Protection of Conscience Project
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The importance of orientation

Review of *Health Care Providers' Consciences and Patients' Needs: The Quest for Balance*

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In June, 2011, as it was becoming clear that the United States was moving towards a major confrontation on freedom of conscience in health care, the Brookings Institution in Washington, D.C. convened a symposium of theologians, philosophers, legal scholars, health practitioners and advocates representing different perspectives on the subject. The participants spoke "off-the-record," probably generating a more free-ranging and thoughtful discussion than would have been possible had individuals thought that their remarks would be cast in stone and then thrown back at them in subsequent dialogue.

The proceedings informed independent research by William A. Galston, a Senior Fellow at Brookings, and Melissa Rogers, director of Wake Forest University Divinity School's Center for Religion and Public Affairs. Drawing from the symposium when appropriate, but citing or quoting participants only with their express permission, Galston and Rogers produced a report that reflects their own views on freedom of conscience in health care.[1]

Health Care Providers' Consciences and Patients' Needs: The Quest for Balance appeared in February, 2012, in the midst of an uproar about freedom of conscience and religion that continues to wrack the United States. Thus the cool, careful, measured and even-handed approach taken by the authors is admirable and particularly welcome.

The Introduction

The five page introduction opens with brief description of a conflict between a hospital and nurses objecting to abortion, which was settled in favour of the nurses after they sued. It then outlines the broader and more complex controversy generated by the Department of Health and Human Services (HHS) plan to force employers to provide insurance for sterilization and contraceptive and embryocidal drugs and devices, even if they find such services morally objectionable. The authors note that both disputes expose "longstanding tensions between claims of conscience and laws of broad scope and application" that are "well-known to experts but less so to public officials and most citizens."

The references to conscientious objection both by those closely associated to a specific procedure in their workplace and by those more distantly associated to contentious services through health insurance suggest an underlying relationship that cannot be ignored. Later in the report, the authors recognize what is implied in this juxtaposition: that federal health care reforms and the

HHS birth control mandate are “changing the landscape.” They also warn that “a failure to value the right of conscience in one context surely threatens that right in other contexts.” These observations support the concern that the outcome of the HHS confrontation, which is occurring at an institutional level, is likely to have an impact on individual freedom of conscience.

Part One: Conscience in General

Conscience in Religion and Philosophy

After touching upon the most widely accepted attributes of conscience, the authors offer an overview of the perspectives of Catholic and Protestant Christianity and Judaism. While they assert that “the idea of conscience does not fit comfortably into a Jewish framework,” the discussion of nuances and differences within the Jewish tradition expose potentially fruitful points for reflection and dialogue.

The authors prudently decline to discuss conscience within the context of non-western and non-religious faiths because of problems of interpretation, but the absence of an Islamic perspective is regrettable. While Islam has historically been considered a “non-western” faith, University of Virginia Professor Abdulaziz Sachedina, an advisor to the Protection of Conscience Project, notes that monotheistic Islam “shares its spiritual moral and cultural genome with Judaism and Christianity.”[2]

Roman and Greek Stoicism and the philosophy of Immanuel Kant are acknowledged to offer well-developed explanations of conscience. The authors also draw attention to manifestations of “secular conscience” in professional life, where unique moral responsibilities associated with the practice of medicine or journalism may conflict with the expectations of regulatory authorities or the law. Very little is said about conscience in this context. The authors do not refer to the fact that professional ethical norms of western medicine have generally developed within and not in opposition to Christian teaching. This point is important because some commentators insist that “the ethics of the profession” ought to supersede the moral convictions of a professional, while others suggest that one person can have two consciences, one “personal” and the other “professional.” These claims - and their rejection - are features of the polemical landscape the authors are attempting to describe.

Discussion of philosophical and religious understandings of conscience is necessarily limited because of complexity of the subject and the brevity of the report. It is followed by a succinct but highly informative discussion of conscience within American legal and constitutional history.

Conscience in U.S. Constitutional History

The authors explain that early constitutional debates began with discussion of freedom of conscience, but ultimately produced a First Amendment that refers only to freedom of religion, an historical fact that can have significant consequences in constitutional law. They point out that the constitutional guarantee of free exercise of *religion* implies that, at some point, a court may be forced to distinguish between what counts as “religion” and what does not: that a secular authority may have to define what it means to be “religious.” Although the report does not mention it, this is one of the most contentious issues in the HHS conflict.

