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Valuing Conscience and the Conscientious Provision of Abortions

CAROLYN MCLEOD*

Some physicians in the United States have strong moral objections to the recent bans or near total bans on abortion in this country.¹ The objections are particularly vehement among those who have been abortion providers. These physicians are concerned about the impact of the new restrictions on patients—on their lives and health, especially patients who are socially marginalized and will not be able to travel to “friendly” states to have abortions (i.e., states that legally permit abortions). They are also worried about the status of women, which they fear will be unequal to that of men in a society where women are not permitted to make such intimate

* © 2024 Carolyn McLeod. This paper is a revised version of the talk I gave at “The Role of Conscience in the Practice of Medicine and the Rule of Law.” I want to thank Reuven Brandt and Dov Fox for inviting me to this wonderful conference, and thank them as well as Sam Rickless, Nadia Sawicki, and Liz Sepper for conversations that helped me think more carefully about some of the ideas I presented. I also appreciate the feedback I received from Andrew Botterell on a draft of this paper.

1. The bans came into effect when *Roe v. Wade* 410 U.S. 113 (1973) was overturned in *Dobbs v. Jackson Women’s Health Org.*, No. 19-1332 (U.S. June 24, 2022). This shocking turn of events left Americans without a constitutional right to abortion. As of the time of writing this piece, at least 13 states had banned abortions, with most providing no exception for rape or incest. See Natalie Proulx, Michael Gonchar, and Jeremy Engle, *Teaching and Learning About Abortion Laws in the United States After Roe*, N.Y. TIMES (Oct. 13, 2022), <https://www.nytimes.com/2022/10/13/learning/teaching-and-learning-about-abortion-laws-in-the-united-states-after-roe.html> [<https://perma.cc/387M-5EAT>].

decisions about their lives.² For these physicians, not to mention their patients, the bans on abortion are morally devastating. They, the physicians, might even feel compelled by their conscience to provide this care—to engage in what some call the “conscientious provision” of care—even though they could lose their careers and their freedom by doing so.³

There is currently no legal protection for the conscientious *provision* of abortion care in the U.S., although there is substantial protection for the conscientious *refusal* of that care.⁴ Physicians working in jurisdictions where there are abortion bans put themselves at serious legal risk if they defy these laws for reasons of conscience. In general, their freedom of conscience is very low compared to that of physicians who conscientiously refuse to provide abortions in jurisdictions where abortions are legal.

One might object to this situation as some bioethicists and legal theorists have done. Should the conscience of physicians not be valued equally regardless of whether they favor abortion access or oppose it? Should there not be equal protection for the conscientious provision of abortions and the conscientious refusal of them? Some would say ‘yes’ in response to these questions because they believe that the current asymmetry in the regulation of these types of action is unjustified.⁵ Others would likely say ‘no,’ not because they welcome the asymmetry, but because they believe that there should have been little to no conscience protection for physicians to begin with;⁶ on this view, we made a mistake in offering

2. See The Daily, *A Post-Roe America, Part 2: The Abortion Providers*, N.Y. TIMES (May 11, 2022), <https://www.nytimes.com/2022/05/11/podcasts/the-daily/roe-v-wade-abortion-providers.html> [<https://perma.cc/7PQ9-H63D>]; Alan Braid, *Why I Violated Texas's Extreme Abortion Ban*, WASH. POST, Sept. 19, 2021, at A31 (both cited in Dov Fox, *Medical Disobedience*, 136 HARV. L. REV. 1030 (2023)).

3. For simplicity, I will focus on physicians, although they are not the only health care professionals who morally object to abortion bans and who could engage in the conscientious provision of abortions. Pharmacists could do both of those things, for example: the latter by conscientiously providing the abortion pill.

4. Some states do legally protect abortion providers against employment discrimination. See Nadia N. Sawicki, *The Future of Health Care Conscience Laws Post-Dobbs*, 25 J. CONTEMP. LEGAL ISSUES 35 (2024). However, that’s not the same as protecting them against legal action when they perform abortions that would otherwise be illegal. It’s not the same, that is, as protecting the conscientious provision of abortion. There is, again, no legal protection for such action in the U.S. By contrast, the protection typically offered for conscientious refusals is great. Health care providers who make conscientious refusals are exempted from having to provide the standard of care and are shielded from being sued or losing their license. That is true in 37 states even if their refusal causes the death of a patient, as we heard from Nadia Sawicki at our conference. *Id.*

5. See Kyle Fritz, *Unjustified Asymmetry: Positive Claims of Conscience and Heartbeat Bills*, 21 AM. J. BIOETHICS 46 (2020); Fox, *supra* note 2.

6. For example, Julian Savulescu has argued that conscience protection is warranted only when it would not compromise the “quality and efficiency” of care. That’s minimal

substantial protection to those physicians who wanted to refuse care (abortion or other forms of care) and so presumably, we should not make the same mistake again with those who want to provide it. Roughly, these commentators contend that society needs to be concerned less about the conscience of physicians or their ability to act on their conscience, and more about whether they do their jobs.⁷

In this paper, I hope to do two things. First, I want to show that we should take the ability of physicians to act on their conscience seriously, because normally something important is at stake in allowing them to do so. That's true regardless of what their views are on abortion. There is value in allowing physicians to act conscientiously, whether that action involves the conscientious provision or conscientious refusal of abortions. I will argue that the value of acting conscientiously supports a system that regulates these two types of action *symmetrically*. Here, I will draw on a theory about the value of conscience that I develop fully in my book, *Conscience in Reproductive Health Care*.⁸

The value of conscience is not all that is relevant, however, in deciding how to regulate the conscientious refusal and provision of abortions; there are other values at stake. The second main claim that I want to make concerns this fact and focuses on the value of physicians using their power as physicians appropriately. Drawing from a moral theory I defend in the book about the professional role of physicians,⁹ I will argue that they abuse or misuse the power they have in this role when they conscientiously *refuse* abortions; however, this outcome does not obviously occur when they conscientiously *provide* abortions. Since their conscientious conduct deserves less protection when it involves an abuse or misuse of power, I am led to conclude that the regulation of the conscientious refusal and conscientious provision of abortions should very likely be *asymmetrical*,

conscience protection indeed. See Julian Savulescu, *Conscientious Objection in Medicine*, 332 *BMJ* 294, 296 (2006).

