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Introduction

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In April 2022 a multidisciplinary group comprised of researchers from the Institute for Practical Ethics at the University of California, San Diego and the University of San Diego School of Law began organizing a conference on the matter of conscience protections in law and ethics. At the time we could not know that our chosen subject would catapult in importance. But just two months later the *Dobbs* decision shattered the constitutional right to abortion that had stood for a half century. On the tail of this decision many states enacted laws making it extremely difficult, if not impossible, to terminate pregnancies in a broad range of cases. The U.S. entered an era of state-coerced gestation.

This dramatic change in the landscape of reproductive rights in the U.S. has brought renewed attention to the ways in which reproductive rights are threatened even in places where they remain enshrined in law. It has also pushed scholars to consider the ways existing legal tools could be repurposed to protect reproductive rights. The standing of appeals to conscience is pivotal to both these projects.

In many jurisdictions healthcare providers have a legally protected right to refuse to participate in medical treatments that they deem deeply immoral. As a consequence, patients are sometimes denied access to healthcare that is both legal and consistent with established norms of medical practice. We might ask if it is appropriate for the law to protect such appeals to conscience, especially when patient wellbeing is at stake. And if we do think that the law ought to allow such refusals, we might further ask whether similar protections ought to extend to those who feel compelled by conscience to provide medical services that are in the

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interest of patients, but prohibited by law or their employer. Otherwise put, we might ask whether *conscientious provision* is deserving of legal protections as well. It is the moral, legal, and pragmatic concerns raised by these questions that is the focus of this special issue.

In the opening essay Professor Carolyn McLeod offers a normative account of what conscience is, why it is valuable and why it is deserving of some degree of protection. McLeod argues for what she calls "The Dynamic View" of conscience. On this view tension between our conscience and explicit moral beliefs gives us pause to reflect deeply about the truth and falsity of moral claims, which in turn provides the impetus for individual moral progress. For McLeod, acting in accordance with one's conscience is important for integrity, which allows individuals to live authentic moral lives. This kind of authenticity has benefits to the individual, but living an authentic moral life also serves an important social role. For society to make moral progress individuals must engage in genuine moral discourse, and this is promoted by allowing individuals to live in accordance with their deeply held moral commitments. Of course, any such allowance must have its limits. McLeod's exploration of these limits in the context of healthcare leads to a surprising and insightful result. McLeod argues that restrictions on appeals to conscience ought to be more stringent in the case of conscientious refusals, and less stringent in the case of conscientious provisions. This is because conscientious refusals are often in tension with the interests of patients, while conscientious provisions generally are not. Since the interests of patients ought to be prioritized in the healthcare context, conscientious provisions are generally less problematic than refusals. The argument thus advocates for a partial reversal of the regulatory status quo that affords greater protections conscientious refusal than conscientious provision.

In the accompanying commentary, Professor Steve Smith argues that the law ought not provide any protections for conscientious refusers or providers. Smith argues that for conscience protections fall prey to the "Paradox of Conscience." The paradox arises because one person's conscience might permit an action that is morally unacceptable from a third-person perspective. If we are confident about the immorality of the act in question then it seems unclear why the act ought to be permitted. Yet those who embrace respect for conscience suggest that society ought to defer to the judgment of the individual and allow the wrongdoing to take place, despite confidence in its wrongness. Matters are made worse by the fact that there is disagreement about what morality is about, and what constitutes "conscience" in the first place. Smith worries that protecting conscience per se requires endorsing a kind of moral subjectivism that is to be repudiated. However, little is said about whether protecting conscience might be important for enhancing our understanding of morality from the third-person

perspective, and the claim that it does is key to McLeod's partial defense of conscience protections. Consequently, there might be less of a gap between the two views than might initially appear.

In the following paper Professor Nadia Sawicki provides an overview of current law governing the provision of medical services generally, and conscientious refusal in healthcare in particular. Sawicki then considers how various laws might be amended by those seeking to improve abortion access and those wishing to restrict it. Of particular importance is the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals participating in Medicare to provide the care necessary to stabilize patients suffering medical emergencies, including those that are pregnancy-related. This extends to the provision of abortion in cases where it is necessary to stabilize the patient. But laws that require the provision of treatment are the exception. In general physicians have no duty to treat until a patient-physician relationship has been established. And even when such relationships exist, the conscience protections in place in many jurisdictions protect medical professionals from sanctions if they refuse to provide treatment consistent with the standard of care on grounds of conscience. Some such protections are enshrined in federal law. For example, the Church Amendment prohibits policy makers from making participation in controversial procedures, such as abortions and sterilization, an eligibility requirement for federal funds. But Sawicki notes that some options remain open to policymakers. For example, policymakers could allow professional bodies to sanction medical professionals for failing to meet the standard of care. They could also remove civil immunity protections that indemnify medical professionals from liability for the harms caused by conscientious refusals. However, there is flexibility in the other direction as well. Policy makers could both increase the breadth of services that fall within the scope of conscience protections, and increase the immunities provided by laws that protect conscientious refusals.

