Civil Disobedience, Not Conscientious Objection, In Medicine

Dana Howard

ABSTRACT: Those arguing that conscientious objection in medicine should be declared unethical by professional societies face the following challenge, conscientious objection can function as an important reforming mechanism when it involves health care workers refusing to participate in certain medical interventions deemed standard of care and legally sanctioned but which undermine patients’ rights. In such cases, the argument goes, far from being unethical, conscientious objection may actually be a professional duty. I examine this sort of challenge and ultimately argue that these acts of conscience done in the interest of reforming professional norms or medical regulations are best understood as episodes of civil disobedience rather than episodes of conscientious objection. In contrast to the private, exempting nature of conscientious objection, civil disobedience is a public breach of a norm or law undertaken with the aim of bringing about a change in governmental policies or professional standards. Consequently, clinicians may have a duty to engage in civil disobedience even while professional societies are right to declare limitations on the ethical appropriateness of conscientious objection.

§1. Introduction

In Jan. 18, 2018, the US department of Health and Human Services [HHS] announced that it would be creating a new Conscience and Religious Freedom Division in the HHS Office for Civil Rights. The purpose of the new division was to provide funding and institutional support to “more vigorously and effectively enforce existing laws protecting the rights of conscience and religious freedom” in healthcare and other human services. This is just one more step among many legislative and regulatory policies that enshrine the right for health care workers and institutions to act on their conscience in medicine.

For the past forty years, medical practitioners have been conferred a extensive list of conscience protections, including the right to refuse to perform abortions or sterilizations on the basis of religious or moral convictions [Church Amendment, 1973], the right to abstain from abortion training [Coats-Snowe Amendment, 1996], and the right not to be fired or discriminated against by a federally funded health care entity on the basis of one’s refusal to perform abortions, offer referrals, etc. [Weldon Amendment, 2005]. In 2009, under the regulatory oversight of the Bush administration, the right to abstain from participation was extended to any treatment or research contrary to one’s religious and moral convictions. This extension was quickly curtailed by the Obama administration to more narrowly understand the original protections under the Church Amendment as pertaining exclusively to abortion and sterilization.

The 2018 HHS announcement signaled a return to a broader interpretation of conscientious objection protections. The proposed rules mention a wide array of health care practices from

1 https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-
which individuals have a right to abstain, including services related to abortion, sterilization, contraception, vaccinations, performance of advance directives, physician assisted suicide, global health care assistance, and specific counseling about reproductive options and other referral services.  

In short, the laws currently on the books afford those in the health care profession a robust set of rights to act according to their conscience when engaging in some medical practice conflicts with their religious or moral convictions. The question considered in this paper is whether professional organizations and societies should similarly be so supportive.

Recently a number of prominent bioethicists have taken a critical stance against conscientious objection in medicine and some have advocated for professional organizations to remove or defang the conscience clauses in their codes of ethics. They argue that when one’s conscience and one’s professional duties conflict, the professional duties should be prioritized in order to ensure equitable access to healthcare and respect for patients’ rights. Defenders of such clauses tend to respond to the criticisms without denying the critics’ main premise that the impetus for conscientious objection grows out of the possible conflict between one’s professional duties and one’s personal convictions. Instead, defenders argue that sometimes, medical practitioners should be afforded some leeway to act on their conscience even if doing so may be unprofessional and that professional societies should publically identify this affordance as a right of its individual members. Call this the “Accommodation Defense” [AD] of conscientious objection.

This paper explores another possible defense for acting on one’s conscience in the realm of medicine: in certain circumstances, acting on one’s conscience in opposition to the current professional standards or regulations can be an influential mode of protest and may be employed as tool to transform the standing professional norms for the better. On this defense, far from being unethical or unprofessional, acting on one’s conscientious objection may actually be motivated by one’s professional duty. Call this the “Fidelity Defense” [FD] of conscientious objection; conscientious objection is understood here as a way in which individual practitioners can show their fidelity to their professional role, even as they act contrary to existing standards. This paper explores this possible line of defense and argues that what FD ultimately ends up defending is not conscientious objection per se, but civil disobedience.