7. See, e.g., *id.*; Julian Savulescu & Udo Schüklenk, *Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception*, 31 *BIOETHICS* 162 (2017); Alberto Giubilini, *The Paradox of Conscientious Objection and the Anemic Concept of 'Conscience': Downplaying the Role of Moral Integrity in Health Care*, 24 *KENNEDY INST. ETHICS J.* 159 (2014); Alberto Giubilini, *Conscientious Objection in Health Care: Neither a Negative nor a Positive Right*, 31 *J. CLINICAL ETHICS* 146 (2020).

8. CAROLYN MCLEOD, *CONSCIENCE IN REPRODUCTIVE HEALTH CARE: PRIORITIZING PATIENT INTERESTS* (2020).

9. MCLEOD, *supra* note 8, at chs. 5–6.

in a way that favours conscientious provision. I call this regulatory scheme, the “new asymmetry.”

My recommendation in favor of the new asymmetry is somewhat tentative; I do not support it fully, because the normative issues here are complex. I also very much doubt that unfriendly states would ever adopt it. I doubt, in particular, that they would ever legally protect the conscientious provision of abortion while maintaining that abortion should be illegal.¹⁰ Given that my position is unlikely to have any purchase with them, I close by discussing what sort of conscientious conduct physicians could engage in when faced with such a legal regime (i.e., one where legally-protected conscientious provision is not an option). Ideally, in my view, they should participate in what Matthew Wynia calls “professional civil disobedience,” which is “collective civil disobedience by a professional group” or groups. In this case, the relevant groups could be any number of medical organizations that have spoken out against the abortion bans (e.g., the American Medical Association, the American College of Physicians, etc.).¹¹

The paper will proceed as follows. To begin, I will clarify how I am using the terms ‘conscientious refusal,’ ‘conscientious provision,’ and ‘civil disobedience.’ I will then discuss the importance of valuing conscience in medicine.¹² Finally, I will present moral reasons in favor of the new asymmetry, and how ideally physicians should react when the states they live in fail to adopt this regulatory option.

I. CONSCIENTIOUS CONDUCT IN MEDICINE

Conscientious refusal, civil disobedience, and conscientious provision are all types of conscientious conduct that can occur in medicine.¹³ In general, conduct of this sort is motivated by conscience and opposes the law or standard of care. Let me elaborate briefly on each of these three types.

10. I make the same claim in Carolyn McLeod, *Justified Asymmetries: Positive and Negative Claims to Conscience in Reproductive Health Care*, 21 AM. J. BIOETHICS 60 (2021).

11. Matthew K. Wynia, *Professional Civil Disobedience—Medical-Society Responsibilities after Dobbs*, 387 NEW ENG. J. MED. 959, 960 (2022).

12. The task I was given for the conference was to speak only about this issue. But I did not want to pass up the opportunity to discuss my views about the conscientious provision of abortion at this critical moment in the history of U.S. abortion law.

13. Conscientious provision has also been called ‘conscientious commitment,’ specifically by Bernard Dickens and Rebecca Cook. See Bernard M. Dickens, *Conscientious Commitment*, 371 THE LANCET 1240 (2008); Bernard M. Dickens & Rebecca J. Cook, *Conscientious Commitment to Women’s Health*, 113 INT’L J. GYNECOLOGY & OBSTETRICS 163 (2011). One further type of conscientious conduct is conscientious compliance. See McLEOD, *supra* note 8, at 5; Mara Buchbinder, Dragana Lassiter, Rebecca Mercier, Amy Bryant & Anne Drapkin Lyerly, *Reframing Conscientious Care: Providing Abortion Care When Law and Conscience Collide*, 46 HASTINGS CTR. REP. 22 (2016).

As I define them, conscientious refusals normally target “patients’ requests for services that make up the standard of care . . . [physicians] are meant to provide to patients, given their specialty or the context in which they work.”¹⁴ Such services—I call them ‘standard services’—are ones that the medical profession deems to be central to good health care.¹⁵ According to my conception, when physicians refuse to provide *nonstandard* services that patients seek (e.g., opioids when the standard of care is not to prescribe opioids), they are not making conscientious refusals. Rather, they are following accepted medical standards. Let me make two further observations about this type of conscientious conduct. First, it normally creates a conflict with patients who wish that the physician would comply with their request rather than refuse it.¹⁶ Second, the intent behind conscientious refusals is generally to gain protection for conscience rather than to bring about changes in law or medical policy.¹⁷ This second feature is one that people normally associate with conscientious *objection*, which I treat as identical to conscientious *refusal* in my book. Of course, conscientious objectors may very well seek changes in the offending law or policy, but that is not their purpose in refusing to provide the service(s) in question. This fact helps to distinguish what they do from civil disobedience.

As a “conscientious breach of law,”¹⁸ civil disobedience is also a form of conscientious conduct. It is one that has occurred in medicine both by individual physicians and by groups of them. The most famous case in Canada of individual civil disobedience is that of Dr. Henry Morgentaler, who opposed a restrictive abortion law that was struck down in 1988, largely because of his efforts.¹⁹ An example of collective (what Wynia

14. MCLEOD, *supra* note 8, at 6.

15. I add in the book that these services are legally permitted or required (MCLEOD, *supra* note 8, at 3), but I wish to define them more broadly here.

