Morally Objectionable Options
Informed Consent and Physician Integrity

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Recent and forthcoming medical technologies and practices (e.g., in vitro fertilization, somatic cell nuclear transfer, oocyte-assisted reprogramming, the creation of chimeras and “savior siblings”) are likely to multiply the occasions for a type of dilemma that physicians have long faced: What are doctors to do when a treatment that they believe to be seriously morally wrong is available and indicated for one of their patients?

In 2001, the U.S. Conference of Catholic Bishops promulgated a fourth edition of the Ethical and Religious Directives for Catholic Health Care Services. The bishops offered this document “to reaffirm the ethical standards of behavior in health care that flow from the Church’s teaching about the dignity of the human person,” and “to provide authoritative guidance on certain moral issues that face Catholic health care today.” The bishops explain that the moral teachings contained in this document “flow principally from the natural law,” and the normative nature of the directives is asserted or implied throughout the document. The practical import of this normativity is clearly expressed in two directives: “Catholic health care services must adopt these Directives as policy [and] require adherence to them within the institution as a condition for medical privileges and employment” (n. 5), and “employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives” (n. 9).
The moral reasoning reflected in some of the seventy-two directives is at the heart of the type of moral dilemma mentioned above. Directive 27, which lays out some of the obligations that health care professionals have to their patients, explains: “Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all” (emphasis added). It would not be unreasonable for a doctor to read this directive as a prohibition against advising her patient that a morally “illegitimate” treatment is available. Other physicians may favor a more literal read of this directive, pointing out that it does not forbid the mentioning of morally illegitimate options, but only requires the mentioning of all morally legitimate ones. Surely, however, many would find such an exculpatory read of this directive to clash with the spirit of the document as a whole and, more narrowly, with its concern about complicity and scandal.2

Directive 36 is also a candidate for a less literal gloss yielding a more restrictive norm. Here one reads that “it is not permissible . . . 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” (emphasis added). Interpreting this directive rather narrowly and literally, one may reason that to inform a patient that an abortion is medically indicated is not to recommend that an abortion be done. One may even reason that to inform a patient that abortion is a medically indicated option and then to refer that patient to an abortion provider is still not to recommend this option. Such a reading of this directive, however, is likely to seem a rather legalistic rationalization to some physicians, especially given the real-world context that the directive is designed to govern. For a doctor “only” to inform the patient of the availability and relative merits, medically speaking, of the morally questionable option is surely, in more than a few instances, tantamount to recommending that option. At the very least, one can easily imagine a reasonable, conscientious, and not excessively scrupulous doctor failing to see in many cases any morally relevant difference between informing and recommending.

So what are doctors committed to following these directives to do in such circumstances? One suggestion would be for these doctors to consider carefully the directives and follow them as they see fit. Those doctors who take the narrower reading will inform their patients of all available treatment options—including those that are “morally illegitimate”—and will, in their judgment, remain within the parameters of the directives. Others may apply a broader reading of these norms and choose to refrain from informing their patients of certain legal and available, but morally objectionable, options. In both cases, it may be argued, the doctors will have done their best to use the directives to navigate morally complex waters.

2 Directive 45, for example, reads, “Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.”
Many, however, reject any solution that would allow a doctor to refrain, on moral grounds, from informing patients about any medically legitimate treatment option. It is typically argued that withholding information of this kind violates patient autonomy. As ethicist Julian Savulescu explains, “For patients to give valid consent to treatment, they must be informed of relevant alternatives and their risks and benefits (in a reasonable, complete, and unbiased way).”3 The American Medical Association’s *Code of Medical Ethics* is clear on this question, maintaining that, “the patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.”4 In the judgment of the AMA, violating this principle “represents unethical conduct and may justify disciplinary action such as censure, suspension, or expulsion from medical society membership.”5 The AMA’s Council on Ethical and Judicial Affairs put the matter rather bluntly: “Withholding medical information from patients without their knowledge or consent is ethically unacceptable.”6 The American College of Physicians concurs with the AMA, maintaining that while a physician is “not obligated to recommend, perform, or prescribe” certain treatments that “may conflict with the physician’s personal moral standards,” the physician nevertheless “has a duty to inform the patient about care options and alternatives, or refer the patient for such information, so that the patient’s rights are not constrained.”7 And in a recent letter to U.S. senators, the president of the American College of Obstetricians and Gynecologists asserted that “doctors who morally object to abortion should be required to refer patients to other physicians who will provide the appropriate care,” and urged the senators to craft legislation to that effect.8

