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REASONABILITY AND CONSCIENTIOUS OBJECTION IN MEDICINE: A REPLY TO MARSH AND AN ELABORATION OF THE REASON-GIVING REQUIREMENT

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ABSTRACT
In this paper I defend the Reasonability View: the position that medical professionals seeking a conscientious exemption must state reasons in support of their objection and allow those reasons to be subject to evaluation. Recently, this view has been criticized by Jason Marsh as proposing a standard that is either too difficult to meet or too easy to satisfy. First, I defend the Reasonability View from this proposed dilemma. Then, I develop this view by presenting and explaining some of the central criteria it uses to assess whether a conscientious objection is proper grounds for extending an exemption to a medical practitioner.

I. INTRODUCTION

The debate regarding the proper role of conscientious objection in medicine continues to rage. Conscientious objection is understood in this paper as a refusal to fulfill a patient's request or to follow an institutional policy based on moral reasons. This definition is framed to cover conscientious *refusals* of care as well as *provisions* of care in accord with one's ethical beliefs, as I will discuss. In previous work, I have defended the view that medical professionals seeking a conscientious exemption must provide reasons in support of their objection and allow those reasons to be subject to evaluation.[1] On this view, the objection must have a reasonable basis in order to successfully ground an exemption. This position has been described as putting in place a 'reason-giving requirement' to answer the question of when a conscientious objection should be allowable and has been criticized by Jason Marsh as being mired in a deep dilemma.[2]

In what follows I will defend the Reasonability View by addressing the relevant criticisms and will further develop the reason-giving requirement by outlining some of the primary criteria it uses to evaluate conscientious objections in medicine.

II. DEFENDING THE REASON-GIVING REQUIREMENT

There are numerous views in the literature which address the question of when a conscientious objection is justified and hence constitutes proper grounds for an exemption. One might argue that conscientious objections are *never* justifiable since they are incompatible with one's role as a medical professional[3] while others propose that an objection is successful simply if it can be established that it is based on a *genuine* belief held by the medical professional.[4] While the Incompatibility View and the Genuineness View occupy opposite ends of the spectrum, the

[1] R.F. Card. Conscientious Objection and Emergency Contraception. *Am J Bioeth* 2007; 7: 8–14; R.F. Card. Conscientious Objection, Emergency Contraception, and Public Policy. *J Med Philos* 2011; 36: 53–68.
[2] J. Marsh. Conscientious Refusals and Reason-Giving. *Bioethics*, forthcoming.
[3] J. Savulescu. Conscientious Objection in Medicine. *J Med Ethics* 2006; 332: 294–297.
[4] C. Meyers & R.D. Woods. Conscientious Objection? Yes, But Make Sure It Is Genuine. *Am J Bioeth* 2007; 7: 19–20.

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Reasonability View is a moderate position in this debate that is to be deployed with a corresponding policy suggestion that we establish a kind of conscientious objector (CO) status in medicine. Practitioners can be granted an exemption in this form if they demonstrate that the basis for their conscience objection is backed by sufficiently good reasons. While Marsh does not explicitly endorse either of these views, since his focus is on critiquing my position, I will have something to say about each in the course of my discussion. In his treatment Marsh proposes a dilemma for the Reasonability View: either this standard is too difficult to meet and therefore does not accord proper weight to conscience, or it is too easy to meet and hence assigns too much value to conscience in medical practice.