16. I say “normally” the refusal creates this conflict because there are exceptions, as when a physician refuses to follow informational requirements that exist for abortions in some states and are outlined in what have been called “Women’s Right to Know Laws.” See Sara Rodrigues, *A Woman’s Right to Know? Forced Ultrasound Measures as an Intervention of Biopower*, 7 INT’L J. FEMINIST APPROACHES TO BIOETHICS 51 (2014).

17. See MCLEOD, *supra* note 8, at 4; Candice Delmas & Kimberley Brownlee, *Civil Disobedience*, in THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward Zalta ed., 2021), <https://plato.stanford.edu/entries/civil-disobedience/> [<https://perma.cc/F83J-XRZS>].

18. Delmas & Brownlee, *supra* note 17; JOHN RAWLS, A THEORY OF JUSTICE 364 (1971).

19. See Tabitha de Bruin & Angus McLaren, *Henry Morgentaler*, in THE CANADIAN ENCYCLOPEDIA (2013), <https://www.thecanadianencyclopedia.ca/en/article/henry-morgentaler> [<https://perma.cc/3RCP-6DWU>].

calls “professional”) civil disobedience in medicine is that of Dutch physicians who collectively relinquished their medical licenses to avoid having to practice under Nazi rule.²⁰ Unlike conscientious refusal, civil disobedience specifically aims to effect change in law or policy.²¹ For this reason, it is also typically very public, whereas conscientious refusal tends to be more private, occurring in the relative privacy of a clinical medical practice.

What theorists have in mind with ‘conscientious provision’ is usually not civil disobedience. They use the term when discussing whether conscience protection in medicine should extend to the provision of banned services such as abortions, rather than exist only for the refusal of these services. They are thinking of conduct that could be accommodated through exemptions to rules that violate the physicians’ conscience. The relevant conduct itself must be focused on conscience: on protecting it rather than changing law or policy. Like conscientious refusal, conscientious provision generally has this aim.

One might think that conscientious provision and conscientious refusal are simply opposites of one another—that the first is the *provision* on grounds of conscience of *nonstandard* services, whereas the second is the *refusal* on grounds of conscience of *standard* services. If only things were so straightforward. They are not because conscientious providers can abide by the standard of care through their conduct; they can be *conscientiously providing standard services*, in other words, which is what I believe they would be doing now if they performed abortions in U.S. states that have banned abortion.²² The standard of care for many patients in unwanted pregnancies in the U.S. still seems to be to offer them an abortion. Organizations representing physicians have said as much, including the AMA.²³ If that’s right, then the conscientious provision of abortion in the U.S. is currently the provision of a standard service in violation of state law.²⁴

20. See Wynia, *supra* note 11, at 961.

21. See Delmas & Brownlee, *supra* note 17; RAWLS, *supra* note 18, at 364.

22. For the abortions to meet the standard of care, they would of course have to be done for the sake of patients’ health and well-being, or in other words, in accordance with physicians’ fiduciary duty to patients.

23. See Press Release, American Medical Association, *AMA Announces New Adopted Policies Related to Reproductive Health Care* (Nov. 16, 2022), <https://www.ama-assn.org/press-center/press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care> [<https://perma.cc/U9TZ-CAUD>]. Policies or guidelines of these organizations shape what are the standards of care. They inform what “reasonable physicians would deem to be medically appropriate in a given context,” which is how the law defines these standards. See Sawicki, *supra* note 4.

24. This description is motivated in part by work of Elizabeth (Liz) Sepper, who writes that conscientious provision “meets acceptable standards of medical practice.”

One way in which conscientious refusal and provision *are* opposites is that the former creates a conflict with the patient whereas the latter does not. In both cases, a physician receives a request from a patient, and in the one case (refusal), the physician turns it down, whereas in the other (provision), they honor it. This difference is morally significant, as we shall see.

II. VALUING CONSCIENCE

As I've noted, the new abortion bans in the U.S. will inevitably create conflicts of conscience for some physicians. But are these conflicts among the many worries we should have with these new restrictions? This question is part of a larger issue that concerns whether conscience, and our ability to act on it, has value. For some people, the answer is, "of course, conscience has value," while for others, the answer is the opposite. For others still, the answer is "often, conscience has value but sometimes it doesn't." I fall into this last camp, as I'll explain.

Many of those who say that it's just obvious that conscience has value have an "objectivist" conception of it.²⁵ On this view, conscience is the voice of moral truth; it tells us what we morally ought to do or not do, objectively speaking. While objectivism may be popular in some circles, it is quite unpopular in academic debates about conscience protection in health care. Reasons that have been offered against it include skepticism that conscience could be "a little voice whispering to each of us infallibly about what we should [or should not] do,"²⁶ together with the fact that understanding conscience objectively "would sound the death knell for conscientious objection in healthcare and the practice of accommodating health professionals with diverse [and often conflicting] conceptions of a morally decent life."²⁷ To elaborate on this second point, conscientious objectors in medicine are generally accommodated by exempting them from policies that apply to all physicians or all those with a particular speciality. If the dictates of conscience were objective or thought to be

Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1508 (2012). My view is somewhat different in suggesting that *some* conscientious provision (but not all) meets *accepted* (not merely acceptable) medical standards.

25. See KIMBERLEY BROWNLEE, *CONSCIENCE AND CONVICTION: THE CASE FOR CIVIL DISOBEDIENCE* (2012).

26. Daniel Sulmasy, *What is Conscience and Why is Respect for it So Important?*, 29 THEORETICAL MED. & BIOETHICS 135, 136 (2008).

