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Recognizing Conscience in Abortion Provision

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The exercise of conscience in health care is generally considered synonymous with refusal to participate in contested medical services, especially abortion. This depiction neglects the fact that the provision of abortion care is also conscience-based. The persistent failure to recognize abortion *provision* as "conscientious" has resulted in laws that do not protect caregivers who are compelled by conscience to provide abortion services, contributes to the ongoing stigmatization of abortion providers, and leaves theoretical and practical blind spots in bioethics with respect to positive claims of conscience — that is, conscience-based claims for offering care, rather than for refusing to provide it.

Pairing of "conscience" and antiabortion sentiment is an understandable consequence of the evolution of conscientious objection in health care. The first conscience legislation, the Church Amendment, arose in 1973 in the wake of *Roe v. Wade*. It declares that a health care worker cannot be required to perform or assist in the performance of abortion (or sterilization) procedures that conflict with "his [sic] religious beliefs or moral convictions,"[1] and it prohibits discrimination against workers who refuse to provide care on the basis of their moral convictions. It also prohibits discrimination against those who do perform "a lawful sterilization procedure or abortion," though it does not recognize that moral convictions might drive such care. Thus, opposition to abortion, and to fertility control generally, catalyzed the development of law, theory, and practice of conscientious objection in medicine. Conscientious refusals and opposition to abortion grew up together, so to speak.

Over the past 40 years, the idea that conscience-based care means *not* providing or referring for abortion or other contested services has become naturalized. In 2008, the Bush administration extended the protections offered by the Church Amendment to workers who chose not to participate, even indirectly, in care that violated their moral beliefs. The Obama administration rescinded that rule. Antiabortion groups embraced Bush's rule and criticized Obama's rescinding of it; prochoice groups responded in the opposite manner. The result is an ongoing false dichotomization of abortion and conscience, making it appear that all abortion opponents support legal protections of conscience and all supporters of abortion rights oppose such protections, with little nuance in either position.

Whether or not abortion pro-

vision is "conscientious" depends on what conscience is. Most ideas of conscience involve a special subset of an agent's ethical or religious beliefs — one's "core" moral beliefs.[2] The conclusion that abortion provision is indeed "conscientious" by this standard is best supported by sociologist Carole Joffe, who showed in *Doctors of Conscience* that skilled "mainstream" doctors offered safe, compassionate abortion care before *Roe*.[3] They did so with little to gain and much to lose, facing fines, imprisonment, and loss of medical license. They did so because the beliefs that mattered most to them compelled them to. They saw women die from self-induced abortions and abortions performed by unskilled providers. They understood safe abortion to be lifesaving. They believed their abortion provision honored "the dignity of humanity" and was the right — even righteous — thing to do. They performed abortions "for reasons of conscience."[3]

Though abortion providers now work within the law, they still have much to lose, facing stigma, marginalization within medicine, harassment, and threat of physical harm. However, doctors (and, in some states, advanced practice clinicians) continue to offer abortion care because deeply held, core ethical beliefs compel them to do so. They see women's reproductive autonomy as the linchpin of full personhood and self-determination, or they believe that women themselves best understand the life contexts in which childbearing decisions are made, or they value the health of a woman more than the potential life of a fetus, among other reasons.[3] Abortion providers continue to describe their work in moral terms, as "right and good and important,"[4] and articulate their sense that the failure to offer abortion care generates a crisis of conscience.[5]

Persistent neglect of the compatibility between conscience and abortion provision not only misrepresents their relationship, but has consequences for law, clinical practice, and bioethics. First, U.S. federal and state laws continue to protect only conscience-based refusals to perform or refer for abortion, offering minimal legal protection for conscience-based abortion provision. For example, the recent Georgia and Arizona bans on abortion after 22 and 20 weeks' gestation, respectively, include no allowances for providers conscience-bound to offer care after that limit. And the global "gag rule" forbidding workers at organizations funded by the U.S. Agency for International Development to discuss abortion has no conscience exemptions.

Second, the equation of conscience with nonprovision of abortion contributes to the stigmatization of abortion providers. If physicians who offer abortion care don't have a legitimate claim to act in "good conscience," like their counterparts who oppose abortion, the implication is that they act in "bad conscience" or lack conscience altogether. This understanding reinforces images of abortion providers as morally bankrupt. Such stereotypes may deter doctors from offering abortion services, thereby contributing to provider shortages. More important, stereotyping may have dangerous consequences: sociologists confirm that harassment and violence are extreme extensions of stigmatization.