The argument for the first horn of the dilemma begins by asking: what makes a belief reasonable? Marsh examines the discussions of reasonability in my earlier work[5] and concludes that '. . . reasoned refusals consist in philosophical arguments for the truth of some moral stance or at least for the claim that such a stance can be reasonably affirmed.'[6] Marsh asserts that the reason-giving requirement asks too much of petitioners for CO status since they must defend the truth of certain moral matters and even ideally convince an audience of agnostics that their religious or ethical view is correct. As Marsh puts the point, 'Particularly difficult is convincing others about controversial metaphysical or moral matters that they already find counter-intuitive. If being rational consists in being able to persuade others with arguments, then it is very difficult indeed.'[7]

Marsh has put his finger on a significant worry, yet fortunately these concerns do not affect the Reasonability View as I envision it. I imagine that reasonability with respect to a conscientious objection will be determined by what we can call a medical conscientious objector review (MCOR) board; this suggestion is derived from the mechanism used in the United States (US) to extend CO status to those who object to participation in combat operations as part of military service. The MCOR board's duties could be discharged by those responsible for licensing medical professionals,[8] and when assessing reasonability its focus should be on *evidence*, not truth. Obviously the evidence for the claim that p is the case is ideally related to the notion that p is true since the stronger the relevant evidence, the more reason there is to believe that p. But evidence and truth are different things. Just as courts assess the evidence in support of a claim according to a certain standard – say, that the preponderance of the evidence supports one's case – so should a MCOR board. We can stop short of requiring that petitioners for CO must prove to an impartial audience that their claim or grounding belief is true. A grounding belief is simply the belief (or belief set) offered by the petitioner in support of the conscientious objection. When interpreting this idea, Marsh skeptically states that on the Reasonability View, '. . . the implication is that the kinds of controversial moral beliefs, for instance, that could make refusals tempting should be deemed guilty until proven innocent.'[9] Overlooking the rhetoric about guilt and innocence, I accept that the Reasonability View does place the burden of proof on the petitioner for CO, and rightly so. Objecting medical providers have special professional obligations that others do not possess, and therefore, only if such practitioners can make the case that their objection is reasonable will they be granted an exemption from what would otherwise be a professional requirement. Reasonability, then, has to do not only with the intrinsic reasonability of beliefs supporting the claim, but also with the proper relative weight these competing considerations should be given in comparison with the professional's duties of care to the patient. This is why the focus on evidence (as opposed to truth) is so important: only if the petitioner can make the case that granting the conscientious exemption strikes a reasonable balance between the provider's fiduciary duties and the patient's interests in receiving timely care should CO status with regard to the activity in question be granted to the practitioner. This suggests that there may be cases where a requirement is so central to one's professional role that one simply cannot make the case that even on the basis of a genuine belief, one should be exempted from participation in certain activities.

Additionally, we should reject the notion that the Reasonability View requires petitioners to convince others of the truth of his or her belief since this relies upon a misunderstanding of conscientious objection itself. It is critical to recognize that claiming CO status relates essentially to the contribution of the agent to the objectionable state of affairs. Conscientious objection, then, has a deeply personal aspect: its essence is not to change others' minds but instead to invoke one's deepest beliefs in order to avoid participation in an action one morally opposes. By contrast, civil disobedience does have as a central element to attempt to inform others of a perceived

[5] Card, op. cit. note 1.

[6] J. Marsh. Conscientious Refusals and Reason-Giving. *Bioethics*, forthcoming.

[7] Ibid: 3.

[8] Discussion of the institutional structure, responsibilities and composition of an MCOR board is beyond the scope of this article. The policy suggestion to establish CO status in medicine stands on its own and itself neither strengthens nor weakens the case for the plausibility of the Reasonability View; the latter is the central concern in this paper. For more on the idea of CO status in relation to medicine, see Card, *op. cit.* note 1.

[9] Marsh, op. cit note 6, p. 4.

injustice and to call into question others' beliefs.[10] Participants in the US civil rights movement had as their core mission to uproot some individuals' belief systems in order to change unjust social norms and abolish a system of institutionalized racism. The scope of objecting practitioners' claims is different: they may or may not wish to change the entire medical system, but their conscientious refusal only attaches to *their* participation to a specific action within that system. In short, Marsh has conflated conscientious objection with civil disobedience. The Reasonability View only speaks to the former by delineating a standard for assessing when practitioners may acceptably refuse their participation in response to a service requested by a patient. Honoring a conscientious objection does not imply that one morally agrees with the petitioner's claim or the belief system upon which this refusal is founded, only that one can see how a reasonable person could hold that view.