§2. When Professional Standards and Conscience Conflict

Recently, scholars have begun to take a more critical stance on the place of conscientious objection in the medical profession. Critics of conscience clauses maintain that they allow individual medical practitioners to prioritize their own personal beliefs above professional standards. Moreover, some have suggested that if medical practitioners find themselves in a

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position in which they cannot fully perform the functions professionally expected of them due to their deeply held moral or religious convictions, they should leave the medical profession or at least choose a specialty that would not require them to perform the sorts of actions they oppose. Ronit Stahl and Ezekial Emanuel, encapsulate this position frankly:

“To invoke conscientious objection is to reject a fundamental obligation in healthcare – the primary duty to ensure patients’ continued well-being. It places a professional’s personal beliefs above professional standards…The health care professional who wants to prioritize personal values over professional duties must choose a less personally fraught occupation.” [1384]

Stahl and Emanuel are critical of the ambivalent language in conscience clauses that professional medical organizations, like the American Medical association [AMA] and the American Pharmaceutical Association [APhA], include in their code of ethics. The APhA, for instance, maintains the pharmacists must respect the dignity and autonomy of each patient, which includes respecting “personal and cultural differences between patients”. At the same time, the APhA “recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal.” While respecting individual APhA members’ right to conscientious objection may seem noble in theory, the following case highlights a number of problematic features of how such objections play out in practice and the lack of ethical guidance that such clauses establish:

Objecting to Contraception: In 2002, pharmacist Neil Noesen refused to refill a woman's valid prescription for birth control pills on the basis of his personal religious beliefs. The woman took her empty prescription package to a different nearby pharmacy. When the pharmacist there called Noesen to transfer the prescription, Noesen refused to give the information necessary to fill the prescription elsewhere, believing it would constitute participating in contraception. As a result, the woman missed the first dose of her medication and had to use a back-up method of birth control. Prior to this episode, Noesen was willing to transfer patients seeking contraception to another pharmacist, “but a recent trip to Calcutta – where he realized that health care is about helping the suffering – had convinced him that this was wrong. ‘Finally my conscience caught up with me,’ Noeson told [Christian Times] – ‘I couldn’t do it anymore. I felt like I was being used by the system, that I was becoming part of the problem rather than part of the solution.” The Wisconsin Pharmacy Examining Board subsequently disciplined Noesen and mandated that he attend ethics classes. This censure was not for his refusal to fulfill the prescription, but for his failure to adequately inform his employer of his religious objections and for his refusal to promptly transfer this prescription to the other pharmacy.

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6 http://www.catholicsforchoice.org/pharmacists-with-no-plan-b/
The examining Board’s censure aligns with the APhA’s official stance; Noesen has a right to refuse to provide contraception, but it is legitimate for health systems to expect him to participate in ensuring that the patient has access to the contraception elsewhere. Opponents of conscientious objection argue that even in refusing to fill the prescription, Noesen fails in his professional duties. This is a lapse of professionalism regardless of whether it grows out of deeply held moral and religious convictions.

A number of arguments have been offered against conscientious objection in medicine. Some of the criticisms relate to the negative impact on patients. First, a medical system that allows for conscientious objection is inefficient even if protocols are in place to ensure formal access to the objected medical services. Patients have to figure out which of the medical practitioners are willing to provide the medically appropriate and legally permitted services. For example, in 2007 a 23-year-old mother in Columbus, OH went to her local Wal-Mart for emergency contraception. She was told that even though the store stocked emergency contraception, there was no one presently on staff who would sell it to her. She subsequently drove 45 miles to find another pharmacy that would provide her with the time sensitive medication. Second, this inefficiency leads to inequity. Only some patients are going to have the resources [the research capacity, the time, the finances] to know what medical services they are entitled to and to track down the willing medical practitioners. So formal access can still lead some patients, who are less informed and more vulnerably situated, to miss out on medical services they have a legal right to receive.

Other criticisms pertain to the voluntary nature of the medical professions and their gatekeeping roles. Unlike conscripted military service, people voluntarily elect to become pharmacists, OBGYNs, nurses. They chose to be part of the medical profession. The profession has a legal monopoly on the services that it provides. Therefore as members of the profession, they are entrusted to fully provide for their patients’ healthcare needs without discrimination. They even take oaths to do so as a matter of initiation into their professional roles.

Now there is controversy as to who determines and what counts as the full provision of patient healthcare needs. Julian Savulescu, whose focus is primarily the public healthcare system in the UK, claims that the state should be the ultimate arbiter: “What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient’s good and the

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8 For a full discussion see, Savulescu J. Conscientious objection in medicine. BMJ. 2006; 332: 296.
patient’s informed desires.” Stahl and Emanuel, on the other hand, argue that “health care professionals work within a matrix of legal, institutional, and professional constraints and obligations, but the primary commitment to patients remains the foundational responsibility of health care. Thus, collectively, the profession — not politicians, judges, or individual practitioners – sets its contours.” So for Savulescu, physicians undermine their professional duties when as a matter of conscience they refuse to provide the care as required by law. For Stahl and Emanuel, physicians undermine their professional duties, when as a matter of conscience they act contrary to the standards set by professional consensus through legitimate organizational deliberative means.

