Conscientious Objection and Civil Disobedience in the Context of Assisted Reproductive Technologies

YARDIMCI ÜREME TEKNOLOJİSİ KAVRAMINDA VİCDANİ İTİRAZ VE SİVİL İTAATSİZLİK

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Summary

In this paper, conscientious objection and civil disobedience in assisted reproductive technologies will be analysed. The analysis will proceed in three steps. The first step will involve an attempt to define conscientious objection and civil disobedience respectively. The second step will try to answer the question of when health care professionals have a right or a duty to follow their own ethical judgements, disregarding the legal position. The third step will then be to analyse whether or not the moral rights and duties developed in step two can be given a satisfactory legal form.

Key Words: Assisted reproductive technology, Conscientious objection, Civil disobedience

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Özet

Bu makalede, yardımcı üreme teknolojisinde vicdani itiraz ve sivil itaatsizlik incelenecektir. Analiz üç basamakta sürdürülecektir. Birinci basamak, sırasıyla vicdani itiraz ve sivil itaatsizliğin tanımını içerecektir. İkinci basamak, sağlık hizmeti verenler ne zaman kendi etik yargılarını izlemek ya da yasal duruma aldırmamak hakkı ya da görevine sahiptir sorusuna cevap verecektir. Üçüncü basamakta ise, ikinci basamakta gelişen ahlaki haklar ve görevlerin tatmin edici yasal bir biçim sağlayıp sağlayamayacağının analizi yapılacaktır.

Anahtar Kelimeler: Yardımcı üreme teknolojisi, Vicdani itiraz, Sivil itaatsizlik

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"Therefore, should you see that there is a lack of hangmen, beadles, judges, lords, or princes, and find that you are qualified, you should offer your services and seek the place, that necessary government may by no means be despised and become inefficient or perish." (1).

"You ask, Why did not Christ and the apostles bear the sword? Tell me, Why did He not also take a wife, or become a cobbler or a tailor? If an occupation or office is not good because Christ Himself did not occupy it, what would become of all occupations and offices, with the exception of the ministry which alone He exercised?" (1).

In the above quotes from Martin Luther he makes his views on the duties of a Christian man perfectly clear. If the secular state needs assistance to uphold itself it is the duty of the Christian to offer that assistance, by accepting the necessary position/profession in society, including the position of hangman or other official wielding the secular sword. For Luther the idea of conscientious objection was simply unthinkable because to live within the confines of a given state was to give allegiance to that state and its religion (or in the terms of today, its ideology and laws). You were allowed to think what you wanted to think, but any outward practice had to be in conformance with the ideas of the state.

Today we do, however, have different views about the relationship between a citizen and the state (at least in those states which have citizens and not subjects). Citizens are allowed to express their different views in public both through word and action. In some specific situations there are, however, some citizens who are better placed to express such views than others, simply because they are the ones who have to perform certain acts which society wants performed. Thus Luther's hangman would be eminently placed to protest against capital punishment and his beadles against

religious oppression. In the context of assisted reproductive technologies (ARTs) health care professionals are often involved in the performance of the interventions, and they thus become the ones who may object or may act.

One feature which unites many ARTs is that they are ethically contentious, i.e. that people of good will and reasonable understanding differ in opinion about whether specific techniques are morally bad, innocuous, or good. Even professional moral philosophers have been known to change their mind about one or more of the ARTs. It is, furthermore, the case that the range of ARTs which are legal varies from jurisdiction to jurisdiction.

This seems to indicate that we do not possess any compelling arguments which definitely demarcates the area of ethically acceptable ARTs.

It therefore becomes interesting to study under what conditions a health care professional is justified in invoking conscientious objection, or opposite under what conditions a health care professional is justified in engaging in civil disobedience in the context of ARTs.

It is probably worth pointing out, that both questions are quite seriously meant. We are perhaps more used to thinking about conscientious objection of health care professionals, but it is not difficult to imagine health care professionals who feel that the laws regulating ARTs are too constraining, and unjustly denies groups of patients the legal right to obtain services they need. A health care professional with such beliefs could very well engage in civil disobedience by publicly offering the forbidden services, or in what Childress calls evasive noncompliance by covertly offering the services[1] (2).