On the other horn of the dilemma he poses for the Reasonability View, Marsh argues that if the standard for assessing reasonability consists in simply having to give a reason, then the standard could be too easy.[11] Marsh sees this as a problem since it is not desirable from a practical point of view to make conscientious refusal too simple to justify and this interpretation assigns too much value to conscience. This seems correct. But the Reasonability View does not unpack the notion of reasonable to mean 'is supported by *some* reason'. This should be clear from what has been said up to this point. In earlier work I outline the standard for a successful conscientious objection by stating that the '. . . beliefs on which conscientious objection is based must be reasonable and should be subject to evaluation in terms of their justifiability.'[12] The Reasonability View clearly requires that the petitioner marshal evidence such that the preponderance of the evidence supports the claim that *the beliefs upon which the objection is based* are reasonable. Further, the Reasonability View requires that *granting the exemption in this case* is reasonable by attending to the circumstances and likely effects on patients of conferring CO status upon this provider with respect to participation in the activity in question. Since this view does not simply require the statement of a reason, it does not fall on the other horn of Marsh's dilemma. In contrast to Marsh, I am an unapologetic defender of reasonability; in the next section I accept Marsh's invitation to flesh out the workings of the standard at the heart of the Reasonability View.

[10] James Childress uses 'conscientious objection' to refer to violations of law based on personal, moral or religious values performed primarily to witness those values, while he understands the term 'civil disobedience' '. . . to refer to public, nonviolent, and submissive violations of law in protest based on moral-political principles and designed to effect or to prevent social, political, or legal change.' J. Childress. Civil Disobedience, Conscientious Objection, and Evasive Noncompliance: a Framework for the Analysis and Assessment of Illegal Actions in Health Care. *J Med Philos* 1985; 10: 63–83: 68.

[11] Marsh, *op. cit.* note 6, p. 7.

[12] Card, *op. cit.* note 1, p. 13.

III. DEVELOPING THE REASONABILITY VIEW

Determining the reasonability of beliefs supporting a putative conscience objection involves examining both the beliefs themselves (intrinsic factors) as well as the circumstances in which the conscientious objection would be exercised (extrinsic factors). The account offered in this section only discusses some of the primary factors, and the extrinsic factors should be viewed as having *prima facie* weight: there are imaginable cases where the gravity of one or several of these factors may support the justifiability of a conscience objection in one circumstance and not another. While I believe there are both justified and unjustified conscience objections, I will focus my discussion on the kinds of factors that would tend to defeat the reasonability of a grounding belief offered to support a conscientious exemption. Furthermore, the examples I will utilize are intended to be as noncontroversial as possible – the goal is to see the force of the relevant factor, not to argue about the example.

A. Intrinsic factors

1. A belief must be genuine in order to ground a successful conscientious objection

The notion of a genuine or sincere belief has been discussed in some depth in US case law involving conscientious objections to military service and participation in combat. The overall sense is that the grounding belief must be so central that one can provide evidence that this belief influences important practices in one's life. Hence, if a person (e.g.) claims an exemption to participation in combat on the basis of being a preacher, s/he must provide evidence of having taken the time to acquire religious training and a history of ministering to others. Several US Supreme Court cases made clear that both religious and secular beliefs can successfully support a conscientious objection; in *Welsh v. US* the Court broadened the interpretation of the relevant law to include exemptions granted to '. . . those whose consciences, spurred by deeply held moral, ethical, or religious beliefs, would give them no rest or peace if they allowed themselves to become an instrument of war.'[13] The same basic

[13] *Welsh v. US* 1970. 398 US 333.

idea applies, *mutatis mutandis*, if we now move back to the medical context. The notion of genuineness is critical since it implies that there is an important difference between a conscientious objection and a mere disagreement with a patient's request. Impugning only the most central of one's ethical beliefs can be grounds for a true conscience objection. On this analysis, calling upon one to violate a sincere belief is only a necessary condition for a successful conscientious exemption.