Having considered the origins and language of the First Amendment, the authors introduce the reader to interpretive problems created by the Declaration of Independence, which has both theological and rationalist foundations and is associated explicitly with a Creator "In practice," they ask, "how can the law distinguish between this religion of reason and other comprehensive views. . . that claim an exclusively rational foundation for binding duties?"

And does the Declaration's reference to a creator imply that religions that do not recognize a creator are to be denied constitutional protection?

The authors demonstrate that the approach of the U.S. Supreme Court has evolved from a literalist reading of the First Amendment to a more expansive interpretation that has brought "explicitly secular beliefs" within its scope, if they are functionally equivalent to religious beliefs. The later rulings, they say, "gave force to an understanding of conscience that the framers of the First Amendment did not contemplate, or rejected outright." With this assertion one encounters another layer of complexity the authors wisely avoid: whether the constitution should be interpreted dynamically (frequently associated with 'judicial activism'), or according to the original intent of its authors, or its original meaning.

In the final section of Part One, the authors shift imperceptibly from a discussion of the meaning of conscience in philosophy, religion and law to problems associated with the exercise of conscience. They begin with a consideration of two theoretical problems that have great practical significance. First: if conscientious objection is permitted to democratically enacted laws and to the policy decisions of democratic authorities, "conscience . . .becomes indistinguishable from political decision-making." Second: if legal obligations can be avoided simply by making a claim that purports to be based upon a religious belief, "everyone could mouth the language of recognized exemptions, and laws would become unenforceable."

One response to this is to insist upon obedience to all generally applicable laws, denying any right to conscientious objection or to accommodation of religious or conscientious convictions.

This was the approach taken by the U.S. Supreme Court in 1990, though the ruling was somewhat qualified by the Court's decision to permit legislatures to enact statutory exemptions and accommodations. The authors explain that this extremely unpopular ruling resulted in the passage of the *Religious Freedom Restoration Act* (RFRA) three years later. The RFRA forces the government to prove that a law that imposes a substantial burden on the free exercise of religion serves some compelling state interest, and serves that interest in "the least intrusive and restrictive" way.

While the authors do not carry the discussion further, it is obvious that what counts as a "substantial burden" or a "compelling interest" are likely to be disputed, as will the question as to whether there are less intrusive or restrictive means available to accomplish the government's purpose.

Part Two: Conscience in the Context of Health Care

General Considerations

The discussion of conscience in health care begins by considering the nature of the health care profession, as exemplified by physicians. The first point is that the physician-patient relationship is voluntary; physicians are not obliged to accept a patient. Having accepted a patient, physicians also accept the responsibility to act always in the patient's interest, but this does not imply that they must always do what the patient wants. Further: physicians may specialize or limit their practices, providing some services and not others. Health care institutions have the same freedom. The authors observe that refusal to provide some services for moral or religious reasons occurs within a system in which it is customary to refuse to provide services for other reasons.

Against this, they note that state licensing of health care professionals "creates ethical as well as legal responsibilities." Here they introduce the familiar argument that licensing - which is done to protect patients - gives the licensed professionals a monopoly on the provision of a wide range of services. They argue that this does not mean that every physician and hospital must offer all of the services, but assert that there is "some obligation" on the health care profession as a whole to ensure "that needed services are provided to patients in a timely and competent manner."

"Conscientious objectors," say the authors, "often request exemptions from broad policy and legal requirements" which may involve costs to the state if it permits the exemptions. The claim that such requests are frequent is open to question.

Citing abortion as the principal example (assisted suicide would be another), the authors recognize that there are fundamental disagreements about whether or not a service that may be provided by health care professionals is actually health care or medical treatment. They do not, however, suggest how such disagreement can be resolved.

Current Law on Conscience in the Health Care Context

Turning to existing protection of conscience laws, the authors review federal legislation (the Church amendment and its subsequent revisions), cite Guttmacher Institute statistics on the number of states that have such statutes, and discuss the use of non-discrimination and accommodation statutes like the *Religious Freedom Restoration Act* and Title VII of the 1964 *Civil Rights Act*. They also outline the short and turbulent history of HHS conscience regulations under Presidents Bush and Obama.