Finally, bioethicists have focused on defining conditions under which conscientious refusals are acceptable but, with rare exceptions, have neglected to make the moral case for protecting the conscientious provision of care. Indeed, there is a real asymmetry between negative duties (to not do something) and positive duties (to do something) and, accordingly, between negative and positive claims of conscience. Violations of negative claims are considered morally worse than violations of positive ones.[2] However, as bioethicist Mark Wicclair argues, the moral-asymmetry thesis does not provide adequate ethical justification for current conscience law, which protects only conscience-based refusals.[2] Moral integrity can be injured as much by not performing an action required by one's core beliefs as by performing an action that contradicts those beliefs.[2]

The moral contours of positive claims of conscience require further elaboration, since they have implications for many other arenas of health care and research in which workers may be conscience-bound to do something — for example, physician-assisted suicide or stem-cell investigation. *Doing* something reflects a conscientious commitment, as legal scholars Bernard Dickens and Rebecca Cook would say, and it is a moral gesture, to borrow the words of bioethicist Laurie Zoloth. Bioethical scholarship, however, is dominated by considerations of conscientious refusal, not conscientious provision.

Abortion opponents may argue that abortion providers are motivated not by conscience but solely by political beliefs. Although I disagree, this critique indeed highlights the importance of distin-

guishing claims of conscience from other types of claims. Certainly, if abortion providers' conscience-based claims require scrutiny, so do conscience-based refusals, to ensure that refusals are indeed motivated by conscience and not by political beliefs, stigma, habit, erroneous understanding of medical evidence, or other factors.

Despite nearly four decades of debate about conscientious refusals, we have no clear path for operationalizing them — no standard curriculum to teach health care professionals how to humanely conscientiously object, and no clinical standard of care for conscientious refusals — although there are presumably good and bad, skillful and haphazard, safe and unsafe ways of carrying them out. Since we need both a standard curriculum and a standard of care, it is perhaps premature to introduce a whole new set of conscience claims. The terms used in the current debate, however, are inadequate and inaccurate.

Recognizing only negative claims of conscience with respect to abortion — or any care — is a kind of hemineglect. Health care workers with conflicting views about contested medical procedures might all be "conscientious," even though their core beliefs vary. Failure to recognize that conscience compels abortion provision, just as it compels refusals to offer abortion care, renders "conscience" an empty concept and leaves us all with no moral ground (high or low) on which to stand.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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The Supreme Court and the Future of Medicaid

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Perhaps the biggest of the many surprises found in the Supreme Court's June 28 decision on the Affordable Care Act (ACA) was the Court's conclusion that the law's Medicaid expansion scheduled for 2014 was unconstitutional.[1] Attention before June 28 was focused on whether the Court would uphold the individual mandate to obtain health insurance coverage, but in the wake of the Court's decision, focus has shifted to the question of whether states will refuse to participate in expanding the Medicaid program, given the Court's holding that the Secretary of Health and Human Services cannot enforce the expansion as a mandate.

Sommers et al. now provide in the *Journal* (pages 1025–1034) a glimpse of the impact of Medicaid expansion in New York, Maine, and Arizona. Medicaid expansion in these states was associated not only with improved health care coverage but also with reduced mortality. The question of whether the states will expand Medicaid, therefore, is not just a question of politics; it is a question of life, health, and death.

The expansion is one of several important Medicaid changes in the ACA. But as Justice Ruth Bader Ginsburg noted in her opinion, changes in Medicaid are not new. Medicaid itself was established in 1965 as an amendment to the preexisting Medical Assistance for the Aged program. Since then, Congress has amended Medicaid at least 50 times, mandating coverage of new categories of beneficiaries (e.g., low-income pregnant women in 1988) and dramatically expanding coverage for others (e.g., low-income children in 1989). Indeed, the Social Security Act has always reserved to Congress "the right to alter, amend, or repeal any provision" of the Medicaid statute.[2] The ACA's expansion of Medicaid to cover all nonelderly low-income persons with household incomes below 138% of the federal poverty level was the latest in a long line of evolutionary program reforms.

The 26 state challengers claimed that the ACA Medicaid amendments crossed a constitutional line. It is clear that Congress cannot force states to par-