Professor Elizabeth Sepper's essay provides both a backward and forward-looking analysis of the state of law governing conscience protections in healthcare. The essay begins with an examination of the expansion of laws protecting conscientious following *Roe*. Sepper notes that this expansion was lopsided in its focus on refusals, and that this development was unjustified. Sepper continues by arguing that in red states the situation for willing providers of morally contested procedures is likely to get worse. The trend amongst physicians to work as part of large health teams imbedded in comprehensive health systems rather than as independent practitioners

creates an environment where surveillance is more present. Consequently, opportunities for discrete rule breaking that once allowed conscientious providers some flexibility have been greatly diminished. Furthermore, the increased power and market share of religiously affiliated healthcare systems makes finding providers of legally permitted but morally contested procedures more difficult. Consequently, physicians bound by the ethical codes of their institutions face increasing difficulty in making referrals to providers able to perform abortions even in places where abortions remain legal. In blue states policymakers are hampered by federal law that prohibits discriminating against institutions and individuals who refuse to perform certain procedures on grounds of conscience. This does not leave blue states without any options. Some have opted for laws that prohibit healthcare institutions from retaliating against providers who provide medical services in violation of the institution's ethical code when the denial of the service would violate the standard of care, risk the life of the patient, or otherwise cause irreparable harm. But these laws do not go far enough, and attempts to expand their scope will likely be hampered by a supreme court willing to take a broad view of First Amendment rights.

In his accompanying commentary Professor Mark Rothstein offers a novel approach for protecting conscientious providers rooted in employment law. Rothstein argues that protections against wrongful dismissal may provide some protection for conscientious providers. Employees can seek damages if they are terminated for reasons that are incongruent with public policy. For example, an employee can seek damages if terminated for reporting violations of workplace safety regulations. Rothstein argues that terminating the employment of a medical professional for conduct they honestly believed was mandated by their professional obligations could be construed as contra public policy. After all, the public expects professionals to honor their professional obligations. However, even if this strategy proves to be successful it would be confined in scope to legally permitted services and thus would be of limited use in jurisdictions with broad legal prohibitions on abortion and other contentious procedures.

In the final essay Professor Dov Fox turns his lens to the current asymmetry between protections for conscientious refusals and conscientious provisions. In jurisdictions that currently protect claims of conscience, it is conscientious refusals that are protected. Thus while a medical professional may have a right to refuse to provide treatments that are both legal and consistent with the medical standard of care, they generally have no corresponding right to provide services that are consistent with the standard of care but are legally prohibited or banned by their employer. But Fox argues that this asymmetry is unjustified. The core justifications given in defense of protections for conscientious objectors, such as the commitment to pluralism and the value of integrity, apply equally to conscientious providers as

well. And while there is overwhelming agreement that patient wellbeing places limits on conscientious refusals, in many cases concern for patient wellbeing will weigh in favor on conscientious provisions. Fox further argues that appeals to the distinction between doing and allowing cannot vindicate the asymmetry either, especially in the healthcare context. This is because healthcare is a domain marked by affirmative duties toward patients. A healthcare professional acts negligently both when she administers the wrong medication, and when she fails to provide any intervention when one is warranted. Since the distinction has less force in the healthcare context, it cannot be used to vindicate conscientious refusals but not conscientious provisions in medicine. The remedy Fox proposes is to tone down the scope of permissible refusals, and to make increased allowances for conscientious provisions. This rebalancing, Fox argues, will be better for patients, providers, and society as a whole.

In his commentary on Fox's essay, Professor Samuel Rickless takes issue with Fox's claim that reasons in support of legal protections for conscientious refusals apply equally to conscientious provisions. Rickless further argues that even if we accept Fox's parity claim, his conclusion does not follow. First, Rickless argues that Fox is too quick to dismiss the moral weight of the doing / allowing distinction, even in the healthcare context where affirmative duties are well recognized. Second, Rickless argues that even if we accept justificatory parity between refusals and provisions, we still ought not accept the rebalancing Fox advocates. This is because, on his view, the case for protecting conscientious refusals in healthcare is weak, and thus appeals to parity ought to lead us to reject protections for both refusals and provisions. For Rickless this does not mean that medical professionals ought to refrain from providing abortions in places where it is prohibited. Rather, those medical professionals committed to reproductive rights ought to engage in civil disobedience and provide the prohibited services despite the penalties that are likely to follow.

The essays that follow thus help illuminate pressing matters that lie at nexus of law, morality, and reasonable pluralism. The extent to which a system of law ought to accommodate the strongly held moral convictions of individuals is a vexing question that requires us to answer foundational questions about both the purpose of law and the value of conscience. And given that we do make some allowances for conscience, there are important questions about whether the distinction between conscientious refusals and provisions is one that withstands scrutiny. But these questions

are not merely theoretical. The law as it stands limits the ways policymakers can constrain or extend existing conscience protections. Furthermore, any concrete proposal must take into consideration the likely impacts on patients and the health system. All this takes place within a backdrop of increasing constraints on reproductive freedoms that places many in harm's way. The answers to these questions are thus of tremendous social importance. It is our hope that this volume is a concrete step towards finding answers.