2. A grounding belief must be consonant with relevant empirical data in order to support an exemption

The relevant empirical data will probably be drawn from basic science and the field of medicine. To take a fanciful example, suppose a physician conscientiously objects to prescribing pain medications since s/he believes that patients do not 'really' feel pain. Even though philosophical puzzles persist regarding the existence of pain in others, it is difficult to imagine a provider meeting the burden of proof of reasonability such that she could receive an exemption on the basis of this reason. It is worth observing that conscience objections must involve an ethical belief yet grounding beliefs may make reference to empirical or clinical data as well; there is a fine line between empirical reasons and moral reasons offered to support a putative conscientious refusal. It is simple enough to underscore the difference between descriptive and normative claims, but in practice it can be more difficult to see the relevance of empirical evidence and the ways in which a moral belief is brought to bear. Some examples will illustrate the point. If a physician refused to offer assisted reproductive technologies (ART) to a fifty year old woman because there is substantial reason to think that she cannot successfully become pregnant, then this objection is grounded in clinical reasons. If the provider refuses to offer same because there is significant reason to believe this will harm her health, this is grounded in clinical reasons but there also appears to be a suppressed moral premise (e.g. 'I should not offer medical services that there is good reason to think will harm one's health, even if an informed adult patient willingly takes on these risks.') Finally, if a provider refuses to provide ART to this woman solely because the patient is unmarried and the physician thinks that having a child out of wedlock is morally wrong, then the grounding reason is ethical in nature. The burden of proof must be met for all 'stand-alone' empirical claims as well as for empirical data that is utilized to show the applicability of a moral premise. As with the factor above, consonance with empirical data is simply a necessary condition for a successful petition for CO status on the Reasonability View.

B. Extrinsic factors

The list of the *prima facie* factors used to assess the reasonability of a conscientious objection include the following:

1. A justified conscientious objection must not cause needless or unjustified harm to patients

If a physician conscientiously refused to prescribe pain medications since she thought that pain was a sign of moral weakness,[14] it is very difficult to imagine that the provider could meet the burden of proof to justify this objection. Much of the pain that is to be felt by patients is avoidable and hence this refusal causes needless harm. Further, even if we granted some sort of initial plausibility to the objection to consider it further, it is far from clear that physicians should be in the business of 'soul-making' by reaching clinical decisions based on their perception of a person's character (and by imagining ways that he or she might improve another's character).

2. A justified conscientious objection should not possess an uncontradicted self-interested appearance and must respect the power inequality between physicians and patients

Imagine a case where a provider refuses to withdraw life-support for a patient because that patient is enrolled in a study that the physician is running and the practitioner does not wish to lose a research subject.[15] Obviously this objection would be difficult to defend on the Reasonability View, though one can imagine that a defender of the Genuineness View might have to grant an exemption in this case to a particularly hard-hearted physician/researcher. Perhaps the physician has the moral belief that s/he should promote his or her own research career at any cost, or (more nobly) a moral belief in the progress of science or (more specifically) that cancer simply must be defeated and continued human research studies are the means to this end.

Part of the appeal of the Reasonability View is that petitioners must state and explain their putative conscientious objection and the beliefs supporting it, thereby allowing an MCOR board the opportunity to understand the objector's reasoning and assess how its weight compares with the provider's professional duties; at the heart of medical professionalism is a dedication to patients' best interests.[16] The altruism inherent in professionalism

[14] M. Wicclair. Conscientious Objection in Medicine. *Bioethics* 2000; 14: 205–227: 216.
[15] Ibid: 212.
[16] E. Pellegrino. Altruism, Self-Interest, and Medical Ethics. *JAMA* 1987; 258: 1939–1940.

is at odds with a self-interested conscientious objection. Further, there is a deep inequality in power between physicians and patients both in terms of knowledge and in terms of access to different parts of the medical system. The notion that medical professionals have obligations with regard to altruism is plausible if we keep in mind the monopoly on legitimate medical services possessed by medical practitioners. This privilege gives rise to concomitant obligations; quite simply, providers have obligations that others do not – both to society in general and to their patients in particular.

