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THE OVERWEIGHTED INTEGRITY PROBLEM

CONSCIENCE, COMPLICITY, AND MORAL STANDING

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When she was eighteen weeks pregnant, Tamesha Means suffered a ruptured amniotic sac. The hospital where she presented, the only one in her county in Michigan, was Catholic. At eighteen weeks, the fetus was not viable, and an abortion would have been the safest option. Nevertheless, Means was given two Tylenol and sent home. She presented two more times, bleeding and in severe pain, but it was only when she went into labor that the hospital provided care. The baby died within hours.[1]

The health care professionals at the hospital did not tell Means that her fetus would not survive or that an abortion could reduce serious health complications for her. In fact, Means had an infection of the fetal membranes and umbilical cord as a result of the amniotic rupture.[2] While one might think that health care professionals and institutions are legally required to disclose medically relevant information to patients, the hospital was protected from malpractice claims because conscience law in Michigan requires only that providers disclose "morally legitimate alternatives" to the recommended treatment. Since the hospital was Catholic and did not see abortion as a morally legitimate alternative, they were not required to disclose that option.[3]

It is unsurprising that a Catholic hospital would refuse to *perform* an abortion for Means. Many states in the United States have conscience laws protecting conscientious refusal to perform some medical service. For instance, in Mississippi, "a health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience."[4] What is striking,

1 Kaye et al., *Health Care Denied*, 9–10.

2 Sawicki, "The Conscience Defense to Malpractice," 1257–58.

3 Sawicki, "The Conscience Defense to Malpractice," 1259–60. Means is not a one-off case. See similar cases detailed in Kaye et al., *Health Care Denied*; and National Women's Law Center, "Below the Radar."

4 Miss. Code § 41-41-215(5). Conscientious refusals are also protected federally through the Church Amendments (42 U.S.C. § 300a-7 et seq.), the Public Health Service Act (42 U.S.C. § 238n), the Weldon Amendment, and the Affordable Care Act (§ 1303(b)(4)).

however, is that the hospital was not even legally required to provide Means with all the medically relevant *information* about her situation so that she could make an informed decision about her health. By not providing information, the professionals at the hospital could avoid any complicity in perceived wrongdoing if Means chose to travel outside the county to seek an abortion.

Providing information is not the only way in which someone may believe they are complicit in wrongdoing. A part-time admissions clerk refused to type lab and admissions forms for abortion patients, while another employee refused to clean surgical tools used in abortion.[5] Depending on the state, some of these objections too might be protected under conscience law. Title 16, section 51.41 of the Pennsylvania Administrative Code protects those who object to even "cooperating in abortion or sterilization," where such cooperation can include "disposal of or assistance in the disposal of aborted fetuses" and "cleaning the instruments used in the abortion or sterilization procedure."[6]

In fact, many state conscience laws protect health care professionals and providers from being even indirectly involved with some procedure they find objectionable. In her excellent study of state conscience laws, Nadia Sawicki finds that of the states that protect a right to refuse to participate in abortion, only Illinois requires that providers inform patients of all available treatment options, including abortion.[7] In most states, providers are not required to disclose to patients that abortion may be medically appropriate and available elsewhere.[8]

Of course, these policies are not restricted to abortion. Mississippi's Health Care Rights of Conscience Act is perhaps the broadest example, granting health care providers the right to conscientiously not participate in "any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions."[9] Notably, the law covers all types of health care professionals, and it is increasingly common to find legal protections for not only physicians but also nurses, pharmacists, emergency medical technicians, physician assistants, public health officials, medical

5 Pope, "Conscience Clauses and Conscientious Refusal," 165.

6 PA Code § 16.51.41. Sawicki clarifies that Pennsylvania does not include recordkeeping in its understanding of cooperation, and so refusing to type lab forms likely would not be protected under Pennsylvania law ("The Conscience Defense to Malpractice," 1265n47).

7 Sawicki, "The Conscience Defense to Malpractice," 1285.

8 Sawicki, "The Conscience Defense to Malpractice," 1283.

9 Miss. Code Ann. § 41-107-3a.

students, researchers, and even institutional health care providers like hospitals and skilled nursing facilities.[10]

In a similar vein, Oklahoma's Freedom of Conscience Act allows health care professionals to refuse to "perform, practice, engage in, assist in, recommend, counsel in favor of, make referrals for, prescribe, dispense, or administer drugs or devices or otherwise promote or encourage" certain health care services, including abortion, reproductive assistance technology, and medical aid in dying (MAID).[11] Other states have attempted to pass similar legislation, with varying success.[12] Crucially, few of these conscience clauses include exceptions for emergency situations.[13]

In this paper, I argue that conscience policies that seek to protect health care professionals from any kind of association with medically accepted care to which they object are unjust. Such policies are often defended because they protect the *integrity* of health care professionals. While this is admittedly important, these policies nevertheless grant too much weight to that integrity in light of competing patient interests and values. Despite the significant attention given to conscientious refusal to *perform* some service, as well as to the duty of referral and whether individuals are *actually* complicit in some activity, too little attention has been given to just how wide-ranging many conscience policies currently are and why these policies are unjust.

I begin in section 1 by explaining the connection between conscience and integrity and the value of integrity. In section 2, I argue that despite its value, protecting integrity even in these indirect cases of complicity requires compromising other key values like autonomy and leads to significant harms. Accordingly, these policies overweight integrity and are unjust. In section 3, I explore whether other considerations in addition to integrity might shift the balance in favor of these policies. I deny that tolerance will provide the needed additional weight, but one unique proposal is the interest the state has in protecting the moral standing of its citizens to hold each other accountable. Despite its initial promise, I argue in section 4 that unwillingly complicit professionals do not necessarily lose their standing, so this cannot serve as an additional weighty consideration for these policies. Consequently, I conclude that such policies are unjustified and should be restricted.

10 Sawicki, "The Conscience Defense to Malpractice," 1263–64.

11 Oklahoma Code § 63-1-728.

12 Pope, "Conscience Clauses and Conscientious Refusal"; and Sawicki, "The Conscience Defense to Malpractice."

13 Wicclair, *Conscientious Objection in Health Care*, 211.

1. THE SIGNIFICANCE OF INTEGRITY

There are various reasons to allow for conscientious refusal in our policies. These policies promote diversity and tolerance and encourage those who are ethically sensitive to join the medical profession.[14] Yet as Mark Wicclair writes, "moral integrity is among the most frequently cited reasons for accommodation—both by its defenders and its critics."[15] Indeed, many in the debate see it as the *strongest* reason for accommodating such refusal.[16] I agree, and I will accordingly focus on integrity in this paper.[17]

Integrity seems the strongest reason for protecting conscientious refusal in part because of the nature of conscience and the value of integrity. Conscience tracks one's moral integrity by advocating for one's deeply held core commitments. Maintaining moral integrity requires acting in accordance with these core commitments and judgments. Sometimes these judgments will conflict with current medical practices, so conscientious refusal allows someone to preserve their integrity.[18] Because integrity is quite valuable, there is good reason to protect it in our policies if we can.

