Is it justified to grant a right to conscientious objection to health care professionals not willing to perform abortion? A problematization of the right to conscientious objection as institutional corruption

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Introduction

The right to conscientious objection in health care is closely linked to the right to abortion. Indeed, as Wicclair explains:

> [t]e earliest statutory recognition of conscientious objection in medicine in the United States grew out of the 1973 Roe v. Wade decision in which the U.S. Supreme Court struck down laws prohibiting abortion. Responding in part to intense and powerful moral and political opposition to abortion, the U.S. Congress enacted `conscience clause' legislation that recognizes a right of conscientious refusal in relation to abortion and sterilization. […] In the UK, the Abortion Act 1967 includes a conscientious objection clause that permits physicians to refuse to participate in the termination of pregnancies. (Wicclair, 2011, p. 207).

However, even decades after the right to abortion is still fragile. Indeed, in October 2016, in Italy, a woman was left to die by blood loss because the medical staff was conscientiously opposed to abortion. The dead woman's family reported that the staff was not willing to intervene as long as the fetuses were "alive" (Kirchgaessner, 2016). In 2015, Portugal tightened its abortion law, charging women* willing to abort and requiring them to undergo various psychological tests beforehand (Agence France-Presse in Lisbon, 2015). In 2011 Spain, Rajoy's government planned to restrict the access to abortion for cases of rape or when the mother*'s life is endangered. The project was finally abandoned due to its controversy even among the members of the conservative Spanish *Partido Popular* (Cué, 2014). In the US, these ultimate years have seen numerous attempts to limit the right to abortion in various of its States, as the so called "heartbeat bills" (Lai, 2019).

However, these instances are only the tip of the iceberg. Indeed, the large spreading of resort to conscientious objection among health care professionals is insidiously undermining the implementation of abortion right in Western democracies. As Ceva and Ferretti explained in a 2014 article, in certain Italian regions, 90% of the physicians are conscientious objector as concerns abortion.

My aim with this *mémoire* is to question whether the right to conscientious objection to abortion for health care professionals is morally justified, both as a legal and as a moral right.

I will first detail the epistemological, methodological, and theoretical frameworks in which I will ground my reflexion, before defining some key concepts through conceptual analysis. I will then submit my judgement to the process of wide reflective equilibrium.

Epistemological, methodological, and theoretical frameworks

An analytical perspective

The main objective of my *mémoire* is to develop an argument to refute the moral and legal permissibility for professionals working in public institutions to appeal to conscientious objection in reproductive health care. To do so, I will take an analytical perspective, since it will allow me to firstly differentiate the concept of "conscientious objection" from other closely meaning-related concepts, such as civil disobedience, whistleblowing, and conscientious evasion. Indeed, analytical philosophy is a useful tool when aiming at differentiating and defining concepts. Then, analytical philosophy will also help me to structure a logical argument extending previously held arguments about the use of conscientious objection in reproductive health care in order to offer an innovative analysis of conscientious objection in health care under the lens of the theory of institutional corruption.

I have chosen a deontological approach to public ethics which means that I will look at the processes within the institutions that lead to public policies. This view opposes the consequentialist approach that focuses only on the impacts of public policies. The latter approach is the one mostly used in the literature referring to the right to conscientious objection in health care. This means that most of the literature focuses on showing the effects of such a right and puts into question the impacts it can have. Their solutions are then to find a compromise to reach desirable consequences which often is to grant a more or less limited right to conscientious objection to health care professionals in order to, nevertheless, guarantee an equal access to health care for all (see the various strategies described on Wide Reflective Equilibrium Part). In taking a deontological point of view, I am aiming at guaranteeing equality *within* the process, not only in its consequences. My approach will then be to question the right to conscientious objection in health care itself. My main concern in having a consequentialist approach is the risk of, while having egalitarian outcomes, resting on an unequal process. One has to keep in mind that having just outcomes does not mean that the process leading to these outcomes is, as a matter of fact, just. On the other hand, taking a deontological approach focuses on the processes that lead to the outcomes and, therefore, allows to set up a fair process. In concrete terms, it means that I will pay attention to guaranteeing equal conditions for the actors implicated in the process, namely health care professionals, institutional actors at large, patients, and citizens.