Of course, both sorts of views concede that there are going to be times when either the law is unclear or consensus has yet to be reached within the profession. Take for example the current lack of professional consensus surrounding physician assisted dying or what constitutes a substantial health risk to the mother or the fetus when it comes to abortions beyond 24 weeks. In these sorts of situations, Savulescu and Stahl and Emanuel accept that individual physicians have the moral prerogative to act on their conscience. But barring such situations that require further legal or professional clarity, these critics hold that appealing to conscientious objection is incompatible with one’s professional duties. Call this view that “Incompatibility Thesis:"

**Incompatibility Thesis:** It is contrary to the healthcare practitioner’s professional duties to refuse, as a matter of conscience, to provide the legal goods and services that are within the scope of their professional competence.

Interestingly, many defenders of the right to conscientious objection as well as the professional organizations who incorporate conscience clauses into their code of ethics do not deny the Incompatibility Thesis. Take for example the AMA code of ethics. It supports the view that calls of conscience comes when there is a “tension” and a “discontinuity” across a physician’s professional and personal roles: “Physicians are expected to uphold the ethical norms of their profession…yet physicians are not solely defined by their profession. They are moral agents in their own right, and like their patients, are informed by and committed to diverse cultural, religious and philosophical traditions and beliefs.” Respect for conscientious objection is couched in terms of giving physicians certain allowances to act against professional norms, when doing so is necessary to “sustain moral integrity and continuity across [their] personal and profession life.”

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13 Savulescu, p. 294. It should be noted that Savulescu claims that insofar physicians are working in private practice, they “have more liberty to offer the service of their choice, based on their values” just as long as patients are fully informed of the alternatives they can receive elsewhere. [p. 296] This distinction between private and public, presumably works in a system where most people access their healthcare publically and so only seek out private medicine electively. It is unclear whether his lenience toward private practice would remain in a healthcare system like the US.

14 Stahl and Emanuel, 1384.


According to the AMA’s statement, invoking conscientious objection is motivated by a possible incompatibility between one’s professional role and one’s deeply held personal convictions. It is the responsibility of the professional society then to recognize this potential conflict and to make allowances for the medical practitioners to act according to their personal values. We can understand this line of defense as the “Accommodation Defense” of conscientious objection [AD]. What is being defended isn’t the conscientious objection per se, but the right to conscientious objection.

The AMA’s stance reflects a number of justifications that have been put forward for accommodating conscientious objection in medicine. First, defenses are often couched in terms of respecting the individual rights of members. Supporting conscience clauses is a way to support the moral integrity of individual medical professionals, which is of integral value for the profession as a whole. Unlike plumbing, medicine is considered a ‘moral enterprise’ and those in the medical profession should not view themselves as “mere ‘technicians’ who will perform requested services on demand.” They must develop their own moral perspective that enjoys critical distance from the preferences of patients, the standards of the profession, and the dictates of law. Respect for conscientious objections is a necessary outgrowth of respect for moral integrity.

The maintenance of one’s moral integrity not only makes one a good physician, nurse, etc. it is also an important value to one’s status as a member of equal standing in one’s moral community. Other defenders have thus focused on the idea that conscience clauses are an important way for professional societies to show respect for the rights of medical professionals as persons. For instance, Mark Cherry asks “why physicians and other health care workers would cease to be individuals with rights and interests simply because they decide to enter the healthcare profession.” On this sort of defense, conscience clauses can offer a way for the professional society to balance the individual rights of patients and of medical practitioners.

Next, including conscience clauses may have important pragmatic benefits for patients as well as clinicians. Feeling empowered to act on one’s conscience may guard against moral distress. According to Andrew Jameton’s classic characterization, “moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.” While the contours of the phenomenon are still up for debate, studies have found that the experience of being unable to carry out what one believes to be the ethically appropriate action is common in the medical profession and is associated with clinician burnout, turnover, and even negative health outcomes and safety risks for patients. Moreover, were professional organizations to take a strong stance against conscientious objection and hold that as a condition of professional licensure people must be willing to provide all services regarded as core by the specialty, such a position would risk

“radically reducing the number willing to go into specialties that already face critical shortages.”