14 Wear, Lagaipa, and Logue, "Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment"; and Wicclair, *Conscientious Objection in Health Care*, 29. I revisit tolerance in section 3 below.

15 Wicclair, *Conscientious Objection in Medicine*, 8.

16 Wester, "Conscientious Objection by Health Care Professionals," 429. See also Benn, "Conscience and Health Care Ethics"; Birchley, "A Clear Case for Conscience in Healthcare Practice"; Brock, "Conscientious Refusal by Physicians and Pharmacists"; Magelssen, "When Should Conscientious Objection Be Accepted?"; and Wicclair, *Conscientious Objection in Health Care*.

17 Those who do not find integrity a plausible justification for conscientious refusal can see my argument conditionally: if integrity *were* to justify conscientious refusal, it would not do so to the extent currently enshrined in policy.

18 Ben-Moshe argues that allowing for conscientious refusal protects individuals from doing not merely what they *believe* to be wrong but what is *actually wrong*. Drawing inspiration from Adam Smith, Ben-Moshe argues that when a health care professional reasons from the standpoint of an impartial spectator and consults their conscience, "[their] claims of conscience are true, or at least approximate moral truth to the greatest degree possible for creatures like us, and should thus be respected" ("The Truth Behind Conscientious Objection in Medicine," 404). I set this view aside for two key reasons. First, it relies on a controversial and, to my mind, implausible view of ethical justification and truth. Second, I am unconvinced that it is sufficiently clear what an impartial spectator might judge in contentious medical cases such as first-trimester abortions and MAID. See Wicclair, *Conscientious Objection in Medicine*, 53–54. Addressing this view fully is outside the scope of this paper, however, so I assume here that protecting judgments of conscience is important not because it tracks moral truth but rather because it protects one's integrity.

Some, like Wicclair, see integrity as *intrinsically* valuable.[19] That is, having core moral commitments and being disposed to act on them is valuable in itself; all else equal, the world is a better place if it includes such individuals of integrity rather than people who act only opportunistically or transactionally.[20]

Even if integrity is not intrinsically valuable, it may nevertheless be quite valuable. Integrity preserves our dignity.[21] It also allows individuals to remain authentic to their true selves. Because the moral judgments associated with one's conscience are often a crucial part of who one is, they bear on one's self-conception or identity.[22] Being forced to act against those beliefs can consequently seem like an act of self-betrayal, which leads to a loss of self-respect.[23] Indeed, some have claimed that "a basic part of an acceptable human life is to live in accordance with one's deeply held beliefs and values."[24] Ben-Moshe goes so far as to suggest that "sometimes life might not be worth living if it cannot be lived according to [one's] evaluative judgments."[25]

Clearly, integrity can be compromised when one is forced to participate in an activity to which one objects. Physicians who are forced to provide MAID when they believe killing is wrong may feel that they have lost a crucial part of their identity in the process. Yet some champions of conscientious refusal have also held that integrity can be compromised even through more indirect involvement. Karen Brauer, president of Pharmacists for Life, explained her objection to referring an individual or providing them information this way: "That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.' What's that saying? 'I will not off your husband, but I know a buddy who will?' It's the same thing."[26] The complaint here is that even if someone does not directly participate in the activity, if they are indirectly

19 Wicclair, *Conscientious Objection in Health Care*, 27.

20 Wicclair, *Conscientious Objection in Medicine*, 9.

21 Dworkin, *Life's Dominion*, 229–30.

22 Brock, "Conscientious Refusal by Physicians and Pharmacists," 189.

23 Ben-Moshe, "The Truth Behind Conscientious Objection in Medicine," 404; Blustein, "Doing What the Patient Orders," 296. Some have argued that even *institutions* that are forced to go against the mission and values that comprise their identity may be said to lose integrity. See Wicclair, *Conscientious Objection in Health Care*, 148–52; and Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" 142–44.

24 Brudney and Lantos, "Agency and Authenticity," 223.

25 Ben-Moshe, "Internal and External Paternalism," 676.

26 Cited in Shahvisi, "Conscientious Objection," 84.

involved in it in some way, they thereby become complicit in the alleged wrongdoing, and their integrity is compromised due to that complicity.[27]

Notably, a health care professional may feel complicit in perceived wrongdoing in a variety of ways. As indicated in Brauer's quote, referrals are one such way. In fact, some have argued that an objection to performing some service already implicitly involves an objection to referring for that service.[28] As Card writes, "it is unclear what actual ethical difference exists" between the duty to refer and the duty to directly provide the service, precisely because one remains part of this causal chain of events.[29]

A health care professional can merely provide information about possible services and procedures without making a referral to another provider. Yet one may worry that this too makes one complicit in wrongdoing, since without that information the patient might not seek out the service elsewhere on their own. Other examples of health care professionals raising concerns about complicity include an emergency medical technician refusing to drive a woman suffering from abdominal pain to an abortion clinic and a county health department employee refusing to translate information on family planning and abortion options into Spanish.[30] In each of these cases, even though the individual is not themself performing the procedure to which they object, they are nevertheless somehow involved in the procedure. This involvement may cause them to feel complicit in perceived wrongdoing, threatening their integrity and perhaps even their self-identity. Call such refusal to be involved in any way with a procedure to which one objects *complicity refusal.*

Some have suggested that while health care professionals may be complicit in these cases, complicity comes in degrees, and referring and informing are minimal forms of complicity that are not morally problematic.[31] Yet drawing the line between what degree of complicity is acceptable itself requires contentious ethical judgments.[32] Because how much complicity is permissible is a matter for conscience as well, individuals will differ in where they draw the

27 Bayles, "A Problem of Clean Hands," 167; Clarke, "Conscientious Objection in Healthcare, Referral and the Military Analogy," 220; Shahvisi, "Conscientious Objection"; and Ben-Moshe, "Conscientious Objection in Medicine."

28 Hill, "Abortion and Conscientious Objection," 347.

29 Card, "Conscientious Objection and Emergency Contraception," 9.

30 Pope, "Conscience Clauses and Conscientious Refusal,"165.

31 Brock, "Conscientious Refusal by Physicians and Pharmacists," 197. See also Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" 141.

32 Wicclair, *Conscientious Objection in Health Care,* 41.

line.[33] For some, "even a minimal degree of complicity would represent a serious violation of their moral integrity."[34]

It is this feeling of complicity or belief that one's integrity has been compromised that is important. Integrity is a *subjective* matter.[35] Even if abortion is entirely morally innocuous, someone who nevertheless believes it is tantamount to murder will still believe that their integrity is compromised if they are somehow associated with the procedure. Whether abortion is actually wrong and whether the individual is actually blameworthy for wrongdoing are irrelevant to their beliefs and their felt integrity violation. They will still feel the telltale pangs of guilt associated with tarnished integrity.[36]

Given the significance of integrity as well as the facts that it can be compromised when one must act against one's conscience and that one's conscience may demand that one not be involved in the perceived wrongdoing in any way, current policies protecting complicity refusals like those I surveyed above may seem justified. In the next section, however, I argue that this justification is merely apparent.

