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RESEARCH ARTICLE

Assessing Public Reason Approaches to Conscientious Objection in Healthcare

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Abstract

Sometimes healthcare professionals conscientiously refuse to treat patients despite the patient requesting legal, medically indicated treatments within the professionals' remit. Recently, there has been a proliferation of views using the concept of public reason to specify which conscientious refusals of treatment should be accommodated. Four such views are critically assessed, namely, those of Robert Card, Massimo Reichlin, David Scott, and Doug McConnell. This paper argues that McConnell's view has advantages over the other approaches because it combines the requirement that healthcare professionals publicly justify the grounds of their conscientious refusals of treatment with the requirement that those grounds align with minimally decent healthcare. This relatively restrictive approach accommodates conscientious refusals from minimally decent healthcare professionals while still protecting good healthcare, the independence of the healthcare professions, and the fiduciary relationships.

Keywords: conscientious refusal; fiduciary relationship; healthcare professional; public justification; public reason

Introduction

Sometimes healthcare professionals (HCPs) face requests for legal, medically indicated treatments within their remit, yet, to provide such treatments would clash with their sincerely held moral or religious beliefs. In these cases, HCPs might conscientiously refuse to provide treatment (CR). The extent to which we should accommodate CRs has been the topic of lively, long-running debate that implicates the varied and conflicting interests of HCPs, patients, the medical professions, and society.

Recently, there has been a proliferation of views that use the concept of public reason to specify which CRs should be accommodated, namely, those of Robert Card,[1] Massimo Reichlin,[2] David Scott,[3] and my own.[4] Roughly, public reason requires that policies and laws be justifiable to, or reasonably acceptable to, the people to whom they apply.[5] Appealing to public reason prioritizes fidelity to a liberal democratic process over moral truth and, in that sense, these views on how to manage CR are unlike typical bioethical approaches.

In this paper, I critically analyze the four extant public reason approaches to CR, as well as one novel approach I outline here. I identify two major differences and one significant convergence between the views. The first difference is methodological. Only Scott appeals exclusively to liberal democratic processes; the others mix methodologies by also appealing to objective standards of good healthcare in various ways. I suggest that the mixed methodologies are preferable because they counteract the (limited) relativism inherent in the purely liberal democratic methodology.

The significant convergence between the four views is that they all agree that publicly reasoned justifications for CR should be compatible with standards of good healthcare. Some people will find this limitation on public reason objectionable because it prevents a subset of physicians from acting on their

reasonable conceptions of the moral life. With this objection in mind, I outline a fifth, more permissive, public reason *simpliciter* approach where CRs grounded in *any* reasonable moral outlook are accommodated unless they will cause the patient disproportionate harm. Although I suspect this approach will be attractive to some, I argue that it is flawed because it will damage both the independence of the healthcare professions and HCPs' fiduciary relationships with patients. Reichlin's view and my own do best on this count because we apply the more stringent standards of good healthcare.

Finally, the views also differ on the burden they place on HCPs who want to make CRs. Card and I claim that, because individual HCPs have a *prima facie* fiduciary duty to their patients, they should be required to publicly justify the grounds of their CR using public reason if they are to be excused from their duty. Reichlin and Scott do not think individual HCPs should face this burden, concluding that policymakers should use public reason to decide which *types* of CRs can be accommodated. I argue in favor of the public justification requirement primarily on the grounds that, without it, HCPs can flout their fiduciary duty to patients. Card's view and my own do best on this count since our systems both require HCPs make public justifications for their CRs, but I also show how a public justification requirement could fall out of Scott's view.

Overall (perhaps unsurprisingly), I favor my own public reason approach because it combines a public justification requirement with a stringent requirement for the grounds of CRs to align with minimally decent healthcare if they are to be accommodated. This approach protects good healthcare, the independence of the healthcare professions, and the fiduciary relationship between HCPs and patients, while still accommodating the CRs of those HCPs with minimally decent conceptions of healthcare.

What is the liberal democratic methodology?

We each develop what Rawls calls a personal comprehensive doctrine, that is, a coordinated set of religious, cultural, moral, and philosophical beliefs that characterize and organize our values and express an intelligible view of the world. Variation in our social contexts, capacities, and personal experiences give rise to a plurality of conflicting personal comprehensive doctrines. This plurality of views is a "permanent feature of the public culture of democracy"[6] and it creates a challenge for organizing the liberal democratic state. To function, the liberal democratic state requires its citizens to democratically agree on certain constitutional matters and matters of justice, including healthcare resourcing, professional licensing, and when, if ever, CRs should be accommodated.