3. A justified conscientious objection must not be based upon discriminatory beliefs

I will understand discrimination as different treatment based upon an arbitrary or irrelevant characteristic.[17] Imagine a case in which male medical students of the Muslim faith conscientiously refuse to learn how to perform physical examinations on members of the opposite gender.[18] Or imagine such physicians who were granted such an exemption then refusing to care for women on this basis. Even though we can identify the tenets of belief system that support this putative conscientious objection,[19] it is imperative that we must be able to evaluate the reasonability of granting a conscientious objection on this basis. Notice that the analysis on the Reasonability View need not totally reject the reasonability of the grounding belief system itself; as an ethic of modesty focused upon the reduction of sexual temptation,[20] the relevant tenet of the Muslim faith could be genuinely held and may not run afoul of any empirical beliefs. (For example, it may be reasonable to believe that if men and women engage in touch and are allowed to be alone in an enclosed space, sexual activity is more likely to occur, even in a clinical setting.) This observation only relates to the intrinsic features of the objection: if the grounding beliefs are genuinely held and do not clearly fail the consonance test, I submit that it would still be troubling to honor this conscientious objection by granting an exemption. If this is correct, then this case illustrates that the Genuineness View (or even the Genuineness View with a consonance condition) is problematic. The relevant part of the present analysis simply highlights that granting an objection on this basis is discriminatory because it would result in a decision to not care for women based upon the patient's gender and not relevant features such as (e.g.) the practitioner's area of specialty or specific medical competence. Unless petitioners can demonstrate the relevance of the feature or features upon which they are refusing care, they will not be successful in pursuing a conscientious exemption on the Reasonability View.

4. Justified conscientious objection must not violate the duty of care by failing to assist patients in an emergency situation or time-sensitive circumstance

Some providers refuse to inform female victims of sexual assault about the utility and availability of emergency contraception (EC). Some practitioners refuse to dispense EC to women who specifically request EC. Until quite recently, the former sort of provider was protected by federal law in the US,[21] and in many states, the latter sort of provider still possesses legal protection. Based on the ethical analysis offered by the Reasonability View, this state of affairs should change. Not informing women of the availability of EC undermines informed consent and pollutes all of the choices a woman facing a possible unwanted pregnancy may make after this clinical encounter. Given the short window period for effective use of EC, a patient may not be able to realistically rebut such a practitioner's conscientious refusal to dispense. The objection is effectively unlimited in practice, which only further deepens the inequality of power between provider and patient. If the refusal is allowed to occur at the point of service – whether this be in a physician's office or in an emergency room – this sidesteps what I regard as one of the greatest virtues of deploying the Reasonability View in conjunction with the establishment of context-specific CO status in medicine. The CO status proposal is meant to be a *pro-active* measure that would accord providers more latitude to preserve their integrity and also afford patients a greater ability to promote their own best interests. (Just as military conscience exemptions are not granted on the battlefield, conscientious objections in medicine should not be adjudicated on hospital floors!) Conscientious objections that do not attend to the requests of patients in time-sensitive circumstances privilege the moral beliefs of providers over those of patients – thereby conveniently forgetting that medical professionals have duties not possessed by patients and effectively inverting the obligations present in the provider-patient relationship.

IV. FURTHER DEVELOPING THE REASONABILITY VIEW

Up to this point, I have focused the discussion on conditions for an acceptable conscientious *refusal*. Yet it is

[17] J. Rachels. 1999. *The Elements of Moral Philosophy*. Boston, MA: McGraw-Hill Publishing: 10–11.

[18] R.F. Card. Is There No Alternative? Conscientious Objection By Medical Students. *J Med Ethics* 2012; 38: 602–604.