The report draws attention to two important legal considerations. First: accommodation of religious belief under Title VII is expected to the point of "undue hardship," but the Supreme Court has defined "undue hardship" to an employer as anything beyond a minimal cost or burden. Second: government accommodation of religious belief may violate the First Amendment if the accommodation imposes significant burdens on others. Absolute protection of a religious institution or practice that disadvantages those outside the denomination could be challenged under the First Amendment as a kind of "establishment of religion."

What law and policy should be:
Areas of agreement and disagreement

Almost one third of the report considers agreement and disagreement about answers to six questions. Only points of particular interest with respect to each are noted here.

- Who should be permitted to refuse to provide, pay for or assist in the provision of certain health care services?

  There is disagreement about whether the exercise of freedom of conscience should be determined by profession (nurse, pharmacist, physician), by relationship with a patient, or upon the degree of involvement with the procedure in question. The authors found general support for the proposition that an employee should not be able to claim a conscientiously based exemption to a substantial portion of the duties of a position. While the principle is satisfactory, it remains necessary to determine what constitutes a "substantial portion" of the duties in a given case, and the authors acknowledge that this may be challenging. They do not raise the problem of conflicts arising from a change of duties imposed by reorganization by the employer, which was the situation in the nurses' case they cited in the Introduction.

- Which institutions, if any, should be permitted to refuse to provide, pay for or assist in the provision of certain health care services?

  In addition to noting the disagreement about whether or not a health care institution can have a "conscience," and whether or not protection of conscience measures should apply exclusively to health care institutions operated by religious groups, the authors draw attention to a suggestion from Catholic theologian Daniel C. Maguire. He argues that religious health care institutions served a purpose when they were the only health care providers accessible to the poor and did not receive government funds, but are now redundant, especially since they are so heavily dependent on public funding. He apparently advocates the transformation of religious to non-religious institutions, thus eliminating conflicts of conscience for denominational health care facilities by eliminating the facilities. This has already begun to occur in Arizona and Saskatchewan.[3] In Switzerland the transformation has been completed.[4]

- What are appropriate grounds for conscientious refusals?

  In most cases, conscientious objection is to a procedure or service that is deemed intrinsically immoral by the objector. However, objections sometimes arise because of circumstances related to the patient. For example: a physician who accepts the use of contraception within marriage may object to providing it for unmarried persons. The authors emphasize the view that this is a form of unjust discrimination based on characteristics of a patient. While they acknowledge a dissenting opinion that the issue is not always clear, they fail to explain that the moral evaluation of an act may be affected by the circumstances (i.e, sexual intercourse may be viewed as morally licit or illicit, depending upon the marital status of the parties). This is an unfortunate and damaging omission.

  Much more significant is their assertion that to require an objection to have a factual basis may be inconsistent with a ruling by the U.S. Supreme Court that religious beliefs need not be "acceptable, logical, consistent or comprehensible." Thus, the authors imply that a religious objection to a drug on the grounds that it may cause the death of an embryo may not be overruled even if it is shown that the drug does not do so. The implication that religious and moral beliefs may be irrational by their very nature and that the law must support irrationality is a caricature of religious beliefs and the position of those who support freedom of conscience in health care.

- What should conscientious objectors be able to refuse to do? Should providers be able to raise an objection to any health care service, or just some of them?

  The report recognizes that there is no consensus about which services or procedures may give rise to conscientious objection, though some argue for singling out those that result in death. However, the authors report widespread agreement that an objector does not have the right to actively prevent a patient from accessing services by, for example, tearing up a prescription.

- What conditions must be present for conscientious objection to be honoured?

  The response to this question produced a lengthy discussion. According to the authors, a minority hold that objections should always be respected, while the majority believe that some kind of balance must be struck between conscience and access, especially in medical emergencies. They note disputes about whether access is a matter of convenience or necessity, how to evaluate inconvenience, and the problem of access in communities where the only health care workers refuse to provide a contentious service. There are significant differences of opinion about whether or not "public" rules should govern "public" services, and the whether or not "public" funds should be denied to those who do not adhere to "public" policy. Holly Fernandez Lynch's suggestion of an "institutional compromise" is given a hearing.

- What sort of rules should govern disclosures of conscientious objections, notifications regarding alternative providers, and referrals to other providers?

  According to the authors, there is general agreement that an objecting health care worker or institution is obliged to notify patients in advance, the form and content of such notice being a matter some debate. It is also agreed that objectors must not harass or evangelize patients. The authors describe the issue of referral as "deeply divisive," but neglect to identify the problem of complicity as central to the division.