27. Mark Wicclair, *Conscientious Objection in Healthcare and Moral Integrity*, 26 CAMBRIDGE Q. HEALTHCARE ETHICS 7, 12 (2017); see also McLEOD, *supra* note 8, at 24.

objective, however, then in responding to conscientious objections, we would need to question either the ethics of policies that the physicians are objecting to or whether their objections are genuinely conscientious (i.e., motivated by conscience as opposed to something else, such as reputational concerns). Those are the options we would have and neither involves providing accommodation for conscience. If that is true, then the practice of accommodating conscience in medicine makes sense only if objectivism is false.

The alternative to objectivism is subjectivism, which is the idea that conscience is governed by subjective moral values rather than objective ones. Most bioethicists—myself included—are subjectivists about conscience. We believe that conscience functions to encourage people to act on their *own* subjective (secular or religious) moral values. Moreover, we think conscience is valuable because acting on conscience allows people (often if not always) to have moral integrity. While it may sound odd to point to a different quality—moral integrity—to describe the value of conscience, this view allows us to explain common intuitions about conscience.²⁸ For example, making an appeal to conscience to avoid having to do an action, Y, is different from making the judgment that Y is wrong. The appeal to conscience expresses something new: arguably, a concern for moral integrity.²⁹ Also, it makes no sense to claim, “My conscience says that *you* ought to do this.”³⁰ The focus instead is on what “I” do; the concern is for me, again, arguably, for my integrity.³¹

The above view describes the value of conscience in terms of having moral integrity, yet one might very well ask, what is the value in that? Bioethicists give different answers to this question because they define integrity differently—as having inner moral unity,³² as acting on identity-conferring moral commitments,³³ or as standing by our best moral judgment.³⁴ I endorse the last of these options, because I believe that the first two—the Unity and Identity views—don’t properly describe the nature and value of moral integrity. I argue that theories of conscience that

28. McLEOD, *supra* note 8, at 22–23.

29. Jeffrey Blustein, *Doing What the Patient Orders: Maintaining Integrity in the Doctor-Patient Relationship*, 7 *BIOETHICS* 294 (1993).

30. Gilbert Ryle, *Conscience and Moral Convictions*, 7 *ANALYSIS* 31, 31 (1940).

31. The view that conscience serves to protect our integrity also fits with the dramatic language that tends to accompany an appeal to conscience (E.g., “I wouldn’t be able to live with myself if I did that.” McLEOD, *supra* note 8, at 23).

32. See Blustein, *supra* note 29; James Childress, *Appeals to Conscience*, 89 *ETHICS* 315 (1979); Martin Benjamin, *Conscience*, I *ENCYCLOPEDIA OF BIOETHICS* (Warren T. Reich ed., 2nd ed. 2004).

33. See Wicclair, *supra* note 27.

34. See McLEOD, *supra* note 8, at ch. 1.

rely on these views to explain the value of conscience are similarly mistaken. In what follows, let me briefly outline this criticism and elaborate on my own theory about the value of conscience,³⁵ which should help us better understand its value in medicine.

According to the Unity and Identity views, people can have moral integrity no matter what moral values they hold or how they hold them. So long as they act on their values in a way that unifies them (the Unity view) or act on those values insofar as they contribute to their moral identity, whatever that identity might be (the Identity view), then according to these theories, they have moral integrity. What is more, this integrity is valuable because it contributes to people having a good life (one where their actions do not cause inner division or alienate them from themselves or their identities) along with self-respect, which comes from taking one's own moral values seriously.³⁶ That is, in brief, how the Unity and Identity views describe integrity's value. For bioethicists who say that conscience is valuable because it promotes moral integrity as understood on these theories, the value of conscience is reducible to that of moral integrity so understood.

My main criticism of the Unity and Identity views is that they don't require people to reflect on their moral values to determine whether they endorse them. People could be unified around moral values that they have simply internalized (e.g., sexist values), or act on identity-conferring commitments that they do not reflectively endorse, and they would still have moral integrity according to these theories. This outcome is especially troubling for feminist philosophers who believe that people inhabit social environments that are sexist, racist, and oppressive in other ways and that shape the kinds of values and identities they tend to find themselves with. My own feminism has caused me to reject these accounts of integrity and to defend instead the view of fellow feminist philosopher, Cheshire Calhoun, that moral integrity involves acting on our best (reflective) moral judgment.³⁷

35. I do that not because I believe that this theory will yield a different answer than the others about whether the conscience of pro-choice physicians has value or value equal to that of anti-abortion physicians. I do it simply because I know that some readers will be as skeptical as I am of these other accounts about the value of conscience and of moral integrity.

36. See Blustein, *supra* note 29, at 297.

37. Cheshire Calhoun, *Standing for Something*, 92 J. PHIL. 235 (1995). I defend Calhoun's theory in my book (*supra* note 8); Carolyn McLeod, *Integrity and Self-Protection*, 35 J. SOC. PHIL. 216 (2004); and Carolyn McLeod, *How to Distinguish Autonomy from Integrity*, 35 CAN. J. PHIL. 107 (2005).