Philosophical discussions about civil disobedience became fashionable at the time of the civil rights movement in the USA, and the discussions about conscientious objection received a major boost by the Vietnam war. At that time many of the most prominent political philosophers developed arguments which could support the practices (3,4). Within bioethics this discussion has previously been conducted with regard to the question of abortion, but it has recently been a rather quiet subject without a lot of work being done, and the most recent work has, somewhat paradoxically, mainly been concerned with providing arguments for curtailing conscientious objection.

In the present paper I will try to resurrect both discussions in the context of ARTs.

The analysis will proceed in three steps. The first step will involve an attempt to define conscientious objection and civil disobedience respectively. The second step will try to answer the question of when health care professionals have a right or a duty to follow their own ethical judgments, disregarding the legal position or the position of their place of employment. The third step will then be to analyse whether or not the moral rights and duties developed in step two can be given a satisfactory legal form.

Acting against the law

What keeps conscientious objection and civil disobedience together is that both kinds of acts involve acting against the law because this is seen to be the ethically right way of acting. The difference is mainly in the purpose of the act.

Conscientious objection is the term applied to the class of acts where a person refuses to perform some act or acts which he or she has a legal or contractual obligation to perform. The refusal must furthermore be public in the sense that the body who holds the corresponding right to the performance of the act or acts knows that the agent refuses to act. The classic case is conscientious objection to military service on the basis of religious or secular pacifism. This kind of conscientious objection is legally recognised in many countries, and a person who is sentenced to jail because of conscientious objection falls within Amnesty Internationals definition of a prisoner of conscience. Some European and other jurisdictions also have laws which allow doctors and other groups of health care professionals conscientious objection to participation in abortion. These laws do usually not apply to persons who are more indirectly connected to the provision of abortions (cf. the English Janaway case).

[1] I do personally know at least two doctors who have been evasively noncompliant by performing ARTs which were/are prohibited in their country of residence.

Civil disobedience is the term applied to the class of acts where a person chooses to perform some act or acts which is legally prohibited. It must, furthermore, be clear that the action is intended and not based on ignorance concerning the legal position, and that the purpose of the action is to state a public protest against the law in question. Civil disobedience is furthermore characterised by the feature that the protester does not try to evade the legal punishment by illegal means. The class of acts which Childress names evasive noncompliance differ from acts of conscientious objection by not being intended as public statements, they are simply transgressions of the law which the agent finds morally justified.

Both types of acts can therefore only occur in situations where the person acting accepts the basic legal framework of the state although he or she may have objections to certain specific laws. The acts thus presuppose a reasonably well-ordered and decent society.

When should health care professionals follow their own ethical judgment?

It seems *prima facie* reasonable to claim that it would be wrong for a person not to follow his or her considered ethical judgement. If somebody has really considered the possible actions, the various relevant ethical considerations, and any probable distortions from personal biases, and has decided that some action is ethically wrong all things considered, then it seems to be wrong for that person to perform the action.

Some philosophers have tried to give further support to this claim by an analysis of what it means to be a person with moral integrity, but this additional support is superfluous. It may be correct that to be a person with moral integrity entails that there are certain acts one does not perform, but all it is necessary to show in the present context is, that if one is a good person (i.e. a person whose actions are controlled by ethical considerations) one does not perform acts one believes to be wrong (all things considered). A lot of moral controversy can be hidden in the specification of the "all things considered" clause, but for the present purpose the clause is sufficiently filled if a person is aware of the facts of the situation, and aware of the moral system of the patient, and has honestly considered whether or not his or her own moral system is better justified than the system of the patient or of society at large.

This paper could be a very short paper, if this analysis was generally accepted, and there were no problems in transforming it into legal regulations. This is, however, not the case.

One counter analysis relies on the premise that health care professionals should be value neutral and not impose their own values on their patients. It is, however, fairly obvious that the principle of value neutrality is in itself a substantive value, and thus not neutral (5). This objection can be circumvented if it is claimed that the principle of value neutrality is a necessary condition for the establishment of a moral community between moral strangers (6), but in that case the obligation to be value neutral can be made void if a) the health care professional clearly states his or her values, and b) the patient is not compelled to seek this specific health care professional. The analysis of compulsion in this case will undoubtedly be very difficult, but could include factors like the compulsion of geography if the physician is working in a very remote locality with difficult travelling conditions.