Finally, conscience clauses can be a way for professional organizations to recognize the diversity of values in society. Defenders argue that conscientious clauses can signal the importance for medicine to be an inclusive and diverse profession. It can also be implemented to avoid alienating certain patient populations who share the religious, ethical and cultural perspectives of the conscientious objectors and who may feel most comfortable being cared for by such clinicians.

Importantly all these kinds of justifications do not deny the Incompatibility Thesis. What is up for debate is not whether the substance of one’s conscientious objections may turn out to be justified — i.e. that it is indeed immoral to fill a medication that will be used solely as a contraceptive. All the points of defense just outlined suggest that professional organizations should accommodate such objections – insofar as they grow out of the member’s deeply held moral and religious convictions – however misguided they might be. AD thus relies on the “humanistic value of protecting the person’s sphere of autonomy in which to act wrongly.” Such a defense can only go so far. It does not defend the professional or the moral fortitude of those who invoke such right to act on their conscience against professional and legal standards. With AD comes toleration, not vindication.

In the next section we will examine a different and more robust line of defense of conscience clauses. The following defense starts with the denial of the Incompatibility Thesis. It rejects the idea that conscientious objections necessarily grow out of an irreconcilable conflict between one’s moral and religious convictions and one’s professional obligations.

§3. The Professional Duty to Act on One’s Conscience?

Those arguing that conscientious objection in medicine should be declared unethical by professional societies face another kind of challenge:

**Fidelity Defense [FD]:** Conscientious objection can function as an important reforming mechanism when it involves health care workers refusing to participate in certain medical services either deemed standard of care or legally mandated, but which undermine patients’ rights. Far from being unethical, conscientious objection may actually be a professional duty.

FD can be made salient by considering the following two cases:

**Objection to Treating Homosexuality as a Disorder:** In 1974 the APA’s DSM-II’s diagnoses of "Sexual Orientation Disorder" was replaced with “Sexual Orientation Disturbance.” The change was made so that only people who were “in

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23 Ibid.
24 Smith, W. and Brownlee, p. 15
conflict with” their sexual orientation would be considered to have a mental health disorder. Two years earlier, Dr. John Fryer was on a panel at the APA annual convention advocating for homosexuality to be removed from DSM altogether. Fryer who was gay himself, was reluctant to come out to his colleagues. So calling himself Dr. H. Anonymous, he wore a wig and a mask to disguise his face and used a microphone to distort his voice. Members of the APA subsequently voted on the matter: 5,854 psychiatrists voted to remove homosexuality from the DSM, and 3,810 to retain it. The 1974 change in the DSM was written as a compromise position in an effort to accommodate the lack of professional consensus. Unfortunately, it was not until 1987 that homosexuality would completely fall out of the DSM. Now imagine, Dr. John Fryer, in 1975 just after the ‘compromise position’ was put in place. He still objects to the idea that he should ‘treat’ patients who feel conflicted over their sexuality, even if these patients are requesting treatment deemed standard of care by the relevant professional societies. This objection to the new designation doesn’t only grow out what Dr. Fryer thinks is best for these patients, it also grows out of his own identity and conviction that there is nothing mentally deviant about being gay.

Objection to Preset Language of Abortion Counsel: In 2011, North Carolina passed the Woman’s Right to Know Act [HB 854], which requires women to receive counseling with state-mandated content at least 24 hours prior to obtaining an abortion. While there is no official script, counsel must include specific information determined by the legislature, such as the name of the physician who will be performing the abortion, the risks of abortion and of carrying the pregnancy to term, that the biological father is liable for child support even if offered to pay for abortion, the alternatives that a woman has to abortion, etc. Dr. Patterson is an OBGYN and an abortion provider, who believes that being required to present the state mandated information undermines her capacity to provide patient centered care and in particular to provide advice that is relevant to the patient’s circumstances. For instance, if Dr. Patterson is caring for a rape survivor, including information about the responsibilities of the “biological father” may further traumatize the patient. Dr. Patterson has taken steps to mitigate the negative effects of providing the mandated information – such as stating in advance of the counseling session that she is required by the state to offer this information and that she doesn’t necessarily believe that all the information is relevant to the patient’s decision. Nonetheless, even with these disclaimers, Dr. Patterson acknowledges, “[t]hey’re still hearing it form our voice, and I think that affects the relationship with doctors and patients and really has no place in providing safe care.”