Calhoun's account is unique in terms of what it says not just about the nature of integrity,³⁸ but about its value. While the Unity and Identity views describe the value of integrity as being purely personal (as having a good life and self-respect), she describes it as both personal and social. For her, while there is personal value in people acting according to their best moral judgment and ultimately having an authentic moral life,³⁹ there is also social value in them taking their best moral judgment seriously. She argues that society needs such a commitment from people so that genuine debates about moral right and wrong will occur, which in turn will help to increase our collective moral knowledge.⁴⁰ On this view, gaining moral knowledge is a social process,⁴¹ and integrity has social value precisely because it contributes to this process.⁴²

I use Calhoun's theory of integrity in my book to explain the value of conscience. Unlike other bioethicists, I don't claim that conscience, or acting with a conscience, *always* promotes moral integrity or always has value. On my view, conscience only fosters moral integrity when the values that inform it conform to what our best moral judgment is. Unfortunately, these values are not always like that; sometimes they are merely a product of internalized oppression, of "parental admonitions," or some other external force.⁴³ Like some other philosophers,⁴⁴ I claim that the voice of conscience usually comes unbidden, nagging us to do what on some level we believe we ought to do but that we are somewhat averse to doing.⁴⁵ There's no reason to think that this inner voice necessarily aligns with our best moral judgment, although it certainly can do so. I argue that when the two are

38. It is unique in stating that integrity involves acting on our best judgment. Consider that the process of coming to decide what our best judgment is can cause us to question much of what we had previously taking for grant, which will destabilize us, at least initially, more than it will unify us. It could similarly cause us to reject identity-conferring commitments that we hold or reject how we understand our identities. For these reasons among others, Calhoun's view about the nature of integrity is different than the Unity and Identity views.

39. The primary value here is having self-respect and avoiding self-betrayal.

40. See Calhoun, *supra* note 37, at 257–60; JOHN STUART MILL, 'ON LIBERTY' AND OTHER WRITINGS (Stefan Collini, ed., 1851/1989).

41. See Calhoun, *supra* note 37, at 253–57; MARGARET URBAN WALKER, MORAL UNDERSTANDINGS: A FEMINIST STUDY IN ETHICS (1998).

42. For Calhoun, the production of moral knowledge crucially depends on people having integrity, and in having integrity, people participate directly in the social process of knowledge production. The latter is true because integrity involves "standing for something," which one does only "for, and before, . . . deliberators who share the goal of determining what is worth doing." Calhoun, *supra* note 37, at 257.

43. Benjamin, *supra* note 32, at 470.

44. See, e.g., Elizabeth Kiss, *Conscience and Moral Psychology: Reflections on Thomas Hill's 'Four Conceptions of Conscience'*, in INTEGRITY AND CONSCIENCE 69 (NOMOS XL, Ian Shapiro & Robert Adams eds., 1998).

45. Kiss calls our conscience our "inner nag." Kiss, *supra* note 45, at 69.

misaligned, our conscience needs to be “retooled,” meaning simply that the value or judgments informing it need to change.⁴⁶ My view of conscience is aptly named the “Dynamic” view because it ascribes value to conscience when it encourages us to act on values that we endorse, while accepting that for most of us, significant retooling will be necessary before our conscience will have this quality. Our conscience needs to be dynamic rather than fixed so that this process can occur. Only then will our conscience promote our moral integrity, as Calhoun understands integrity, and have the personal and social value that goes along with that.

Clearly, according to my Dynamic view, not everyone’s conscience will have the same personal or social value. People who abide by their conscience, when its message is inconsistent with what they endorse will have a conscience with little value to it. People who do not defer to the conscience they simply find themselves with and who change their moral commitments but do so unreflectively—without having good reasons for making those changes—will also have a conscience with little value to it. Among the latter, I count people who retool themselves so that their moral values become more oppressive (e.g., more racist) than they were before, which is surely possible given the noxious social environments that adults can become immersed in, especially online. I assume that when asked to explain these types of changes, people “invariably come up short.”⁴⁷ It may be that their conscience is still worth something, for just having a conscience means that they care about doing what is morally right as they perceive it, and that is better than not caring at all. Still, their conscience must be worth substantially less than it would be if they had values they could support. That’s true, in part, because the moral judgments that influence their conscience would add little to social debate about what’s morally right or wrong.⁴⁸

Roughly, then, on my view, some people will have a conscience worth valuing and some people won’t. That goes for physicians as well as for other members of the public. People who fall into the first category, moreover,

46. I describe how this process could go and how our conscience could even help with it. McLEOD, *supra* note 8, at 36–37.

47. McLeod, *Integrity and Self-Protection*, *supra* note 37, at 228. See also Adrian M. S. Piper, *Higher-Order Discrimination*, in *IDENTITY, CHARACTER, AND MORALITY: ESSAYS IN MORAL PSYCHOLOGY* 285 (Owen Flanagan & Amelie O. Rorty eds., 1990); Kwame Anthony Appiah, *Racisms*, in *ANATOMY OF RACISM* 3 (David Theo Goldberg ed., 1990).

48. This paragraph comes almost verbatim from my book. See McLEOD, *supra* note 8, at 39.

will have the sort of dynamic conscience that I've described. There are important values at stake in denying them the ability to act on their conscience: the personal value of leading an authentic moral life and the social value of them contributing to social debate about what is worth doing. For physicians (among others), the relevant debates include what is worth doing in health care.

Let me make the charitable assumption here, as I do in my book, that most physicians have a dynamic conscience or a conscience that is dynamic enough that we should take their claims to conscience seriously.⁴⁹ The alternative would be to maintain that many physicians are unreflective morally, which seems both uncharitable and unlikely given how often physicians face serious moral challenges in their practices. I also believe that we should value the conscience of physicians equally regardless of what beliefs they hold about abortion or other controversial moral issues. One might try to argue for the opposite: more specifically, that physicians who are pro-choice about abortion are more likely to have a conscience of value than physicians who are anti-abortion. However, I doubt that such a line of argument would succeed, because I suspect that many anti-abortion physicians have thought about the ethics of abortion carefully and no less than many pro-choice physicians have. Our charity should arguably extend to them as much as to pro-choice physicians.⁵⁰

Assuming that my charitable stance is appropriate and that my theory of conscience is well-grounded, we can conclude the following about the conscience of physicians in "post-Roe America"⁵¹: among the many worries policymakers should have about the new abortion bans is that they create crises of conscience for pro-choice physicians. The ability of these physicians to act on their conscience matters because their moral integrity is at stake; it matters no less than that of anti-abortion physicians, whose moral integrity is at stake as well when abortion policies conflict with their conscience. Thus, if we are focused singularly on the value of conscience (or of acting with a conscience), then we should not support the usual

49. Here, I am suggesting that the value of conscience could admit of degrees, which I believe it can, although I won't make that argument here and don't really make it in the book. I think the more that the values informing our conscience resemble those that we endorse, the more value our conscience has.

