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Applying the Concept of Judicious Dissent in Matters of Conscience
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Melanie was a patient at City Fertility Clinic, Inc. She had been trying to conceive for more than a year and had gone through two cycles of in vitro fertilization (IVF) and embryo implantation. Although neither effort had succeeded, Melanie had not given up hope. She had confidence in Dr. Boyles' professional competence. He had helped her arrange for sperm donation and implantation. Melanie decided to introduce him to her partner, knowing that it might be a surprise to him because, when she started treatment, it was as a single parent. Melanie was now happily in love with Bridget and they lived together. A baby would complete their household, she told Dr. Boyles, and they could share the parenting responsibilities.

A few days after the visit, Melanie received a letter from Dr. Boyles' office asking that she find another doctor and recommending other clinics. Dr. Boyles wrote that he could not, in conscience, help in bringing a child into a same-sex household and hoped she'd understand that these beliefs were deeply held and grounded in his religious faith. He thought that another physician could act in Melanie's behalf with greater understanding and enthusiasm than he could.

Shocked at what she read and angry at being abandoned by her physician, Melanie called his office. "I need to speak to Dr. Boyles," she told the receptionist. "I just got a letter telling me to find another doctor. How can Dr. Boyles dump his patient after more than a year? Just where am I going to find another clinic? You've got all my records. It will take weeks to sort this out. You can tell him that I'm reporting him to the state licensing board. This can't be legal. It's discrimination."

Response
Much of what can be said about the topic at hand is applicable to the broader question of whether modern medicine can or should tolerate moral dissenters within its midst. The world in which doctors practice is marked by a pluralism of beliefs heretofore unseen. Thus, complete agreement between a doctor and her patients is no doubt a rare achievement, especially in the area of reproductive medicine. Still, many observers view idiosyncrasies of practice motivated by religious or moral beliefs as roguish or discriminatory.

Despite the diversity, when it comes to ethics many seek solutions that will please everyone. Certainly, this desire for consensus springs from a basic human desire for justice. One suspects that nobody truly wants to trample over another's deeply held beliefs or belittle another's personal identity. Nevertheless, it is likely that ethical

proposals are not going to please all parties and that some measure of tension will accompany ethical guidelines as long as our society enjoys the aforementioned pluralism, with all its benefits and occasional burdens.

Conscientious objection can be thought of as a refusal to perform a given act out of the personal conviction that such an act is objectively wrong. In health care, it takes the form of a medical professional's refusal to provide a given service or facilitate its accomplishment. For example, society permits physicians to opt out of certain activities such as elective abortion. The present case differs from this more common form of conscientious objection in that the physician here is not opting out of a given procedure, but refusing to provide it for a particular type of patient. The question, then, must be asked: is it discrimination for a doctor to recuse himself from some aspect of a patient's care due, not to his belief that the procedure is wrong, but to his belief that the patient's lifestyle is wrong? This particular question and the broader question of the rightness of conscientious objection go to the very nature of medicine as a profession.

Addressing the President's Council on Bioethics in 2008, Farr Curlin, an internist and ethicist at the University of Chicago, observed that "at the heart of every controversy about physician refusals lies a debate about what medicine is for" [1]. Put simply, should doctors act as functionaries of their patients or does the "doctor know what's best?" Which model of the patient-physician relationship is correct: patient sovereignty, paternalism, or something in between?

Views regarding conscientious objection lie along a spectrum from the liberal—health care professionals may object to anything as a matter of conscience—to the restrictive. One notable proponent of the restrictive view is Julian Savulescu, director of Oxford's Uehiro Centre for Practical Ethics, who holds that, "If 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" [2]. One suspects that most people's opinions fall somewhere between these two extremes: that is, society should tolerate some, but not all, conscientious objections to certain practices within medicine.

Consider two approaches to conscientious objection in the case of IVF for lesbian couples: one restrictive and the other liberal [3]. In November 2007, the American College of Obstetricians and Gynecologists (ACOG) ethics committee released a controversial ethics opinion entitled, "The Limits of Conscientious Refusal in Reproductive Medicine" [4]. ACOG offered guidelines for physicians who conscientiously object to some practices in reproductive medicine (e.g., prescribing contraception or participating in fertility services for lesbian couples) and advocated a more restrictive view of conscientious objection.

According to ACOG, physicians should provide patients with prior notice of their moral commitments and should use four criteria to determine whether or not conscientious objection is licit: (1) the potential for imposition of the physician's

beliefs on the patient, (2) the effect on the patient's health, (3) scientific integrity, and (4) the potential for discrimination. In sum, the first of these requires respect for autonomy; the second precludes conscientious objection when the patient's health is at risk; the next limits conscientious objection when scientific misinformation is the impetus; and the fourth entails fair treatment of all patients.

Apropos the present case, ACOG considers conscientious objection in the setting of infertility services for same-sex couples. Commenting on the justice criterion (4), the committee observes that, "Another conception of justice is concerned with matters of oppression as well as distribution. Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well" [4]. Recognizing the nonemergent setting of the present situation and the likelihood that no physical harm would result from conscientious objection here, the committee nevertheless concludes that "allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult" and might even reinforce "the oppressed status of same-sex couples" [4]. Ultimately, on this model, conscientious refusal to provide infertility services—for whatever motivation, be it religious or moral—to lesbian couples is deemed illicit because it violates the ethical principle of justice that requires fair treatment of all persons. Hence, refusal here would indeed be wrongfully discriminatory.

By contrast, organizations such as the Christian Medical and Dental Association (CMDA) advocate a liberal invoking conscientious objection. CMDA maintains that, while some artificial reproductive technologies are considered morally permissible, they are only so within the context of traditional marriage. Hence, the organization concluded in a 2004 statement, "CMDA believes it is morally inappropriate to use reproductive technologies to produce children outside the boundaries of the traditional Biblical family model," and elucidates further that, "The following alternative family forms do not meet this Biblical model: Same-sex couples, Domestic partners, Polygamy, Polyandry, Incestuous unions, Open marriages, and the like" [5].