Methodologies

The first part of my *mémoire*, will be employed to differentiate related concepts characterizing actions that defy what the authorities having a moral claim over one asked them to do. One of the best methodologies in analytical philosophy to disambiguate closely meaning-related concepts is conceptual analysis (Olsthoorn, 2017, p. 168). Indeed, conceptual analysis is designed to meticulously define concepts, in giving "individually necessary and jointly sufficient conditions for the concept to apply" (Olsthoorn, 2017, p. 164). This leads to the possibility of clearly and logically differentiating closely meaning-related concepts, and thus to develop a consistent argument without having terminological problems.

The second part of my *mémoire*, will determine whether my intuition, or "*judgement*" (Knight, 2017, p. 47), that conscientious objection cannot take place in public hospitals can, reasonably, be held as justified. To do so, I have chosen to use the methodology of wide reflective equilibrium, which aims at "bring[ing] principles and judgements into accord", where "[p]rinciples are relatively general rules for comprehending the area of enquiry", and "[j]udgements are our intuitions or commitments, 'at all levels of generality' (Rawls 1975: 8), regarding the subject matter" (Knight, 2017, p. 46). Concretely, this method implies seven steps detailed by Carl Knight: the first is to make considered judgements, and the second is to establish a list of contending principles. The third one consists in testing the principles implications against the judgements. The fourth step implies "bring[ing] in devices of representation and background theories" (Knight, 2017, p. 58). The fifth step is to review the process, the sixth is to establish priority rules and, lastly, the seventh step concludes the process (Knight, 2017, pp. 56–59). I will go through this process after having defined the main concepts used in this *mémoire.* Before that, I will set up the main conception of the public order I am going to follow all along my *mémoire*, namely the Rawlsian liberal theory.

Rawlsian liberal theory

In his famous 1971 book *A Theory of Justice*, Rawls gave the criteria that a just liberal society should follow to be considered a well-ordered society and his model has, since then, been a solid basis for liberal theory and contemporary political theory. I have chosen to anchor my argument in a Rawlsian liberal theory because of its importance in contemporary debates

over the use of conscientious objection regarding abortion. Indeed, most of the literature on this topic mobilizes a conception close to Rawls's conception of justice as fairness.

The Rawlsian theory of justice is based on the assumption that "justice is the first virtue of social institutions" (Rawls, 2005, p. 3), which guarantees the equal consideration of each individuals constituting society. Under the veil of ignorance are established the basic principles that are to guide the conception of justice and thus the establishment of laws and institutions (Rawls, 2005, p. 13). The two basic principles of justice, agreed upon through the original position are:

1. "The principle of greatest equal liberty.
2. (a) The principle of (fair) equality of opportunity
   (b) The difference principle"
   (Rawls, 2005, p. 302)

Rawls states that:

> [t]he two principles are in lexical order, and therefore the claims of liberty are to be satisfied first. Until this is achieved no other principle comes into play. The priority of the right over the good, or of fair opportunity over the difference principle, is not presently our concern. […], the precedence of liberty means that liberty can be restricted only for the sake of liberty itself (Rawls, 2005, p. 244).

Rawls explains that it means that liberty can be reduced only if this or another basic liberty is to be protected. In that case, the system of liberties has to be adjusted following the guidance of the representatives (Rawls, 2005, p. 204). The lexical order for the principles, and the first principle itself, thus underline the importance Rawls gives to liberty in his theory. However, he does not provide a consistent and comprehensive account of "basic liberties"[1].

A strong emphasis is put upon the necessity of fairness and, if inequalities are to be tolerated, they should always be at the benefit to the least advantaged. This is an important

[1] On page 61 of *A Theory of Justice*, Rawls gives a list of basic liberties: "The basic liberties of citizens are, roughly speaking, political liberty […] together with freedom of speech and assembly; liberty of conscience and freedom of thought; freedom of the person along with the right to hold (personal) property; and freedom from arbitrary arrest and seizure as defined by the concept of the rule of law" (Rawls, 2005, p. 61). However, he later states that "[l]iberty, as I have said, is a complex of rights and duties defined by institutions. The various liberties specify things that we may choose to do, if we wish, and in regard to which, when the nature of the liberty makes it appropriate, others have a duty not to interfere." (Rawls, 2005, p. 239), and on page 199, he uses the phrase: "the fundamental liberties of the person and liberty of conscience and freedom of thought" (Rawls, 2005, p. 199). This variety of terminologies shows that the "basic liberties" can differ depending on the context.

point to keep in mind when distributing rights and when one's rights are conflicting with others' rights.