Given the plurality of comprehensive doctrines, it is inevitable that some citizen's preferences are not fully satisfied when a policy or law is chosen. So how can policy disputes be fairly resolved? In liberal democracies, reasonable citizens treat each other as free and equal and, therefore, respect others' conflicting personal doctrines where they too are reasonable. This attitude entails that the majority should not simply impose their views on everyone else. Rather, public policy should be supported by reasons that are intelligible to the dissenters, derive from a process that permits dissenting voices to be heard, and, where possible, accommodate dissenters' preferences. Unreasonable comprehensive doctrines, for example, those that are prejudiced, biased, self-interested, or willfully ignorant, cannot contribute to public reason and do not have to be appeased.

For the reasons grounding public policy to be intelligible to all and for dissenting reasons to be considered when making public policy, those reasons must be *public* reasons.

> As far as possible, [public reasons] are to rest on plain truths now widely accepted, or available, to citizens generally. Otherwise the political conception would not provide a public basis of justification.[7]

On controversial issues, reasonable people will reasonably disagree on which policy is best supported by public reason. In such cases, the majority decides which policy to adopt but, being reasonable people, they make concessions to the dissenting minority where possible and make sure that the minority

understand the public reasons used to justify the policy. The dissenting minority should accept the outcome of this process, to resist it with force would be unreasonable.

Appealing to public reason is a promising approach for managing CR in a liberal democratic state because we need to decide on policy despite the conflicting personal doctrines of HCPs and patients. To date, four theorists have put forward proposals that use public reason to specify which CRs should be accommodated.

How public reason is put to work in systems for managing CR

Card

Card was the first to make use of public reason in a system for managing CRs and has provided the most detailed of the four views.[8] He believes that we should be open to accommodating CRs out of respect for HCPs' moral integrity, but that HCPs should have to publicly justify their CRs if they are to be accommodated. There is such a public justification requirement, in his view, because HCPs have a *prima facie* fiduciary duty to promote patients' healthcare interests. The justificatory onus, therefore, rightly falls on HCPs because they are asking to be excused from their duty.

Public reason enters Card's theoretical picture when he sets out his reasonability standard for assessing whether HCPs' justifications are adequate. HCPs must justify their CRs in public reason because this provides the common normative language required to make a reasonability assessment. HCPs are not required to win the debate over what healthcare practices or CRs should be allowed but to show that they have *pro tanto* public reasons in favor of their moral position.[9]

To be reasonable, on Card's system, the beliefs grounding CRs must be sincerely held, consonant with medical science, and nondiscriminatory (e.g., not racist, sexist, etc.). He sets several additional criteria for reasonableness, but the central one is that CRs must not be made in circumstances where they would entail breaching one's duty of care to a patient. So CRs cannot be made in emergency circumstances when there is nobody else to treat the patient and HCPs making a CR must refer the patient to an HCP who can treat them.

Practically, objectors must justify their CR in front of a tribunal that judges whether the reasons grounding a CR meet the reasonability standard. Where a provider's justification is accepted as reasonable, this ruling is added to a public record so that patients and employers can plan accordingly.

McConnell

I agree with Card that individuals face a public justification requirement where they have to justify their CR using public reason,[10] but Card and I assess reasonability in different ways.[11] On my variation of the reasonability standard, the HCP must convince the tribunal that her objection is consistent with "minimally decent healthcare."[12]

> Objections grounded in beliefs that are incompatible with objectively good health care, including discriminatory, disrespectful, empirically false, and normatively unreasonable beliefs, cannot be accommodated because they are incompatible with being a minimally decent HCP.[13]

I have argued that this is an improvement on Card's system because, by explicitly building a standard of good healthcare into the assessment of reasonability, we get a more parsimonious system that more thoroughly prevents CRs at odds with good healthcare. My reasonability standard is more parsimonious because minimally decent healthcare requires HCPs' beliefs to align with clinical evidence and be nondiscriminatory, so I can dispense with extra criteria for ruling out CRs based on discriminatory or empirically false beliefs. My reasonability standard better protects good healthcare because it can rule out CRs based on unusual normative positions that would be accommodated on Card's view, for example, CRs to providing antibiotics based on the belief that bacteria have moral status[14] and CRs to providing pain medication on the belief that "pain is the working out of life's karma."[15]

Reichlin

Reichlin also puts forward a reasonableness standard to assess which CRs (or in his terms "CO") should be accommodated.

