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RESEARCH ARTICLE

The Reasonable Content of Conscience in Public Bioethics

Abram Brummett[1] and Jason Eberl[2]

[1]Department of Foundational Medical Studies, Oakland University William Beaumont School of Medicine, Rochester, MI, USA
[2]Albert Gnaegi Center for Health Care Ethics, Saint Louis University, St. Louis, MO, USA
Corresponding author: Abram Brummett; Email: abram.brummett@gmail.com

Abstract
Bioethicists aim to provide moral guidance in policy, research, and clinical contexts using methods of moral analysis (e.g., principlism, casuistry, and narrative ethics) that aim to satisfy the constraints of public reason. Among other objections, some critics have argued that public reason lacks the moral content needed to resolve bioethical controversies because discursive reason simply cannot justify any substantive moral claims in a pluralistic society. In this paper, the authors defend public reason from this criticism by showing that it contains sufficient content to address one of the perennial controversies in bioethics—the permissibility and limits of clinician conscientious objection. They develop a "reasonability view" grounded in public reason and apply it to some recent examples of conscientious objection.

Keywords: conscientious objection; public bioethics; public reason; reasonability view; religion

Introduction

Bioethicists aim to provide moral guidance in policy, research, and clinical contexts using public reason, which is appropriate in a pluralistic society because it eschews argumentation grounded in religious as well as nonreligious (e.g., Marxism, utilitarianism) comprehensive doctrines.[1] This public reason-based bioethics was largely successful in the 1970s and 1980s, but subsequent decades have seen increasing criticism of this methodology, resulting in what John Evans refers to as the "crisis of the bioethics profession," namely, the wavering public confidence in public reason to secure common moral ground sufficient to resolve bioethical controversies.[2] If public reason fails as a viable methodology for bioethics, then the whole discipline would need to be reconsidered.[3] Leonard Fleck has recently surveyed and responded to a litany of criticisms against public reason, such as the argument from Tristram Engelhardt and Mark Cherry that public reason cannot rationally secure moral content in a secular society and thereby reduces to moral relativism where content is provided by the majority or reigning political power.[4]

In Part 1 of this essay, we further develop the concept of public reason by distinguishing internal (having to do with logical structure) from external (having to do with widely shared content) criteria. We then describe Engelhardt's critique in greater detail and show why it is unreasonable. In Part 2, we show how public reason can resolve at least one of the perennial controversies of bioethics by developing a public reason-based "reasonability view" of conscientious objection. We review some recent forms of conscientious objection and explain why they would be prohibited by a reasonability view.

Part 1: Developing public reason and the moral relativism critique

Developing public reason

Public reason has its roots in John Rawls's account of political liberalism.[5] The foundational criterion of public reason is that of *reciprocity*:

> Our exercise of political power is proper only when we sincerely believe that the reasons we would offer for our political actions … are sufficient, and we also reasonably think that other citizens might also reasonably accept those reasons.[6]

The goal of the reciprocity criterion is to establish the limit of *justifiable* reasons that may be given in an idealized constituency[7] for one's exercise of power in the public square; it does not aim to track ultimate truth in the manner of a comprehensive doctrine:

> Public reasoning aims for public justification. … Public justification is not simply valid reasoning, but argument addressed to others: it proceeds correctly from premises we accept and think others could reasonably accept to conclusions we think they could also reasonably accept.[8]

Public reason does not provide sufficient criteria for determining which among competing reasonable truth-claims is correct, but rather defines the parameters for determining reasonable truth-claims that may remain mutually contradictory. For example, while public reason arguments can be made in support of legalizing abortion, Rawls affirms as an instance of public reason an argument against abortion provided by Joseph Cardinal Bernardin's "consistent ethic of life;"[9] he then states, "Whether [Bernardin's argument] is itself reasonable or not, or more reasonable than the arguments on the other side, is another matter. As with any form of reasoning in public reason, the reasoning may be fallacious or mistaken."[10] Rawls sees Bernardin's arguments, despite their source being a public religious authority, fulfilling his *proviso* regarding positions and arguments that stem from a "comprehensive doctrine" such as Catholicism:

> … reasonable comprehensive doctrines, religious or nonreligious,[11] may be introduced in public political discussion at any time, provided that in due course proper political reasons—and not reasons given solely by comprehensive doctrines—are presented that are sufficient to support whatever the comprehensive doctrines introduced are said to support.[12]