It seems then that physicians who take the less narrow reading of the Bishops’ directives may sometimes find themselves obligated to act in ways that conflict with the norms of their profession. A recent study published in the *New England Journal of Medicine* indicates that most physicians believe that in such circumstances they are “obligated to present all options” and even “to refer the patient to another clini-

4 American Medical Association (AMA), *Code of Medical Ethics*, opinion E-10.01, “Fundamental Elements of the Patient-Physician Relationship” (updated 1993). The code is available online at http://www.ama-assn.org/apps/pf_new/pf_online?category=CEJA&ass n=AMA&f_n=mSearch&s_t=&st_p=&nth=1&.
5 AMA Code, E-1.01, “Terminology” (updated 1996).
cian who does not object to the requested procedure.”9 Yet the study’s authors are careful to note that

the number of physicians who disagreed with or were undecided about these majority opinions was not trivial. If physicians’ ideas translate into their practices, then 14 percent of patients—more than 40 million Americans—may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29 percent of patients—or nearly 100 million Americans—may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments.10

The concerns of this significant minority of physicians are not unreasonable. To inform a patient of the availability of a procedure that one finds morally unacceptable, and then to refer the patient to another provider for this treatment may make the physician complicit in a morally wrong act. The AMA is itself wary of unacceptable moral entanglements and directs physicians to avoid any participation in the morally questionable practices of sex selection for gender preference, capital punishment, and patient suicide.11 Still, refusing to inform patients of all medically reasonable options may itself be morally wrong, as noted above. So we have arrived at the crucial question: Is there any way for these morally conflicted physicians to fulfill at once both the duties expressed in the directives and their professional obligations? In what follows I will consider the various options available to these physicians, beginning with those that are unacceptable and ending with a recommendation.

Nonsolutions

One option for physicians facing the dilemma described above has already been mentioned: simply provide patients with complete information on all available options without any mention of one’s moral objections. This approach enables the doctor to steer clear of providing any morally objectionable treatment, yet allows the patient to consider the full range of treatment options. The physician would perhaps follow

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10 Ibid., 597.

11 The AMA *Code of Medical Ethics* states: “In the case of single women or women who are part of a homosexual couple, it is not unethical to provide artificial insemination as a reproductive option. Sex selection of sperm for the purposes of avoiding a sex-linked inheritable disease is appropriate. However, physicians should not participate in sex selection of sperm for reasons of gender preference. Physicians should encourage a prospective parent or parents to consider the value of both sexes” (E-2.05, “Artificial Insemination by Anonymous Donor,” updated 2004). Also, “a physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution” (E-2.06, “Capital Punishment,” updated 2000). Consider, too, the following: “However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer” (E-2.211, “Physician-Assisted Suicide,” updated 1996).
a formula along the lines of, “One course of action is X, and here is why. . . . I don’t provide that treatment, but if you would like I will refer you to a physician who does.” The rationale for this approach is simple: since a patient cannot give fully informed consent to a particular treatment if purposefully kept ignorant of an alternative, anything less than full disclosure of all options undermines informed consent and, consequently, patient autonomy. As was explained by a U.S. Court of Appeals more than three decades ago, “true consent to what happens to one’s self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available.”

Savulescu believes that physicians opting out of informing their patients of an available treatment option and refusing to refer their patients to other physicians for such treatment will lead to a situation in which

the service that patients receive depends on the values of the treating doctor. Not only does this imply that patients must shop among doctors to receive the service to which they are entitled, introducing inefficiency and wasting resources, it also means some patients, less informed of their entitlements, will fail to receive a service they should have received.

And, he asserts, “this inequality is unjustifiable.” Savulescu endorses the full-disclosure option for the conflicted physician, explaining that, “Any would-be conscientious objector must ensure that patients know about and receive care that they are entitled to from another professional in a timely manner that does not compromise their access to care.”