50. But relevant here is whether the values that motivate anti-abortion physicians are oppressive, for recall that I doubt whether conscience can have significant value if it is informed by oppressive norms. Although I accept that conscientious refusals to perform abortions can reinforce sexism or other forms of oppression (MCLEOD, *supra* note 8, ch. 2), I assume that the beliefs motivating these refusals are not oppressive. Rather, they concern when human life begins and how valuable such lives are relative to patients' interests in obtaining abortions.

51. The Daily, *supra* note 2.

asymmetrical protection of conscientious provision compared to conscientious refusal. Instead, we should endorse the opposite: the symmetrical treatment of the two. Notice that we could come to the same conclusion if we subscribe to a theory of conscience in bioethics that defines moral integrity differently than I do (e.g., in accordance with the Unity view). But then we would be employing a theory that conflicts with intuitions that many people have about when conscience has value.

The value of conscience is an important concern in deciding how to regulate the conscientious provision or refusal of abortions. It cannot, however, be our only concern. There are other values at stake (e.g., patient autonomy or welfare) and some of them might trump conscience, making it the case that conscientious provision or refusal or both should be severely restricted.⁵² In short, the moral issues of valuing conscience and valuing conscientious conduct by physicians are distinct. The next section focuses on the second of these topics: more specifically, on valuing conscientious provision.

III. VALUING THE CONSCIENTIOUS PROVISION OF ABORTIONS

How much should we value the conscientious provision of abortion care, particularly relative to the conscientious refusal of it? Should the regulation of the two be symmetrical, all things considered? This sort of question is too difficult for me to provide a complete answer, although I hope to move us close to an answer. I have already said that the value of conscience speaks in favour of a symmetrical form of regulation. I will now contend that a concern about the abuse or misuse of physicians' power will likely do the opposite by causing us to endorse an asymmetry of legal protection, one where there is *more* protection for the conscientious provision of abortions. I have called this the "new asymmetry." My support for it, while admittedly tentative, is stronger than my support for symmetry in the regulation of the conscientious refusal and provision of abortions. I provide reasons for the new asymmetry that are grounded in a moral

52. It is also relevant that physicians tend to have avenues for expressing their conscience outside the clinic, an example being professional meetings where professional standards are set. MCLEOD, *supra* note 8, at 41. *Full* protection for their conscience, at least, does not require that they be permitted to act conscientiously against the status quo while interacting with patients. We can therefore value their conscience to some degree without protecting them from reprisals if they engage in the conscientious provision or refusal of care.

theory I develop in my book about the professional role of physicians, a theory that defines the role as a fiduciary one.

The central claim of the book is that conscientious *refusals*—especially typical ones in reproductive health care⁵³—involve a misuse or abuse of fiduciary power and so should be protected much less than they currently are in jurisdictions such as the U.S. where the protection for them is broad. Let me summarize my argument for this claim and then discuss why the same reasoning does not straightforwardly apply to the conscientious provision of abortions.

In Chapters 5 and 6, I argue in favor of significant restrictions on the ability of physicians (and other gatekeepers of basic reproductive services) to make conscientious refusals. My reasoning has to do with the power that physicians wield as fiduciaries for their patients and the public they are meant to serve. Their fiduciary role has both legal and moral dimensions. As a bioethicist, I am focused squarely on its moral dimensions and thus on how fiduciaries ought to act morally. However, I take my cue from legal theorists—especially Paul Miller⁵⁴—in describing the fiduciary role. Miller defines it in terms of the kind of power that fiduciaries possess⁵⁵:

1. Power that is discretionary—there is “scope for judgment in the exercise of it.”
2. Power in the form of authority; fiduciaries are authorized—normally by beneficiaries themselves through their consent—to act in their (the beneficiaries’) interests.
3. Authority over significant interests of the other (e.g., welfare interests), normally only within a certain sphere (e.g., the beneficiary’s health).⁵⁶

Fiduciaries are obligated to use this power to serve only beneficiaries’ interest; they have a duty of loyalty that requires them to give primacy to these interests.⁵⁷ Beneficiaries authorize them to behave in this way, and their authorization often rests on the fiduciaries having a certain expertise (e.g., in medicine), and includes the expectation that they will use this expertise to further the beneficiaries’ interests.

53. These are refusals that are grounded in a moral concern about unborn human life, and they include, of course, refusals to provide abortions. MCLEOD, *supra* note 8, at 9. Although I focus on this type of medical conscientious refusal in the book, my central argument extends to other types including refusals to provide medical aid in dying. MCLEOD, *supra* note 8, at 2.