Rawls's *proviso* includes "no restrictions or requirements on how religious or secular doctrines are themselves to be expressed; these doctrines need not, for example, be by some standards logically correct, or open to rational appraisal, or evidentially supportable."[13] In other words, one could hold and even publicly express a position based on one's comprehensive doctrine; however, for one's position to inform public policy, it needs to be transmutable into publicly reasonable terms. For example, as we discuss further below, a Roman Catholic bishop may believe and publicly express his view that God endows every human being with a rational soul at conception, and hence abortion ends the life of a human person with inherent dignity. The idea of "ensoulment," however, is another way of claiming that a human embryo or fetus follows a developmental plan encoded in its genotype, and "dignity" is the shorthand for something's possessing a high, perhaps inviolable, moral status.[14] While these metaphysical and moral claims are contentious, they can be made without any reference to "God" or other theological tenets.[15]

We aim to develop Rawls's view of public reason in more detail, supporting additional criteria for evaluating the reasonability of clinicians' appeals to conscience. The set of criteria we have in mind may be categorized as *internal* and *external*.[16] Internal criteria first require that basic rules of logical deduction and induction not be violated—what logicians refer to as *validity* in argument structure, avoiding both formal and informal fallacies. Internal criteria also include the standards of good abductive reasoning (or inference to the best explanation), such as *clarity* of key terms by avoiding vague or ambiguous language that can hamper discourse by creating a mirage of "disagreement" where interlocutors are only using the same key terms with very different meanings. For example, some of the scholarship in the ethics expertise debate may be based on an equivocation over key terms like "moral recommendation" or "furnishing answers" that, when clarified, dissolves the perceived disagreement.[17] Good abductive reasoning also requires maintaining *consistency* across arguments. For example, one should not adopt a psychologically based criterion of personhood as a premise in arguing that human embryos and fetuses do not count as persons, while also arguing against a higher-brain concept of death. Other common

standards of abductive reasoning include comprehensiveness, simplicity, explanatory power, and practicability.[18]

External criteria examine the *soundness* or epistemic *warrant* of particular premises in one's argument. For instance, we can ask whether a particular premise is consistent with empirical scientific findings. Granted, empirical science is itself an epistemic enterprise that aims toward but does not claim to arrive at indubitable truth-claims; however, we can question whether a particular premise requires accepting a claim that does not cohere with well-demonstrated empirical laws, theories, or hypotheses, at least not without being substantiated by competing empirical evidence. Consider, for example, someone who develops an argument based on the premise that the earth is only 6,000 years old despite the clear empirical evidence to the contrary. A second external requirement is that any moral or metaphysical claims in an argument's premises satisfy the reciprocity criterion. For example, a moral claim that would satisfy the reciprocity criterion is that—*a la* Kant—one ought to respect persons as ends in themselves; an example of a publicly reasonable metaphysical claim would be that irreversible cessation of neurological function (including the cerebrum, cerebellum, and brainstem) constitutes the death of a human person.[19]

Within these parameters is permitted a range of claims and arguments, more restrictive than Rawls's concept, that may be considered valid forms of public reason. Next, we turn to describing Engelhardt's critique of public reason and demonstrating its critical failures on several points.

The moral relativism critique

Tristram Engelhardt has forcefully argued that public bioethics cannot secure the moral content required to resolve bioethical controversies. Engelhardt's core argument is that no ethical disagreement between moral strangers—those who do not share basic moral premises and rules of evidence—can be settled by using discursive reason without ending in circularity, an infinite regression of reason-giving, or question-begging.[20] He asserts that because secular society comprises moral strangers, their moral disagreements cannot be rationally resolved, and therefore, all the content purportedly "secured" by public reason reduces to rule by majority or reigning political power. Engelhardt's solution is to reject any notion that moral content can be secured—and thereby imposed on dissenters—in a secular context and instead rely only on a "contentless" *principle of permission* for navigating moral disagreement: "Do not do to others that which they would not have done unto them, and do for them that which one has contracted to do."[21] The only way through moral disagreement using the principle of permission is to secure agreement about how to proceed among dissenting parties. If no agreement can be reached, then dissenters should be permitted to go their separate ways.