Savulescu argues that physicians who refuse to follow this full-disclosure-and-referral approach should leave (or not enter) the profession, since such a refusal is incompatible with being a doctor. He explains,

People have to take on certain commitments in order to become a doctor. They are part of being a doctor. Someone not prepared on religious grounds to do internal examinations of women should not become a gynecologist. To be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system. If we do not allow moral values or self interest to corrupt the delivery of the

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14 Ibid., 295, 296.

15 Savulescu claims that “if people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.” Ibid., 294. The American College of Obstetricians and Gynecologists seems to agree. In a recently published opinion, that body’s Committee on Ethics asserted, “By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice.” “The Limits of Conscientious Refusal in Reproductive Medicine,” *ACOG Committee Opinion* 385 (November 2007): 3, www.acog.org/from_home/publications/ethics/co385.pdf.
just and legal delivery of health services, we should not let other values, such as religious values, corrupt them either.16

He offers two hypotheticals to support his position:

Imagine an intensive care doctor refusing to treat people over the age of 70 because he believes such patients have had a fair innings. This is a plausible moral view, but it would be inappropriate for him to conscientiously object to delivering such services if society has deemed patients are entitled to treatment. Or imagine in an epidemic of bird flu or other infectious disease that a specialist decided she valued her own life more than her duty to treat her patients. Such a set of values would be incompatible with being a doctor. If there is any justification for compromising the care of patients, it must be a grave risk to a doctor’s physical welfare. But if self-interest and self-preservation are not generally deemed sufficient grounds for conscientious objection, how can religious or other values be?17

Savulescu’s argument, though, ignores a significant disanalogy between the hypotheticals he offers and, say, a pro-life doctor seeking to avoid complicity in abortion. In each of Savulescu’s scenarios, the doctor refuses to aid a patient who presumably could be aided without purposefully harming anyone else. Yet in the case of the pro-life doctor, there is a refusal to aid one individual (the mother) by purposely harming another (the fetus). The doctor’s refusal is not grounded in self-interest but in the interest of the individual who would be purposefully killed as a means to aid his patient. Perhaps a more apt analogy to this case would be one in which an intensive care doctor refuses to kill one patient in order to help another. It seems clear to refuse to do that, and to refuse to refer it to be done by someone else is hardly incompatible with being a doctor. Yet this is just what the pro-life doctor sees himself doing.18 To reply that abortion is legal while killing one patient in order to help another is not is to beg the question by assuming that doctors are morally required to cooperate in all legal treatments. But is it the case that doctors must commit to cooperating (at least through referral) in all current (and future!) legal treatment options regardless of their moral convictions? What if the law allowed intentionally killing those over seventy in the treatment of one’s patients? Surely Savulescu’s plausible “compatibility with being a doctor” standard would at times seem to guide one in the direction of refusal rather than referral.

There are other problems with the full-disclosure-and-referral approach. One is that it does not convincingly resolve the question of complicity. A physician who

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16 Savulescu, “Conscientious Objection in Medicine,” 295.

17 Ibid.

18 In counseling that the “referral to another provider need not be conceptualized as a repudiation or compromise of one’s own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees,” the American College of Obstetricians and Gynecologists Committee on Ethics fails to appreciate the gravity of the dilemma faced by those physicians who believe that innocent lives are purposefully ended by the procedures in question (ACOG, “Limits of Conscientious Refusal,” 2).
chooses to inform a patient about the appropriateness and availability of a treatment option (morally questionable or not) cannot be said to be merely tangentially involved in that patient's choice of that option. It is just because physicians are so important to their patients' choices of treatment options that Savulescu and others demand that they inform their patients of the full range of options. Indeed, the complaint that withholding information about a morally questionable treatment undermines patient autonomy is not plausible if the physician's choice in this matter does not make a difference in what the patient ultimately decides to do. This complaint seems to rest on the assumption that in the absence of the physician's guidance regarding the objectionable treatment option, the patient might not (or may be less likely to) choose it. Yet if this assumption is true, and it is reasonable to believe that it is true in at least in some cases, then the informing-and-referring physician is indeed at least sometimes significantly involved in the patients' choices of the objectionable option. In this way, then, many reasonable physicians may find the full-disclosure solution to be no solution at all, since the case for it confirms, rather than assuages, their concerns about complicity in morally objectionable treatments.