Conclusion: Suggestions for Policymakers

The authors avoid detailed recommendations, but close with eleven suggestions, most of which can accepted as they stand, or subject to some qualifications.

The first is purely pragmatic: "Don't spend much time looking for bright line solutions." Their advice is based upon the conviction that the differences among the parties to the disputes are foundational:"there is no way of resolving clashes over first principles." A proposal that completely satisfies one party will, they warn, antagonize their opponents and cause lawsuits and legislative and regulatory battles, effectively thwarting any resolution. Understood as a warning against simplistic expectations (rather than as an invitation to utilitarian ethical horse-trading) the suggestion is reasonable.

Five more (paraphrased here) can be endorsed:

- Conscientious objection may be acceptable, but actively obstructing a service never is.
- Conscientious objectors must not harass or evangelize patients.
- Defending the right to conscientious objection need not imply support for the merits of the objection.
- Recognize that moral diversity in health care is a public good.
- Whenever possible, try to respect competing principles and divergent interests.

The last of this group is closely related to the warning against "bright line solutions" with which the authors begin. Taken together, they reflect an awareness that, in some cases, policymakers may be confronted with problems of irreducible complexity.

A seventh suggestion may be accepted, subject to an important qualification:

- Accept the presumption of non-discrimination and equal treatment of individuals as a basis for public policy.

  Project comment: This recommendation refers to a refusal to provide a service for some reason connected with the status of the patient. The goal is to ensure that objections are not to the person (as in the case of racial discrimination) but to conduct (such as extra-marital sex). The authors suggest that the burden of proof should lie on an objector to demonstrate that refusal based on lifestyle (such as marital status) is not discriminatory. This does not preclude the possibility of objections in such circumstances, but puts the objector on notice that he must explain how providing the service would make him morally complicit in the conduct enabled by it. The approach is acceptable only if it is agreed that an objector is entitled to take into account not only the intrinsic nature of the service, but the circumstances that, *from his perspective*, are relevant to assessing its morality. Otherwise, as Holly Fernandez Lynch demonstrates, the presumption may become a *de facto* strategy for the suppression dissenting moral views.[5]

A recommendation concerning disclosure can be accepted in part.

- Early and full disclosure of services not provided is expected, with complete and prompt disclosure of available alternatives. The authors admit that there is no consensus that referral is required, but assert that an objector may be forced to notify the patient of available alternatives.

  Project comment: It is common ground that conflicts should be avoided - especially in circumstances of elevated tension - and that they often can be avoided by timely notification of patients, erring on the side of sooner rather than later. However, it is unreasonable to expect physicians or institutions to anticipate, in advance, every conceivable request that might be made by patients.

  The interests of patients and physicians are best served by open and continuing communication, not inflexible notification protocols. On the part of the physician, this involves a special responsibility to be attentive to the spoken and unspoken language of the patient, and to respond in a caring and truthful manner. Notice should be given when it would be apparent to a reasonable and prudent physician that a conflict is likely to arise. In some cases - but not all - this may be when a patient is accepted. The same holds true for notification of patients when a physician's views change significantly.

  With respect to the provision of information, one must distinguish explicitly between information needed by a patient in order to make an informed decision about treatment, and the name and address of someone willing to provide the contentious service. Providing the first kind of information does not, in the Project's experience, generate "moral distress" among objecting physicians. However, they often refuse to provide information about where to obtain a procedure to which they object because they consider that to be a form of unacceptable complicity in an immoral act.

Precisely the same view is sometimes reflected in the policies of regulatory authorities. If a physician in British Columbia were to give her the address of someone willing to provide a *sex selective* abortion, he would risk prosecution for professional misconduct by the College of Physicians and Surgeons because the College believes that sex selective abortion is "socially repugnant" and that "it is unethical for physicians to facilitate such action."[6] The American Medical Association (AMA) prohibits physician "participation" in executions, which is defined to include "rendering technical *advice*."[7] The AMA also prohibits physician participation in torture, which includes"providing or withholding . . .knowledge to facilitate the practice of torture."[8]

It is true that an undetermined number of objectors might be willing to give some kind of general information to patients: to consult a telephone directory or a medical regulator's website. But the preceding examples demonstrate that it is disingenuous to suggest that objectors should be compelled to provide contact information for service providers on the ground that communicating knowledge or information to a patient is always a morally neutral act.

The three remaining recommendations (abbreviated below) are problematic.

