumed by the professions could also be voluntarily changed or abandoned by them. But these responsibilities also derive from the professions having received a monopoly on medical or pharmaceutical practice in return for being licensed and regulated by the state. Various licensing and regulatory procedures and requirements are clearly in the public interest—they protect the public from incompetent and potentially harmful practitioners and practice, and the profession assumes much of the responsibility to ensure that public protection. The precise nature of these responsibilities develops and evolves over time in a complex process in which the state, federal agencies, courts, the public, and the professions all play a part. For example, the FDA determines which pharmaceuticals are licensed for sale, individual states license and regulate pharmacists in their state, and the profession through its associations develops norms for pharmaceutical practice; in particular, a number of states have adopted laws and regulations regarding conscientious refusal by pharmacists, with wide variation in the nature of their policies [1, 10–12]. Likewise, the norms of professional medical practice develop from state laws and regulations, court decisions, standards of care developed by the profession, etc. [13, 14]. To the extent that the norms governing a profession derive from state or federal laws and regulations, they are imposed on, rather than voluntarily adopted by the professions. Nevertheless, there are two respects in which these norms are voluntarily adopted. First, those developed by the profession itself, sometimes in negotiation with state or federal bodies, are self-imposed. Second, individual members of each profession voluntarily make the choice to enter the profession and thereby to take on the responsibilities of its members.

Before turning to the responsibilities of each member of the profession, I want to consider whether the profession itself could reasonably exercise an ethically based conscientious refusal to provide a specific service otherwise part of its

responsibilities. Here, it is important to distinguish between a profession claiming a right not to require, as opposed to not to permit, its members, some or all, to provide specific services. For example, could a state medical society legitimately exempt its members from providing contraceptive services to unmarried minors if doing so would violate their conscience? This is controversial, but I believe this could be permissible if the exemption to some individual members of the profession did not interfere with the profession meeting its social obligation to provide the service. On the other hand, the profession could not exempt all of its members from having to provide a legally permissible and beneficial service on the grounds that the profession, as an organized profession, had decided that a particular service was deeply immoral. The reason is that the profession does not and should not have unfettered autonomy to determine its responsibilities; instead, as already noted, they are determined in a complex process also involving the state, courts, and regulatory bodies. (It is also problematic to considering what sense an organized profession, as opposed to its individual members, has a conscience that can issue in moral judgments.) I believe it is even clearer that the profession could not legitimately forbid its members from rendering an otherwise legal and beneficial service on grounds that the profession, acting as a professional body, had decided that the service was immoral. This would be to claim sole authority in defining its responsibilities and what actions of its members are permissible that the profession does not, and should not, possess. So when the state of Oregon legalized physician-assisted suicide (PAS) a decade ago, it would have exceeded the profession's authority for the Oregon medical society to require that no member participate in PAS, on pain of losing their professional membership and prohibiting them from practicing. That coercive authority properly belongs to the state, which alone grants professional licenses, and Oregon had chosen to permit physicians to engage in the practice. On the other hand, Oregon could, and did, permit individual physicians who had serious ethical objections to PAS not to take part in it [15].

Individual professional's responsibilities—the conventional compromise

We have just seen that a profession's responsibilities are to the society it serves and by which it is licensed and regulated, and the determination of those responsibilities is not within the sole authority of the profession. But it does not follow that each member of the profession has all of the same responsibilities and duties as the profession as a whole. The profession has a responsibility to ensure the provision of a full range of medical services to the public, but no single physician has the training, skills, and experience to provide that full range of services; at most, individual physicians' responsibilities cannot extend beyond the range of their individual abilities, competence, and specialization. But what if an individual physician or pharmacist has a strong moral objection to providing a legal service that is within the profession's responsibility to provide, and within his or her area of competence and practice? There are many examples: ob/gyn physicians who object to providing abortion services; physicians who object to providing contraceptive services to unmarried patients or minors; pharmacists who object to filling

prescriptions for the contraceptive Plan B; general internists who object to providing terminal sedation to their dying patients who request it because they consider it tantamount to euthanasia; pediatricians who object to providing the HPV vaccine to young female patients in the belief that it will encourage underage and unmarried sex; and the list could be extended indefinitely.

Elsewhere in this issue, Mark Wicclair argues that what he calls the "incompatibility thesis"—that conscientious objection is incompatible with a physician's professional obligations—cannot be sustained on any plausible account of the nature and basis of the profession's obligations. It is important to be clear that I would accept an analogue of the incompatibility thesis applied to the medical profession, as opposed to individual physicians; the profession cannot claim on grounds of its (the profession's) conscience that every physician can refuse to provide a legal and beneficial medical service. But Wicclair's incompatibility thesis concerns an individual physician's conscientious objection to providing such a service, and I am in agreement with him that this thesis is mistaken. It is mistaken because what I shall label the "conventional compromise," covering examples like those cited above, spells out the conditions under which physicians' conscientious refusals *are* compatible with their professional obligations.