> 1) CO should not apply in emergencies; 2) laws should restrict acceptable cases; 3) a doctor's CO should be publicly known; 4) healthcare authorities should guarantee the presence of an adequate ratio of non-objectors; 5) CO should be based on deeply held moral beliefs; 6) such beliefs should not be intolerant, violent, or discriminatory; 7) they should not be based on disreputable scientific or philosophical views; and 8) they can be shown to be a part of a conception of good medicine for which plausible reasons can be given.[16]

These eight criteria more or less combine the criteria for reasonableness that Card and I put forward (so I think there is significant redundancy among them). Reichlin's major point of difference is that he denies that individual HCPs face a public justification requirement. In his view, "reasonableness requires a fair distribution of burdens between the parties"[17]; therefore, when HCPs' and patients' interests clash, it would unfairly burden HCPs to have to publicly justify their CR. Instead, "the medical practices that can be the object of CO should be defined by public policies, after public hearings and discussion of the ethical issues they raise."[18] These decisions should be guided by his eight conditions for reasonableness. All legal healthcare practices not designated as possible objects of CR must be provided when requested and medically indicated.

Scott

Scott's view is like Reichlin's in that he develops a system for specifying which types of CR should be accommodated. What is distinctive about Scott's approach is that he emphasizes an aspect of liberal democratic methodology that the other accounts do not consider.

> An account of healthcare's normative structure ought to be supportable by principles that are universally shared (or very nearly so) and *consistent with the evolutionary path* our healthcare system has followed [or] *traceable to considered convictions that form part of our shared history.*[19]

In other words, any new healthcare norms, such as which CRs, if any, should be accommodated, must be consistent with the body of healthcare norms "within professional codes of ethics, enshrined in law, or the product of universal consensus among competent practitioners and public stakeholders."[20] Scott thinks there are "obvious democratic reasons" for this constraint, by which he presumably means that we should respect the outcomes of prior democratic processes.

Scott accepts that there will be a range of different views on how to manage CR that would be consistent with liberal democratic methodology, but he puts forward his preferred, two-stage view that he borrows from Ronald Dworkin. In the first stage, "fitness," we assess whether a policy governing CR fits with the relevant healthcare norms.

> The determination of fitness necessarily takes place at multiple levels of specificity, as each jurisdiction includes norms internal to democratic citizenship, healthcare generally, specific healthcare professions, and certain specialties or sub-specialties within those professions… A rule that departs too much or too often from these sources is not an attempt to describe medical obligations as they are currently understood, but an attempt to describe an essentially new practice or impose one's own conception of the good.[21]

Sometimes the assessment of fitness will settle the matter because a putative policy will be incompatible with existing norms, so it should be rejected, or it will cohere much better with existing norms than any competing policies, so it should be adopted. Where mutually exclusive possibilities survive the fitness assessment, we move to the second stage, "justification," where we "consult our own moral and political

ideals" to judge which normative direction is best. Scott suggests that an adjudicating body will undertake both the fitness and justification steps when setting policy on which the types of CR can be accommodated.

Compared to the other three theorists, Scott is more hesitant to say exactly which CRs are reasonable because, on his view, the kinds of CR that should and should not be accommodated depend on what the local healthcare norms happen to be.[22] Although Scott cannot provide a complete, context-independent set of CR policies, he can rule out those kinds of CR that are incompatible with *any* plausible set of healthcare norms, for example, CRs to providing pain medication on the grounds that pain is the working out of karma.

So much for the initial exposition. In what follows, I describe and critically assess the main contours of the four views, beginning with their methodological differences.

Methodological differences

The first major point of difference is methodological. Only Scott uses a thoroughgoing liberal democratic methodology for saying how CRs should be managed. Card, myself, and (I suspect) Reichlin all use hybrid methodologies; we combine public reason justifications for CR (provided either by individuals or committees) with traditional bioethical arguments for context-independent moral truths.

Card, for example, argues (and I agree) that individual HCPs face a public justification requirement because the nature of the doctor-patient relationship just makes it true that "practitioners possess professional duties to their patients, duties that patients do not possess toward providers."[23] Furthermore, both Card and I appeal to objective standards to limit which justifications of CR are acceptable. Card requires the beliefs grounding CRs to be consonant with the objective facts of medical science, while I rule out CRs grounded in beliefs that are inconsistent with the objective standard of minimally decent healthcare.[24] In each case, Card and I argue that these aspects of our theories are true or, at least, better than competing possibilities; we do not suggest that a liberal democratic process would inevitably arrive at the same conclusions (though below I argue that they could).