- "Whenever possible, move debate from principles to specifics. . .[A] fact-rich description of what is at stake. . . will make some proposed resolutions seem fairer and more reasonable than others."

  Project comment: The authors are aware that they cannot bridge the deep differences of principle that divide the parties involved in the conflict about freedom of conscience in health care, so their desire to shift discussion away from irreconcilable differences is understandable. However, the example they offer actually illustrates the problem with the recommendation. They observe that nurses directly involved in an abortion are not doing the same kind of work as those who "perform routine administrative duties tangentially related to the procedure." True enough, but this alone is insufficient to determine which group can be said to participate in the procedure and might have a claim to conscientious objection, unless there is already agreement about what counts morally as "participation." The recommendation presumes an agreement about moral principles that the authors admit may not exist. This was precisely the situation in the case of the objecting nurses offered in the introduction to the paper. One does not avoid disputed principles by adopting solutions that rely upon them.

- "Distinguish between what matters and what doesn't. . . Reasonable people will see the difference."

  Project comment: One might hope that reasonable people can agree, but the authors themselves admit earlier in the paper that this is not always the case, and that this can give rise to differences that are "worthy of respect." Agreement about "what matters and what doesn't" is impossible in the absence of a common moral standard. Some agreed-upon standard is also implied in the concepts of "substantial or undue burden." The recommendation effectively invites policy makers to establish their own views the norm.

- Take the logic of institutions seriously.

  Project comment: Contrary to what might be expected, this is not a reference to the moral integrity of health care institutions. The authors' meaning would be better expressed as, 'Take employment and professional responsibilities seriously.' That is: it is not reasonable to accept a job or professional role "while claiming a broad exemption" from the responsibilities associated with the position. Unfortunately, it is difficult to distinguish this recommendation from assertions that, for example, physicians who object contraception should not practise clinical medicine. They put forward here the argument by Holly Fernandez Lynch that "the profession as a whole . . .has an obligation to do everything it can to meet the needs of patients; not so with individual practitioners." Collective cooperation can provide a means to provide contentious services without involving objectors, and this is likely an effective pragmatic method of accommodating both patients and physicians. But that the "needs of patients" include morally contentious services is an assumption that reflects contested anthropological and moral judgements. Where assisted suicide is legal, does it thereby become a need that "the profession" is obligated to meet?

The orientation of the report

It is hardly surprising that the authors focus on what others (not the authors) have called "the problem of conscientious objection" in health care. They are responding to developments in the United States, where some health care workers conscientiously object to and refuse to provide some services. This has disturbed those who want such services or believe that they should be provided, and the difference of opinion has caused serious legal and political problems.

However, even if the controversy *begins* with conscientious objection (and that is disputed) it does not follow that the problem *is* conscientious objection. One could as readily describe the problem as one of intolerance for moral or religious beliefs, or of social irresponsibility: that too many American health care workers are unwilling to do what they believe to be gravely wrong. The authors' decision to discuss conscientious objection in health care rather than intolerance of moral beliefs suggests an orientation that is suspicious of the convictions of those who challenge the dominant professional and cultural ethos.

This orientation is also evident in the authors' terminology. They acknowledge that there is a significant difference of opinion about whether or not controversial services like abortion are, in fact, legitimate forms of health care. It is obvious that to decide one way or the other on this point will determine the course of subsequent discussion, but the authors nonetheless use the terms "health care" or "health services" in relation to contentious services, and (as illustrated above) presume that such services all address patient "needs." This introduces a subtle but continuous bias in their presentation.

But the most striking example of bias is found in their formulation of key questions, beginning with the first: "Who should be permitted to refuse to provide, pay for or assist in the provision of certain health care services?"

The question includes no reference to the reason for the refusal. Especially when combined with the loaded reference to "health care services," this could easily create an impression of unreasonableness that inclines the reader against refusal. However, one can assume, from the context, that the authors mean refusals for reasons of conscience, whether the reasons are moral or religious. Thus, we can rephrase the question to incorporate the element of conscientious objection and attenuate the description of the services:

> "Who should be permitted to refuse to provide, pay for or assist in the provision of lawful services that he believes to be wrong?"