While Engelhardt's view has a seductive allure at first blush to those living in a pluralistic society that highly values autonomy, it has several fatal problems. First, it leads to morally abhorrent results (a failure of the external criterion to accord with common sense morality) and fails to satisfy its own contentless ideal (a failure of the internal criterion of consistency). Disturbing implications of Engelhardt's view for pediatrics reveals several substantive moral commitments on his part. For instance, the principle of permission would allow religiously motivated parental refusals of treatment that may result in death, disability, or suffering for children. As Jeremy Garrett elaborates, "One core assumption underlying Engelhardt's pediatric bioethics is that parents 'own' their offspring, first by expending 'labor' and 'extending themselves into' their children, and then later (following the point that children become 'self-conscious') by their submission as 'indentured servants' to 'parental authority in exchange for parental support.'"[22] As James Nelson notes, the ownership of children by their parents on Engelhardt's view is nearly absolute, and would permit "toddlers, rather than veal calves, to be fattened for the table in factory farms."[23] As Steven Hanson argues, the key point is not only that Engelhardt's view entails morally disturbing results for pediatrics, but that it does so by presuming a *content-full Lockean sense of property* that belies the claim that his view is devoid of moral or metaphysical content.[24]

Another fatal problem in Engelhardt's view is his commitment to a foundationalist epistemology that requires *certainty through reason*, where reason means logical deduction from universally true axiomatic

foundational premises. Describing Engelhardt's view, Lisa Rasmussen writes, "morality is never a half-measure, never merely the best we think we can do. One is certain, or one knows nothing."[25] This view of moral epistemology fails the internal criterion of *practicability* because it articulates a standard that cannot be met. If such a maximally stringent moral epistemology is granted, then discursive moral justification will be rendered a priori impossible to achieve. Further, it will not be possible to contain the resulting skepticism to bioethics, but most human inquiry would be immediately undermined. For example, the sciences rely on a host of moral and metaphysical assumptions that cannot be secured with certainty: that an external world exists, that the human mind is able to apprehend it, that the world was not created 30 min ago with an appearance of age, that the natural laws in the future will be the same as those of the past, that other minds exist, and so forth The sciences also rely on a host of moral assumptions that cannot be known with certainty, such as the good of pursuing truth and determining which truths are best pursued given pressing human concerns. The credibility of astronomy, biology, or physics is not undermined when a radical skeptic points out these disciplines rest on moral and metaphysical foundations that someone somewhere is willing to dispute, so why should bioethics be any different? Finally, Engelhardt's own view of moral justification may be self-defeating because it is not *itself* known with certainty, where certainty is interpreted as either self-evident (e.g., simple mathematical truths) or incorrigible (e.g., beliefs of one's own experience, such as "I am in pain").[26]

We aim here only to canvass briefly *some* of the challenges undermining the credibility of the contentless critique. Additional objections are developed in further detail elsewhere.[27] We turn now to arguing that public reason contains sufficient justifiable content to address one of the perennial controversies in bioethics—the permissibility and limits of clinician conscientious objection in healthcare.[28]

Part 2: A public reason-based approach to conscientious objection

A clinician invokes a conscientious objection when they refuse to provide a legal and professionally accepted medical good or service on the grounds that doing so would violate their core religious or moral beliefs.[29] Legal protections for individuals and institutions that conscientiously object to performing, or assisting in the performance of, abortion or sterilization procedures have been in place since the passage of the Church Amendments on the heels of the *Roe v. Wade* decision in 1973. Subsequent federal and state conscience clauses have been passed, resulting in robust protections for conscientious objection that protect virtually any objection unless it violates federal or state antidiscrimination statutes or is invoked when a patient shows up to the emergency department in need of urgent care. Clinicians are not even legally required to disclose that their refusals are based on moral (rather than medical) grounds or to refer patients to willing providers.[30]

Mark Wicclair identifies three broad approaches to conscientious objection: the incompatibility thesis, conscience absolutism, and compromise.[31] The incompatibility approach denies a legitimate role for conscience in healthcare by prioritizing the positive moral obligation of clinicians to provide the legal and professionally accepted medical care that patients seek.[32] Conscience absolutism is the view that there should be "no ethical constraints on the exercise of conscience by healthcare professionals" by prioritizing the moral integrity of clinicians.[33] Engelhardt's view outlined above would support conscience absolutism, and the recent examples we describe (and reject) below are attempts to move closer to conscience absolutism in public policy protecting clinician conscience. Compromise approaches are any view that falls between conscience absolutism and the incompatibility thesis by attempting to permit conscience claims *within limits.*[34]