Reichlin's reliance on context-independent truths is implicit. He limits the kinds of CR that can be accommodated to those that are grounded in reasonable conceptions of good healthcare, but the way he applies this standard suggests that he has an objective standard of good healthcare in mind. For example, Reichlin thinks that his system will rule out CRs to providing expensive treatments to elderly people based on a "fair innings" view of distributive justice, since such views are not compatible with good healthcare. However, it is not clear why this view of distributive justice does not count as a reasonable conception of good healthcare. Reichlin seems to need a narrower standard of good healthcare to draw the conclusion he wants. In any case, if we took Scott's more throughgoing liberal democratic methodology, we could not rule out these CRs *a priori* because, in some, perhaps unusual contexts, policies accommodating such CRs would fit with existing healthcare norms.

The significance of this methodological difference between the four views depends on the relative value one places on liberal democratic process and context-independent truth. Specifying the best way to balance these values goes beyond what I can achieve here; however, if one values liberal democratic process more highly, then Scott's view will be preferable because the others recommend systems that might clash with democratically chosen healthcare norms.

The hybrid approaches will be more attractive if one thinks that democratic processes are important but should be guided more strictly by truth. For example, one might think that there are strong arguments for an egalitarian distribution of resources in healthcare and therefore that "fair innings" policies denying healthcare to the elderly are wrong no matter the normative context of the day. On Scott's view, fair innings policies could be considered reasonable by society if their healthcare norms happened to evolve in ways that were amenable to such policies. In other words, Scott's pure liberal democratic methodology involves a degree of relativism (within the bounds set by reasonableness) and this might be more relativism than many are comfortable with.

We can also note that it is not necessarily anti-democratic to impose truth on liberal democratic processes. To promote what one takes to be true is not necessarily motivated by an undemocratic desire to foist one's conclusions on others. One might simply hope that democratic institutions will consider one's arguments in decisionmaking. If bioethicists were *not* to argue for substantive positions on context-independent grounds, then those substantive decisions would be left to authorities, and bioethicists would be left to merely argue over whether those authorities' decisions were consistent with liberal democratic process.

One significant alignment

A major point of alignment between the four accounts is that, in different ways and to different extents, they all require the beliefs grounding CRs be consistent with professional standards if they are to be accommodated. On Card's view, one of the criteria for reasonableness is that the grounds of a CR must be consonant with medical science. The threshold that Card sets for reasonability when HCPs justify their CRs is, therefore, higher than the general threshold for reasonability outside that context; typical citizens can be considered reasonable despite understanding little medical science. However, Card's reasonableness standard does not explicitly require HCPs' CRs to align with norms of good healthcare in other ways. This leads Reichlin and I to adopt reasonableness standards whereby CRs can only be accommodated if the beliefs grounding them are consistent with a reasonable conception of good healthcare or minimally decent healthcare, respectively. This more thoroughly restricts CRs to those that are grounded in conceptions of good healthcare in the ways described above.[25]

Scott arrives at a similar conclusion from a different direction by arguing that "local" healthcare norms should be preferred when assessing the fitness of policies governing which kinds of CR to accommodate.

> We generally have good reason to suppose that those on the inside of a profession have knowledge and experience that warrants some degree of deference regarding services that are beyond public understanding or regular public concern. As such, insiders' voices are weighty in the fitness analysis without being dispositive or insurmountable.[26]

Scott suggests that, if the profession deviates too far from what the wider public believes, the public can override professional norms through the law-making process, for example, by making a kind of CR legal or illegal. However, in the absence of such laws, the adjudicatory bodies set which CRs are to be accommodated by assessing which policies on CR fit with the established professional norms.

So, all four theorists agree that CRs should only be accommodated when they are grounded in either a reasonable or minimally decent conception of good healthcare. It is illustrative to contrast the four views with the significantly more restrictive system put forward by Ronit Stahl and Ezekiel Emanuel[27] that also limits CRs with professional standards. According to Stahl and Emanuel, CRs should only be accommodated when they are refusals to provide professionally disputed interventions. However, they conceive of professional disputes quite narrowly. They judge that CRs to abortion and physician-assisted dying, for example, are not acceptable because, although they remain socially and politically contentious, their medical value and suitability are not professionally disputed. The public reason approaches to CR are more permissive because, even the CRs of small minorities can be accommodated if grounded in a reasonable or minimally decent conception of good healthcare. These four systems do, however, remain more restrictive of CRs than some would like because they rule out all CRs based on reasonable moral beliefs that are incompatible with reasonable or minimally decent standards of good healthcare.