Another major point concerns Rawls's conception of individuals as autonomous agents willing and capable to pursue their own life plans without having to account for this to public institutions (Rawls, 2005, p. 13). Thus, this means that institutions should help to enable individuals to pursue their willing life plans, as long as they comply with the principles of justice. Rawls also emphasizes the necessity to consistently apply laws in order to guarantee equal treatment for individuals (Rawls, 2005, p. 59).

Now that I have given the main theoretical framework, I will turn to characterizing and defining useful concepts for the remaining of my *mémoire*.

Some preliminary definitions and characterizations

Institutions

> By democracy I shall understand a form of decision making in which all of those who are bound by the decisions have the right to participate equally in their making. The fundamental idea of democracy is that of a people, a 'demos', ruling itself and it is that idea that I have sought to capture in this definition.
> (Jones, 1994, p. 172)

One of the major features of a democratic organization is the possibility for its citizens to participate in the process of decision-making, and thus the possibility to justify collective decisions if taken by equal citizens. This justification is qualified as "the proceduralist account of political justification" (Ceva, 2015, p. 26). These decisions are then enacted in the law and implemented by various institutions. Therefore, when institutions implement these decisions, they must take care not to betray the spirit of decisions reached democratically. Institutions are thus responsible for the implementation of democratically reached decisions. As such, public hospitals[2] are considered as public institutions because health care professionals are mandated to implement health care policies (Ceva & Ferretti, 2014, p. 130).

For Ceva and Ferretti:

[2] I will not enter the differentiation between public, semi-public or healthcare institutions under contract with the State. See Ceva & Ferretti, 2014 for an overview of the various statuses of the health care institutions in charge of implementing health policies in the Italian case.

> […] an institution is a system of embodied rule-governed roles (the offices that human persons occupy) to which powers are entrusted with a mandate. All roles in an institution are interrelated. Institutions are defined by what their members do as an interrelated group of agents in virtue of the powers entrusted to the various institutional roles. (Ceva & Ferretti, 2021, pp. 22–23).

These roles when interacting make the institution function in a way that must correspond to its raison d'être, which encompasses the normative ideals for which it was created. In order to keep with the raison d'être of the institution, institutional actors must use their powers of office in a way that corresponds to their mandate (Ibid.).

I will follow Ceva's and Ferretti's conception of institutions as interrelations between officeholders because it focuses on the power mandates (thus rights and duties) held by officeholders in virtue of their institutional role. It is relevant to conceptualize institutions as relations between officeholders' actions within their mandate for qualifying a possible right to conscientious objection for health care professionals as officeholders within a public institution, because it rests on the necessity of the rightness of officeholders' action for the well-functioning of an institution. Based on this description of "institution", I will now turn to the characterization of "institutional corruption" which designates one of the dysfunctional instances of an institution.

Institutional corruption

> So a public ethics of office accountability concerns not only the conduct of elected politicians, judges, and public administrators, but also that of workers in the public sector. […] In this light, we can see that political corruption may concern the conduct of public officeholders entrusted with the institutional power to make and implement laws and policies, and it may occur within strictly political institutions […] as well as in public institutions such as state schools and hospitals. (Ceva & Ferretti, 2021, pp. 30–31)

I will keep up with Ceva's and Ferretti's conceptualization concerning institutional corruption too. They characterize one instance of dysfunction within institutions as institutional corruption; it is worth noting that not all types of institutional dysfunction are institutional corruption. In order to be qualified as "institutional corruption", a phenomenon of institutional dysfunction has to possess the following two conditions: "[t]here must be a public official who (1) acts in her institutional capacity as an officeholder (office condition) (2) pursuing an agenda whose rationale may not be vindicated as coherent with the terms of the mandate of her power

of office (mandate condition). The office condition regards the agent of political corruption, whereas the mandate condition concerns the action." (Ceva & Ferretti, 2021, p. 22). If we are to take these two conditions together, the dissociation between a private agent and its role as a public officeholder is a necessity. One's action, or use of powers of office, as an officeholder should follow one's own mandate, disregarding private or agent-related considerations.