One version of a compromise approach is the reasonability view, which holds that, in cases where a conscience claim places burdens on patient access to legal and professionally accepted care, the content of the objection, the context of the objection, and the obligations of objecting clinicians must all be justifiable with public reasons.[35] The reasonability view is fundamentally opposed to extreme approaches (i.e., conscience absolutism and the incompatibility thesis) to the conscience debate because taking an extreme approach *requires ignoring reasonable moral concerns.*[36] The debate over clinician conscience

arises because of a genuine ethical dilemma between the good of protecting the moral integrity of clinicians and the obligations of medical professionals.[37] Because of this fundamental moral dilemma, the reasonability view we articulate aims to *balance* professional obligations with protecting clinicians' moral integrity. This pursuit of balance will be evident in the examples that follow.

On the reasonability view, the content of a conscientious objection must be supportable with public reasons. For example, a significant point of division between secular and Catholic healthcare systems is whether medicine is essentially *pathocentric*—that is, focused solely on managing painful symptoms, prolonging life, and preventing or curing diseases—or also includes actions aimed toward a patient's overall well-being—for example, terminating a pregnancy if a child is unwanted (in cases where the pregnancy does not constitute a threat to life or physical health) or medically assisting a patient's death.[38] Either view would be reasonable on our account, thereby allowing both for public policies that permit healthcare professionals to provide abortions or participate in medically assisted deaths, as well as conscience protections for healthcare professionals who refuse to provide or participate in such services insofar as, in their view, they do not properly constitute "medicine." As a result, the reasonability view would protect some existing individual and institutional conscientious objections, not because they are grounded in sincerely held religious beliefs (though they may be), but because they can be given public justification grounded in a pathocentric account of medicine.

While a pathocentric view of medicine provides a public reason for many traditional forms of conscientious objection, there are additional kinds of relevant public reasons. Consider the Roman Catholic Church's stance regarding abortion. One may be forgiven for thinking that the Church's official position is that human embryos and fetuses are "rationally ensouled" beings, who thereby are *persons* with an inviolable "right to life" due to their inherent "dignity." While many Catholic authorities and bioethicists do in fact argue precisely in this way, the most formal pronouncement from a magisterial authority, Pope St. John Paul II, carves out a more nuanced line of reasoning:

> Some people try to justify abortion by claiming that the result of conception, at least up to a certain number of days, cannot yet be considered a personal human life … Even if the presence of a spiritual soul cannot be ascertained by empirical data, the results themselves of scientific research on the human embryo provide "a valuable indication for discerning by the use of reason a personal presence at the moment of the first appearance of a human life: how could a human individual not be a human person?" Furthermore, what is at stake is so important that, from the standpoint of moral obligation, the mere probability that a human person is involved would suffice to justify an absolutely clear prohibition of any intervention aimed at killing a human embryo [or fetus].[39]

Note that the above argument invokes no theological claims; even the concept of a "soul" is foundationally a *philosophical* concept going back to the Greek pagans Plato and Aristotle.[40] Rather, the argument appeals to "scientific research" regarding the genetic identity and development potential of human embryos.[41] It then implicitly invokes a version of the *precautionary principle*, which generally holds that when in doubt about a morally significant fact—such as whether a particular being or kind of being is a person—one should err on the side that will result in the least amount of moral damage.[42] Granted, this is a non-standard view from the perspective of the mainstream medical establishment, since, for example, the American Medical Association's *Code of Medical Ethics* recognizes elective abortion as falling within the scope of accepted medical practice; yet, dissenters persist in arguing that elective abortion does not fall within the scope of acceptable medical practice.[43]

Conscientious objection to prescribing pre-exposure prophylaxis to gay and bisexual men

The content of some recent forms of conscientious objection moves toward conscience absolutism and would be prohibited by the reasonability view. For example, some patients have been refused pre-exposure prophylaxis (PrEP) by clinicians who, on discovering the gay or bisexual orientation of the patient, conscientiously object to enabling "immoral sexual behavior."[44] Recent legal actions in the United States have attempted to further empower clinicians and insurance providers who wish to refuse

PrEP to patients on the basis of their sexual orientation, arguing that compelling such treatment would violate the Religious Freedom Restoration Act.[45]

This form of conscientious objection would be permitted by conscience absolutism because of its overriding commitment to protecting the moral integrity of clinicians to refuse anything, in any context, with no further obligations. One can even imagine a clinician offering public reason arguments against gay and bisexual behavior grounded in the natural law tradition as a justification for their refusal.[46] While the reasonability view would acknowledge the importance of protecting clinician moral integrity, and even recognize natural law arguments against gay and bisexual behavior as cast in public reason form, it would nevertheless prohibit this form of conscientious objection for several countervailing public reasons.