Another problem with the full-disclosure approach is that following it may compromise the physician's integrity. Each of our moral commitments is important to us but, as Lynne McFall notes, for many people certain commitments are more than simply important; they are identity-conferring. What this means is that some of these commitments are so much a part of one's sense of self that to choose to violate them is to change one's identity. McFall explains,

> We all have things we think we would never do under any imaginable circumstances... some part of ourselves beyond which we will not retreat, some weakness however prevalent in others that we will not tolerate in ourselves. And if we do that thing, betray that weakness, we are not the persons we thought; there is nothing left that we may even in spite refer to as I. I think it is in this sense that some commitments must be unconditional: they are conditions of continuing as ourselves.¹⁹

Consistent with this, and closer to the matter at hand, Luke Gormally writes,

> A commitment to assist someone to kill for a particular type of reason (the mother doesn’t want the unborn child, or the adult children no longer want to care for their senile mother) contributes to shaping a disposition to kill for that kind of reason. And that kind of disposition can become second nature; that’s what character is—second nature.²⁰

Although the number and content of these commitments will surely vary from person to person, one would expect, or at the very least hope, that first among any physician's identity-conferring commitments is one which prohibits purposefully harming innocent human beings. If one assumes this commitment among physicians, then it is not difficult to imagine many physicians finding a legal and medically acceptable

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treatment such as abortion to be morally objectionable. To ask these physicians to perform an abortion, or to refer their patient to someone who will, is to ask them to set aside a most important moral commitment and to participate in what they consider to be the killing of an innocent human being. James Childress and Mark Siegler, following Robert Veatch, find fault in this demand for a “moral abdication” on the part of the physician, pointing out that it “offers autonomy to the patient...at the expense of the professional’s moral agency and integrity.”

There are those who find this subordination of physician integrity and identity to patient autonomy to be appropriate, since the dictates of the physician’s conscience are personal, subjective, and often religiously grounded. As R. Alta Charo cautions, “Conscience is a tricky business. Some interpret its personal beacon as the guide to universal truth. But the assumption that one’s own conscience is the conscience of the world is fraught with dangers.” Savulsecu seems to have similar worries, explaining that

Values are important parts of our lives. But values and conscience have different roles in public and private life. They should influence discussion on what kind of health system to deliver. But they should not influence the care an individual doctor offers to his or her patient. The door to “value-driven medicine” is a door to a Pandora’s box of idiosyncratic, bigoted, discriminatory medicine. Public servants must act in the public interest, not their own.

Charo agrees with Savulsecu’s charge that the kind of conscientious objectors being considered here are acting in their own interest. Of these objectors she writes, “And of course, the professionals involved seek to protect only themselves from the consequences of their actions—not their patients.” But while this charge may be true in some cases, it is no doubt false and unwarranted in others. Many of the conscientious objectors of the kind we are discussing are acting in the name of what they consider to be the innocent victims of objectionable treatments.

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23 R. Alta Charo, “The Celestial Fire of Conscience—Refusing to Deliver Medical Care,” New England Journal of Medicine 352.24: 2473. We will consider in a moment whether this full-information model does not actually undermine autonomy.


26 One may note again the statements by the Association of Pro-Life Physicians and the American Association of ProLife Obstetricians and Gynecologists, cited in fn. 21.
Furthermore, while the concerns of Charo and Savulescu are not unreasonable (recall Savulescu's hypothetical case of a doctor refusing to treat patients over the age of seventy), the most plausible cases of conscientious objection are not grounded in a set of peculiar and idiosyncratic values and commitments. Consider, again, doctors who believe abortion to be morally objectionable because it purposefully destroys an innocent human being. The conflict these physicians experience is grounded in large part in their valuing (for whatever reason) of innocent human life and in their commitment never purposefully to harm it. Yet these two elements are not only constitutive of the personal integrity of some conscientious-objector physicians, they are also endorsed by the medical profession itself. The American Medical Association offers its “Declaration of Professional Responsibility” as “an oath by which 21st century physicians can publicly uphold and celebrate the ideals that, throughout history, have inspired individuals to enter medicine and the conduct that, by giving life to those ideals, has earned society’s trust in the healing profession.”27 Addressed to physicians, the declaration urges the profession to “reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind.” After declaring that “humanity is our patient,” the first principle listed in the oath commits the physician to “respect human life and the dignity of every individual.”28