33 Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" 142.

34 Minerva, "Conscientious Objection, Complicity in Wrongdoing, and a Not-So-Moderate Approach," 118. Similarly, Blustein suggests that even if one believes some service is generally wrong, informing or referring the patient in certain circumstances is, all things considered, morally permissible ("Doing What the Patient Orders," 314). But again, the objector may not always make this judgment, and in fact many of them do not.

35 Gerrard, "Is It Ethical for a General Practitioner to Claim a Conscientious Objection When Asked to Refer for Abortion?" 600; Sepinwall, "Conscientious Objection, Complicity, and Accommodation," 206; and Wicclair, "Conscientious Objection in Healthcare and Moral Integrity," 12.

36 One might respond that if an individual feels so violated, they simply ought to leave the profession, or at least shift to a subfield compatible with the requirements of their conscience. See Brock, "Conscientious Refusal by Physicians and Pharmacists"; and Stahl and Emanuel, "Physicians, Not Conscripts." After all, entering a profession is a voluntary choice, and objectors should have known that their job would involve actions that could conflict with their conscience and threaten their integrity. See, e.g., Schuklenk, "Conscientious Objection in Medicine." While I do not disagree, we must appreciate that health care professionals *do* know what they are getting into: a field that explicitly allows for conscientious refusal. See Robinson, "Voluntarily Chosen Roles and Conscientious Objection in Health Care," 721. In many states, policies protecting complicity refusal are already in place, so someone entering the field could reasonably expect that their right to refuse even indirect involvement in some perceived wrongdoing would be legally protected. This only bolsters my point that legal protection of complicity refusal is too broad, because refusing to inform or refer patients clearly conflicts with professional obligations to care and advocate for patients and promote their health and well-being, and the law should better reflect the professional obligations of medical professionals. Thanks to two anonymous referees for encouraging me to address this point.

2. THE OVERWEIGHTED INTEGRITY PROBLEM

Whether it is intrinsically valuable or merely instrumentally valuable, integrity provides only a *pro tanto* reason for protecting conscience.[37] We also must consider competing reasons and values, including what is threatened or lost when we protect integrity in our policies. Accommodating someone's refusal to perform a medical service can be burdensome. It is burdensome for patients who will face delays in receiving care while they wait for a willing professional. It is burdensome for other professionals, who must take on additional work. Nevertheless, if these burdens are acceptably small, it may be justified to protect integrity.[38]

There are various ways to keep these burdens minimal when a professional refuses to perform some service: ensuring that there are enough willing providers within a certain geographical area, careful management of staff, etc.[39] Accordingly, it may be reasonable to protect conscientious refusal to directly provide some service in such cases. Yet I am focused not on *direct conscientious refusal* but rather on complicity refusal. It is much more difficult to keep someone from being involved *in any way* with procedures to which they object while keeping the burdens to patients and coworkers at acceptable levels.

Protecting complicity refusal can have serious consequences for patients. The types of treatments institutions and individuals typically object to are concerned with beginning- or end-of-life care and can be life altering.[40] For instance, in ectopic pregnancies, the fertilized egg implants and grows outside of the uterus, which means the developing embryo cannot survive. If left untreated, the embryo can cause serious harm to surrounding organs and lead to the death of the mother.[41] Although one treatment option is the termination of the pregnancy, many Catholic institutions will not even inform the patient of that option, let alone assist in referral. When patients are not informed of key options, including termination of pregnancy, their lives and well-being are put at serious risk.[42]

Of course, not every pregnancy will be life-threatening in this way. But withholding information about options regarding abortion can still lead to a delay in the actions that a patient takes, limiting their family planning options. Some

37 Wicclair, *Conscientious Objection in Medicine*, 8.

38 Magelssen, "When Should Conscientious Objection Be Accepted?" 19.

39 Minerva, "Conscientious Objection, Complicity in Wrongdoing, and a Not-So-Moderate Approach," 116.

40 Ben-Moshe, "The Truth Behind Conscientious Objection in Medicine," 405.

41 National Women's Law Center, "Below the Radar," 4–5.

42 Kaye et al., *Health Care Denied*; and Uttley et al., "Miscarriage of Medicine."

states have stricter laws regarding second- and third-trimester abortions, which means that if patients do not learn of care options early or if they have their care significantly delayed due to someone's complicity refusal, they may have little option but to complete the pregnancy.[43] This can have a drastic impact on the mother's life as well as the child's.

These consequences illustrate the way in which complicity refusal has the potential to violate several key values, some of which are familiar in biomedical ethics. Perhaps most salient is patient *autonomy*, a crucial value of self-direction regarding one's life.[44] Patients who are not informed of all the medically relevant options cannot make informed decisions about their own health. This was illustrated in the case of Tamesha Means, though refusals to translate information also run afoul of patient autonomy. Without autonomy, it can be hard for patients to live their lives authentically in the way they want. Indeed, just as one may feel an acceptable life requires the ability to live with integrity, an acceptable life plausibly requires a high degree of autonomy.

Additionally, the principle of *beneficence* values enhancing the welfare of others, and the principle of *nonmaleficence* calls for avoiding imposing harm on others.[45] Both of these principles are threatened by complicity refusal. As we have seen, those who are unaware that abortion could save their life or protect their health are at significant risk of physical and psychological harm. This is, of course, to say nothing of the professional obligations a health care professional has to their patients and to ensuring they are cared for.[46]

Refusing to refer a patient for certain kinds of reproductive care or emergency contraception may also reinforce an oppressive social norm that can increase a patient's feeling of social stigma.[47] When patients feel vilified, their *moral identity* as a good person and sense of self-respect may consequently be threatened.

Integrity is an important value. But we must consider the consequences of protecting integrity to the extent we do in complicity refusal, as well as the way moral and professional values like autonomy, beneficence, and nonmaleficence are threatened. Integrity may protect one's moral identity and self-respect, but protecting complicity refusal may sometimes threaten the moral identity and

43 Sawicki, "Mandating Disclosure of Conscience-Based Limitations on Medical Practice," 97.

44 Beauchamp and Childress, *Principles of Biomedical Ethics*.

45 Beauchamp and Childress, *Principles of Biomedical Ethics*.

46 Brock, "Conscientious Refusal by Physicians and Pharmacists," 192; May and Aulisio, "Personal Morality and Professional Obligations," 32; and Sawicki, "The Conscience Defense to Malpractice," 1295–301.

47 McLeod, *Conscience in Reproductive Health Care*, 52–55. This is not to say the professional themself endorses oppression or intends to ostracize patients, but this may be an unwelcome byproduct of refusal.

self-respect of patients. Integrity alone does not seem weighty enough to compete with these other values and consequences. This is plausibly true even if integrity is intrinsically valuable, as autonomy also has a strong claim to intrinsic value.