First, unlike objections to abortion, contraception, or sterilization, an objection to providing basic preventive medical care cannot be grounded in a pathocentric or otherwise reasonable account of medicine because the prevention of disease is a core obligation of medicine.[47] Physicians accept some core obligations when they freely choose to join the profession and thereby acquire significant power over already marginalized and vulnerable patients who have not chosen their sexual orientation.

Second, this form of conscientious objection is not an objection to providing a medical good or service, but to providing it for a particular kind of patient (gay and bisexual men), which amounts to a form of invidious discrimination thereby violating another core obligation of medicine. The American Medical Association has many policies opposing discrimination based on sexual orientation, even if state antidiscrimination laws do not contain explicit protections for this group.[48]

Finally, if these conscientious objections are based on the belief that a lack of PrEP will discourage unprotected sex and lead to an overall reduction of HIV transmission among gay and bisexual men, then the objection is empirically false on at least two counts. First, while a lack of PrEP may discourage some gay and bisexual men from having unprotected sex, it will not discourage all, thereby resulting in an *increase* of HIV transmission. Second, the increase in HIV transmission will not be limited only to gay and bisexual men, but will have effects throughout the broader population, thereby undermining public health at large.

In sum, a physician is free to make public reason arguments in the public square that gay and bisexual behavior is immoral *qua* citizen, but they should not be free to act on those commitments *qua* physician, because doing so violates two core obligations of medicine (to prevent disease and to not discriminate), a profession into which they have freely entered, and their reasoning may further suffer from a false empirical assumption that their refusal will lead to a reduction of HIV transmission in the population.

Conscientious objection to providing life-saving treatment

There have also been recent attempts to prohibit the Emergency Medical Treatment and Active Labor Act (EMTALA) from requiring clinicians to perform abortions in a medical emergency. Following the ruling in *Dobbs v. Jackson Women's Health Organization*, which overturned *Roe v. Wade* to return the legal question of abortion back to be decided at the state level, the U.S. Department of Health and Human Services released guidance explaining that the requirements of EMTALA override state law.[49] The state of Texas, as well as some antiabortion groups, denounced this "Abortion Mandate," claiming it would violate established federal conscience protections.[50]

This form of conscientious objection would be permitted by conscience absolutism due to the sole overriding commitment of protecting clinician moral integrity. In these cases, the objecting clinician presumes 1) that a fetus is a human person, and 2) the existence of an absolute prohibition over ever directly causing another's death. While the reasonability view acknowledges that both assumptions qualify as public reasons, this will not be sufficient to permit conscientious objection in a life-threatening emergency for several countervailing reasons.

First, otherwise pro-life ethicists have provided good reasons why cases of "vital conflict" between a pregnant patient and the fetus they are carrying provide an exception to the general prohibition of abortion.[51] These reasons can be based on consideration of analogous cases of *innocent material threats*,

such as a mentally incapacitated gunman who threatens to shoot up a school; just as one is arguably justified in killing the gunman to save their intended victims, one may be justified in intentionally ending the life of a fetus whose presence within a pregnant person's body gravely threatens their health. Further, these cases may not, depending on the circumstances, require an abortion procedure (such as dilation and curettage) that violates the fetus's bodily integrity. Rather, if the pregnant patient's condition permits, either vaginal delivery could be induced or a C-section performed to terminate the life-threatening pregnancy, but leave the fetal body intact. If the fetus is previable, then its ensuing death would arguably be justified by appeal to the *principle of double-effect*. If the fetus is viable, then measures could be taken to sustain its life postnatally.

Second, refusing abortion in a life-threatening medical emergency is not supported by any reasonable account of medicine. For example, it *violates* a pathocentric approach (used to support conscientious objections to otherwise non-emergent procedures) to medicine because it permits the patient to die from want of a life-saving procedure. Granted, a pathocentric approach does not require providing life-saving treatment if doing so would harm or kill another person—for example, killing someone in order to use their vital organs to save someone else—but the personal status of the fetus is reasonably disputed, and thus a pathocentric approach could support privileging the pregnant patient's life (as an undisputed person) over that of a *putative* person. As in the case of refusing preventive care above, the reasonability approach does not permit physicians to conscientiously object to meeting the core obligations (e.g., those prescribed by a pathocentric or internal morality of medicine) of medicine, which they accept on freely choosing the societal role of physician and its attendant power over vulnerable patients.