A fifth, reasonability simpliciter view

One might object that the requirement for CRs to be consistent with a conception of good healthcare is inconsistent with liberal democracy. Bryan Pilkington alludes to this objection when he claims that

restrictions on CRs should not rule out physicians acting on reasonable accounts of the moral life.[28] Pilkington is arguing against those who think that there should be no room for CR, but the requirement that CRs align with good healthcare faces the same objection because it restricts CRs grounded in reasonable comprehensive doctrines that prioritize values, such as religious expression or personal freedom, over good healthcare.

This generates an argument for a more permissive way of managing CRs using public reason. This fifth approach builds on the claim that, as citizens, HCPs and patients occupy equivalent normative positions (a claim that at least Reichlin appears to accept). If HCPs and patients occupy equivalent normative positions, then it would be unfair to limit the protection of HCPs' moral integrity to cases where their comprehensive doctrines align with reasonable conceptions of good healthcare. The alternative would be to allow CRs that are grounded in reasonable comprehensive doctrines *simpliciter*. This would protect the moral integrity of all reasonable citizens equally, whether they happen to be HCPs or not. Reasonable CRs that clash with standards of good healthcare include those that prioritize values such as religious expression or a libertarian conception of freedom over public health. Discriminatory CRs would still be ruled out since they do not respect others as free and equal. Furthermore, HCPs making CRs would still have to refer patients so that they could receive treatment and could not refuse to treat in an emergency; otherwise, the patient would face an excessive burden.

We can arrive at a similar view through Scott's methodology if we conceive of the fitness assessment in a wider way. Why should the norms we adopt have to fit with existing healthcare norms? Instead, we could adopt policies that fit with the norms governing the interaction of citizens more generally, for example, regarding freedom of expression. Scott preferences local healthcare norms on the grounds that "those on the inside of a profession have knowledge and experience that warrants some degree of deference regarding services that are beyond public understanding or regular public concern."[29] But is the issue of managing CRs a professional issue or is it a society-wide issue about how public goods and individual freedoms should be balanced? If it is a wider issue, then there is less reason to prioritize the expertise of HCPs and local healthcare norms; placing profession-specific limitations on reasonability appears *ad hoc*.

Since this fifth approach puts HCPs and patients on equivalent normative footing, individual HCPs would not face a public justification requirement. In this sense, this position aligns with Reichlin's in seeing such a requirement as placing an unfair burden on HCPs. Furthermore, because such a wide range of CRs could possibly be grounded in a reasonable comprehensive doctrine, it would be difficult for policymakers to specify any kinds of treatment where CR would be unacceptable. So, practically, this approach would rely on the honesty of HCPs to only make genuine, nondiscriminatory CRs.

As it happens, this reasonability *simpliciter* system for managing CR closely resembles that put forward by Daniel Sulmasy, and a public reason approach might be seen to offer a new line of argumentative support for his view.[30] Sulmasy uses a Lockian conception of tolerance to argue that physicians should be allowed to act on their consciences as long as it would not be "destructive to society." The resulting limitations on CR are very similar to those generated by reasonableness. In short, discriminatory CRs are not allowed, and patients still must be treated in emergency situations where a CR would seriously harm them. However, outside of those restrictions, Sulmasy believes that physicians should have wide-discretionary space to practice medicine as they see fit. In his view, this promotes the independence of the medical profession by protecting it from excessive interference by the state.

The grounds of CRs should align with good healthcare

Despite having gone to the trouble of articulating the reasonability *simpliciter* approach to CR, I think it has serious flaws. I continue to believe that CRs should only be accommodated if they align with a reasonable or minimally decent conception of good healthcare and that HCPs rightly face greater restrictions on their professional actions than citizens do in daily life.

Before arguing against the reasonability simpliciter approach, I will respond to the above objection that requiring the grounds of CRs to align with standards of good healthcare undermines HCPs' status as free and equal citizens. In my view, this misunderstands what it is to be a free and equal citizen. Outside work

hours, the HCP is in the equivalent normative position to other citizens and free to act on their (reasonable) conscience.[31] In their professional role, however, the HCP's conduct is governed by role-specific duties that place extra normative restrictions on behavior. One might think that in a truly free and equal society, nobody would be bound by role-specific duties. However, it is difficult to see how their could be robust roles without role-specific duties, and a role-less world would be unappealing. My opponent might concede that HCPs have various role-specific duties but that those duties can be overridden when their moral integrity is at stake (as long as they have a reasonable comprehensive doctrine).

