In defence of medical tribunals and the reasonability standard for conscientious objection in medicine

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Cowley[1] has recently objected to the idea of using a medical tribunal to make determinations regarding conscientious objections and has criticised using reasonability as a standard for any such tribunal. In prior work, I defend the view that in order for a conscientious objection in medicine to properly generate an exemption, the objector must state the reasons supporting the refusal and allow the grounding reasons and the objection to be subject to evaluation in terms of reasonability.[2] Furthermore, I have suggested that this Reasonability View on conscientious objection can be carried out as a policy by establishing conscientious objector (CO) status within medicine; these matters could be adjudicated by a committee or tribunal similar to how determinations of military CO status are made in the USA.[3] I argue that Cowley's discussion sells the idea of medical tribunals short and illustrates serious misunderstandings regarding how the reasonability standard should be deployed in practice.

THE DISANALOGY BETWEEN THE UK AND USA REGARDING ABORTION

Cowley focuses his discussion of medical tribunals specifically on abortion in the UK. He does not aim to take a stance on the morality of abortion nor does he wish to adopt a general position on the permissibility of conscientious objection in medicine. Furthermore, he assumes that a particular provider's refusal does not interfere with a pregnant woman's access to abortion services provided by a willing practitioner. Finally, Cowley notes the lack of political debate about abortion in the UK, stating the following regarding the Abortion Law that made abortion legal: "Since the Act became law in 1967, it has been tweaked but never seriously challenged in Parliament or in the press."[4] Cowley's aim is to criticise medical tribunals as a general notion and to defend the status quo wherein providers' objections are not scrutinised in any way, yet his treatment involves a serious disanalogy that infects the entire discussion. Using the UK as an example to reject the very notion of a tribunal that assesses petitioners' objections before granting or denying an exemption is questionable because the UK situation is so strikingly different from other countries in the world. In the USA, *Roe v. Wade*[5] has been challenged numerous times in the Supreme Court and the outcomes have not simply been tinkering around the edges; the Court has, for example, sharpened the standard for the existence of fetal interests, has adjudicated concrete conditions placed on the provision of abortion by states and has specifically addressed the issue of late-term ('partial birth') abortions. (In fact, *Roe* is not even the fundamental controlling precedent case at this time; that honour belongs to *Planned Parenthood v. Casey*.)[6] This is not to mention the scores of state cases that have served to limit women's access to abortion services in the USA (eg, 24 states have requirements that ultrasounds be offered or administered before an abortion is performed).[7] Rejecting the very idea of a medical tribunal by defending the status quo in a country where abortion is not politically contentious is at the very least disingenuous—it is not surprising that one would dismiss the examination of providers' objections in a place where these refusals make little difference. In a country like the USA, allowing *carte blanche* conscience objections by providers regarding abortion threatens to turn the lack of access to abortion services into a genuine (worsening) crisis.

Furthermore, Cowley finds tribunals to be unnecessary since there are few non-moral reasons for practitioners in the UK to refuse to perform abortions. The facts on the ground in the USA indicate otherwise and strongly suggest the need for a *reasoned* approach to conscientious objections. Abortion services are marginalised in the USA and serious issues exist with respect to women's access to abortion in many places; this problem is not simply limited to a few rural areas. US medical providers may decide to not perform terminations to avoid losing their life or jeopardising their personal safety, as well as to prevent harassment at their office and at their personal residence.[8] Cowley's arguments rejecting the notion of a medical tribunal based on the UK and abortion are not generalisable to other countries. Even if Cowley is correct about medical tribunals and the UK, nothing necessarily follows about their use in other places. There is an important general lesson here. An acceptable account of conscientious objection policy should allow contextual factors to play a role. Medical CO review boards[3] are important because they bring local standards to bear—if women have problems gaining access to abortion services via referral or if there are substantial politically and socially motivated reasons for providers to opt out (as there are in the USA), these would be relevant considerations for a medical tribunal to take into account. In short, context matters. Even if Cowley's argument against using tribunals in the UK is successful, the conclusion that follows is narrow, possessing limited impact for the conscientious objection in medicine debate. In effect, Cowley's assumptions about the background conditions for conscientious objection are precisely those that downplay the importance of medical tribunals. He only discusses one context, assumes that a refusal does not block access to the required procedure and uses a setting in which there is a lack of political or moral disagreement regarding the practice in question. One could even grant that medical tribunals become *pro forma* in such circumstances, but the fact that these idealised conditions exist in very few places, and even then, not with regard to every type of service, makes clear the need for some form of assessment in cases where a provider's refusal actually makes a difference to a patient's wellbeing.