According to the conventional compromise, a physician/pharmacist who has a serious moral objection to providing a service/product to a patient/customer is not required to do so only if the following three conditions are satisfied:

1. The physician/pharmacist informs the patient/customer about the service/product if it is medically relevant to their medical condition;
2. The physician/pharmacist refers the patient/customer to another professional willing and able to provide the service/product;
3. The referral does not impose an unreasonable burden on the patient/customer.

I did not say that the refusal is always justified if the conditions of the conventional compromise are satisfied because I do not believe the freedom to refuse and the employment of the professional compromise should always be offered or available to physicians or pharmacists. We saw in the cases of Drs. A and B two kinds of reasons for not offering the conventional compromise: if doing so would permit the physician to violate legal requirements of social justice, as with Dr. A; if doing so would be incompatible with the fulfillment of central responsibilities of the physician's professional role, as with Dr. B. (Alternatively, one might argue that Dr. B could not satisfy condition three in emergency conditions.) I am acutely aware that I do not have, and so have not provided, a full principled account of when the conventional compromise should, and should not, be offered and available to physicians/pharmacists.

Now some comments on the three conditions of the conventional compromise. The first condition uses the phrase "relevant to his or her medical condition," and this is obviously vague, in need of interpretation in particular cases, and subject to controversy. I would interpret it as any service/product that most other members of the profession would deem reasonable or appropriate for the patient's condition if they had no moral objection to it. This should be reasonably determinate in most circumstances, if only because there will nearly always be other professionals

without the moral objection whose practice can be observed and who can be consulted about a questionable case. Sometimes, the physician or pharmacist may inform all new patients or customers earlier that they will not provide certain services should they later become relevant. A physician might inform a new patient when initiating a physician/patient relationship that he or she does not provide specific services—e.g. abortions, contraceptive services, or terminal sedation. Patients are then informed and free at the outset of the relationship to decide whether they would prefer another physician who would provide the objected to service. Even if this informing has taken place at the outset of the physician/patient relationship, it will be necessary to repeat it later at the time the service becomes relevant for the patient's condition. Likewise, pharmacies might post signs or otherwise inform customers that they do not provide certain products, such as Plan B, and again customers can then decide whether to begin or continue using that particular pharmacy.

The second condition requires physicians or pharmacists to become knowledgeable beforehand about other professionals willing and able to provide the service/product to which they morally object, and to whom they can refer patients/customers. For physicians, sometimes this may be a colleague in the same practice group or institution, sometimes it may have to be a colleague in a different group or institution (for example, a Catholic hospital that does not provide abortion or contraceptive services). For pharmacies, if it is only a particular pharmacist who has the moral objection in question, then a pharmacy might ensure that another pharmacist without the same objection will always be available when that pharmacist is on duty. If the pharmacist or owner who controls a pharmacy's policies decides that a particular product will not be provided in that pharmacy at all, then they are responsible for learning of other pharmacies to which the customer can be referred to obtain the product in question. It is not acceptable for either a physician or pharmacist with a moral objection to providing a particular service/product to wait until asked to provide it, and only then to try to locate a possible referral; this could potentially violate the third condition of the conventional compromise.

Like the first condition, the third condition too is unavoidably imprecise and will require interpretation in specific cases. The imprecision comes from the requirement that the referral does not impose an "unreasonable burden" on the patient/customer. If the nearest pharmacy willing and able to provide the product in question is one hundred miles away, referral is likely not reasonable, and certainly not if the customer lacks transportation to get there. Also relevant to whether a burden is unreasonable is how quickly the product is needed and how important it is to the customer's well-being—to take again the example of Plan B, referring for Plan B on a Saturday evening to a nearby pharmacy that will not be open until the following Monday would impose an unreasonable burden on the customer. Judgment and interpretation will be needed of what constitutes an unreasonable burden—how urgently is the service needed, how important is it to the patient's well-being, how difficult or feasible is it for the patient to go to the referred physician/pharmacist, and will the referred physician/pharmacist be able to provide comparable, or at least acceptable, quality care?