There are a number of reasons for thinking that these role-specific duties cannot be overridden, and that the HCP must prioritize the interests of the patient over their own interests. Here, I will outline Carolyn McLeod's argument based on the HCP's fiduciary duty to the patient.[32] HCPs are in fiduciary relationships with patients because they act on behalf of the patient, exercising discretionary authority to pursue the patient's healthcare interests. The patient must trust the HCP to pursue their interests because they do not share the HCP's specialist knowledge and are therefore vulnerable to being exploited. "Loyalty is the appropriate moral response when others are vulnerable to discretionary authority that one possesses over them."[33] This duty to prioritize patients' healthcare insterests falls out of the structure of the fiduciary relationship; therefore, HCPs have such a duty to their patients whether or not they consent to it.

Now, as free and equal citizens, people can choose whether they want to become HCPs and enter into fiduciary relationships with patients. However, once they enter those fiduciary relationships, then they take on the associated obligations. So, I think limiting CR with standards of good healthcare is perfectly compatible with considering HCPs free and equal citizens.[34]

In addition to undermining HCPs' fiduciary duty to patients, the reasonability *simpliciter* approach has two other problems. If we accommodate CRs based on *any* reasonable comprehensive doctrine, this will undermine good healthcare and the independence of the profession by allowing CRs that are incompatible with all reasonable conceptions of good healthcare. This argument against the reasonability *simpliciter* approach is essentially the same one that I level against Sulmasy's view based on Lockian tolerance.[35]

The reasonability *simpliciter* approach would accommodate CRs grounded in unusual but not unreasonable comprehensive doctrines, for example, CRs to providing antibiotics for mild infections based on the belief that bacteria have non-negligible moral status or CRs to providing pain medication on the grounds that pain is the working out of karma. We would also be unable to rule out CRs to treating people of the opposite sex (unless the grounds for the CR were sexist), or CRs to treating rashes, headaches, depression, and anxiety, on the grounds that the patient and society would be better if they were more stoic. Arguably, it would also enable the conscientious provision of treatments that patients request but that go against good healthcare. For example, an HCP with a libertarian comprehensive doctrine might conscientiously provide medical services (including enhancements) as if it were a retail service.

Without placing professional limitations on HCPs, good healthcare would become just whatever each individual HCP wanted it to be (as long as their comprehensive doctrine was reasonable). As a result, the healthcare professions would dilute and potentially lose their distinctive normative outlook.[36] So, far from protect the independence of the healthcare professions, as Sulmasy hopes, this wide-discretionary space would undermine professional independence, leaving the healthcare professions less able to lend a distinctive perspective to public debate and thereby worsen the health of the liberal democratic state. Sulmasy is right that the independence of the professions is threatened by excessive state interference, but it is also threatened by granting individual professionals the power to practice however they want. The solution is for the profession to be able to protect its norms from both state interference and wayward practitioners. Therefore, if we want to protect an independent medical profession, we should require HCPs to uphold the normative standards of good healthcare while they are in the clinic.

There is some variation in how the public reason views require the grounds of CRs to align with good healthcare. Card's system is the most permissive because it only requires the grounds of CRs to be consonant with medical science; the other three views require CRs to align with a wider set of healthcare norms, such as those governing distributive justice. Therefore, these three views are preferable in that they will better protect good healthcare and the independence of the healthcare professions. For those who strongly value the liberal democratic process over context-independent truths, Scott's system will be best. Those who are uncomfortable with the relativism inherent in Scott's view should prefer the systems put forward by Reichlin and myself.

Do individuals face a public justification requirement?

The final difference between the public reason approaches to CR that I will address is the burden they place on individual HCPs. Card and I believe that individual HCPs must publicly justify the grounds for their CR if it is to be accommodated, while Reichlin and Scott disagree. According to Card and myself, the public justification requirement is entailed by a moral truth—HCPs have a *prima facie* fiduciary duty to their patients. Scott, in contrast, thinks it is wrongheaded to require HCPs to justify their CRs in public reason because public reason is designed for making policy decisions.[37] For his part, Reichlin concludes that a public justification requirement would be unreasonably burdensome on HCPs. I will respond to Scott and Reichlin in turn.

Even if Scott is right that public reasons should only be used to guide policy decisions, a policy requiring HCPs to publicly justify their CRs could emerge from that process. Such a policy could be selected by Scott's two-stage system if it was sufficiently amenable to local healthcare norms. A norm that requires public justification of CRs might well be compatible with some contemporary normative contexts, given that HCPs are often required to justify their decisions to patients, their families, colleagues, and employers.

Moreover, Scott is clear that his two-stage view is only one of several possible systems for managing CR that would be compatible with liberal democratic methodology. It seems *prima facie* possible that Card's system or my own could be justified in public reason. That is to say, a majority of reasonable people might agree that the vulnerability of patients entails that HCPs have a fiduciary duty to patients and therefore should face a public justification requirement for their CRs to be accommodated. Such a requirement is not, therefore, obviously or necessarily incompatible with liberal democratic process.