The case is even stronger when one considers that integrity is plausibly violated to a lesser degree in cases of complicity. If someone is forced to kill despite moral objections, they are *the cause* of an individual's death. Yet if someone is complicit in such an act, they are merely a part of the causal chain that leads to the individual's death. This is not to say the complicit individual will not feel their integrity has been violated, but directly participating in an act that they believe is wrong is likely a greater affront to integrity than complicity. That this is so is borne out upon reflection: if forced to choose between performing an act one thinks is wrong and being complicit in such an act, I suspect nearly everyone would prefer complicity. While integrity is important, then, it plausibly bears less weight in indirect cases of complicity.[48]

To summarize, the value of integrity may plausibly justify protecting direct conscientious refusal, provided steps are taken to ensure burdens to patients are minimized. But I contest that it is not valuable enough to outweigh the significant harms, burdens, and value violations that result from protecting that integrity from all possible violations. Current policies that protect health care professionals from even indirect involvement in a procedure to which they object overweight the professionals' integrity compared to the interests of patients and competing values. I call this the *overweighted integrity problem*. The overweighted integrity problem is, in my view, a powerful reason why conscience clauses, at least in medicine, should be worded in a more restrictive way

48 An anonymous referee worries that we cannot compare integrity with other values or reasonably weigh integrity against other consequences; perhaps these are simply incommensurable values. While I admit that these values may *seem* incommensurable, I am also partial to Schmidtz's insight: "At some level, commensuration is always *possible*, but there are times when something (our innocence, perhaps) is lost in the process of commensurating" ("Value in Nature," 394). Integrity is indeed valuable. Yet so are autonomy, health, and well-being. "The hard fact is that priceless values can come into conflict. When they do, and when we rationally weigh our options, we put a price, in effect, on something priceless.… The world hands us painful choices. Weighing our options is how we cope" ("Value in Nature," 393). Nevertheless, even if these values are incommensurable, that does not entail they are *incomparable*. See Chang, "Value Incomparability and Incommensurability": items are incommensurable when "there is no cardinal unit of measure that can represent the value of both items" (207), but they are incomparable when "they fail to stand in an evaluative comparative relation" (205). In that case, my talk of scales and weighing may be inapt metaphorically, but even if these values are incommensurable, they are nevertheless comparable, and protecting autonomy, health, and well-being is more important than protecting integrity in the case of complicity refusal.

to rule out complicity refusal. While integrity is valuable, competing values and consequences are weightier.

Advocates of complicity refusal might initially resist this conclusion in several ways. First, despite the high stakes for patients, if complicity refusal is uncommon, these negative consequences and value violations may occur only rarely, leaving a stronger case for protecting integrity. It is difficult to know exactly how many patients might be impacted by conscientious refusal, let alone how many are impacted by complicity refusal, since many of these refusals will go undocumented. Nevertheless, there are some data that can be useful, especially regarding reproductive care. Conscientious objection to reproductive services is common at the institutional level and may affect millions of patients.[49] Four of the ten largest US hospital systems are Catholic, and Catholic hospitals treat one out of every seven patients, yet they almost universally refuse to provide abortions or sterilizations.[50] Presumably, such refusals spill over into mere complicity refusals, as was the case with Tamesha Means.

Although individual conscientious refusal is not as common as institutional refusal, survey studies of health care professionals suggest a sizeable portion value their integrity even at the expense of patient autonomy.[51] For instance, 22 percent of US primary care physicians surveyed disagreed with the statement "Physicians should not let their religious beliefs keep them from providing patients legal medical options."[52] Similarly, in a survey of over one thousand Idaho nurses, almost 25 percent responded that a nurse's right to conscientious objection should take precedence over a patient's right to health care choices.[53] And in a survey of gynecologic oncologists, 45 percent of those surveyed reported that their personal religious and spiritual beliefs "play a role in the medical options they offered patients."[54] The takeaway lesson is that complicity refusals from both institutions and individual health care professionals may be more common than many of us realize:

> If physicians' ideas translate into their practices, then 14% of patients—more than 40 million Americans—may be cared for by physicians

49 Sawicki, "The Conscience Defense to Malpractice," 1287.

50 Sawicki, "The Conscience Defense to Malpractice," 1288.

51 Sawicki, "The Conscience Defense to Malpractice," 1290.

52 Lawrence and Curlin, "Autonomy, Religion and Clinical Decisions," 216.

53 Davis, Schrade, and Belcheir, "Influencers of Ethical Beliefs and the Impact on Moral Distress and Conscientious Objection," 745.

54 Ramondetta et al., "Religious and Spiritual Beliefs of Gynecologic Oncologists May Influence Medical Decision Making," 576. It should be noted that the response rate for the survey was 14 percent, and Ramondetta and colleagues recommend further research.

> who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29% 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.[55]

The likelihood of a patient being affected by a complicity refusal is not insubstantial.

Despite the probable frequency of complicity refusal, one might suggest that we can mitigate the harms of such refusals and thereby protect competing values more easily than I suggest. For instance, physicians could discuss with new patients at the outset that they have moral objections to certain procedures and will not perform or refer patients for such procedures nor inform them when such procedures might be medically relevant options.[56] Yet physicians cannot know beforehand all the relevant procedures that may apply to a new patient, and such a conversation at an initial meeting might be overwhelming and stressful for patients. Alternatively, physicians or institutions could post signs clearly indicating that they do not offer certain services.[57] While this may avoid some harms to patients, it is far from clear it reduces them sufficiently. Someone like Means may not even have known that abortion was a possible treatment for her condition, so knowing abortions are not offered at that hospital would not have been helpful. Respecting patient autonomy and self-determination requires ensuring patients have information about what their relevant options are, and signage does not provide this knowledge.

Similar issues arise with Ben-Moshe's creative suggestion that objectors advertise their conscientious objections in a publicly accessible online database and allow patients to choose practitioners who do not object to some practice.[58] First, as with posted signs, this still assumes that patients will have the relevant knowledge of which procedures they need in order to search the database effectively. Connecting patients with advocacy groups to help them navigate such issues requires significant resources, and it would also plausibly be a significant source of anxiety for patients. Additionally, as Ben-Moshe

55 Curlin et al., "Religion, Conscience, and Controversial Clinical Practices," 597. Notably, this data concerning referrals is lower than other researchers have reported. In a survey of two thousand US physicians, Combs et al. found that 43 percent disagreed that physicians are obligated to make referrals that they believe are immoral ("Conscientious Refusals to Refer," 399).

56 Wear, Lagaipa, and Logue, "Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment," 155.

57 Minerva, "Conscientious Objection, Complicity in Wrongdoing, and a Not-So-Moderate Approach," 117; and Dresser, "Professionals, Conformity, and Conscience," 10.

58 Ben-Moshe, "Conscientious Objection in Medicine."

acknowledges, this solution is limited in that it does not work in emergencies or geographically limited areas.[59]

Although we ought to pursue routes to limit harms to patients whenever feasible, I am unconvinced that the proposals above sufficiently address these harms or the threats to autonomy and self-respect that complicity refusal also poses. When considering just how broad policies protecting conscientious refusal are, it can be quite difficult to respect an individual's wish to not be associated with some perceived wrongdoing in any way. Impactful attempts to mitigate harm to patients unfortunately come at the cost of significant resources, trading some negative consequences for others without significantly shifting the balance on the scale.

