conscientious refusal. However, the fact that there is a non-zero probability of something immoral happening is not all we can know about a given situation, and certainly not all the conscientiously-objecting pharmacist can know about the use of EC. We can know that the immoral thing is more or less likely to occur — often our approximation will be considerably more specific than merely non-zero. We can know whether or not the immoral thing is intended, by whom, and for what reasons. We can know whether the immoral thing is a more or less direct causal result of the professional's actions. We can know that the immoral thing is a more or less seriously wrong. We can know roughly on a scale whether the immoral thing is widely understood as such or whether it is uniquely understood that way by the individual professional. Each of these is necessary for evaluating the reasonableness of the professional's refusal to participate. In fact, we assume there are other categories relevant to the comprehensive ethical evaluation of contributing to an unethical act.

It seems clear from these observations that Card (2007) uses the zero probability argument as a bit of a straw man. The conscientious objector does not rely on such a simplistic claim. In fact, conscientious objection can and should be evaluated in light of a variety of components, rather than the mere possibility that one's actions will contribute to an unethical result. Specifically, conscientious objection appears to be made more plausible by a variety of factors, including the likelihood, intentionality, causal directness, degree of consensus, and not least, the severity of the unethical action.

REFERENCES

Card, R. F. 2007. Conscientious objection and emergency contraception. *American Journal of Bioethics* 7(6): 8–14.

Strong, C. 2007. Conscientious objection the morning after. *American Journal of Bioethics* 7(6): 32–34.

Caution: Conscience is the Limb on Which Medical Ethics Sits

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> Conscience: The faculty or principle which pronounces upon the moral quality of one's actions or motives, approving the right and condemning the wrong.
>
> — Oxford English Dictionary

Card (2007) joins many others (Charo 2005; Savulescu 2006) who are disturbed that clinicians would refuse on moral grounds to provide or help patients obtain emergency contraception (EC) or other legal but controversial clinical practices. Card's essay purports to meet these clinicians in the ring of moral discourse and knock them out fair and square. Yet, further scrutiny suggests the vanquished are only strawmen substitutes for the real opponents, and instead of boxing by the rules, Card has taken off the gloves and thrown 'the kitchen sink' instead. If this approach wins, ethics loses.

In the tradition of moral discourse that constitutes what ethicists do *qua* ethicists, Card (2007) might have described and critiqued his opponents' best reasons in order to argue that it is unethical for practitioners to refuse to provide EC. It is always possible that if opponents' arguments are presented fairly and addressed thoroughly, some will change their minds. This journal and all other ethics journals depend on that being the case. Unfortunately, although Card speculates about how "astute" and even "very astute" interlocutors might respond to his arguments, his essay does not address or even accurately reproduce the reasons those interlocutors actually give. For example, the essay includes no uncaricatured form of the two most common arguments against providing EC:

> Argument 1: Practitioners are not morally obligated to provide EC except in cases of sexual assault because a) humans ought always to act in accordance with their nature; b) the nature of human sexuality includes both a procreative and unitive aspect of sexual intercourse; c) any action which intentionally and directly separates either of those two aspects of sexual intercourse is an act against human nature and is therefore illicit; and d) apart from sexual assault, the use of EC is intended to directly separate procreation from sexual intercourse.
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> Argument 2: Practitioners are not morally obligated to provide EC because a) although contraception is ethically permissible,

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causing the death of a human embryo is not; and b) the good of preventing a pregnancy is not proportionate to the gravity and the risk of causing the death of a human embryo by using EC.