54. See Paul Miller, *A Theory of Fiduciary Liability*, 56 MCGILL L.J. 235 (2011).

55. See MCLEOD, *supra* note 8, at 121–22.

56. Miller, *supra* note 54, at 272–73.

57. MCLEOD, *supra* note 8, at 121–26.

I argue that physicians are fiduciaries because they have fiduciary power over patients including competent ones,⁵⁸ those whose autonomy they are obligated to respect. Physicians have discretionary authority over whether these patients will receive access to health care services, how and whether they will be informed of their health care options, how their autonomous decisions will be acted upon, and so forth.⁵⁹ Their duty of loyalty requires that they decide these things based on patients' health interests. Moreover, patients generally trust that they will abide by medical standards of care when making these decisions.⁶⁰

If we accept the fiduciary model of physicians' relationships with patients, then we need to evaluate physicians' conscientious conduct in terms of how they are using their fiduciary power. Are they misusing or abusing it? I say 'yes' in the case of conscientious refusals,⁶¹ and let me explain why by applying my argument specifically to refusals that target abortions. In such cases, the physician decides, based on their conscience alone, whether (or when or where) the patient will access the abortion services they seek. But the patient has not consented to the physician using their fiduciary power in this way. Similarly, they have not consented to their physician prioritizing their (the physician's) moral integrity over the patient's own interest in accessing care. Some physicians who conscientiously refuse abortions will say that the interests they are prioritizing are those of the 'second patient'—the fetus. But again, no one has granted them the authority to do so;⁶² no one has authorized them to act for a fetus in a context where a pregnant patient is requesting an abortion, and the standard of care is for the patient to receive an abortion. I conclude that such actions

58. I also include prospective patients, not just actual ones. The latter are patients with whom physicians have an established medical relationship. The former are members of the public that the physicians are licensed to serve. I claim that physicians are fiduciaries to both groups. My point about them being fiduciaries for the public is motivated by the work of legal theorists, Evan Criddle and Evan Fox Decent, specifically their *Guardians of Legal Order: The Dual Commissions of Public Authorities*, in *FIDUCIARY GOVERNMENT* (Evan J. Criddle et al. eds., 2018).

59. See MCLEOD, *supra* note 8, at 126–32; Carolyn McLeod and Emma Ryman, *Trust, Autonomy, and the Fiduciary Relationship*, in *FIDUCIARIES AND TRUST: ETHICS, POLITICS, ECONOMICS, AND LAW* (Paul B. Miller & Matthew Harding eds., 2020).

60. See MCLEOD, *supra* note 8, at ch. 3.

61. See MCLEOD, *supra* note 8, at ch. 5.

62. It would make a difference to my argument if a jurisdiction granted such authority to physicians (*i.e.*, to decide on behalf of fetuses); however, I doubt that would happen in a jurisdiction where abortion is legal, which is where conscientious refusals to perform abortions occur.

amount to a misuse or abuse of power and should therefore be severely restricted.⁶³ While physicians have a (moral) fiduciary obligation to prioritize the health care interests of patients over their conscience when the two conflict,⁶⁴ they do the very opposite—prioritize their conscience—when they conscientiously refuse to provide abortions (or any other standard service).⁶⁵

By contrast, when engaging in the conscientious *provision* of abortions, it is not at all obvious that physicians misuse or abuse their fiduciary power. That’s particularly true when—as noted above—the abortions provided meet the standard of care, as many abortions presumably still do in the U.S., even where abortions have been banned. When physicians conscientiously provide abortions in such circumstances, they decide based on their conscience and accepted medical practice whether (or when or where) patients will access the abortions that they seek. The patient *has* consented to them using their fiduciary power in this way; unlike with conscientious refusals, they, the physicians, are exercising discretionary *authority* rather than mere power to do what they judge to be in their patients’ health interests. Thus, it appears that rather than misusing or abusing their power, they are using it properly.⁶⁶

The upshot of this discussion is that we have good reason to endorse what is essentially the opposite regulatory scheme to what we have now, which affords protection for the conscientious refusal of abortions but none for their conscientious provision. In other words, we have reason to embrace the new asymmetry. A crucial factor here is that with the conscientious provision of abortion services, the physician complies with the patient’s request, which means that there is no patient-physician conflict as there is with conscientious refusals. The fact that the patient authorizes what the physician does in one case but not the other is morally significant. I agree

63. MCLEOD, *supra* note 8, at 137–43.

64. That is basically my central claim in the book, and it is certainly controversial. Many bioethicists say that conscientious objectors should have to balance their conscience with the interests of their patients or agree to a compromise that promotes both sets of interests simultaneously. This compromise approach to conscientious refusals is dominant in bioethics, with one of its key proponents being Mark Wicclair. *See, e.g.*, MARK WICCLAIR, CONSCIENTIOUS OBJECTION IN HEALTH CARE: AN ETHICAL ANALYSIS (2011). I defend instead a “prioritizing approach” where the priority goes to patients’ health care interests and requires serious restrictions on conscientious refusals.

65. To be clear, I do not rule out the possibility that physicians who engage in such conduct should make referrals to colleagues who are willing and able to provide the relevant service (in this case, abortions). Instead, I argue that prioritizing the interests of patients will sometimes *require* these physicians to make referrals, and to do so specifically when it is in their patient’s interests to receive the service from someone else. MCLEOD, *supra* note 8, at 141.

66. *See* MCLEOD, *supra* note 8, at 144–47.

with others who have made this point,⁶⁷ although I explain why this difference matters differently than they do, by focusing on the professional role that physicians occupy. Physicians abuse or misuse the power they have within their role as fiduciaries if their actions fail to conform to the authorization they have been given to act on behalf of their patients.

The presence or absence of patient consent is not the only morally significant difference between conscientious refusals and conscientious provision, however, especially when the latter is practiced in a way that adheres to accepted medical norms. The mere fact that the patient agrees with what the physician does in the case of conscientious provision doesn't make this conduct worthy of legal protection. The care being provided must also meet relevant accepted standards of care. I have suggested that patients normally authorize physicians, qua physicians, to abide by these standards; yet even when that's not the case (i.e., the patient's consent challenges these norms), physicians should nonetheless abide by them for moral reasons that include patient health and the integrity of their profession.⁶⁸ Assuming that the conscientious provision of abortion would now be practiced in a way that meets these professional expectations, we can reasonably endorse the new asymmetry.