In any case, Scott appears ambivalent in his opposition to individuals using public reason to justify their actions. At one point, he suggests that individual HCPs might justify their CRs *to themselves* in public reason before acting on them: "A provider using this methodology as a guide for their own conduct might simply (albeit in good faith) consult their sense of what their profession's consensus (or lack thereof) *is*."[38] That is, if one judges that one's CR is compatible with existing healthcare norms, then one can conclude that a policy accommodating such CRs would be reasonable and thus the CR is justified.

Scott's issue with individual's using public reason does not, therefore, seem to be based on the view that it is inappropriate for individuals to use public reason in decisionmaking. Indeed, one might think that a good citizen should be interested in whether their public actions are acceptable to people with different comprehensive doctrines, and justifying one's actions to oneself in public reason is a way of assessing this. Presumably, then, Scott's issue with the public justification requirement is not that individual HCPs would use public reason but that they should be required to do so publicly to have their CRs accommodated.

If this is correct, then his view is similar to Reichlin's—a public justification requirement is overly burdensome on HCPs. Reichlin does not explain exactly why he thinks this, but he doesn't recognize the normative imbalance between HCPs and patients that Card and I appeal to. I have already outlined the reasons for thinking that HCPs have a fiduciary duty to patients and that HCPs cannot avoid their duties by appealing to their status as free and equal citizens, so I will not repeat them here.

Furthermore, Reichlin and Scott's rejection of a public justification requirement creates some tension in their views. They are both committed to standards of good healthcare, which is why they require the grounds of CRs to align with good healthcare if they are to be accommodated. Presumably, they see fiduciary duty as an important part of good healthcare, yet they do not explain why HCPs can breach their fiduciary duty without providing a justification. If one thinks that HCPs' behavior in the clinic should be guided by standards of good healthcare, then that brings fiduciary duty with it and suggests that a public justification requirement should apply; that is, a view like Card's or mine is best.

However, there are ways of maintaining the apparently inconsistent view that CRs can only be accommodated if their grounds align with good healthcare, yet individual HCPs do not need to justify their CRs. This is because there are pragmatic reasons for giving up on enforcing the public justification requirement. A system that assesses each individual's CR will require more resources than a centralized system that decides which kinds of interventions can be the basis of a CR. Furthermore, a centralized

system ensures greater consistency across the healthcare system, whereas different tribunals could come to different conclusions about similar CRs (though, presumably, this could be mitigated by coordination between tribunals). There is, however, a significant downside of making this concession—without enforcing a public justification requirement, HCPs can easily make CRs of the accepted kinds while acting for unacceptable reasons (e.g., selfish or discriminatory reasons). Requiring public justifications makes it harder for insincere objectors who must, at least, go to the trouble of rehearsing the *pro tanto* public reasons for the CR in front of a tribunal. In my view, it is worth investing the resources to assess individuals' grounds for CR, this helps reinforce the importance of fiduciary duty and better protects both the standards of good healthcare and the independence of the healthcare professions.[39] Therefore, despite the practical challenges of a public justification requirement, I still think that it is an advantage of both Card's view and my own that we insist on it. Although I have shown how a public justification requirement could emerge from Scott's view, there is no guarantee that it would.

In conclusion, then, I suggest that my own view has advantages over the other public reason approaches to CR. I combine the advantages of a public justification requirement with a relatively stringent requirement that the grounds of CRs align with minimally decent healthcare. This accommodates CRs from minimally decent HCPs while protecting good healthcare, the independence of the healthcare professions, and the fiduciary relationship.