Controversy may be unavoidable in any particular case about whether each of these three conditions is met, but at least then the controversy is within the context of agreement on the conventional compromise. But what is the moral case for requiring that professionals invoking conscientious refusal meet the three conditions of the conventional compromise? That case rests on the profession's obligation, discussed and defended above, to ensure that the service/product is available to patients or the public. One way the profession could ensure availability, or the state through legally imposed obligations could do so, would be to require every individual member of the profession to provide the service/product, regardless of any moral objection they may have to doing so [16, 17]. This would ensure that the profession's obligation is satisfied, but would take no account of the importance of the individual professional's moral integrity. The conventional compromise, on the other hand, balances the profession's obligations to its patients/customers with protecting the individual professional's moral integrity. I will return shortly to consider the objection that the conventional compromise still leaves the professional complicitous in the objected to service, and so does not adequately protect his or her moral integrity.

To what extent do physicians/pharmacists accept the conventional compromise? I know of no data with regard to pharmacists, but the recent nationwide study by Farr Curlin and colleagues of 1,144 randomly selected physicians provides troubling data [18]. In that study, 14% of physicians said they did not believe that they were required to present all options to a patient if those options included an intervention to which they had serious moral objection. And 29% said they did not believe they were required to refer a patient to another willing provider for a service to which they had serious moral objections. That implies, for example, that 14% of physicians of dying patients whose suffering could not be otherwise be adequately relieved would not inform the patient of the alternative of terminal sedation if they had a serious moral objection to the practice, and 29% would not refer such a patient to another physician willing and able to provide terminal sedation. I believe this is more than troubling—it should be regarded by the profession and state regulatory authorities as unacceptable. Both the profession and state law should state clearly that any physician who has a serious moral objection to providing a relevant and legal service to one of his patients *must* meet the three conditions of the conventional compromise. Failure to do so should be regarded as professional negligence or misconduct and should subject the physician to disciplinary and/or civil actions. Failure to meet the three conditions in effect claims a protection of one's moral integrity, but ignores one's professional obligations to one's patients.

States could and should pass legislation or adopt regulations requiring that conditions one to three of the conventional compromise be satisfied by any physician refusing on moral grounds to provide a relevant and legal service to one of her patients. States could and should do the same for pharmacists, although we lack data regarding the frequency of such refusals by pharmacists. Some states have responded to this controversy by permitting physicians and/or pharmacists to refuse to provide services to which they have moral objections without satisfying conditions one to three; in the worst cases, without satisfying any comparable conditions, it is enough that they object [1]. This is wrong because although it

protects physicians/pharmacists' moral integrity, it fails to ensure that the responsibilities and obligations of the professions to its patients/customers are met. Indeed, in some cases it is hard not to see very open ended rights of refusal as another piece of broader abortion and culture wars, with the intent to make the contested services unavailable [16].

The complicity objection to the conventional compromise

There remains a serious objection to take up to the conventional compromise that I have supported above, which is that its three conditions still leave physicians/pharmacists unacceptably complicit in the practices to which they have serious moral objections. Although no one denies that doing the morally objectionable action would be worse, the complicity objection continues, both informing the patient/customer of that alternative, and even more referring the patient/customer to someone who will provide it, each make the physician/pharmacist unacceptably complicit in the wrongful action. Informing and referring each causally contribute to the increased probability that the wrongful action will take place, and in many cases they may be causally necessary conditions for particular instances of it taking place; physicians/pharmacists who inform and/or refer seem to remain wrongful contributors to evil. I want to separate the complicity objection into two distinct questions: first, does informing, and in turn referring, make the physician/pharmacist who does so complicit in the immorality? Second, if they do, does this justify the profession or state permitting individual physicians/pharmacists not to inform or refer patients/customers as the conventional compromise requires? I shall answer yes to the first question, and no to the second.

Complicity is not all or nothing, but can come in different degrees. Suppose, as I and many others believe, that thousands of innocent Iraqis have died unjustly in the Iraq war. Donald Rumsfeld's complicity in those deaths is great; senators who voted to authorize President Bush to initiate the war have complicity that is significant though lesser; ordinary citizens whose tax dollars help pay for the war have complicity that is minimal at most. So, consider a physician who believes that terminal sedation is intentional taking of innocent human life and so is immoral. She has a patient near death who is suffering greatly despite maximal efforts at palliation. Suppose that for most other physicians there would be three significant care options for this patient, one of which is terminal sedation. The patient's physician wishes to satisfy the conventional compromise, and so informs the patient of these three options, but makes clear that she considers terminal sedation immoral, could not provide it herself, and so recommends one of the other two alternatives. If the patient and/or the patient's family then seek out another physician who provides terminal sedation to the patient, how complicitous is the patient's initial physician who told the patient about terminal sedation? The act of informing may play a causally necessary role in the terminal sedation taking place if the patient/family would not otherwise have known about it, but if the physician who does the informing also recommends against it, makes clear why she believes it to be immoral, and doesn't help the patient to obtain it, then her complicity seems relatively minimal.