[19] A. Padela & P.R. del Pozo. Muslim Patients and Cross-Gender Interactions in Medicine: An Islamic Bioethical Perspective. *J Med Ethics* 2011; 37: 40–44.

[20] Ibid.

[21] Card, *op. cit.* note 18.

worth adding that the Reasonability View combined with the CO policy suggestion can be extended to *provision* of care. Discussions of conscientious exemptions in medicine have focused largely on refusals of care, but this neglects the fact that some provisions of care (such as performance of abortion procedures) are also motivated by conscientious moral beliefs.[22] We could capture the final extrinsic criterion to be explained and defended in the upcoming discussion as follows:

5. A conscientious refusal requires a greater burden of proof, all things being equal, as compared to a conscientious provision of care

I will first focus on explaining why 'positive' acts of conscience are important, and will then proceed to argue that the logic of conscience objections requires that both refusals and provisions be discussed, even though the burden of proof differs for each. Dickens and Cook[23] observe that 'conscientious commitment' to (e.g.) protect women's health typically arises in response to a failure on the part of others to provide proper requested care. An example will underscore the point. In the US, some ethics committees in Catholic-owned hospitals refuse to approve uterine evacuation for women suffering a miscarriage when a fetal heartbeat is present, due to moral opposition to abortion. This has forced physicians to delay care or to arrange for transport of miscarrying patients to non-Catholic owned medical centers. Some medical staff have violated this protocol because they felt it jeopardized patient safety.[24] In this case of conscientious commitment we would probably find a successful petition for a conscientious exemption to provide care. That is, given the importance of women's health and the fact that we can ethically (and perhaps even legally) distinguish between uterine evacuation in circumstances of miscarriage and an elective abortion, the case for providing timely care to such women even in light of institutional barriers to the contrary is compelling.[25] In this case, since the provision of care conflicts only with a policy that ill-describes medical interventions to address miscarriages as intentional abortions, while the refusal of care conflicts with considerations related to patient safety, meeting the standard of care, and physicians upholding their fiduciary duties to patients, the onus seems to be heavier for the defender of refusal. As a general matter, because conscientious refusal is at cross-purposes not only with the conscientious beliefs of members of the profession who would provide the indicated care, but also obviously with the stated wishes of the adult patient, conscientious provision in line with the patient's request appears, all things being equal, easier to justify. In this sort of case, the Reasonability View would in all likelihood grant CO status to providers allowing provision of such care to women suffering a miscarriage; a policy prohibiting practitioners from obstructing care that simply requires referral to a willing provider or institution is insufficient since this compromise solution endangers women's health and safety.

Once we recognize that provision of care can also involve conscientious beliefs, we are provided with new insights into defects in some of the standard views on conscience objections. I have already suggested that the Genuineness View lacks sufficient normative edge, and this point is simply underscored by the preceding discussion since it would seem that the Genuineness View would be committed to honoring the conscientiously inspired policies that led to the refusal of care related to miscarrying women. I do not doubt the sincerity of those within Catholic hospitals who caused this refusal of care, yet the genuineness of their beliefs does not counter the fact that this refusal (e.g.) causes unjustified harm to patients, fails to assist women in emergency situations, and may even fail the consonance with empirical information condition by improperly considering a uterine evacuation addressing a miscarriage to be equivalent to an elective abortion (if the equivalence is considered to be a medical equivalence).

The incompatibility view is also shown to possess a special problem. If we now recognize 'positive' conscience claims as legitimate, then removing conscience objections from medicine altogether can only serve to make moral progress in medicine more difficult. Interestingly, in his defense of the Incompatibility View, Julian Savulescu not only makes clear that he has no sympathy for conscientious refusals but also emphasizes that regarding doctors' actions in the public sphere,

[22] L. Harris. Recognizing Conscience in Abortion Provision. *N Eng J Med* 2012; 367: 981–983.