Part of the CMDA's mission is to "[advance] Biblical principles in bioethics and health to the Church and society" [6]. Here, conscientious objection to providing infertility services to lesbian couples proceeds not from malice but from a desire to be faithful to a religious belief. This can certainly be construed as de facto discrimination, but only in the descriptive sense.

Another theory of conscientious objection—arguably in the middle of both of the above views—can be found in the work of Edmund Pellegrino, bellwether of bioethics and former chair of the President's Council on Bioethics. His important essay, "The Physician's Conscience, Conscience Clauses, and Religious Belief" [7], presents a practical approach to conscientious objection. In general, conscience is a reasoned judgment about the rightness or wrongness of a moral act to be performed or already performed. Beginning with the conundrum of how to balance pluralism and the right to freedom of conscience, Pellegrino offers three alternatives to this

dilemma: dissenting physicians may adopt a value-free stance that separates the personal from the professional life; they might abandon medicine as a profession (e.g., the Savulescu option); or they may adopt the position of "judicious dissent" while maintaining moral integrity.

Pellegrino criticizes the first two options as inadequate in that they do not respect the moral agency of both physician and patient. At the same time, the "value neutrality" assumption elevates secularism, says Pellegrino, to the "level of social orthodoxy" [8]. Authentic pluralism, then, would be abandoned in favor of, in the words of the late Richard John Neuhaus, a kind of "naked public square" that exalts secularism at the expense of diversity. For many physicians, religion impels professional activities and inspires care for patients. For these, and other conscientious objectors, "to practice medicine that contravenes religious teaching would be to subvert conscience to secular society and its "values," to act hypocritically, and to violate moral integrity intolerably" [8].

Instead, Pellegrino maintains the idea of judicious dissent in implementing conscientious objection. The rationale for this lies in the common humanity of both physician and patient who are equally entitled to person autonomy. He recognized the inherent imbalance in the patient-physician relationship and has done much to flesh out the ethical implications of this inequality and the responsibilities it imposes on the physician. Nevertheless, "respecting a physician's conscience claims," he observes, "does not mean that the physician is empowered to override the patient's morally valid claim to self-determination. . . . Neither one is empowered to override the other" [9]. The issue of conscientious objection is not about imposing the physician's personal beliefs on the patient or violating his or her right to informed consent, but rather of the physician's "right not to participate in what she thinks morally wrong, even if the patient demands it" [9].

The ethical foundation for Pellegrino's solution rests on the assumption that the patient's "moral and legal right to self-determination has limits" [9]. Of course there is truth to this; medicine recognized that not every patient request should be honored: antibiotics for a viral syndrome, growth hormone to boost athletic performance, or surgery that imposes too great a risk for a patient. Many other examples could be adduced.

When objecting on the basis of conscience, the physician must always

> treat her patient with respect, avoid moralizing condemnations, and explain the reasons for her moral objections. She must also be aware that every matter of conscience is not of equal gravity. Choosing when to take a morally dissenting stand is crucial if one's exercise of conscience is to be valid and respected [10].

Some physicians fail in this connection. For instance, when the issue is abortion, there are stories of physicians refusing to manage the complications of abortion in fear of somehow being implicated in or contributing to an act believed to be morally wrong.

In the present case, Melanie and Dr. Boyles hold fundamental beliefs about the nature of the family that are at odds with those of the other. Melanie views Dr. Boyles' refusal to treat her as an affront to her civil rights. Dr. Boyles' refusal stems from a desire to be faithful to his religion. What to do?

On the judicious dissent model, Dr. Boyles' refusal is justified on the basis of the plurality of beliefs—society's disagreement—regarding the nature of the family. Though his refusal is certain to be distasteful to some—especially considering the loathsome marginalization and even criminalization homosexual persons have experienced even in the recent past—it seems to be the "least worst" option. It preserves Dr. Boyles' moral and religious integrity, respects diversity, and Melanie is still free to seek infertility treatment from someone willing to provide it to her. Melanie's autonomy is preserved, even if she is inconvenienced.

Because Dr. Boyles' objection is not to IVF itself but to its use by a particular class of persons, his justification is more tenuous. If the prevailing social and professional mores move toward at least near unanimity regarding the use of IVF in lesbian relationships, it will become more difficult for him to maintain this stance. In important ways, society sanctions who may practice medicine, and Dr. Boyles could find himself in an increasingly small minority of professionals and eventually be forced out of at least some aspects of practice—particularly since he has chosen reproductive medicine as his field.

In fine, as consensus regarding many fundamental moral issues is not likely to be achieved in our pluralistic world, the medical profession will require deep introspection into its philosophical foundations—its reason for being, its purpose, and its goals—to determine whether moral homogeneity among providers will be ultimately beneficial or detrimental to the profession, society, and patients. On the whole, preserving conscientious objection will no doubt inconvenience and offend some patients, but when inconvenience is the main outcome, it is a more tolerable one than requiring doctors to choose between personal integrity and their profession. There will always be disagreement; the challenge is to discern how we can best live together while extracting the good that comes from the strengths of our diversity. Judicious dissent does not solve these tensions, but it does simultaneously preserve, to the greatest extent possible, the autonomy of patient and physician.

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invoke the clause, so it is in line with what we normally consider "liberal" political views. The "liberal" interpretation of the clause, on the other hand, gives professionals permission to invoke the clause broadly, which is in line with what we normally consider "conservative" political views.
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8. Pellegrino, 297.
9. Pellegrino, 299.
10. Pellegrino, 300.

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