Elsewhere, in its “Principles of Medical Ethics,” the AMA declares that “a physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”29 Given these statements, one might expect a physician who believes that unborn human beings are members of humankind, and are the subjects of rights, to find support for his conscientious objection in his profession’s own standards. While these same standards will generate conflict for the conscientious objector who would refrain from even informing the patient about certain treatments,30 it is enough for now to note as a reply to the concerns of Charo and Savulescu that the moral pull toward refraining from complicity in certain objectionable treatments is not necessarily generated by a set of eccentric and private moral commitments but by those seemingly promoted by the medical profession itself. Finally, it is worth noting that both Savulescu and the AMA accept the notion that incompatibility with one’s role as a physician is a good reason to refrain from

29 AMA Code, E-0.00, “Principles of Medical Ethics,” principle I (2001).
30 Recall the AMA policy mentioned previously: “Withholding medical information from patients without their knowledge or consent is ethically unacceptable.” AMA Council on Ethical and Judicial Affairs, “Withholding Information,” 5.
certain practices.\textsuperscript{31} Given these shared basic principles and values, one ought to be careful not to caricature the conscientious objector as an unreasonable zealot blindly following an idiosyncratic set of values.

The foregoing is not meant to imply that withholding information from patients does not undermine their autonomy. That may be the case, for the reasons mentioned. More will be said about this below. Yet it may also be the case that a physician’s choice to withhold his genuine moral concerns about a treatment out of fear that sharing these concerns would have an undue influence on the patient’s choice may itself constitute an objectionable form of paternalism that undermines patient autonomy in its own way. In those cases where understanding their physician’s moral objections would influence a patient’s choice of treatment, to choose not to share those objections with the patient is, in effect, to withhold information that the patient would have found valuable (and perhaps decisive) in making decisions about care. While it may be true that in some cases the physician’s presentation of moral concerns will be condemnatory and overly zealous, and that the patient may be inappropriately influenced by such rhetoric and by the stature of the physician, it is also true that to follow a policy of withholding all moral objections in the face of these concerns is to treat the patient as a child, unable to weigh and otherwise independently evaluate the concerns expressed by the physician. In this way, then, following the simple inform-and-refer policy outlined above could result in patients’ \textit{considered} decisions being preempted by the choice of physicians who remain silent about their own moral concerns. One may well wonder how such a policy would enhance informed consent and promote patient autonomy.

Some argue that patient autonomy and at least some integrity-preserving choices by conscientious-objector physicians need not conflict, and that the value-free inform-and-refer approach to the kind of dilemma we have been discussing simply abandons the patient to data and options. Physicians Timothy Quill and Howard Brody believe that this approach “reflects a limited conceptualization of autonomy. Under this model, it is thought that an independent choice is best made with no external influence, even when one’s competence to make the choice is limited.”\textsuperscript{32} The concern that patients would be unduly influenced by a physician informing them of the existence and nature of the physician’s moral reservations concerning some procedure is, in these authors’ judgment, “patronizing” to patients. Indeed, in the judgment of these two physicians, “enhancing patient autonomy requires that the physician engage in open dialogue, inform patients about therapeutic possibilities and their odds for success, explore both the patient’s values and their own, and then

\textsuperscript{31} See Savulescu, “Conscientious Objection in Medicine,” 295. Note, too, the AMA’s position on euthanasia and physician-assisted suicide as “fundamentally incompatible with the physician’s role as healer.” AMA Code, E-2.21, “Euthanasia” (1996), and E-2.211 “Physician-Assisted Suicide” (1996).

offer recommendations that consider both sets of values and experiences.”