[23] B. Dickens & R. Cook. Conscientious Commitment to Women's Health. *Int J Gynaecol Obstet* 2011; 113: 163–166.

[24] Ibid: 165.

[25] More recently, the case of Savita Halappanavar, a 31 year old woman living in Ireland who died after being refused a uterine evacuation, came to light. Doctors said her baby would not survive yet surgeons would not remove the fetus until its heartbeat stopped several days later. These actions were seemingly in accordance with Ireland's strict anti-abortion laws dating back to the 1980s; these laws do not indicate when a threat to the life of the mother is sufficiently high to justify termination. This lack of clarity in the law seems to allow doctors to conscientiously refuse to perform a uterine evacuation. Unfortunately, no medical professionals provided assistance to Ms. Halappanavar. This case underscores the importance of allowing and encouraging conscientious commitment by medical providers to women's health and safety. L. Turner & C. Humphries. 2012 New Inquiry Begins into Case of Woman Who Died After She Was Refused Abortion in Ireland. *NBCNews.com*, 23 November. Available at: Worldnews.nbcnews.com/_news/2012/11/23/15390810-new-inquiry-begins-into-case-of-woman-who-died-after-she-was-refused-abortion-in-ireland?lite [Accessed: 23 November 2012].

conscience has no proper place in medicine: 'But values and conscience have different roles in public and private life. They should influence discussion on what kind of health system to deliver. But they should not influence the care an individual doctor offers to his or her patient.'[26] Extending the discussion of conscience exemptions to include conscientious provision of care demonstrates that conscience *can* serve a proper role in medicine: not only can appeals to conscience be necessary to preserve providers' integrity (for both refusals and provisions of care), but also conscientious commitment can be essential to improve access to care and to promote the goal of *humanitas* in medicine. More generally, appeals to conscience in medicine serve as an acknowledgement of moral diversity and as an impetus for continued dialogue and reflection about ethical issues in medicine. While I have emphasized throughout this paper that we must exercise care when extending conscience-based exemptions to practitioners, the Incompatibility View is shown by this discussion to shortchange the proper role of conscience within medicine. I hasten to add that even if the burden of proof for conscientious provisions is, all things being equal, lower than that for conscientious refusals, this does not imply that all conscience-based provisions of care will be justified. We can easily imagine cases where a providers' conscience-inspired desire to provide continued life-sustaining care against the wishes of a competent adult may not in fact be justified after due evaluation of the grounding reasons in accordance with the analysis presented in this paper. Finally, it is not assumed that the intrinsic and extrinsic factors discussed above are the only ones to consider when applying the Reasonability View to determine whether a conscientious exemption is justifiable. If this attempt to break ground in the project of developing the Reasonability View is deemed successful, then sussing out the additional factors will be a worthwhile endeavor.

[26] J. Savulescu. Conscientious Objection in Medicine. *J Med Ethics* 2006; 332: 294–297: 297.

CONCLUSION

It makes no sense to protect conscientious refusals but not egalitarian claims stemming from conscientious commitment that serve to undo misguided practices that do not best serve patients' interests. Policies persistently fail to protect conscientious provision of services and instead focus solely on conscientious refusals. Since a provider's integrity can be compromised just as much by failing to perform an action in accord with one's conscientious scruples as it can by being obliged to perform an action that conflicts with one's moral beliefs, we need to protect conscientious provision as well in order to not undermine the philosophical justification of conscientious refusals themselves. I have proposed doing this by extending a form of CO status[27] to providers asserting a conscientious refusal or a conscientious commitment. Providers seeking a conscientious exemption in the form of CO status must provide reasons supporting their objection to the practice in question and allow these reasons to be subject to evaluation. In this paper I have proposed some of the criteria to be used to determine when a conscience claim is justified and have defended my view from the criticism that it makes achieving a conscience exemption either too difficult or too easy. This discussion supports the claim that the Reasonability View is a viable position in the debate regarding the proper role of conscience in medicine.

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[27] Card, *op. cit.* note 1.