Both Dr. Fryer and Dr. Patterson, as a matter of conscience, object to some standard or rule that they are expected to adhere to given their professional roles. Dr. Fryer, objects to the standard of care that has been determined through the legitimate deliberative channels of his professional organization. Were he to act on his conscience and refuse to treat patients for

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being gay, he would presumably be failing to live up his professional duty according to Stahl and Emanuel’s account. Dr. Patterson objects to the standard of care that has been determined through the ostensibly legitimate democratic channels of the legislative system. Were she to act on her conscience and refuse to communicate to her patients the legally mandated information, she would be failing to live up to her professional duty according to Savulescu’s account.

In both cases, we see the potential limits of the strategies of conscientious resistance and reform that can be done through the established channels afforded to them as members of a particular profession. Dr. Fryer appealed to fellow members at his annual convention and was active in trying to get the language changed in the DSM. However this process took years and it is unclear that as a matter of professional duty Dr. Fryer had to accept the current DSM designations and treat patients who came to him conflicted about their sexual orientation as suffering from a mental health disorder.

Using her mitigating strategies, Dr. Patterson, engages in what Buchbiner et. al. describe as “conscientious compliance.” Since HB 854 does not require that clinicians use specific language, they can work “within the constraints” of the law while simultaneously engaging in a “strategic effort to mitigate the threats that compliance with a law or policy pose to one’s conscience.” Other strategies available to Dr. Patterson and colleagues are the use of expert testimony and lawsuits to modify the mandated practice. However, again, it is unclear whether Dr. Patterson would have been failing to live to her professional role were she to take a public stance and refuse to adhere to the mandates of the law. Far from being unethical, conscientious objection on the part of Dr. Patterson and Dr. Fryer start to look much more like a professional duty.

Such actions would be reminiscent of Martin Luther King, Jr.’s famous description of the moral power of publically breaking the law as a matter of conscience: “I submit that an individual who breaks a law that conscience tells him is unjust, and who willingly accepts the penalty of imprisonment in order to arouse the conscience of the community over its injustice, is in reality expressing the highest respect for the law.” While risky, publically refusing to designate patients as disordered and publically refusing to use the state mandated information because it can further traumatize patients, carries with it a distinctive moral authority. This is especially forceful if such action is clearly done out of respect for patient rights and because one cannot quietly go along with current practices or established channels of reform. Such a public action and a willingness to be held accountable for one’s decision, communicates to others the seriousness of one’s position. It can thus be used as one more tool of resistance to hasten necessary changes to the professionally or legally dubious practices. This sort of reasoning grounds the Fidelity Defense of conscientious objection.

Critics of conscientious objection may respond in different ways to these sorts of cases. Savulescu, for example, argues that “[i]f people are not prepared to offer legally permitted,
efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.\textsuperscript{31} Recall however that Savulescu made allowances for situations in which the law was unclear. It is in keeping with his argument to maintain that it is unclear how legally mandating pre-abortion counseling that includes such information is actually efficient or beneficial to the patient. On this interpretation of his view, insofar as the law itself fails to clarify the medical benefits and justice of certain medical practices, healthcare workers have a legitimate right to refuse to participate in such practices. It follows that there is ample room on Savulescu’s view to justifiably engage in acts of conscience since many laws that regulate health, in particular reproductive health, have not yet clarified how doing so is actually beneficial to patients or a just way of distributing scarce healthcare resources. On this interpretation, Savulescu may end up agreeing with the Fidelity Defense of conscientious objection in situations such as Dr. Patterson’s and others.

Stahl and Emanuel have a different possible response to cases such as Dr. Fryer’s. They might accept such cases as illustrative of a limited set of situations in which conscientious objection is ethically justifiable:

“There is, however, a specific role for conscientious objection. It provides limited recourse in professionally contested interventions – that is, interventions about which the health care community is currently debating whether participation is appropriate or not…Defending professional integrity means limiting conscientious objection to professionally disputed interventions.”\textsuperscript{32}

Some medical interventions remain socially and politically contentious long after consensus has been reached within professional societies about whether such interventions are medically appropriate and beneficial to patients. Stahl and Emanuel compare abortion to physician assisted suicide on this front. While both interventions continue to be politically and culturally contentious, the medical value and suitability of abortion are no longer professionally disputed. At the time that Dr. Fryer took an anonymous stance in front of the APA, the designation of homosexuality as a mental illness still lacked professional consensus. And so, on Stahl and Emanuel’s view, conscientious objection may have been appropriate. Professional consensus does not mean unanimity however. The fact that one’s personal convictions differ from the majority of the profession is not yet evidence that some medical practice is professionally contentious. It is only when there is disagreement amongst a sufficient plurality of the profession that acting on one’s personal convictions rather than the established professional norms is acceptable on Stahl and Emanuel’s view.