APPLYING THE REASONABILITY STANDARD FULLY AND EFFECTIVELY

The context matters, and facts about providers' objections themselves matter as well. Intuitively, we do not want to treat all conscientious objections as on a par. If a practitioner's refusal is premised upon a sexist or racist basis, that objection is weaker all things being equal than an objection founded upon another grounding belief derived from a genuinely held (non-discriminatory) moral or religious belief. As Rawls[9] argues, in the public sphere we can acceptably require that

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individuals act on the basis of reasonable conceptions of the good. To be clear, we are not talking simply about provider's personal moral convictions, but instead about beliefs that are instantiated into actions carried out within the institutional structure of medicine. This is part of the thinking that motivates my view that a provider's objection must meet a standard of reasonability in order to be acceptable. Cowley understands assessing an applicant's objection according to the reasonability view as follows:

> In this case the tribunal's aim would be to distinguish those applicants with inherently reasonable (i.e. intelligible and respectful) beliefs from those applicants with unreasonable beliefs…[10]

Cowley rejects using a reasonability standard to assess petitioners' beliefs by saying that all the evidence is in regarding an objector's belief that abortion is morally wrong—a tribunal would not be likely to change any applicant's mind and this makes fruitful use of the reasonability standard difficult or impossible. Since no one is going to change their beliefs in such a proceeding, determining what is 'reasonable' is ungrounded or, even worse, arbitrary. I am not convinced that Cowley's arguments pose a deep worry for the very idea of a tribunal that would employ a reasonability standard. Even granting that the abortion wars have made the arguments supporting both sides sufficiently clear, is this the case for other issues in medical ethics such as, for example, degrees of participation in dispensing emergency contraception (EC), refusals to use stem cell research or objections to participation in physician-assisted death or death by cardiac donation? The respective arguments here appear to be more unsettled than the abortion case, and it is far from clear that all the evidence is in. Medical tribunals can be useful if the goal is not to change another's mind—and this is the case on my view. The aim is not to change the petitioner's mind or for the applicant to convince the tribunal conducting the proceeding. The broad goal is to test for bias and, in the first instance, to ascertain if the objection is reasonable, which at least means that the claim (1) is understandable by others and (2) avoids arbitrariness such as that which infects sexism or racism. Cowley's arguments hit their mark only if the aim of using a reasonability standard is to convince another, but that is not (and should not be) the case.

Furthermore, Cowley's argument assumes that the reasonability view *only* applies its standard to the applicant's beliefs, but that is not the case. This view applies the standard of reasonability intrinsically to the beliefs supporting the objection themselves by asking for evidence that the petitioner holds his or her core beliefs genuinely, and second, by requiring that the grounding beliefs are consonant with empirical evidence.[3] So, for example, providers possessing genuinely held beliefs who object to dispensing EC because they believe it is equivalent to a 'chemical abortion' that kills human life postfertilisation would not be granted an exemption since they would fail the empirical consonance test. But that is not all. The reasonability view also looks to extrinsic factors regarding whether granting an exemption in a particular circumstance would be reasonable—for example, whether the objection denies care in an emergency or time-sensitive circumstance or causes needless or unjustified harm to patients.[11] Therefore, the concern in a medical tribunal which uses this standard is not with changing minds or convincing others that one's beliefs are true, but is instead only with showing that one's beliefs meet minimal conditions of reasonableness and that the circumstances in which one wishes to be granted an exemption from what would otherwise be one's professional obligation make acceptance of this conscientious objection reasonable in such a case.