The authors' remaining questions can be similarly rephrased:

> "Which institutions, if any, should be permitted to refuse to provide, pay for or assist in the provision of lawful services that they believe to be wrong?"
>
> "What are appropriate grounds for refusing to do what one believes to be wrong?"
>
> "What should people be able to refuse to do? Should they be able to refuse to provide any lawful service they believe to be wrong, or just some of them?"
>
> "Upon what conditions may one honour a refusal to provide a lawful service because it is believed to be wrong?"
>
> "What sort of rules should govern disclosures of what lawful services one will refuse to do because they are believed to be wrong, notifications regarding other people who would be willing to provide such services, and referrals to others who would provide such services?"

It becomes clear that the premise underlying all of these questions is that people and institutions ought to do what they believe to be wrong, and that refusal to do what one believes to be wrong requires special justification. This is exactly the opposite of what one would expect. Most people believe that we should *not* do what we believe to be wrong, and that *refusing* to do what we believe to be wrong is the norm. It is wrongdoing that needs special justification or excuse, not conscientious objection.

Small wonder that the authors find it difficult to make the necessary distinction between the exercise of conscientious judgement and the morality of particular procedures.

> The conscience question is not whether particular health services are legitimate, but whether an individual or institutional provider has the liberty to abstain from providing them due to religious or moral objections. Nonetheless, it often proves difficult to divorce these matters.

It is probably impossible to divorce the dispute about the legitimacy of services and the legitimacy of the exercise of freedom of conscience if one begins with the conclusion that contested services *are* health services (thus, legitimate) and that participation in perceived wrongdoing is the norm, at least for health care workers.

This inversion gives the entire report an orientation subtly but decidedly adverse to the exercise of freedom of conscience in health care, as illustrated in the three problematic recommendations. The orientation can be illustrated by asking the authors' questions from the opposite perspective:

> "Who should be compelled to provide, pay for or assist in the provision of lawful services that he believes to be wrong?"
>
> "Which institutions, if any, should be compelled to provide, pay for or assist in the provision of lawful services that they believe to be wrong?"
>
> "What are appropriate grounds for compelling someone to do what he believes to be wrong?"
>
> "What kind of wrongdoing should people forced to do? Should they be forced to provide any lawful service they believe to be wrong, or just some of them?"

If we ask the wrong question, we get the wrong answer. But how is one to determine the right question when basic premises are in dispute? Had the authors seen the problem as one of intolerance of moral beliefs, or if they held that the contentious services are *not* health care, the problem of orientation would remain. One cannot eliminate bias by substituting one form of it for another.

Certainly, one could explicitly acknowledge one's bias so that readers can take it into account. However, given the tone and carefully balanced approach taken by the authors, it is very doubtful that they even recognized the orientation given to their work by the context they adopted: "conscience" within the context of "health care."

This may reflect the influence of Holly Fernandez Lynch, whose book is cited and quoted at several points in the report. In her view, the central issue is securing patient access to services when those who control access to them are uncooperative.[9] Within the context of a book about patient access to services, she offers arguments about the importance of freedom of conscience that are accessible and that many people will find convincing. Her book is a very useful, but it is not a book about freedom of conscience.[10] The same can be said of *Health Care Providers' Consciences and Patients' Needs: The Quest for Balance*.

Changing the context

What is missing from the report is a consideration of the nature of freedom of conscience and its relationship to the human person and society: the goods that it serves, the benefits it provides and the harms it wards off or ameliorates. It is no more appropriate to discuss the regulation of conscientious objection in health care without reference to freedom of conscience than it would be to discuss the regulation of speech in politics without reference to freedom of expression.

Adopting this wider perspective would make it somewhat easier to distinguish between disagreement about the morality of procedures or services and disagreement about the exercise of freedom of conscience. It would also help to identify broader and potentially useful principles that may otherwise be overlooked.

A principle that has been overlooked, both in the report and in the Brookings' symposium last year, is that there is a significant difference between preventing someone from doing something he believes to be right and forcing him to do something he believes to be wrong. The distinction has recently been emphasized by the Protection of Conscience Project. It permits an approach that is divorced from moral disagreements about abortion and other contentious services, but squarely within religious and secular traditions that emphasize respect for the human person and the importance of rational democratic pluralism.[11]

Closing comment

The authors have sought to build on what they believe to be common ground among those who believe that protecting freedom of conscience and securing access to health care are both important goals that can be harmonized. They hope to encourage good will on all sides so that balanced approaches can be found that will accommodate competing claims to the greatest extent possible.

Health Care Providers' Consciences and Patients' Needs: The Quest for Balance makes a good start in that direction. It is a significant contribution to the current debate in the United States about freedom of conscience in healthcare, notwithstanding the reservations and criticism offered above.