Now it may be the case that some patients are simply unprepared to consider the moral dimensions of certain treatment options. Yet such cases hardly recommend the silencing of physicians; because some patients will not or cannot engage the physician on these important questions, or at least understand the physician’s concerns, must the physician remain silent in all cases? Again, such a policy seems excessively restrictive and, as explained above, might deprive many patients of the opportunity to make a more fully informed choice about their treatment.

**Recommendations**

Are there any approaches that fully respect both patient autonomy and physician integrity? Is there an approach that would not deprive patients of information about all available treatment options and, at the same time, would not compromise the integrity of physicians who are committed to avoiding complicity with certain morally objectionable treatments?

One approach that may satisfy the interests of each party is for the physician to offer notice to patients that information on certain listed, legal options will be not offered. Such was the approach of a Canadian physician who posted the following notice in his waiting room:

On February 8, 2000, I established a policy in this Medical Centre to stop prescribing birth control pills to unmarried patients for the purpose of birth control. I also established a policy of not prescribing Viagra to unmarried men.

I have never involved myself in abortions. As a Christian physician, the prescription of birth control pills to unmarried women for birth control purposes is contrary to the dictates of my conscience and religion. Similarly, arranging for abortions and the prescription of Viagra to unmarried men is contrary to the dictates of my conscience and religion.

According to the Canadian Medical Association Code of Ethics, one of the responsibilities of a physician is to inform the patient “when his morality or religious conscience alone prevents him from recommending some form of therapy…”

In accordance with my Christian beliefs and the Canadian Medical Association’s Code of Ethics, I am setting out my policy so that you are informed in advance of my beliefs and practice. If you wish further information about the religious basis for my policy, please feel to ask me about it.

Here the physician avoids complicity by declining to offer recommendations or referrals for treatments that he finds morally objectionable. Since prospective patients will know of this policy, and the list of procedures it covers, the demands of informed consent and patient autonomy are also satisfied. Still, some may find this solution to

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33 Ibid.

be only partly satisfying. Missing in this approach is the opportunity for the physician and patient to engage in a dialogue about the moral dimensions of the treatments in question; the approach thus perpetuates the rather attenuated and impersonal dynamic of physician-as-technician and patient as problem-to-be-solved.

A better option than this is to inform the patient about any relevant but morally troublesome treatments but also explain the nature of these moral objections and why some physicians neither perform these procedures nor offer referrals for them. Like the notice-posting alternative above, this approach allows the physician to maintain integrity and avoid complicity while at the same time respecting patient autonomy and satisfying the requirements of informed consent. But in addition, this approach provides an opportunity for patients to become more deliberative about their options and hence more fully responsible for their choices. If the physician were to share moral concerns in this way, the patient would be assured of knowing about the existence and nature of serious moral objections that some have regarding some treatment options. No harm would be done to patients already familiar with these points of view, and if this information is new to some patients, then their informed consent and autonomy should be enhanced by this approach.

But some may object. What about the patient who did not know about the objectionable option prior to the physician’s witness against it? Is not the informing physician complicit in those cases where the patient goes on to choose the objectionable treatment? I think not. Although the concept of complicity is somewhat difficult to define and, at times, even more difficult to apply, at the heart of it lies commonsense distinctions between the levels of moral responsibility that one agent can have in another agent’s choice, with the levels ranging from no responsibility at all to full responsibility. That said, the notion of complicity at work in the objection just mentioned seems implausible, since it appears to rely on the claim that simply having some sort of contributing role in another agent’s morally wrong choice is sufficient to establish an objectionable level of complicity in that choice. But if this were true, then each of us would be complicit in countless morally objectionable acts, since many, if not all, of our choices will sooner or later be connected by a series of other choices and events to some objectionable choice of some other agent. For example, those who armed and trained a bank security guard who then used his weapon and training to rob a bank would be complicit in that robbery (as would the bus driver whose route the robber took, the school guidance counselor who suggested he enter that line of work, etc.). Similarly, a journalist who reported on a kidnapping in order to notify the public and help find the victim would be complicit in a subsequent kidnapping were his report to plant the seed of this crime in the mind of another kidnapper. In each of these situations, though, the objectionable choice (bank robbery or kidnapping) was surely not intended by the agent (the security trainer or journalist) who is, by this account, complicit in those acts.