Finally, healthcare professionals and institutions should maintain *epistemic humility* with respect to their own moral viewpoint when conflicting viewpoints can also be given public reason justifications (such as those above) and *there is significant and undisputed harm that will result.*[52] This involves an application of the precautionary principle described earlier, weighing the moral cost of ending the life of a being that *may* reasonably count as a person with that of someone who is unquestionably a person.

Thus, while we have defended a general right to conscientious objection to elective abortion, a reasonable limit on that *prima facie* right would be the emergency context due to the requirement for epistemic humility in the face of undisputed serious harms, the good reasons to support abortion exceptions in the case of vital conflicts, and the violation of a core obligation of the medical profession into which the physician has freely entered.

Conscientious objection to prescribing emergency contraception to rape victims

While Catholic moral teaching is generally opposed to the use of contraception, Directive 36 of the Ethical and Religious Directives for Catholic Healthcare Services (ERDs) reads, "A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, *after appropriate testing*, there is no evidence that conception has already occurred, she may be treated with medications that would *prevent* fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."[53] Bishops are allowed to select more or less restrictive interpretations of "appropriate testing" for the Catholic hospitals in their diocese to follow when applying Directive 36. Some bishops choose to follow the interpretation provided by the Catholic Medical Association, which holds that providing emergency contraception is morally prohibited in all cases because the data has not ruled out potential abortifacient effects.[54] For example, 13 Catholic hospitals in Pennsylvania have given notice to the Department of Health that they will not provide emergency contraception due to religious or moral belief.[55]

Recently, the FDA has updated the labeling information describing the mechanism of action (MOA) for Plan B One-Step (PBOS), which is a levonorgestrel-based form of emergency contraception.[56] The most significant change is the removal of a statement, which had been included since 2006, that PBOS "may inhibit implantation (by altering the endometrium)."[57] At issue is both whether the FDA is giving a scientifically well-grounded account of PBOS's MOA,[58] as well as what constitutes an "abortifacient"

pharmaceutical: the FDA holding that pregnancy is established by implantation, whereas the ERDs consider intentional interference with the implantation of a conceived embryo to be abortifacient.[59] The ensuing debate over this relabeling raises two complicating questions with respect to the reasonability view: 1) How should the view take into account conscientious objection when there is basic disagreement regarding the definition of ethically salient terms (e.g., "pregnancy," "abortifacient")? 2) How should the view adjudicate between disputed understandings of relevant scientific data (e.g., MOA of PBOS)?

Space does not permit us to fully resolve these questions here; however, we can outline some basic parameters. To start with, so long as the controverted views regarding either terminological definitions or data interpretations—without regard to the other view—meet the internal and external criteria of public reason outlined above, then both views should be accepted as reasonable. For example, if the only countervailing evidence proposed to one interpretation of the data concerning the primary MOA of PBOS is that purported by the competing interpretation, with no independent means of adjudicating the validity of either interpretation, then both interpretations should be accepted as fulfilling the external criterion of cohering with empirical facts. While only one of the competing interpretations is the fact of the matter, we have no reasonable means of verifying which of them is true. This conclusion would support the current standard of care to provide PBOS, as well as conscientious objection on the part of those who refuse to provide PBOS. Further, one of us has argued elsewhere that reasonable *internal* disagreement among Catholics over the correct interpretation of "appropriate testing" in Directive 36 provides a compelling reason for Catholic hospitals to allow for conscientious provision of PBOS by employed physicians within limits, as opposed to imposing a strict prohibition.[60] With respect to adjudicating the reasonability of competing terminological definitions, we can again apply the same internal and external criteria. In this case, both competing definitions of "pregnancy" are reasonable insofar as they are clear and cohere with the broader system in which they are each embedded.

The obligations of conscientious objectors

Conscience absolutism places no moral obligations on conscientiously objecting clinicians, such as disclosing that a refusal is being done because of conscience and not for a medical reason, because the clinician may also object to these obligations. In contrast, the reasonability view assigns some moral obligations to the objecting clinician. On the reasonability view, an objecting individual or institution should be *transparent* that a medical treatment is both legal and professionally accepted but being refused for reasons of conscience. Further, individuals and institutions with conscientious objections should provide *advance notification* of the medical goods and services they do not provide to the public they serve.[61] The duty to improve advance notification can be addressed by practices such as placing treatment restrictions on websites, in waiting rooms, and on patient portals.