Both of these lines of reasoning are subject to rational scrutiny. Neither requires particular religious commitments, although the first has its fullest expression in Catholic moral theology. In principle, both may be defeated either by showing that one or more of the premises are wrong or by showing that the conclusions do not follow from the premises. For example, Argument 2 is particularly vulnerable to evidence that suggests that EC is highly unlikely to ever cause the death of the embryo. Yet, in contradicton to Card's inferences, neither has to do with the autonomy rights of professionals. Neither puts the practitioner's interests above those of the patient. Neither requires a claim that EC is equivalent to abortion or that sexual intercourse is ethical only if the goal is procreation. Neither depends on how the American College of Obstetricians and Gynecologists (Washington, DC) defines pregnancy. Neither comes close to what Card calls a "zero-probability argument" (Card 2007, 8). And I am not aware of any living physician that professes the Monty Python-ish idea that every sperm (and ovum) is sacred and deserves a chance to become a person. Card would have done better to address the arguments of those who disagree with him rather than knocking down a series of straw men.

The problems go deeper. Card (2007) does not merely claim that practitioners are obligated to provide EC; he argues that they are obligated to do so *even if they have a conscientious objection*. This last clause may seem harmless on the surface, but a closer look reveals that it effectively saws off the limb on which the first clause and all medical ethics sit. To begin, what is a conscientious objection, but an individual's judgment that it would be unethical for him or her to act in a certain way? A genuine conscientious objection, even if misinformed, is an expression of a commitment to acting morally, and although religious persons are somewhat more likely to report conscientious objections (Curlin et al. 2007), judgments of conscience need not be informed by explicitly religious ideas. Moreover, all ethical arguments are appeals to conscience. As such, acting conscientiously is the most fundamental of all moral obligations.

Consider the fact that an individual's conscience does not provide moral concerns to consider: rather, the conscience makes judgments with the moral concerns in view. In this respect of judging, the work of the conscience is much like the work of a jury. Both take into account the available evidence and the accompanying arguments in order to make a reasoned judgment. A judgment can be reconsidered in light of new evidence and new arguments, but evidence and argument cannot be weighed against a judgment made after considering that evidence and argument. In other words, practitioners who believe it would be unethical to provide EC can reconsider that judgment in light of Card's points about patients' autonomy rights and physicians' role responsibilities, just as jurors who believe the defendant is guilty after hearing the prosecution may reasonably reconsider that judgment in light of the defense. Yet, claiming that practitioners have an ethical obligation to dispense EC, even if they have a conscientious objection, is like claiming that a jury has an ethical obligation to convict the defendant, even if they are persuaded the defendant is innocent. We should ask, in either case, on what grounds?

Indeed, the very act of presenting evidence and making arguments presumes that the one to whom those arguments are directed, whether practitioner or juror, is committed to acting according to their best judgment after taking all relevant considerations into account. It would be useless for an attorney to make arguments to jurors if those jurors were not committed to deciding a verdict based on their best judgment of the guilt or innocence of the defendant. Likewise, it is useless for Card or anyone else to make ethical arguments if practitioners are not committed to practicing according to their best judgment of what is in fact ethical. A commitment to acting conscientiously is as fundamental to the moral life as a commitment to judging impartially is to the work of a juror.

To be sure, a judgment of conscience may be wrong, but it can not be put right by setting it aside. That would be like a jury giving up deliberation about whether the defendant is innocent or guilty and instead just doing what some contingent says they should do because that contingent professes to know better. To the extent jurors take any such tack, the possibility of a fair trial disappears. Likewise, whatever reasons one might give for acting against conscience, they cannot be *moral* reasons, and to the extent such reasons are followed against the judgments of conscience, the possibility of medical ethics disappears. We can still tempt or threaten, but the carrot and the stick are instruments of control and enforcement; they are not instruments of moral persuasion.

There is one thing left. Although no practitioner should do what he or she believes is unethical, not everyone is qualified to be a healthcare practitioner. A juror may be from any walk of life, but he or she must be able to attend to details, weigh evidence, work with other jurors, and most importantly, judge impartially. The question is whether a willingness to dispense EC is as constitutive of good medical practice for physicians as these activities are constitutive to the work of jurors. It is a question, as Hardt (2007) notes, of whether the use of EC is consistent with the ends of medicine. If so, then an unwillingness to provide EC would in theory disqualify a physician from practicing in a domain where EC is likely to be requested. A fuller treatment of this issue goes beyond the scope of this brief commentary, but might begin with Kass's claim that the only rational and proper end for the practice of medicine is *health*, an objective, natural norm which he defined as "the well-working of the organism as a whole" (Kass 1975, 29). The question is whether, apart from sexual assault, EC is required for the well-working of the human organism. Yet there is no point in asking this question if practitioners are not to act according

to their best judgment regarding the answer. Conscience is the limb on which medical ethics sits. ■

REFERENCES

Card, R. F. 2007. Conscientious objection and emergency contraception. *American Journal of Bioethics* 7(6): 8–14.