It should be explicitly noted that the reasonability view does not automatically declare all religious beliefs to be unreasonable via the empirical consonance condition. Cowley states that "The 'reasonableness' criterion becomes even more difficult to apply in the case of a GP [general practitioner] whose moral beliefs ultimately flow from a foundational set of religious beliefs… [due to the] … notorious difficulty of justifying religious belief to a non-believer…."[12] Proponents of the reasonability view do not aim to 'bully' petitioners by asking them to prove the existence of God or to provide sufficient evidence for a specific religious tenet by using a scientific standard or else be denied an exemption. This would shrink the scope of religious tolerance to near zero. I have said that a crucial part of reasonability is that one's claim is understandable by others, and the proposition that a zygote possesses full moral standing at conception is a statement that is intelligible, whether one believes it to be true or not. While medical science can provide empirical evidence bearing on the attainment of developmental milestones during pregnancy, there is no empirical evidence that verifies or falsifies the prolife proposition. Therefore, if an objector possesses such a genuinely held belief and on this basis the empirical consonance test is not failed, the adjudication then turns to focus upon the extrinsic factors of the analysis in order to determine if granting an exemption is reasonable in this case.

ARE MEDICAL TRIBUNALS POINTLESS?

Finally, Cowley argues that medical tribunals are pointless: they would simply require a petitioner to "cram and regurgitate one of the many 'reasonable' arguments"[10] and would make such a proceeding farcical and burdensome to medical professionals-applicants. As Cowley states, "Surely it is too much of a burden to ask the GP [general practitioner], on top of her existing professional commitments, to prepare for a test on material that remains so complex and contentious even for professional philosophers."[12] This argument misrepresents the basic idea behind using the reasonability standard in concert with the notion of establishing medical CO status. Several of the points I have already made help us to see why this is the case. This proponent of medical tribunals does not envision giving physicians written examinations on the abortion debate, moral theory or theology. The focus of a tribunal conducted in accord with the proposed view is to determine whether the petitioner's belief is reasonable, and reasonable people can disagree. (Or individuals can disagree about reasonable propositions.) I have spelled out above the criteria for intrinsic reasonability, and have stated that whether or not full moral standing attaches at fertilisation is not a descriptive question amenable to the empirical consonance condition. A provider who possesses a genuine belief that blastocysts possess full moral standing on the basis of, for example, a religious reason that a soul is then present in this entity would satisfy the intrinsic conditions for reasonability. A petitioner who held the same genuine belief on the basis of a blastocyst's cognitive abilities or artistic talents would not. The tribunal is not a pointless exercise. This proceeding allows for the use of local standards—once intrinsic reasonability is determined, only a tribunal conducted within a particular country (or state within a country) can assess whether granting an exemption is reasonable given the circumstances in that place.

Regarding Cowley's point that tribunals are burdensome, they should not be unreasonably so. We must keep in mind that the burden of proof regarding a conscientious exemption lies with the

petitioner, since as a medical provider he or she possesses a (defeasible) obligation to provide treatment to his or her patients. Practitioners' fiduciary obligations to give primacy to their patients' interests do not simply vanish in the face of an asserted conscientious objection. Therefore, since the onus lies on the provider, I simply do not accept that a medical tribunal will necessarily involve a burden that is inappropriate given the professional obligations voluntarily accepted by the medical provider. Only if the practitioner satisfies the burden of proof that his or her objection is reasonable does this provide countervailing considerations that defeat the provider's *prima facie* obligation to provide legally available, appropriate, and requested services to the patient—thereby allowing the practitioner to properly discharge his or her professional duty by referring the patient to a willing provider, assuming this does not unduly impede the patient's access to the services in question.

CONCLUSION

I have argued that medical tribunals are not a hopeless idea. If they are, Cowley's discussion has not proved this point. Even if his antitribunal arguments were successful, they would not necessarily impugn my Reasonability View on conscience objections. Creating medical CO status via a tribunal or other mechanism is simply a policy suggestion to deploy the reasonability view, and both positions stand and fall independently on their respective merits. Furthermore, since the reasonability view applies its standard both to the intrinsic reasonability of the petitioner's beliefs as well as to extrinsic factors that bear on the reasonability of granting an exemption in a particular case, this position does not have the problems it is alleged to possess. Medical tribunals and the reasonability standard for adjudicating conscientious objections in healthcare remain live ideas. The jury is still out.

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11 This list is not intended to be complete. For instance, regarding medical students, it matters in generating a conscientious exemption whether or not performing the act in question contributes to cultivating a core competency; see Card, RF. Is there no alternative? Conscientious objection by medical students. *J Med Ethics* 2012;38:602–4. For further discussion regarding practicing professionals, see Card, RF. Reasonability and conscientious objection: a reply to Marsh and an elaboration of the reason-giving requirement. *Bioethics* 2014;28:320–6.
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