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Notes

1. Card RF. Conscientious objection, emergency contraception, and public policy. *The Journal of Medicine and Philosophy* 2011;**36**(1):53–68; Card RF. Reasonability and conscientious objection in medicine: A reply to Marsh and an elaboration of the reason-giving requirement. *Bioethics* 2014;**28**(6):320–26; Card RF. The inevitability of assessing reasons in debates about conscientious objection in medicine. *Cambridge Quarterly of Healthcare Ethics* 2017;**26**(1):82–96; Card RF. *A New Theory of Conscientious Objection in Medicine*. New York: Routledge; 2020.
2. Reichlin M. The reasonableness standard for conscientious objection in healthcare. *Journal of Bioethical Inquiry* 2022;**19**(2):255–64.
3. Scott DC. Democratizing conscientious refusal in healthcare. *HEC Forum* 2022:1–31. doi: 10.1007/s10730-022-09502-x.
4. McConnell D. Conscientious objection in healthcare: How much discretionary space best supports good medicine? *Bioethics* 2019;**33**(1):154–61; McConnell D. Conscientious objection in health care: Pinning down the reasonability view. *The Journal of Medicine and Philosophy* 2021;**46**(1):37–57.
5. Quong J. Public reason. In: *The Stanford Encyclopedia of Philosophy*. Stanford, California: The Metaphysics Research Lab, Philosophy Department, Stanford University; 2013.
6. Rawls J. *Political Liberalism Expanded Edition*. New York: Columbia University Press; 2005:36.
7. See note 6, Rawls 2005, at 225.
8. See note 1.
9. See note 1, Card 2020, at 155.
10. McConnell D, Card RF. Public reason in justifications of conscientious objection in health care. *Bioethics* 2019;**33**(5):625–32.
11. See note 4, McConnell 2021.
12. A concept I borrow from Alida Liberman. See Liberman A. Wrongness, responsibility, and conscientious refusals in health care. *Bioethics* 2017;**31**(7):495–504.
13. See note 4, McConnell 2021, at 53.
14. Giubilini A. Objection to conscience: An argument against conscience exemptions in healthcare. *Bioethics* 2017;**31**(5):400–8.

15. Wicclair MR. *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge: Cambridge University Press; 2011:93.
16. See note 2, Reichlin 2022, at 260–61.
17. See note 2, Reichlin 2022, at 261.
18. See note 2, Reichlin 2022, at 261.
19. See note 3, Scott 2022, at 9, my emphasis.
20. See note 3, Scott 2022, at 9.
21. See note 3, Scott 2022, at 12.
22. He recognizes that this appears to leave him open to a charge of relativism but replies that he is not relativist about the fundamentals of liberal democratic process, for example, treating reasonable others as free and equal, and offering and accepting reasonable terms of cooperation.
23. See note 1, Card 2020, at 34.
24. See note 4, McConnell 2021.
25. Card and I are clear that our systems can accommodate CRs that are grounded in religious conceptions of good healthcare if the HCP can show that the CR-grounding aspect of their religious conception of good healthcare is supported by *pro tanto* public reasons. See note 10.
26. See note 3, Scott 2022, at 14.
27. Stahl RY, Emanuel EJ. Physicians, not conscripts — Conscientious objection in health care. *New England Journal of Medicine* 2017;**376**(14):1380–5.
28. Pilkington BC. Conscience dissenters and disagreement: Professions are only as good as their practitioners. *HEC Forum* 2021;**33**(3):233–45. Similarly, Mark Cherry asks "why physicians and other health care workers would cease to be individuals with rights and interests simply because they decide to enter the healthcare profession" page 4 in Cherry M. Conscience clauses, the refusal to treat, and civil disobedience—Practicing medicine as a Christian in a hostile secular moral space. *Christian Bioethics* 2012;**18**(1):1–14. Although these public reason approaches to CR limit rather than eliminate HCPs' rights and interests, Cherry might well ask why HCPs rights and interests should be limited simply because they have decided to enter the profession.
29. See note 3, Scott 2022, at 14.
30. Sulmasy DP. Tolerance, professional judgment, and the discretionary space of the physician. *Cambridge Quarterly of Healthcare Ethics* 2017;**26**(1):18–31.
31. I gloss over the question of whether the off-duty doctor has a *professional* obligation to help in a medical emergency or if this situation is governed by other duties.
32. McLeod C. *Conscience in Reproductive Healthcare*. Oxford: Oxford University Press; 2020.
33. See note 32, McLeod 2020, at 124.
34. This argument leads McLeod to come down more strongly against CR then the public reason approaches described here. This raises the question of whether we should even allow CRs that align with reasonable conceptions of good healthcare. I cannot do justice to this topic here but if the healthcare professions benefit from a degree of moral pluralism in their ranks, then we might accept some risk to the fiduciary relationship to protect the overall health of the profession.
35. See note 4, McConnell 2019.
36. For a more detailed argument of this kind, see Kolers A. Am I my profession's keeper? *Bioethics* 2014;**28**(1):1–7.
37. Wicclair also questions whether the ideal of public reason applies to HCPs making CRs. See note 27, Wicclair MR. Preventing conscientious objection in medicine from running amok: A defense of reasonable accommodation." *Theoretical Medicine and Bioethics* 2019;**40**(6):539–64, at 558.
38. See note 3, Scott 2022, at 14.
39. See note 1, Card 2020, for a much more detailed treatment of these issues.

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