It has also been suggested that health care professionals because of their professional status are obligated to carry out acts which society through its legislation has deemed to be permissible. This argument has been put forward in discussions about conscientious objection to abortion. The core argument is that when a person enters a profession he or she enters an implicit contract with society where society confers the professional privileges in exchange for a duty to serve individual and societal needs. This argument shares the problem with most other implicit contract arguments that it is unclear whether such a contract really exists, what its contents are, and who are bound by it. A more specific problem for this account of professional obligation occurs if major changes in the required services occur after a person has entered a profession. If a society through democratic means introduced capital punishment by lethal injection administered by

a licensed physician, would individual physicians then be wrong if they refused to participate in executions using the argument that this was not part of the professional duties of the profession they entered 10, 20, 30 years ago?

That an act or a set of acts are permitted by a society, or even thought to be good, socially beneficial, or otherwise worthwhile cannot be a sufficient condition for the existence of an obligation on somebody to perform those acts. This is obvious if we look at the example of medical research. It is generally acknowledged that medical research is a good thing and that society ought to promote research but this does not create a strong obligation on anybody to be a research subject.

When does a moral right become a legal right?

It has been argued above that health care professionals have both a right and a duty not to perform acts they find wrong, and a right and a duty to perform acts they find right (given the provisos outlined above). Can these rights and duties be converted into legal rights or duties?

The idea that duties of conscientious objection or civil disobedience can be transformed into legal **duties** can be dispensed with fairly easily. The enforcement of such a duty would only be possible if we had a way of getting good evidence about the ethical judgements of agents, prior to the time when these judgements issue in action. Since introspection is only possible in the first person case this requirement raises insurmountable problems.

But what about a legal right to conscientious objection or civil disobedience?

A legal right to civil disobedience is both self-defeating and problematic in other ways. It is self-defeating because it would remove the component of civil disobedience which provides the power to the symbolic nature of this kind of act. If there was a right to civil disobedience in certain context, the person wanting to break the law, thereby publicly and symbolically signalling that the law ought to be changed (i.e. the person performing civil disobedience), would suddenly not be breaking the law, but would be acting within the limits of the law. The act of civil disobedience would thus be instantly converted into an act of lawful demonstration.

The other reason why no legal right to civil disobedience could be established is, that it would in practice empty any law containing such a right of its normative force.

Because conscientious objection does not necessarily contain the same element of symbolic action as civil disobedience a legal right to conscientious objection is not self-defeating. We could therefore establish legal rights to conscientious objection in a number of areas, but traditionally such legal rights have been kept fairly limited in their scope. This is probably partly because we (i.e. society / the state) only feels obliged to establish such rights in areas where the acts in question concern fundamental moral categories, like killing in the case of objection to the military or to abortion, partly because establishing such legal rights leads to a number of problems. With ARTs it is unfortunately the case that a number of fundamental moral categories may be important in varying proportion for different people. For some only ARTs involving the destruction of embryos are problematic, for others any ART involving use of sperm obtained by masturbation is problematic, whereas for yet others there are fundamental problems in the use of donated gametes. Society at large may see some of these problems as more fundamental than others, and may put quite arbitrary limits on any legal right of conscientious objection.

A legal right to conscientious objection in a given area may create a number of problems. The three main problems are a) what level of proof of seriously held ethical beliefs should be required for a person to invoke conscientious objection, b) what happens if so many persons invoke their right to conscientious objection that the societal practice in question breaks down, and c) what duties does a health care professional have with regard to referring patients who need procedures the professional will not perform due to conscientious objection?

The first of these problems has been extensively discussed in connection with conscientious objection to military service. Apparently the American Uniform Code of Military Justice re-

quires that the belief system leading to the objection must be strictly religious and may not include "essentially political, sociological, or philosophical views, or a merely personal moral code". The applicant must articulate the basis for his objection and has to be opposed to all war, not merely a specific war (7)[2]. Would similar restrictions be reasonable in connection with conscientious objections to participating in the delivery of ARTs? It seems very strange to require that the belief system in question has to be of a particular kind. Philosophical and religious belief systems may in the final analysis only differ from each other in very few basic assumptions, but the arguments leading to moral objections may be largely independent of these basic assumptions. Both atheists and Christians have, for instance, argued against war on the basis of a belief that it is wrong to kill innocent human beings. We can require that the objector has consciously adopted his or her belief system after due consideration, and that the objection flows from the ethical parts of the belief system. It is not sufficient if the objection flows from an unconsidered belief or just from a non-ethical belief (i.e. "this practice is aesthetically displeasing" or "if I engage in this practice it may hurt my income"). It is probably also legitimate to check whether the objector engages in blatant inconsistent reasoning, but the standards for inconsistency may be difficult to fix firmly without bias, since inconsistency in real life argument is often much more a matter of degree than inconsistency in arguments formalised in standard first order predicate logic (8-10).

