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Why the Post-*Roe* Era Requires Protecting Conscientious Provision as We Protect Conscientious Refusal in Health Care

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Abstract

The US Supreme Court overturned *Roe v Wade* in June 2022, and now each state's legislature will decide if and when its citizens will have legal access to abortion care and if and when its physicians will be criminalized for providing what is considered to be the standard of care by multiple health-related organizations. This extraordinary change in the medico-legal landscape requires reevaluation of health profession codes of ethics related to clinician conscience. This article argues that these codes must now be expanded to address 2 newly critical areas: physician advocacy to make abortion illegal and affirmative protection for "conscientious provision" in hostile environments on par with protection of conscientious refusal.

Conscience After *Roe*

The US Supreme Court overturned *Roe v Wade* in June 2022, and now each state's legislature will decide if and when its citizens will have legal access to abortion care and if and when its physicians will be criminalized for providing what is considered to be the standard of care by multiple health-related organizations. This extraordinary change in the medico-legal landscape requires reevaluation of health profession codes of ethics related to clinician conscience.

Existing conscience provisions were developed when abortion was a constitutional right. Therefore, they focus on moments when a patient asks for reproductive care to which they have a legal right but which conflicts with an individual physician's personal morality. For example, the 1980 revision of the American Medical Association's (AMA's) Principles of Medical Ethics states: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."[1,2]

We do not dispute the premise of this principle and other ethics opinions,[3,4] which is that individual physicians can refuse to provide care that violates their personal morality in nonemergent situations. Instead, we argue that these codes must now be expanded to address 2 newly critical areas: physician advocacy to make abortion illegal and

affirmative protection for "conscientious provision" in hostile environments on par with the protection of conscientious refusal.

Physician Advocacy in Public Spheres

Role morality describes ethical standards specific to a professional role.[5] These standards are not imposed on people outside a given profession and can be different than the personal ethics of some within that profession. "Do I think abortion is ethical?" is a personal morality question relevant to whether physicians choose to participate in abortion care in their professional life and to how they choose to respond to an unwanted pregnancy in their personal life. Personal morality is the foundation of conscientious refusal, and no physician should be forced to perform an abortion if it conflicts with their individual beliefs. However, role morality is key to public action by physicians, both individually and collectively. "What is my duty to my patients as a physician on the topic of abortion?" and "What is my duty to other physicians?" are role morality questions that should guide physicians' activities in the public sphere to protect the legality and accessibility of abortion.

Advocacy. Physician advocacy in favor of abortion bans is an unethical misuse of professional privilege because it wields the institutional expertise of the profession in service of the personal conscience or morality of the individual physician. Instead, professional ethics should require physicians who think abortion is immoral to be "pro-choice and anti-abortion,"[6] because seeking to protect abortion's legality while personally opposing the act of abortion honors the commitment to the health and autonomy of a diverse population of people seeking medical help that is ethically required of physicians. State laws that ban or severely restrict abortion access are in direct conflict with accepted standards of care in medicine because they harm patient health, as well as patient autonomy and dignity.

Preservation of patient health. Established international medical organizations, such as the World Health Organization (WHO), recognize abortion as essential health care, and the WHO asserts that "multiple actions are needed at the legal, health system and community levels so that everyone who needs abortion care has access to it."[7] Additionally, 10 major US organizations representing practitioners and scholars in reproductive care (the American College of Obstetrics and Gynecology, the Society for Maternal and Fetal Health, the Society of OB/GYN Hospitalists, the American Society for Reproductive Medicine, the American Academy of Nursing, Nurse Practitioners in Women's Health, the Society of Family Planning, the American College of Nurse Midwives, and the Association of Women's Health, Obstetric and Neonatal Nurses) joined together to denounce the Supreme Court's retraction of constitutional protection for abortion care:

> This decision promises to severely limit many of our members' ability to provide high-quality, patient centered maternal health care, and it will certainly lead to unnecessary patient suffering and harm.... A broad medical consensus holds that abortion is an essential part of reproductive health care and that without access to abortion, people will face harmful and enduring repercussions.[8]

Bodily risks of pregnancy are undeniable, and they provide one reason that mainstream medical organizations support legal access to safe abortion. The United States is the only developed country with a rising maternal mortality rate,[9] which disproportionately affects Black patients.[10] However, the maternal mortality rate is significantly lower in states with policies protecting abortion access than in states restricting abortion access,[11] and legal restrictions on abortion will disproportionately affect people of color

and other marginalized populations.[12] This pattern is consistent with the finding that the risk of death from childbirth was approximately 14 times higher than the risk of death from abortion between 1998 and 2005.[13] The safety of abortion compared to childbirth is likely higher today. The maternal mortality ratio (MMR) used in this study was 8.8 deaths per 100 000 live births compared to 0.6 deaths per 100 000 reported legal abortions.[13] For 2018, the Centers for Disease Control and Prevention reported the MMR as 17.4 deaths per 100 000 live births compared to 0.41 deaths per 100 000 reported legal abortions.[12,14] Conversely, when following pregnant people seeking abortion, the Turnaway Study found decreased risk of physical or psychological harms for those able to obtain the abortion they desired.[15] Medical professionals must be concerned about the increased health risks a pregnant person faces when continuing a pregnancy, which is one reason the pregnant person's beliefs about the moral status of their embryo or fetus should be paramount. The medical community at large must protect the ability of a patient and clinician to acknowledge these known medical risks when grappling with the multifaceted dilemma of an undesired or complicated pregnancy during informed decision making and must protect access to full spectrum reproductive care.

Respect for patient autonomy. Abortion bans are a violation of patient autonomy. They foreclose patient moral decision making and ignore the personal conscience of many patients in our country's diverse population. One of the complexities of abortion is negotiating the concept of fetal personhood. There is no one understanding of fetal personhood—if it exists and, if so, when it begins—that the profession of medicine can gather behind. However, it can gather behind one decision maker—the pregnant person. Those who oppose abortion's legality sometimes position themselves as defenders of voiceless fetuses. Individuals can, and obviously do, disagree on what's "right" in terms of abortion using many different secular and religious moral frameworks. Yet we are all "former fetuses," with equal moral authority on the moral status of fetuses generally. And, like many Americans, the 59% of US abortion patients who already have children[16] can draw on their prior experience of pregnancy and parenting. The only person with unique insight into and authority to define the moral status of any individual fetus is the person in whom it lives and on whom so much of its life depends, both before and after birth.

The roughly 1 in 4 women in the United States who will have an abortion by the age of 45 have voted with their feet to tell us they believe abortion is morally neutral or morally good,[6,17] and individual physicians or physician groups advocating for abortion to be illegal are assuming the mantle of moral decision makers for these patients instead of medical advisors. Ethics codes should be clear that leveraging the credibility and social capital of the profession for self-interested ends is unethical because it harms both patients and the profession. Recognizing that moral authority for decision making lies with the pregnant person acknowledges the plurality of moral views concerning abortion and allows patients and clinicians to navigate this complicated space informed by the principle of respect for autonomy.

Respect for colleagues. Finally, abortion bans harm a physician's colleagues. Abortion is a complex and nuanced topic on which individual physicians hold a range of beliefs. In contrast to conscience codes that allow physicians to decline to provide legal health care, criminalizing the provision of health care that some physicians believe is morally good or morally required leaves them no option for navigating the conflict between law and personal morality. Instead, abortion bans force these physicians to choose between

committing a crime or violating both their affirmative conscience and their professional duty to protect patient autonomy and health and to provide evidence-based care to a morally diverse group of patients. Therefore, codes of medical ethics should be updated to state that, where abortion is illegal, breaking the law to provide care for reasons of conscience is not unethical.