While it can explain away Dr. Fryer’s case, this distinction between social and professional contestation is problematic. Sometimes the fact that a treatment is socially controversial is reason enough to question legitimacy of the established professional consensus. Take as an example the guidelines for the medical and psychosocial care of intersex infants. Until very recently standard of care was based on the research of John Money conducted in the 1950s and 1960s.\textsuperscript{33} Money believed infants under two years of age had no stable gender identity

\begin{thebibliography}{99}
\bibitem{31} Savulescu, p. 294.
\bibitem{33} Creighton S. “Surgery for intersex.” J R Soc Med. 2001;94(5):218-20. For the research conducted in the 50s and 60s under John Money, see Money J, Hampson JG, Hampson JL. Hermaphroditism: recommendations
and that for an intersex child’s healthy development, it was necessary to surgically create unambiguously sexed genitalia and encourage parents to provide their unequivocal reinforcement of the surgically determined gender. Although there was little evidence to support his theory, his surgical recommendations for intersex infants served as medical guidance for over 40 years. Many intersex infants underwent invasive genital surgery and were raised as girls since such surgeries were deemed easier to conduct. Social and political advocacy against these practices came way before this became a contentious matter for professional organizations.

Similar worries about the social/professional distinction can be lodged against professional consensus over the appropriate medical treatment of many types of disabilities. Stahl and Emanuel may be right that the medical profession uses a kind of reflective equilibrium to self-correct. However such a process is only going to be as dynamic as the perspectives that have power within the organization allow it to be. Often it is one’s professional responsibility to ally oneself with vulnerable communities who are contesting a specific medical practice but who have been marginalized or altogether shut out of the medical profession.

Stahl and Emanuel need a different sort of justification for how individual members of the profession can adjudicate between the sorts of situations where it is professionally appropriate and inappropriate to be critical of a medical practice based on one’s deeply held moral and religious convictions. Until a new justification is on offer, it is unclear if they can really dismiss the Fidelity Defense as a candidate justification for conscientious objection to a medical practice that is not professionally disputed.

§4. Conscientious Objection vs. Civil Disobedience

So far, we have explored two different sorts of defenses of including conscience clauses in professional organization codes of ethics – the Accommodation Defense [AD] and the Fidelity Defense [FD]. Whereas AD defends conscience clauses on the basis of offering professional members rights to act unprofessionally, FD defends conscience clauses in a more full-throated way. There is a kind of double standard that is lurking behind demands for accommodation of even one’s most deeply held moral and religious convictions. When one expects accommodation for one’s conscience, one is not objecting – at least not directly – to the system that allows others to engage in practices that one finds morally repugnant for oneself.

The risk of committing oneself to a double standard when one invokes one’s conscience as a way to exempt oneself has been picked up by critics. For instance, in arguing against conscientious objection in medicine, Savulescu points to the following remarkable finding: “80% of clinical geneticists and obstetricians specializing in ultrasonography believed that termination of pregnancy should be available for a normal 13 week pregnancy if the woman wants it for career reasons. However, only 40% were prepared to facilitate it.” According to

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34 Stahl and Emanuel, 1382.
AD, conscientious objections can be painted as a way to burden others in one’s profession to do the moral dirty work that one refuses to do oneself.

Not so with FD. In order to show fidelity to one’s professional values through one’s conscientious action, one acts publicly and unequivocally, repudiating an established practice or rule. One does this not with the expectation that others in one’s profession will pick up the slack, but with the hope that one’s action [perhaps in coordination with other likeminded objectors] can serve as a catalyst for change so that no one in the profession will have to engage in such a practice down the line.

Notice what sorts of actions FD is defending then. It is the right to act against some professional standard or legal mandate, even if doing so goes against one’s patient’s wishes, but only with the aim that such an action can spark change within the profession. What is being defended in FD thus is a slightly different sort of act of resistance than what is traditionally understood as conscientious objection. In this concluding section, I want to suggest that ultimately, what FD is defending is the right to engage in civil disobedience. This reframing has certain ramifications for how people who wish to use FD as a defense for the right to act on their conscience may actually go about justifying their claims.