The conclusions concerning the first problem for a legal right to conscientious objection can be summed up as follows: It is legitimate to check whether the objection is based on a considered, sincerely held, ethical belief system, which is not blatantly inconsistent.

The second problem occurs if a sufficiently large number of persons invoke conscientious objection, and this collective effect of individual choice results in a collapse of the social practice being objected to. In what circumstances is this a problem? First of all the practice in question must fulfil certain criteria. It is not sufficient that the practice is legal. This can be illustrated by two examples. If prostitution is legal in a given country (as it is in Denmark) this does not generate a claim against the state or anybody else to make sure that prostitutes are available for continuing the practice. It is not a moral problem if all potential prostitutes invoke conscientious objection to prostitution. Similarly the mere fact that a given religious ritual or practice is legal does not entail that it is a socially important ethical problem if nobody wants to be a priest officiating at this specific ritual. If the mere fact that something is legal could constitute a *prima facie* assumption that it should also be available, society would have to directly support both prostitution and religion.

For widespread conscientious objection to be a problem the practice objected to must be a practice which society believes should be available to people who need, or in some cases, want it. This may in a democracy either be because the majority supports the practice, or because they accept that it is sufficiently important for a minority to be made available. This can create problems if the service can only be provided by persons with specific skills, and a majority of these persons object to the service. Here personal ethical ideals and public policy comes into conflict. In such circumstances it has been suggested that the personal ethical ideals should give way (9), and that health care professionals should be forced to perform the services in question, for instance by being threatened with dismissal. It is difficult to see why this solution it the ethically superior. It may well be the case that the employer has a legal right to dismiss health care professionals in such circumstances, but this is

[2] I have tried to verify this in the Uniform Code of Military Justice, but has been unable to obtain a copy of the Code. The information in the article quoted is, however, contradicted by the U.S. Selective Service System web-site, where the page on conscientious objection (http://www.sss.gov/FSconsobj.htm accessed 11/11/03) state "Beliefs which qualify a registrant for CO status may be religious in nature, but don't have to be. Beliefs may be moral or ethical; however, a man's *(sic)* reasons for not wanting to participate in a war must not be based on politics, expediency, or self-interest. In general, the man's lifestyle prior to making his claim must reflect his current claims."

not sufficient to make it the right action. If the conscientious objection is really sincerely based in the ethical values of the health care professionals, it would be wrong to force them to act against these values (this is, by the way, also a consequence of the principle of value neutrality if one accepts that principle). A more defensible solution would be not to institute a legal right of conscientious objection, so that everybody entering the profession in question would know that it could involve a duty to perform a certain range of acts. This solution is, however, problematic for new ethically contentious techniques since they will usually have to be performed by professionals who have entered their profession years before the technique was invented.

It is often claimed that a doctor who has personal ethical objections to a given medical procedure should refer patients with this procedure to a colleague who is known to perform such procedures. Sometimes this claim seems to involve the tacit assumption that whereas it is ethically problematic for the person to perform the procedure it is ethically innocuous to refer to somebody else. This tacit assumption is, however, more problematic than it appears. Let us imagine that a doctor practices in a country where female circumcision, or surgical amputation for penal purposes is legally accepted, but that the doctor has ethical objections to these practices. Should he or she just refer patients or authorities to another doctor known not to have such objections? Obviously not, but why do we then expect health care professionals to refer for abortion or euthanasia (in countries where these practices are legal)? The only explanations seems to be, that we (the persons expecting referral) judge the practices differently, abortion etc. being acceptable whereas female circumcision (or perhaps more correctly described female genital mutilation) is unacceptable. But in that case expecting referral only amounts to forcing persons to act against their own values, because we think those values are wrong.

What are the consequences of these analyses for ARTs?

First, persons may have valid reasons to engage in conscientious objection or civil disobedience with regard to one or more ARTs.

Second, a right to conscientious objection with regard to ARTs could be made a legal right, but there is neither a compelling argument showing that such a legal right should be established, nor a compelling argument showing that it should not be established.

Third, a health care professional exercising conscientious objection has no obligation to refer the patient/client to another health care professional willing to perform the procedure in question.

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