I have argued that current policies protecting complicity refusal overweight integrity in the face of competing values and harms, and consequently such policies should be reformed to better balance integrity with these other values and consequences. This is not to deny that protecting the conscience, and consequently the integrity, of individuals is an "important component . . . of our social and political structures."[60] It is rather to point out that the state has competing interests, including protecting the health and autonomy of its citizens. Even if the state can balance integrity and competing values in direct conscientious refusal, it is implausible that it can do so for complicity refusal. Nevertheless, one might insist that there are yet other considerations in addition to integrity that could justify the state legally protecting complicity refusal, and so these policies do not overweight integrity after all. I turn to these considerations next.

3. Integrity, Tolerance, and Moral Standing

In addition to integrity, tolerance has been offered as a reason to protect conscientious refusal. For instance, Sulmasy writes, "Respect for conscience is at the root of the concept of tolerance. I define tolerance as mutual respect for conscience."[61] Wear and colleagues argue that requiring physicians to refer for care that they find objectionable "lacks any sensitivity toward or toleration of such moral views."[62]

59 Ben-Moshe, "Conscientious Objection in Medicine," 282. Wicclair, "Commentary," offers additional concerns with Ben-Moshe's proposal. While I find these concerns compelling, I cannot devote more attention to them here. Thanks to an anonymous referee for encouraging me to consider these methods of mitigating harms.

60 May and Aulisio, "Personal Morality and Professional Obligations," 33.

61 Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" 145.

62 Wear, Lagaipa, and Logue, "Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment," 153.

While tolerance is a value that can support protecting conscience, the more significant point for our purposes is that tolerance is a state interest and something that states should protect in their laws and policies. Liberal societies, at least, are committed to state neutrality about the good, which speaks in favor of tolerance.[63] Wear and colleagues claim tolerance of moral diversity is "a first principle, particularly in post-industrial, democratic societies."[64] Tolerance can promote diversity and moral reflection, which in turn promotes a healthy democracy.[65]

Tolerance is an important value and a state interest, and adding tolerance to integrity does add some weight in favor of protecting conscientious refusal generally. Nevertheless, I am unconvinced that tolerance can provide enough extra support for complicity refusal. Tolerance is valuable because it promotes diversity, moral reflection, and cooperation.[66] Yet as those who advocate tolerance recognize, it can be trumped by other values, especially when it fails to promote diversity and cooperation. Clearly, if a practice is itself intolerant (e.g., racist, sexist, etc.), it need not be respected.[67] But we need not go this far; if respecting someone's conscience "entails a substantial risk of serious illness, injury, or death to the party that disagrees with the practice, there are grounds for considering whether the practice can justifiably be tolerated."[68] I have argued above that tolerance of complicity refusal does involve these substantial risks, and it also seriously threatens crucial values of respect and autonomy. Significantly, these values are also important for a healthy democracy. Adding tolerance to the scale alongside integrity is insufficient against these competing values and does not provide the needed support for complicity refusal.

Yet perhaps we can add something further to integrity and tolerance in support of complicity refusal. Maybe those who lose their integrity when they are made complicit in activities that they believe are wrong also lose their *moral standing*—often cashed out as a moral right—to hold others accountable for similar activities. Because it is a valuable state interest to have a society in which

63 Ben-Moshe, "The Truth Behind Conscientious Objection in Medicine," 404.

64 Wear, Lagaipa, and Logue, "Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment," 147.

65 Wester, "Conscientious Objection by Health Care Professionals," 430.

66 Indeed, at times, some advocates write as if tolerance is valuable *because* it protects integrity. Wear and colleagues write of objectors who are forced to be complicit feeling morally responsible for wrongdoing rather than "off the moral hook" ("Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment," 150). If tolerance is valuable in part because of its role in protecting integrity, it adds even less weight when added to integrity.

67 Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" 146.

68 Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" 146.

individuals have the right to hold each other accountable, perhaps protecting complicity refusal is justified after all.

To understand this argument, it is useful to briefly survey the nature of moral standing and its relationship with hypocrisy and the closely related concept of complicity. Theorists writing on standing have largely seen it as a right or entitlement.[69] Even if an individual is blameworthy for wrongdoing, we cannot automatically assume that just anyone has the right to blame them. To illustrate, suppose that Nidhi disrespects her students by regularly arriving late to teach her class. She is plausibly blameworthy for wrongdoing. But if I am also regularly unapologetically late to teach my class, *I* do not have the right to blame Nidhi for her lateness. I would be hypocritical, and being hypocritical with regard to some norm or value undermines one's right to blame others for that norm or value.[70]

This is relevant because some have claimed that individuals who are required to be involved in activities to which they conscientiously object are made to be hypocritical. For instance, Gerrard writes when discussing referrals, "From this, it is easy to imagine that conscientious objectors could be viewed as judgemental hypocrites."[71] Yet even if such individuals should not rightly be called *hypocrites*, many in the literature have argued that they may plausibly be seen as *complicit*. Both hypocrisy and complicity are generally thought to undermine moral standing. Nicolas Cornell and Amy Sepinwall argue that this concern with moral standing is a state interest: "a state should care about protecting individuals' standing to engage in moral address for reasons related to the benefits of the so-called marketplace of ideas.... Being put in a position where one's standing to make certain claims is undermined should be viewed as an impairment of an individual's speech interests."[72] Citizens need standing to advocate for their beliefs, and there is great value in citizens being able to advocate for those beliefs freely so that society can discover the best ideas. Compromised standing impacts the equality of citizens in moral accountability, and this is something the state has an interest in protecting. The ability to engage in legitimate moral discourse is a weighty consideration, and alongside integrity and tolerance, perhaps it could provide what is needed to compete with the burdens to patients caused by complicity refusal.

69 Fritz and Miller, "A Standing Asymmetry Between Blame and Forgiveness," 766–68.

70 Cohen, "Casting the First Stone"; Wallace, "Hypocrisy, Moral Address, and the Equal Standing of Persons"; Fritz and Miller, "Hypocrisy and the Standing to Blame"; and Todd, "A Unified Account of the Moral Standing to Blame."

71 Gerrard, "Is It Ethical for a General Practitioner to Claim a Conscientious Objection when Asked to Refer for Abortion?" 601.