Ceva and Ferretti insist upon the needlessness of (negative) consequences in order to qualify an act as "institutional corruption"; they rather stick with the deontological postulate to look at the process in itself (Ibid., p. 81); it is because an officeholder is not able to account for their use of power of office in a way that follows the rationale of their mandate that there is an instance of institutional corruption.

An officeholder must thus act coherently with the letter and the spirit of their mandate in regard to the other officeholders, who should question the rationale of their use of power of office. That is, officeholders must follow both explicit requirements and duties as well as making sure not to betray the spirit of their mandates when using their powers of office. As Ceva and Ferretti put it: "it is necessary that officeholders are in the position of vindicating the rationale of their action in their institutional capacity by invoking the raison d'être of their institution, which determines their power of office mandate" (Ceva & Ferretti, 2022, p. 286). They qualify this notion as a "duty of office accountability" (Ceva & Ferretti, 2021, p. 105). This duty is combined to a "duty of answerability" that consists in answering, *ex post*, other officeholders' questions about the use one makes of their powers of office (Ibid., p. 25). This interrelated scheme of accountability and answerability underlines the fact that the well-functioning of an institution depends on each of its officeholders' uses of powers of office and on their respective questioning on how others use their powers of office (Ibid.). It is thus fundamental that all officeholders follow the terms of their mandate when using their power of office, in this sense, "office accountability" is an action-guiding concept aiming at regulating (*ex ante*) the conduct of officeholders (Ibid., p. 30), while the duty of answerability occurs only *ex post* (Ibid., p. 25).

A failure regarding the duty of office accountability is a form of interactive injustice because it involves a relational wrongness between officeholders who do not treat themselves as they normatively should in their interactions (Ibid., p. 104). Indeed, Ceva characterizes interactive justice as "[…] a normative property of interpersonal relations; it concerns the kind of treatment that people owe to each other in their deontic interactions" (Ceva *in* Ceva &

Ferretti, 2021, p. 99). Interactive injustice is thus a wrongful treatment of someone, within an interaction, because they are treated in a way that does not correspond to their normative status (Ibid., p. 104).

The view of institutional corruption as an unaccountable use of powers of office and thus as a relational injustice is useful for the case of health care professionals because they tend to be granted a large measure of discretion as they hold very specific knowledge, it is thus fundamental that they act in a way they are able to account for. According to Ceva and Ferretti "office accountability" should not reduce the latitude of discretion but it should guide their use of the power of discretion in making sure that they act in an accountable way in regard to the rationale of their mandate and thus assuring that the interrelated actions of officeholders guarantee the well-functioning of the institution (Ibid., pp. 32-33; p. 105).

After having presented the theory of institutional corruption, which will be used as a background theory for the Wide Reflective Equilibrium part, I will now define the concept of conscience, which is central to my work.

Conscience

There is not a consensual and clear definition of the concept of "conscience" in the literature. Nevertheless, some elements are recurrent. Indeed, "conscience" is frequently associated with the making of moral judgements (Brock, 2008, p. 188) or beliefs (LaFollette & LaFollette, 2007, p. 249). It is said to be central to an individual's identity and to their well-being (Morton & Kirkwood, 2009, p. 352), and it is often described as a means to guide personal behaviors according to central values (Brock, 2008, p. 188). Morton and Kirkwood insist on the necessity to equally consider "both secular and religious centrally held values" (Morton & Kirkwood, 2009, p. 357). Brock presents as necessary the notion of *commitment* for one to act on their moral judgement (Brock, 2008, p. 188). Morton and Kirkwood warn that to prevent someone from following their conscience too often leads to a desensitization to the warning of conscience and thus to moral distress and moral residue (Morton & Kirkwood, 2009, p. 352).