On the contrary, the acts that supposedly make these agents complicit were chosen in order to prevent the kind of subsequent event in which these agents are putatively complicit. Furthermore, it is a reasonable expectation that the choices of the would-be complicit agents (training a guard, reporting on a kidnapping) would hinder, rather than aid and encourage, the subsequent objectionable acts. Indeed,
the notion of degrees of complicity is plausible and necessary in just these sorts of cases, acknowledging a genuine moral difference between acts that are aimed at, or would reasonably be expected to lend support to, certain objectionable choices, and acts that *de facto* have some identifiable connection to such choices, but were not meant to, and could not reasonably have been expected to, lend such aid or encouragement. An account of complicity that is unhelpful in making and maintaining these commonsense distinctions, that never fails to find *some* level of complicity in all our choices, and that leads one to such far-fetched conclusions as those above should surely not be considered a reasonable barrier to a physician’s choice to share with patients any serious moral reservations concerning a treatment option.

With this objection set aside, I now turn to the question of whether a conscientious-objector physician should simply post some sort of policy statement in the waiting room and avoid any discussion about it with patients or, instead, voice her moral concerns about the practices in question directly to the patients in question. Let us approach this question by considering the case of a pregnant woman whose medical condition could be improved by directly terminating her pregnancy. Among the important goals of a pro-life physician contemplating such a case is the protection of the unborn child. With respect to this goal the question for the physician is, What is the *best* way to protect this unborn human being? The answer is not obvious, but of the two options we have been considering—refuse to inform the mother that abortion is an indicated and available option, or inform her about the abortion option and share the moral objections to that option—the latter appears to be the more promising.

It may sometimes be the case that saying nothing and posting no notice—either about the problematic treatments that will not be mentioned or about any moral reservations concerning these treatments—would accomplish this goal, but only if the patient is, and remains, ignorant of the abortion option.36 But if this were the way that conscientious objectors handled their serious moral objections, then patients who did become informed of a morally questionable option (abortion) would most likely become so by doctors (or others) who have no moral objections to that option and who are thus less likely (to say the least) to raise any serious moral questions for the patient to consider. Furthermore, withholding information about legal and available treatment options without the patient knowing is deceptive, given the patient’s reasonable presumption of full disclosure. As we have seen, such an approach could also run afoul of professional and legal standards and could lead to a loss of the privilege of practicing medicine through license revocation, malpractice suits, and patient flight.

Finally, as we have also seen, such silence would undermine patient autonomy and fail to take advantage of an opportunity to change the patient’s

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35 Perhaps the woman is suffering from recently diagnosed breast cancer or diabetes and her pregnancy has not reached viability. I thank my friend Dr. Patrick Cahill, an obstetrician, for these examples.

36 This is highly unlikely in our culture.
mind on such a morally grave matter. Given all this, perhaps a better long-term solution would be for the conscientious objector to try to persuade the patient by describing the serious moral reservations and questions clearly and sympathetically. Informing the patient of the objectionable option and sharing moral concerns with her in this way is not necessarily an abandonment of the goal of protecting the unborn child and will not make the physician complicit should the patient choose to have the abortion.

Mutually Understood Values

Physician Mark Seigler explains that, “The physician-patient encounter is the site of human agency, the point at which individuals possessed of special needs and personal perspectives and values interact. . . . Relationships based on mutually understood values and ends are those most likely to result in an exchange of trust, and trust remains an essential component of the healing relationship.” 37 If Seigler is right, then the approach outlined above is the preferred way to deal with the kind of conflict we have been considering. A physician who is seeking to maintain integrity and avoid complicity in morally objectionable treatment options, but who values patient autonomy and respects the demands of informed consent, should follow the route of informing patients of all available treatment options while also carefully discussing any serious moral concerns that either of them has about any of those options. Even if it is the case that some patients end up choosing an objectionable option despite their physician’s counsel, we have seen that it would be quite difficult to make the case that the physician was complicit in this choice.