72 Cornell and Sepinwall, "Complicity and Hypocrisy," 169.

Why do Cornell and Sepinwall think that those who are involved in some activity they find objectionable lack standing? Their argument begins with hypocrisy. Much of the literature on standing has focused on what Cornell and Sepinwall call *hypocritical moral address*, which involves some kind of blame or holding accountable for wrongdoing when one is hypocritical.[73] There are multiple possible explanations for why the hypocritical blamer lacks the right to blame, but two dominate the literature. On the moral equality view, the hypocritical blamer rejects the moral equality of persons when they are disposed to blame others without blaming themselves for relevantly similar faults. Because the right to blame is grounded in the equality of persons, however, the hypocritical blamer lacks the right to blame others for the relevant norm violation.[74] A different view, the commitment view, holds that the trouble with hypocritical blame is that such blamers are not sufficiently committed to the relevant norm they blame others for violating. If they were so committed, they would blame themselves as well as others for violating the norm. This lack of commitment to the relevant norm undermines one's right to blame others for violating the norm.[75]

Yet Cornell and Sepinwall suggest there is a weaker sort of hypocrisy than hypocritical moral address: *mere hypocritical inconsistency*. Mere hypocritical inconsistency "involves failing to conform one's conduct to one's moral judgments, but without blaming or addressing others."[76] This mere inconsistency, they suggest, does not undermine an individual's standing to blame. After all, they are not blaming anyone. But because of this inconsistency, if the merely inconsistent hypocrite *were* to blame someone, *then* they would open themselves up to the charge of hypocritical moral address. As Cornell and Sepinwall write, "mere hypocritical inconsistency is a proto version of hypocritical moral address. This suggests a reason not to be hypocritically inconsistent: it makes one's future moral address liable to being hypocritical."[77] The idea is that even

73 Cornell and Sepinwall, "Complicity and Hypocrisy," 157.

74 Fritz and Miller, "Hypocrisy and the Standing to Blame," 125–27, and "The Unique Badness of Hypocritical Blame," 546–50.

75 Riedener, "The Standing to Blame, or Why Moral Disapproval Is What It Is"; Todd, "A Unified Account of the Moral Standing to Blame"; Lippert-Rasmussen, "Why the Moral Equality Account of the Hypocrite's Lack of Standing to Blame Fails"; and Piovarchy, "Hypocritical Blame as Dishonest Signaling." Why lack of commitment to a norm undermines one's right to blame has been disputed. Todd and Riedener both see it as a fundamental fact. Piovarchy, however, suggests that blame is justified by signaling commitment to a norm, but hypocritical blame is dishonest signaling that undermines the very function of blame.

76 Cornell and Sepinwall, "Complicity and Hypocrisy," 157.

77 Cornell and Sepinwall, "Complicity and Hypocrisy," 164.

if one does not lose one's standing to blame through mere hypocritical inconsistency, such inconsistency limits one's ability to hold others accountable for wrongdoing in the future. Once one morally addresses another for wrongdoing that one has been inconsistent about oneself, one enters the realm of hypocritical moral address, and the arguments for why one's standing to blame is undermined come into play.

Importantly, complicity is also thought to undermine the standing to blame. If I am involved in some wrongdoing, I forfeit my right to blame you for the wrongdoing. After all, I am partly to blame. While it may be more objectionable to be willingly involved in wrongdoing, Cornell and Sepinwall argue that there is a weaker form of complicity: *mere involvement complicity*. This complicity is merely being involved in some wrong regardless of whether one intends to contribute to the wrong and regardless of whether one's actions could prevent the wrong from happening.[78] The connection to the wrong, however tenuous, is enough for mere involvement complicity. Just as being hypocritically inconsistent prevents one from holding others accountable on pain of engaging in hypocritical moral address, mere involvement complicity prevents one from holding others accountable on pain of becoming something akin to a hypocrite.[79] In other words, even mere involvement complicity can limit an individual's ability to morally engage in the community and blame others for certain perceived wrongdoing.

We can formalize the heart of Cornell and Sepinwall's argument and apply it in the current context of the overweighted integrity problem:

1. When the state denies complicity refusal, it forces others to be associated with behaviors that they believe are wrong.
2. If one is associated with some activity that one believes is wrong, then one's standing to hold others accountable for that behavior is undermined.
3. So when the state denies complicity refusal, it undermines the standing of its citizens to hold others accountable for behaviors that they believe are wrong.
4. The state should protect the standing of its citizens to hold others accountable for behaviors that they believe are wrong.
5. So the state should protect complicity refusal.

I have explained Cornell and Sepinwall's reasoning for the premises above. If the argument works, the state ought to keep complicity refusal in place not

78 Cornell and Sepinwall, "Complicity and Hypocrisy," 161.

79 Cornell and Sepinwall, "Complicity and Hypocrisy," 166.

merely to protect integrity but to protect the moral standing of its citizens and to ensure a flourishing society that can engage in moral discourse. In the next section, however, I will argue that the argument fails with the second premise.

4. The Fall of the Moral Standing Argument

A key premise of the argument above is that being associated with some activity that one believes is wrong undermines one's standing to hold others accountable for that behavior. Cornell and Sepinwall say that one reason not to be merely hypocritically inconsistent is that "it makes one's future moral address liable to being hypocritical."[80] Something similar can be said about mere involvement complicity. If I am in some way connected to the wrong behavior—however tangentially—it might seem that I would not be entitled to criticize others for that behavior.

This raises an important question though. When is standing undermined, and why? Cornell and Sepinwall are not clear on this point, but the quote above could be read to suggest that standing is undermined *in the process of blaming*. On this picture, being weakly complicit *itself* does not undermine one's standing; that standing is lost only when one attempts to make a moral address. Alternatively, one might think that standing is undermined before ever making an address.

The first option is implausible. It suggests that one lacks the standing to do something only when one tries to do it, and not before. Yet it is difficult to see how only by engaging in *X* do I thereby lack the right to *X*. If one lacks a right to *X* only by engaging in *X*, then it is too late to lose that right. Instead, it is more plausible that the right to blame is lost *before* any address. To illustrate, an unfaithful lover might be unaware that his partner is also unfaithful. Because he is unaware, he does not blame his lover. But he lacks the standing to blame for infidelity before ever actually blaming.[81] It is not the case that the lover has the standing to blame just up to the point at which he begins to blame and then loses that right when trying to exercise it in the process of blaming.

If standing is undermined before one makes any moral address, there must be something that undermines that standing prior to the address itself. So does mere involvement complicity undermine one's standing to blame? And if so, why?

80 Cornell and Sepinwall, "Complicity and Hypocrisy," 164.

81 This is the example of Cato and Danae I have used elsewhere. See Fritz and Miller, "Two Problems of Self-Blame for Accounts of Moral Standing," 846.

If involvement complicity undermines standing, the first point to appreciate is that nearly everyone will lose standing to blame for a variety of wrongs in the world. Through politics, capitalism, trade markets, and dumb luck, each of us lies in some causal chain that could plausibly be tied back to wrongdoing.[82] To illustrate, using a variety of electronic devices makes one complicit in the mining of rare earth elements, climate change, and other environmental harms.[83] Nevertheless, most of us believe that we have the right to blame polluters, companies that contribute to climate change, or celebrities and billionaires with large carbon footprints. Residents of the United States pay taxes that may fund wars, thereby making them complicit in those wars. If this involvement complicity undermines standing, no tax-paying US resident has the right to blame their government for what they see as an unjust war.[84]

The upshot is that many of us are complicit, however weakly, in a great deal of activities that we may think are wrong. If this weak complicity undermines one's standing, many of us lack the standing to morally address others for such wrongdoing. That would be an unwelcome conclusion—especially if the state has a strong interest in ensuring citizens are entitled to morally address each other. But this conclusion on its own does not show that complicity does not undermine standing. Perhaps there is good reason to think that this unwelcome conclusion is nevertheless true. To determine that, we must turn to the most common explanations of when standing is undermined and see if they apply to the case of involvement complicity.