Now suppose the patient's physician seeks to satisfy the second condition of the conventional compromise, and so refers her patient to another physician who provides her with terminal sedation (and assume this satisfies the third condition as well of not imposing an unreasonable burden on the patient); she again recommends against this alternative, making clear to her patient why she believes it to be immoral. Here, her complicity in the action she deems immoral is greater because she helps the patient obtain the terminal sedation; while there is no precise measure for complicity, her complicity now seems at least significant, if not substantial. So the first two conditions of the conventional compromise do leave the objecting physician complicitous to some degree.

The second question distinguished above was whether either of these degrees of complicity would justify the physician refusing to inform her patient about, or refer her for, terminal sedation? I believe it would not, and that the crucial point is that the physician is acting in the role of a medical professional, which carries professional obligations with it. A patient in the next bed, who has no obligation to help, need do nothing by way of informing or referring the patient, if he believes terminal sedation to be immoral. Likewise, if I ask a stranger on the street for a recommendation for a good steakhouse, she has no obligation to tell me of one if she happens to be a vegan. But this physician (and the same for the pharmacist who believes Plan B to be immoral) is acting in a professional role as this patient's physician, and that carries with it professional obligations to her patient.

In particular, we should say to the physician/pharmacist, "This is *your* patient/customer, and so *you* are obligated to discharge your profession's obligation to him or her. You can do that by providing the service/product that you deem immoral, or instead by meeting the conditions of the conventional compromise, which balances your professional obligations with respecting your moral integrity. If you are unwilling to do either, then you should leave the professional role that has these obligations. You freely entered and/or remained in a profession with that duty, and if you are unprepared to discharge it then you should leave the profession, or at least find a position within the profession whose duties do not conflict in this way with your moral commitments." Consider the example of a general internist who becomes a vitalist and believes it is always immoral to take actions that will shorten life, such as foregoing life-sustaining treatments. The law, professional norms, and a consensus in medical ethics, however, all concur that patients have the right to forego life-sustaining treatments, and that this right must be respected by others. Referring a patient who decides to forego life support to another physician who will do so does make one complicit in the foregoing, but the patient's right together with the profession's duty overrides the physician's claim of moral integrity to avoid complicity. Such a physician should at the least inform all of his patients at the outset of a physician/patient relationship with them of his belief in vitalism so that they can make a decision whether to seek another physician who does not hold this moral view. But even if he has done so, he must also still satisfy the conventional compromise with any of his patients that come to want to forego life support. It is arguable whether an institution such as a hospital who employs him, or a large group practice to which he belongs, should have to accommodate his moral beliefs in the way the conventional compromise does; that is, it is unclear whether his case

is closer to that of the Jehovah's Witness emergency physician mentioned above or the physician whose religion did not permit work on Saturdays.

Here is one final objection to my argument that avoiding complicity with what a physician/pharmacist deems seriously immoral does not justify refusing to provide the service/product while not satisfying the conditions of the conventional compromise. At least a few physicians could object that abortion was not legal when they entered medicine, and so they never freely chose to enter a profession with the obligation to provide that service; likewise, pharmacists might object that Plan B did not exist when they entered pharmacy. However, both of these objections implausibly assume that professionals' obligations cannot change over time as the obligations of the professions to which they belong change. I noted above that a profession's obligations are the result of a complex process involving it, its members, the public, courts, and government legislative and regulatory bodies. Moreover, this is not a static, once and for all, process, but a dynamic, evolving process as circumstances and conditions change over time. And as they change, the responsibilities of individual members will change with them. If Dr. A, who believed that the mixing of races was immoral was instead a public school teacher in the early 1950s, he would have found himself with a new responsibility to teach in a mixed race classroom after the Brown vs. Board of Education Supreme Court decision desegregated public schools [19]. He could not have successfully argued that because segregated schools were legal when he entered teaching, he should still be permitted to teach in a segregated classroom—public and legal policy had changed, and with it his duties as a school teacher.

Conclusion

Let me summarize what I have sought to do in this paper. First, I have offered a brief account of the basis and limits of the claim to be free to act on one's conscience. Second, I then sketched an account of the basis of a profession's, in particular medicine's and pharmacy's, responsibilities and the process by which they are specified and change over time. Third, I set out and defended the "conventional compromise" as a reasonable accommodation to conflicts between these professions' responsibilities and the moral integrity of their individual members. I gave examples, but no full principled account, of when the conventional compromise should, and should not, be offered and available to the objecting professional. Finally, I examined and rejected the complicity objection to the conventional compromise. Put together, I hope to have given and defended my own answer to the question posed in the title of my paper: "conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?".

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