To see the general difference between conscientious objection and civil disobedience, we can look at the way these two types of conscientious actions have been characterized by John Rawls. Rawls defines civil disobedience as “a public, nonviolent, conscientious yet political act contrary to law usually done with the aim of bringing about a change in the law or policies.”

On Rawls’s view, one should think of civil disobedience as a form of address; one is communicating to one’s community one’s deep political conviction. For this reason it must be public, political, and nonviolent. It is public when one justifies one’s infraction by invoking the convictions and the values of the community at large. It is political in the sense that it is solely political principles, i.e. the principles of justice, that guide and justify one’s action. In contrast to conscientious objection, “[i]n justifying civil disobedience one does not appeal to principles of personal morality or to religious doctrines, though these may coincide with and support one’s claims.” And such a conscientious act is nonviolent, in that it is intended to address one’s community’s sense of justice and not just make use of threats or force to get others to submit to one’s will. One’s actions of resistance are meant to convince of others of one’s sincerity and one’s overall fidelity to the law’s underlying values. It follows that there is one additional desideratum; one of the best ways to communicate to others one’s sincerity is through one’s own “willingness to accept the legal consequences of one’s conduct.”

In contrast to civil disobedience, Rawls has the following characterization of conscientious objection:

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37 Ibid. p. 324.
38 Ibid, p. 322.
“One simply refuses on conscientious grounds to obey a command or to comply with a legal injunction. One does not invoke the convictions of the community, and in this sense conscientious refusal is not an act in the public forum. Those ready to withhold obedience recognize that there may be no basis for mutual understanding; they do not seek out occasions for disobedience as a way to state their cause. Rather, they bide their time hoping that the necessity to disobey will not arise…they may entertain no expectation of changing laws or policies.”

While there are many ways to dispute this precise specification of either type of conscientious act of resistance, the contrast between the two activities is useful. There seem to be three important distinctions that are relevant to thinking about the case of conscientious action in medicine. First is a difference in ends. With conscientious objection one communicates one’s opposition in order to exempt oneself from some law or practice, whereas civil disobedience communicates one’s opposition in order to change the law or practice. Second is a difference of justification. Conscientious objection is justified by appeal to one’s personal moral and religious convictions, civil disobedience is justified by appeal to the publicly shared convictions espoused by one’s community and by the political principles of justice. Third is a difference in reasonable hope. Conscientious objection is invoked when one is skeptical of the power of one’s own action to move the community any closer to some sort of consensus, civil disobedience is invoked when one still has hope that one’s actions can spark change, even as all other communicative and deliberative strategies have been exhausted.

Given this distinction, it seems clear the insofar as the Fidelity Defense justifies the conscientious actions of Dr. Fryer and Dr. Patterson, it is justifying actions more akin to civil disobedience than to conscientious objection.

Both Dr. Fryer and Dr. Patterson would not be aiming to just exempt themselves from a medical practice but rather to change the way in which all members of their profession (or their state) provide patient care. Second, Dr. Fryer and Dr. Patterson would not be employing their own personal values to justify their infractions, rather they would be communicating the values that are already espoused within their professional community. Third both physicians would be risking a lot in order to publically refuse treatment. Such risks would not make sense unless there was some hope that bold action could affect change.

The risks of conscientious action are palpable in either case. Dr. Fryer did not formally divulge that he was the one behind the mask until 22 years later. In a 1985 bulletin of the Association of Gay and Lesbian Psychiatrists, Fryer wrote about his masked plea, “I had been thrown out of residency because I was gay. I lost a job because of was gay. It has to be said. But I couldn’t do it as me. I was not yet full time on the faculty.”

The risks of taking a public [and non-anonymous] stance were grave. The risks for Dr. Patterson would be similarly high. Not only does she experience the professional risks of losing her license and

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39 ibid. p. 324.
possible jail time, her choice would put at risk the prospect of her patients losing access to one more skilled abortion provider. It would be imprudent for them to make such a public stance and risk so much if they didn’t believe that such a public conscientious action could make a difference in the public and professional discourse.

It should be noted that Rawls’s depiction of civil disobedience is premised on the condition that one lives in a nearly just society. Insofar as we are applying the concept of conscientious objection and civil disobedience in our society, the characterization of conscientious resistance can be the subject of important criticisms and amendments. For instance, some theorists have suggested that civil disobedience need not be employed only in the hopes of achieving change through one’s conscientious resistance. Instead, it is sometimes appropriate for marginalized groups to register their deep frustration at a seemingly intractable system since doing so can reaffirm their agency and sense of dignity.