The authors have indicated that the report is subject to revision. One hopes that a future revision will incorporate the broader context and change of orientation suggested here.

Notes

1. Galston, William A. and Rogers, Melissa, *Health Care Providers' Consciences and Patients' Needs: The Quest for Balance.* Brookings Institution, Governance Studies, 23 February, 2012. (http://www.brookings.edu/~/media/Files/rc/papers/2012/0223_health_care_galston_rogers/0223_health_care_galston_rogers.pdf) Accessed 2012-03-27

2. Sachedina, Abdulaziz, *Islamic Biodmedical Ethis: Principles and Applications*. Oxford University Press, Oxford, 2009, p. 3.

3. In 2010 in Phoenix, Arizona, Bishop Thomas J. Olmsted declared that St. Joseph's Hospital and Medical Center was no longer a Catholic hospital because it had provided an abortion because it believed the mother's life was in danger and it could not be certain that the health care provided in the facility was consistent with Catholic moral teaching. Long-Garcia J.D, "Bishop Olmsted revokes Phoenix hospital's status as Catholic facility." *Catholic News Service*, 21 December, 2010. (http://www.catholicnews.com/data/stories/cns/1005213.htm) Accessed 2012-03-27

In 2006, St. Elizabeth's Hospital in Humboldt, Saskatchewan, operated by the Saskatchewan Catholic Health Association, decided to stop doing contraceptive sterilizations. Public protests resulted, and a woman denied a tubal ligation filed a human rights complaint. In June, 2007, St. Elizabeth's was transferred to the Saskatoon Health Region and re-named the Humboldt District Hospital. Three months later, the Saskatchewan Catholic Health Corporation agreed to pay almost $8,000.00 to the complainant in the human rights action to settle the case. *CBC News*, 13 September, 2007, "Woman given settlement after being denied tubal ligation."(http://www.cbc.ca/news/canada/saskatchewan/story/2007/09/13/tubal-ligation.html) Accessed 2012-03-27)

4. In 2002, the Swiss embassy in Canada advised the Project that "there are no more hospitals existing in Switzerland that are based on a catholic foundation; all of them are now managed by secular directors." The situation was confirmed by the General Secretary of the Swiss Bishops' Conference. Letter to the Protection of Conscience Project from the Embassy of Switzerland, 2 October, 2002; Letter to the Protection of Conscience Project from the General Secretary of the Swiss Bishops' Conference, 6 January, 2003. (http://www.consciencelaws.org/archive/documents/2002-10-02 swiss hospitals.pdf)

5. See the review of Fernandez-Lynch, Holly, *Conflicts of Conscience in Health Care: An Institutional Compromise.* Cambridge, Mass.: The MIT Press, 2008. (hereinafter "*Conflicts*.") "No 'invidious' discrimination" at http://www.consciencelaws.org/issues-ethical/ethical090.html#No_invidious_discrimination

6. College of Physicians and Surgeons of British Columbia, *Fetal Sex Determination*. (https://www.cpsbc.ca/files/u1/Fetal-Sex-Determination.pdf)Accessed 2012-03-27. See also Society of Obstetricians and Gynaecologists of Canada Policy Statement No. 198*: Statement on Gender Selection* (November, 2007) (http://www.sogc.org/guidelines/documents/guiJOGC198PS0711.pdf) Accessed 2012-03-27; SOGC Policy Statement No. 192: *Fetal Sex Determination and Disclosure* (April, 2007) (http://www.sogc.org/guidelines/documents/192E-PS-April2007.pdf) Accessed 2012-03-27.

7. American Medical Association Policy E-2.06: Capital Punishment (http://www.ama-assn.org/ama1/pub/upload/mm/369/e206capitalpunish.pdf) Accessed 2012-03-26)

8. American Medical Association *Code of Medical Ethics- Opinion E.2.067: Torture*. (http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2067.page)Accessed 2012-03-6)

9. *Conflicts*, p. 24, 99, 224

10. See the Project review *of Conflicts of Conscience in Health Care: An Institutional Compromise* at http://www.consciencelaws.org/issues-ethical/ethical090.html

11. Murphy, Sean, *Notes toward an understanding of freedom of conscience.* Protection of Conscience Project (March, 2012) (http://www.consciencelaws.org/issues-ethical/ethical134.html)