Lack of respect for colleagues is also shown by failure to recognize the difference between personal morality and role morality, which could lead some physicians to advocate for abortion bans that impose their values on patients who have different and equally valid values. The distinction between personal morality and role morality should lead every specialty's professional organization to establish physicians' ethical obligation to support abortion's legality and accessibility regardless of their personal views on its morality and to establish that it is unethical for physicians to publicly advocate to make abortion care illegal.

Reciprocal Respect for Conscientious Provision

Advocacy for conscientious provision is not new,[18] but serious protection of it would be. There have never been laws that force a clinician to perform an abortion against their will. However, as family planning specialist and American studies scholar Lisa Harris notes: "the persistent failure to recognize abortion provision as 'conscientious' has resulted in laws that do not protect caregivers who are compelled by conscience to provide abortion services."[18] The important physician freedom identified by the AMA—to "choose whom to serve … and the environment in which to provide medical care"[1]—will be—and in some states already has been—stripped from many physicians who feel morally obligated to provide safe abortion care. Reciprocal respect requires that ethics codes on clinician conscience must include an understanding that clinicians have a right to provide care that is equal to the right to withhold it.[18] In addition, the American College of Obstetricians and Gynecologists' statement in opinion 385 that accommodation of clinician conscience must not harm patients by preventing them from accessing necessary health care must be underscored and added to other codes.[4] In this watershed moment for reproductive rights (and the lack thereof), it is imperative that the boundaries of physician conscience in individual patient-physician interactions be further clarified.

Finally, abuse of conscientious refusal must be eliminated in those states where abortion is legal, to which even more patients from outside jurisdictions will come seeking abortion care. Conscientious refusal is an important value when it is used as a "shield" to safeguard physicians from being forced to act in a way that would compromise their integrity.[4,6] But when the balance between physician and patient autonomy becomes unethically tipped toward physicians, that shield can transform into a "club" that causes patient harm.[6] Conscience as a shield includes refusing to perform or assist in an abortion procedure, and it protects the physician who genuinely believes an embryo or fetus is also "their patient." Exploiting conscience as a club betrays the fiduciary obligation of the clinical relationship through actions that obstruct patients' ability to get abortion care. These actions include providing incomplete or false counseling, refusing to refer to another clinician (whether in-state or out-of-state) capable of providing abortion services, and providing medical director services for crisis pregnancy centers that mislead patients. These behaviors harm patients by denying their moral agency.

Furthermore, when physicians delay or deny care, people are more likely to present to abortion facilities at a later gestational age, which can increase the risk of complications—or force them to undergo an undesired childbirth, which is associated with multiple short- and long-term adverse health outcomes.[15] Institutional and legislative policies that enable and support these unethical acts and that prevent reproductive health clinicians from providing full-spectrum, evidence-based reproductive health care to those who want it should be reevaluated and rewritten. Physicians must separate their fiduciary responsibilities to patients from their personal views about their decisions in order to ensure that patient care is not compromised by the privilege of conscientious refusal.

Conclusion

An exclusive focus on clinician conscience obscures that there are 2 consciences at stake in every patient-clinician encounter. For too long, an imbalance in favor of clinician conscience has burdened patients who suffered from care gaps created by physicians who express their personal opposition to abortion through their support of antiabortion legal, institutional, and pedagogical policies. This privileging of clinician over patient conscience also manifests in the public sphere when physicians leverage their social capital as physicians with legislators and voters to decrease the legal options pregnant people have for reproductive care. Instead of advocating their personal moral perspective in the public and professional spheres, physicians should advocate to preserve the moral agency of all patients.

When engaging in clinical care, physicians make an explicit agreement to put themselves in uncomfortable, vulnerable, ethically challenging spaces. Everyone must have the courage necessary to serve people in need and to recognize and rectify gaps in reproductive health care that are unfairly harming people capable of pregnancy. In this pivotal moment in reproductive health care in the United States, clarification of important boundaries around physician conscience should be codified within professional codes of ethics.

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