Charo, R. A. 2005. The celestial fire of conscience: Refusing to deliver medical care. *New England Journal of Medicine* 352(24): 2471–2473.

Curlin, F. A., R. E. Lawrence, M. H. Chin, and J. D. Lantos. 2007. Religion, conscience, and controversial clinical practices. *New England Journal of Medicine* 356(6): 593–600.

Hardt, J. 2007. The necessity of conscience and the unspoken ends of medicine. *American Journal of Bioethics* 7(6): 18–19.

Kass, L. R. 1975. Regarding the end of medicine and the pursuit of health. *Public Interest* 40: 11–42.

Savulescu, J. 2006. Conscientious objection in medicine. *British Medical Journal* 332: 294–297.

Conscientious Objection the Morning After

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Robert F. Card (2007) argues that pharmacists who conscientiously object to filling prescriptions for emergency contraception (EC) should, despite their personal views, always fill them. His view, according to which a pharmacist's conscientious objection concerning EC should always yield to the patient's interests, is at one extreme of a spectrum of possible views. The opposite extreme, that a pharmacist's right to conscientious objection concerning EC is never overridden by patient interests, has been advocated by others (Stein 2005). A middle-ground view might be something like this: when conscientious objection can occur without an undue risk of harm to the patient, it is permissible; when it cannot be performed without such risk, the pharmacist's duty to promote the interests of the patient overrides the right to conscientious objection. This wording of the middle ground view leaves open the definition of an undue risk and suggests that a variety of views is possible. I believe that both of the extreme views are mistaken, but here I shall argue only that the defense Card puts forward for his view is defeated by several serious objections.

WHY ELIMINATE REFERRAL AS AN OPTION?

One problem with Card's (2007) argument is that he rules out, for a pharmacist who conscientiously objects to dispensing EC, the option of referring the patient to another pharmacist, and he does not give good reasons for rejecting this possible approach. To see this, let us consider the arguments he gives for eliminating this option. First, he points out that in some situations it might not be possible to refer without causing harm to the patient. Patients in rural areas who are referred, for example, might not be able to obtain the medication within the time period in which it would be effective and therefore might be exposed to risks associated with pregnancy or abortion. However, it does not follow from this consideration that referrals are *never* justifiable. After all, one could hold that *in the type of scenario in question*—that is, when non-dispensing would cause significant harm—the option of referring is overridden by the interests of the patient.

Second, Card (2007) claims that pharmacists who refer are not fulfilling their role responsibilities because they are not checking for drug interactions. However, one can counter this by claiming that, in cases of referral, it is the pharmacist to whom the patient is referred who has the responsibility to check for drug interactions. Card's argument fails to consider that those who regard referral as sometimes acceptable might understand the pharmacist's professional duties as follows: the pharmacist has a duty to fill the prescription and carry out all responsibilities associated with filling it or to refer the patient, provided there are not factors in the particular situation that override the right to refer. According to this understanding, a pharmacist who refers when there are no overriding factors is not *ipso facto* violating a professional duty.

Third, Card (2007) argues that a public confrontation between pharmacist and patient when other customers are present at the pharmacy counter would compromise patient confidentiality. In reply, one can agree that such public discussions should be avoided, while also recognizing that there are alternative ways for pharmacists to handle such situations. One could step to a less public location or ask a non-objecting pharmacist to fill the prescription, among other possibilities. One might even hold that if there is no

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