While this seems like a worthy amendment to the concept at large, we should question whether it changes the ethical appropriateness of civil disobedience on the part of medical professionals. When medical professionals engage in civil disobedience in their workplace, they risk not only their job security and personal wellbeing, but also the well-being and healthcare access of their patients. Consequently, healthcare workers, especially those working in low resourced communities and in rural locations, need to consider how their conscientious action [even if justifiable in other contexts] would directly affect their patients who have entrusted them with their care. If healthcare workers are engage in conscientious action merely out of protest and not out of a future oriented goal of changing the standards of their profession, the potential burden placed on patients may outweigh the value of such action.

Second, Peter Singer has challenged Rawls’s political and public conception of civil disobedience. We live in a society where there is no settled conception of justice and where some of the most important objects of our moral concern – i.e. the changing climate, animal welfare, and the rights of people with profound intellectual disabilities – cannot be cashed out by Rawls's two principles of justice. Accordingly, civil disobedience should not be limited to appealing to the political principles that Rawls has laid out or the publically espoused values of the community at large. This seems like an important amendment to Rawls's account, especially since some of the medically relevant moral considerations may involve medical treatment of individuals with intellectual disabilities. However, there is something important about the general public/private distinction that Rawls is appealing to when he compares conscientious objection with civil disobedience. Insofar as one is going to be using the Fidelity Defense for acting on one’s conscience, one has to engage with others in such a way that expresses a respect for the underlying values of their professional community and an interest in future collaboration. While the two principles of justice are too narrow to guide and justify one’s choices to engage in civil disobedience, some appeal to common values and principles remains pressing.

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41 Rawls, TOJ, 319.
It follows that the Fidelity Defense applies under the following conditions. If the health care worker:

1. **Aim:** Acts conscientiously in order to bring about a change in the law or policy there is reason to believe.
2. **Justification:** Can justify their action by appeal to the public values of the relevant community – in this case the professional norms of the society or organization.
3. **Hope:** Acts with the reasonable hope of actually being successful.
4. **Deference:** Is willing to accept the consequences that one would expect from such an infraction in an effort to communicate one’s sincerity.

As I have already discussed, I believe that were Dr. Fryer and Dr. Patterson to act on their conscience in opposition to the current laws and professional norms, such actions would be good candidates for professionally justifiable civil disobedience on this gloss. But where does this leave our pharmacist from the original example?

It is noteworthy that Noesen justifies his actions on the basis of a public concern that healthcare is, at its heart, about “helping the suffering”. In its abstraction, this is not an appeal to his private Catholic convictions and could be used to appeal to a diverse set of health care practitioners. Moreover, he saw it as no longer appropriate to expect to be personally exempted from the practice he found repugnant. In refusing to refill the contraceptives and then referring the patient to another pharmacist, Noesen saw himself as part of the problem. It seems then that at least on the broadest strokes, the aim and the justification are of the right sort to invoke the Fidelity Defense.

However, is it reasonable for Noesen to hope that his action of refusing to fulfill prescriptions can change the professional standards? I am not so sure. Moreover, let’s assume for the sake of argument, that Noesen were conscientiously refusing to fulfill the prescriptions with the hope that doing so will spark a change in the pharmaceutical profession. For the outside observer, such an action may be indistinguishable from Noesen doing what he can presently to block as many individual patients as individually possible from receiving reproductive healthcare, regardless of whether such an action changes the professional standards in the long run. Insofar as the point is to just block patients, the Fidelity Defense is no longer in play. For this reason, the fourth condition is of utmost importance if Noesen is going to be communicating to others his sincere aim of transforming the profession through acts of civil disobedience. Noesen should willingly accept the consequences of his actions and not expect to be able to engage in the practice of refusing to fulfill prescriptions free of professional censure. If he is not willing to accept the consequences, the burden is on Noesen to communicate his sincerity in some other way. In this way FD is different in one further way from AD as a defense of conscientious action. Whereas AD understands conscientious objection as a personal right to be protected, FD understands the power for civil disobedience as a responsibility that must be publically established in order to be respected.

Consequently, health care workers, like Noesen may sincerely hold that they have a professional duty to engage in civil disobedience, however the best way for them to communicate the sincerity of this position, is if they welcomed or at least were open to professional reprimand. Civil disobedience can thus be understood as a professionally...
appropriate in certain situations, even while professional societies are right to declare limitations and set penalties on conscientious objection.