Although I hope to have shown that the new asymmetry is highly plausible, morally speaking, I do not pretend to have given a knockdown argument for it. Bioethicists may want to develop my line of argument further, if only to demonstrate how flawed the current system is in regulating the conscientious refusal and the conscientious provision of abortion. They might even want to convince regulators to embrace the new asymmetry, particularly in states that have outlawed abortions, although I highly doubt that such efforts would succeed. Surely, these states would not legally protect the conscientious provision of abortions and would certainly not protect them more than the conscientious refusal of these services.⁶⁹ With that being said, what should pro-choice physicians do who are governed by a legal regime that cares little about their conscience and what it says about abortion rights? Debate on this question has begun in earnest and

67. See, e.g., Fritz, *supra* note 5; Fox, *supra* note 2; Alison Reinheld, *Conscience in Transgender Health Care: Yet Another Area Where We Should Be Prioritizing Patient Interests*, 15 INT'L J. FEMINIST APPROACHES TO BIOETHICS 144 (2022).

68. On this last issue of the profession's integrity, see MCLEOD, *supra* note 8, at ch. 5; Avery Kolers, *Am I My Profession's Keeper?* 28 BIOETHICS 1 (2014).

69. For in their view, abortion is murder, and preventing murder is always more important than respecting conscience.

should certainly continue.⁷⁰ I want to lend my support to the option proposed by Wynia that physicians engage in professional (i.e., collective) civil disobedience. I will do that out of concern both for physicians’ ability to act on their conscience and the injustice that I believe is caused by a lack of abortion access.

Wynia’s proposal is that physicians should act collectively in defiance of the new abortion bans and that such action should be organized and supported by medical associations such as the AMA. As he says, many such organizations have come out strongly against these new laws, and they should now act by making professional civil disobedience a genuine option for their members. They can do that by encouraging physicians to accept “en masse” fines, license suspensions, and even imprisonment, and by providing legal, financial, and other support for those who incur these penalties.⁷¹ Collective action would likely be effective, for as Wynia writes: “How long could a dangerous state law survive if the medical profession, as a whole, refused to be intimidated into harming patients, even if such a refusal meant that many physicians might go to jail?”⁷² *Professional* civil disobedience would surely be more effective and less risky than the individual variety that was performed by physicians in the past, such as by Henry Morgentaler, David Gunn, or Barnett Slepian. With individual civil disobedience or the less public option of conscientious provision, physicians would not have their professional association and colleagues backing them up, which would both heighten the risk and limit the impact of their action.⁷³ There would still be risk to individual physicians, to be sure, with professional civil disobedience. Each physician would have to weigh the risk to them against the value of participating in the collective effort to dismantle the abortion bans. Such action would be successful, of course, only if many physicians decided that the risk was worth the cost.

Is it realistic to think that many physicians in the U.S. would participate in professional civil disobedience of unjust abortion laws? I said that I doubt unfriendly states would implement the new asymmetry and protect the conscientious provision of abortions. So, why not be equally pessimistic about professional civil disobedience? There *is* reason for pessimism given that physicians “have rarely been radical, and most have conformed with bad laws and policies, even horrific ones.”⁷⁴ But there is also reason

70. See, e.g., Wynia, *supra* note 11; Selena Simmons-Duffin, *Doctors Who Want to Defy Abortion Laws Say It’s Too Risky*, NPR (Nov. 23, 2022), <https://www.npr.org/sections/health-shots/2022/11/23/1137756183/doctors-who-want-to-defy-abortion-laws-say-its-too-risky> [https://perma.cc/Q74M-W8D5].

71. Wynia, *supra* note 11, at 960–61.

72. *Id.* at 960.

73. On the various risks, see Simmons-Duffin, *supra* note 70.

74. Wynia, *supra* note 11, at 960.

for optimism because of how united medical associations are against the new abortion bans. I believe that there would be cause for even greater optimism if professional associations other than those representing physicians supported the professional civil disobedience of abortion bans. For example, professional associations of nurses and pharmacists could encourage their members to actively participate in the illegal provision of abortions (including, in the case of pharmacists, medical abortions). Also, law associations and associations of legal academics, bioethicists, and philosophers could persuade their members to lend their legal and academic expertise to the fight. Legal academics could follow Dov Fox, for example, in insisting that something like a “defense of medical disobedience” should be available to civilly disobedient physicians.⁷⁵ Bioethicists or philosophers could write in favor of such conscientious action on the grounds that abortion is indeed health care and is also morally permissible. In short, physicians need not be the only health professionals engaging in professional civil disobedience; professionals in areas other than health care could, and should, do what they can to support such a movement. This way forward would allow many professionals, not just physicians, to act on their conscience in the face of the recent bans on abortion.

Unless or until there is a movement of professional civil disobedience, however, conflicts of conscience will occur for many health care professionals. With a focus (for simplicity⁷⁶) on physicians, I have argued that these conflicts need to be taken seriously because the conscience of physicians has both personal and social value. That is true regardless of whether their conscience opposes or favors abortion access. The value of conscience alone speaks in favour of a symmetrical form of regulation for the conscientious provision and refusal of abortion. But, in my view, this value together with that of physicians using their fiduciary power appropriately support an asymmetry in regulation that favors conscientious provision. Since I’m under no illusions that this “new asymmetry” will be put in place in unfriendly states, however, I have encouraged and supported the professional civil disobedience of physicians and other health care professionals in such jurisdictions. I do that not only for the sake of their conscience, but also for the many patients there who will suffer without access to legal and safe abortions.

75. Fox, *supra* note 2.

76. *See supra* note 3.