A more contentious requirement of the reasonability view would be *referral* of the patient to another provider. Such a requirement raises the specter of *moral complicity/cooperation*. Consider someone whose friend asks them to help them kill their spouse; the person objects but offers their friend the phone number of a for-hire assassin to do the job. This would be a clear-cut case of illicit cooperation by helping one's friend commit a premeditated murder, even if one takes no active part in the murderous deed itself. There is an important difference, however, between this example and that of a conscientiously objecting physician referring their patient to, say, an abortion provider. While it is unreasonable to murder one's spouse, there is reasonable disagreement regarding the moral permissibility of abortion. Nevertheless, the objecting clinician may not see these cases as morally different and hence their conscience demands of them not only to refuse the abortion but also to avoid cooperating with the patient in obtaining the abortion elsewhere. The concern of moral complicity through referral has generally been dismissed by proponents of compromise and incompatibility thesis positions, who stipulate an "obligation," "duty," or "rule" to refer.[62] However, one of us has provided several examples of referral beyond traditional contexts of abortion or sterilization (e.g., referral for "gender normalizing" surgery of a neonate) that could be considered morally problematic by even those who generally argue for referral.[63]

The need and form of referral must be contextualized to different healthcare systems. In the United States, the primary need for referral is to ensure that the medical service the patient is seeking will be covered by insurance; also at stake is the patient's ability to identify providers willing to provide such service. As one of us has argued elsewhere, an ideal system would eliminate the need for referrals by objecting clinicians altogether by virtue of the state providing a means for patients to identify and obtain the desired service; for example, in Canada, Ontario's Medical Assistance in Dying Statute Law Amendment Act mandates that the Minister of Health establish "a care co-ordination service" (essentially a hotline) that provides information and referrals to ensure patients' access to medical aid-in-dying.[64] At the very least, it is arguable that objecting clinicians should not be compelled to refer to specific clinicians or institutions known to provide the objectionable service—what is referred to as "effective referral."[65] However, those clinicians concerned with the moral complicity of effective referrals should offer a *generic* referral for insurance authorization to any other clinician whose services the patient may seek out on their own accord.[66]

These obligations to inform patients that a refusal is based on clinician conscience (not medical indication), provide advance notification, and, when needed, provide a generic referral to authorize insurance payment are the minimum obligations of objecting clinicians on the reasonability view, and pluralistic societies should pursue solutions (e.g., the proposed Ontario system) that bypass the need for physician referral for contested services altogether.

Conclusion

In this paper, we have defended public reason from the charge that it lacks sufficient moral content to resolve the controversies of bioethics. In Part 1, we developed internal and external criteria of public reason to be used for adjudicating the reasonability of claims in public bioethics. We then showed that one alternative to public reason-based bioethics—a contentless principle of permission—contains several serious flaws, one of which is presuming a view of discursive moral justification that cannot be satisfied. In Part 2, we applied public reason to the debate over clinician conscientious objection in healthcare, sorting conscience claims into reasonable (e.g., refusal to perform abortion based on a pathocentric view of medicine) and unreasonable (e.g., refusal to prescribe PrEP based on invidious discrimination) categories, as well as describing some obligations of objecting clinicians (e.g., to give advance notification).

The content of public reason cannot be rationally proven with discursive argumentation among moral strangers; but we are not moral strangers, and we should not aspire to apodictic certainty regarding the content of public bioethics.[67] The impetus to balance competing reasonable moral claims, which is perhaps the *summum bonum* of public reason-based approaches to bioethics, must ultimately be chosen. In the face of "contentless" or comprehensive doctrine alternatives, we must choose wisely.

Notes

1. Fleck LM. *Bioethics, Public Reason, and Religion: The Liberalism Problem.* New York: Cambridge University Press; 2022. For an argument that public reason is the appropriate mode of discourse in the clinical context specifically, see: Greenblum J, Hubbard RK. Responding to religious patients: Why physicians have no business doing theology. *Journal of Medical Ethics* 2019;45(11):705–10.
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6. See note 5, Rawls 1997:771.
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10. See note 5, Rawls 1997:798n82.
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13. See note 5, Rawls 1997:784.
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