82 As the band Spanish Love Songs mourns in their song, "Optimism (As a Radical Life Choice)," "Can't even have my coffee without exploiting someone or making another millionaire a billionaire."

83 Balaram, "Rare Earth Elements."

84 Cornell and Sepinwall acknowledge this concern with taxes: "One might think that, by paying taxes that support a war effort one becomes complicit in that war" ("Complicity and Hypocrisy," 178n31). Nevertheless, they suggest that taxes are different from conscription:

> Because everyone pays taxes, we are all placed in a similar position, which it is hard then to view as a disability insofar as it is generally shared.... One might think of this difference as based on a shared understanding that none of us will treat the *de minimis*, fungible contributions of our tax dollars as undermining each other's standing, because we all know that the government will inevitably fund projects that each of us does not believe in from time to time (178n31).

Yet the idea that we are all in a similar position is precisely the point. If mere involvement complicity undermines standing, then it is not particularly useful to reply that we can just ignore everyone's undermined standing in some cases. One still lacks the right to blame in such cases. Yet this seems the wrong result: I suspect many of us would insist that we *do* have the right to blame a government for some war to which we are morally opposed, even knowing that our taxes help fund that war. The explanation for this, as I explain below, depends on an individual's attitudes.

Let us begin with the commitment view. On this view, if someone demonstrates they are not sufficiently committed to some norm, they lack the standing to blame for violations of that norm. This could apply when someone hypocritically blames others for wrongdoing but not themself. If that person were properly committed to the norm, they would blame themself for violations just as they blame others. Or it could occur when they are problematically involved in wrongdoing, since that involvement could indicate that they lack sufficient commitment to the norm.

Does involvement with some norm violation show that one lacks sufficient commitment to the norm? Not necessarily. Patrick Todd, a proponent of the commitment view, writes, "It is, at most, only a particular *kind* of involvement that removes standing.… Involvement removes standing only when it indicates a lack of commitment to the values that would condemn the wrongdoer's actions."[85] The commitment at issue requires "*endorsement* of the value as a genuine value" and "at least some degree of *motivation* to act in accordance with the value."[86] The better question to ask, then, is whether one can be committed to some norm (or value) while still being complicit in some violation of that norm.

The answer is plausibly affirmative—especially if one is *unwillingly* complicit in the violation. Those who are legally compelled to be complicit in a norm violation can nevertheless strongly endorse that norm and remain motivated to act in accordance with it. This is precisely the situation many health care professionals might find themselves in if we no longer protect complicity refusal. It is not as if someone who thinks that performing an abortion violates a norm against killing will no longer endorse such a norm simply by cleaning instruments used in the procedure. Even those who provide information on abortion can endorse norms that forbid it. Similarly, they will retain their motivation to act in accordance with the norm. The very fact that their involvement is unwilling indicates their commitment to the norm.

At this point, one might object that sufficient commitment is quite strong: perhaps "one must be unassailably free of taint from a wrong if one is to condemn others for it."[87] Phrased differently, one might think that an unblemished moral record with respect to some norm is required to show that one is committed to a norm, yet involvement complicity taints that moral record.

It is important to stress that one can remain committed to a norm without being a moral saint who perfectly complies with the norm. Consider the case of

85 Todd, "A Unified Account of the Moral Standing to Blame," 355. Todd frames his view in terms of commitment to *values* rather than commitment to *norms*, but nothing of substance hangs on this distinction.

86 Todd, "A Unified Account of the Moral Standing to Blame," 355.

87 Cornell and Sepinwall, "Complicity and Hypocrisy," 168.

Nina, who claims to be deeply committed to a norm against losing one's temper when a child misbehaves. Nina takes various steps to ensure she abides by this norm, including meditation and exercise. Yet one day, she loses her temper with her child, in part due to factors out of her control. Even when she fails to comply with the norm on this one occasion, it would be implausible to claim that Nina is not seriously committed to the norm against losing one's temper.[88] And in this case, Nina directly violates the norm herself; she is not merely associated with the violation. While we may disagree about exactly how compliant with a norm one must be in order to be sufficiently committed to it, moral perfection is, in my view, clearly too high of a bar.

If individuals need not be morally perfect to be committed to a norm, then if there is any moral taint that comes with merely being involved in some potential wrongdoing, it might not be problematic for the commitment view. Being willingly complicit in something one claims to believe is wrong may suggest that one lacks the relevant commitment. But being unwillingly complicit does not suggest that one does not endorse the relevant value or lacks the motivation to uphold it. This shows the importance of attitudes and beliefs in determining an individual's standing; it is not merely a matter of whether an individual is somehow connected to some wrongdoing. The citizen who pays her taxes knowing that those taxes fund a war to which she is morally opposed may still endorse pacifist values and norms. Perhaps she shows this endorsement by participating in protests, calling her representatives, and actively writing about why the war is wrong. She pays taxes only because they are compulsory—but what demonstrates one's commitment to a norm is what one does *freely*. Compulsory actions reveal little about the norms one endorses internally.

In sum, if standing requires commitment to a norm, complicity does not necessarily undermine that standing. One can remain sufficiently committed while being complicit, depending on one's attitudes and what external forces are at play. There is simply no good motivation for understanding the necessary commitment to a norm as so impossibly high that it means one cannot be in any way involved or associated with anything that violates that norm.

If involvement complicity does not necessarily show that one is not sufficiently committed to a norm and thereby lacks the standing to blame for that norm, then premise two cannot be supported with the commitment view. Yet the moral equality view stands as the other chief explanation for undermined standing. If mere involvement in wrongdoing shows that one rejects the moral equality of persons, then premise two could be supported in that way.

88 Fritz and Miller, "Two Problems of Self-Blame for Accounts of Moral Standing," 840.

Currently, the most developed version of the moral equality view is the one I have advocated with Daniel Miller.[89] We argue that an individual's standing is undermined when they are unfairly disposed to blame differentially for violations of some norm. The reason for this is that such unfair differential blaming dispositions implicitly reject the moral equality of persons, yet that equality of persons is what grounds the right to blame in the first place.

It is important to highlight the role of dispositions in explaining why standing is undermined on this view. Miller and I hold that merely engaging in behavior you have condemned as wrong does not thereby undermine your standing.[90] What matters are your attitudes regarding that behavior, both towards yourself and others. Inconsistency in one's professed values and behaviors does not automatically show that one has implicitly rejected the moral equality of persons. For example, if an akratic vegetarian eats a burger but feels guilty and blames themself for wrongdoing, they do not reject the equality of persons. They treat themself just the same as they would others who eat meat.

As discussed above, if we reject complicity refusal, health care professionals would be *compelled* to be involved with actions that they believe are wrong and thereby would be compelled to be inconsistent in their actions and attitudes. Just as in the case of the commitment view, this compulsion is significant because it likely indicates a lack of any problematic differential blaming dispositions.

Consider three different types of agents. Julien holds very high standards and thinks that being in any way involved with perceived wrongdoing is blameworthy. Although Julien is compelled by the state to be complicit in something she believes is wrong, she is disposed to blame herself just as she is disposed to blame others. She feels her integrity is tarnished due to her complicity, and this produces guilt and self-blame. Julien is consistent in her blaming dispositions and so maintains the standing to blame despite being complicit, because she holds herself to the same standards as others.

A second agent, Lucy, is less strict than Julien. Lucy believes that compulsion by the state is a reasonable excuse for engaging in mere tangential involvement in some perceived wrongdoing. Accordingly, when Lucy is compelled by the state to be complicit in something she believes is wrong, she is not disposed to blame herself. Yet Lucy also lacks any unfair differential blaming disposition, because she is not disposed to blame anyone *else* who is compelled to be complicit either. While Lucy may be disposed to blame those who *willingly*

89 Fritz and Miller, "Hypocrisy and the Standing to Blame" and "The Unique Badness of Hypocritical Blame."

90 Fritz and Miller, "Hypocrisy and the Standing to Blame," 121.

violate the norm, she grants the same grace to others that she grants to herself regarding compulsion. Consequently, she too retains the standing to blame on a moral equality account, because she lacks any differential blaming disposition.

The final agent is Phoebe. In contrast to Julien and Lucy, Phoebe is disposed to let herself off the hook for being compelled to be complicit in something she believes is wrong but nevertheless is disposed to blame others who are similarly compelled to be complicit in wrongdoing. Phoebe *does* lack the standing to blame others, as she has an unfair differential blaming disposition.

While there could be health care professionals like Phoebe, such agents seem straightforwardly hypocritical, and we should expect them to lack the standing to hold others accountable for the relevant norm violation. But more likely are agents like Julien or Lucy, who are consistent in their blaming dispositions. Some individuals will see compulsion as a reasonable excuse for everyone and will let themselves and others off the hook as a result. Others will refuse to see compulsion as an excuse and so will blame anyone who is compelled to be complicit in wrongdoing—themselves included. After all, the sorts of agents who see mere involvement in some activity as a threat to their integrity will also probably blame themselves for being involved in that activity. Either way, such individuals do not lack the moral standing to blame on the moral equality account, and premise two remains unsupported.[91]

Cornell and Sepinwall are quick to reject the notion that compulsion can protect one's standing, especially when we consider the excuses offered by individuals during trials after the fall of the Nazi regime or apartheid.[92] But even if one maintains the standing to blame others, this does not imply that they are not guilty of any wrongdoing. We can condemn the actions of those who were complicit in Nazi Germany or apartheid without holding that their standing to blame others is undermined. What matters for standing is not simply compulsion but the consistent blaming dispositions of the agent; if someone blames themself just as they blame others for their unwilling involvement in the Nazi regime, they maintain their standing to blame. Nevertheless, it is plausible that the unwillingly complicit should have done more to resist these great atrocities. We need not deny their standing to condemn their complicity.[93]

91 Notably, an agent's standing is not completely at the mercy of the state on the moral equality account. Individuals who have lost their standing via differential blaming dispositions could regain that standing simply by coming to be disposed to blame themselves the same as others who are similarly compelled.

92 Cornell and Sepinwall, "Complicity and Hypocrisy," 168.

93 It is worth emphasizing that there are relevant differences between complicity in a genocidal regime and complicity in providing medically accepted but morally contested care. The

Cornell and Sepinwall do consider that these attitudes could be significant: "The compelled actor might well feel terrible, acknowledge his fault, and blame himself for it. Shouldn't this person's standing then remain intact? Perhaps. But even if this person treats others just as he treats himself, no one else will know this."[94] This is an odd response, however. Whether one *believes* someone has blamed themself clearly has no bearing on whether they have *actually* blamed themself. Someone may have standing to blame regardless of whether anyone knows this. If the state is to have an interest in protecting moral standing, it must be *actual* moral standing, not simply what people might *believe* about moral standing. It would be portentous to make accommodations at great cost to society merely because some individuals *think* their standing is undermined when it in fact is not.

In sum, we were hunting for something valuable to place on the scale alongside integrity and tolerance that might justify protecting complicity refusals. Moral standing was a promising candidate. But one must first show that being associated with some activity that one believes is wrong, even if unwilling, undermines one's standing to hold others accountable for that behavior. There is no good reason to believe this. Neither of the leading explanations of undermined standing, the commitment view and the moral equality view, support it. Without the support of that crucial premise, there is no reason to believe that moral standing is actually undermined when the state compels individuals to be associated with behavior that they believe is wrong.

5. Conclusion

Current policies protecting complicity refusal are unjustified. Significant values that are integral to biomedical ethics, such as autonomy, beneficence, and nonmaleficence, are on the line, as well as patient rights and negative consequences for society. Integrity alone cannot compete with these values, and tolerance adds little additional weight. If the moral standing of health care professionals would be widely undermined without complicity refusal, this may be enough to tip the scales, since the state has an interest in ensuring citizens can hold each other to account. Yet this appeal to moral standing fails. Complicity refusal is, in the end, unjustified.

What are the policy implications for such a conclusion? First, conscience clauses need to be rewritten to exclude such broad complicity refusals. How

stakes are much higher in the former case, so there may not be the same duty to resist in the latter set of cases.

94 Cornell and Sepinwall, "Complicity and Hypocrisy," 168–69.

restrictive these clauses should be depends on empirical evidence regarding how often patients are denied relevant information about their care and the negative consequences of this ignorance. It may be reasonable to accommodate direct conscientious refusal while still respecting patient autonomy and well-being, provided patients can nevertheless receive the information and care they need in a timely manner. Whether this is possible for some subset of complicity refusals is unclear. Health care professionals, philosophers, and policymakers should all be involved in that discussion. One thing is clear though: the way many policies are currently worded is too broad.

Second, institutions should provide a method of making clear that some individual is only involved in some activity because of a legal requirement. Even Cornell and Sepinwall make this suggestion: "where the state imposes a contested legal requirement on someone who objects, it might incur an affirmative duty to make clear to others that the objector complies only because she is legally compelled to do so."[95] This allows those who object to stand apart from those who willingly participate, ensuring the objectors do not unfairly condemn other compelled actors and thereby undermine their own standing. It also provides a way for objectors to credibly demonstrate their moral beliefs in some manner, even if they must act in ways that they see as inconsistent with those beliefs. It may even minimize feelings of guilt or remorse or mitigate the threat to an individual's moral identity. There are various methods that institutions could adopt to share such information, including maintaining a database or encouraging objectors to wear some token to signal their objection.

The current state of conscience policy in US health care is unjust. In many states, policies protect the integrity of health care professionals to such an extent that professionals need not be involved in any way with care to which they object. Yet these policies leave patients without sufficient information about their own care, and the policies can result in serious negative health outcomes for patients like Tamesha Means. Despite the value of integrity, it cannot compete against autonomy, benevolence, and nonmaleficence. Valuing patients requires restricting complicity refusal.[96]

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95 Cornell and Sepinwall, "Complicity and Hypocrisy," 171.

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