Wicclair avoids entering the debate of the nature of conscience; he rather focuses on what is a conscience-based refusal. He points to the fact that refusals based on conscience differ from refusals based on professional integrity and one's understanding of professional

norms. This means that "conscience" refers only to the individual as a *private agent* and not to them as a *professional* (Wicclair, 2011, pp. 6–7). He further distinguishes "conscience" from one's conception of justice. He states that justice-based refusal can be considered as conscientious objection only if: "(1) the physician has a core set of moral beliefs; (2) the physician's conception of justice is among her core moral beliefs; and (3) providing the requested treatment is incompatible with the physician's conception of justice. He warns however that one's conception of justice is rarely among one's "core moral beliefs" and thus seems to be less determinant upon the agent's conception of the self. (Wicclair, 2011, p. 8). Nevertheless, in regard to the Rawlsian framework I have adopted, we can consider that one's conception of justice can be a central part of one's identity and thus a "core moral belief".

LaFollette and LaFollette argue that as "[n]ot all conscience is created equal; not all conscience should be treated equally". They give the example of conscience that derives from racist prejudices as an instance of problematic conscience (see LaFollette & LaFollette, 2007, p. 249). They further give six main ways in which consciences may differ, thus having a potential impact on how it should be considered: (1) whether conscience is self-regarding or whether it may significantly impact on others; (2) the centrality of the belief; (3) the sincerity of the agent; (4) the moral character of the belief; (5) the ability to justify one's own belief, rather than parroting others' belief; and (6) the reciprocation one shows in regard to the consideration of others' conscience (Ibid.). These six considerations inform us of the importance of reciprocity and consideration of others in the legitimation of one's conscience, as well as they warn us against the risk of having a conscience built on prejudices.

The concept of "conscience" is thus protean. The important features we can nevertheless underscore allow us to formulate the following definition of "conscience": as formed by (1) core values (2) central to one's conception of themself and (3) action-guiding (4) that one is able to *justify* with their own words. This "conscience" can be respected if and only if (1) it does not rest on prejudices, and (2) one shows equal consideration to the conscience of others.

Now that I have given a definition of "conscience", I will turn on the next section, to the conceptual analysis of the concept of "conscientious objection".

Conceptual analysis

Conscientious objection and conscientious *exemption*

In order to be considered as "conscientious objection", an action should comply with certain conditions. Determining "the set of conditions that are individually necessary and jointly sufficient for the concept to apply" (Olsthoorn, 2017, p. 164) is what this subsection is dedicated to. Following the step-by-step methodology given by Olsthoorn, I will try to determine these conditions in looking at how "conscientious objection" is defined in the literature and then I will determine what are the most relevant elements to define it in the frame of this *mémoire*, to eventually propose a conceptual distinction between "conscientious objection" and "conscientious exemption".

At first sight, there are a few common features shared among scholars when it comes to defining "conscientious objection". They include the nature of conscientious objection as an unlawful instrument used when someone refuses to perform a legally required action on the ground of their moral values. The act must be public, coherent, and justified.

In that sense, it is different from the notion termed either as "conscientious evasion" (Ceva, 2015) or "evasive non-compliance" (Childress, 1985) which uncovers the action of ignoring a law enforcement, on moral grounds, without admitting it publicly.

Conscientious objection also differs from whistleblowing in the sense that the latter refers to someone blowing the whistle on an illegal action, generally of which they have been the witness[3]. Ceva and Bocchiola define whistleblowing as "the practice of reporting immoral or illegal behavior by members of a legitimate organization with privileged access to information concerning an alleged wrongdoing within that organization" (Ceva and Bocchiola *in* Rochat, 2019, p. 9). Whistleblowing is thus based on the public denunciation of an *illegal* action, while conscientious objectors oppose *legal* enforcements. The following example is an instance of whistleblowing. Let us imagine an employee who witnesses an illegal action (such as their employer giving a bribe to a regulatory agent) within the firm where they work. They decide to report this wrongdoing internally (to their employer or to a specific organ dedicated to this task) or externally (for example, to the media). This is an instance of whistleblowing because the employee is blowing the whistle on an *illegal* action occurring *within their*

[3] I have previously written on the practice of whistleblowing for my Bachelor final paper "Institutionnaliser la pratique du lancement d'alerte au sein des agences de sécurité nationale et en légitimer les aut.eur.rice.s" (in French) in 2019 at the University of Geneva.

company. While in the case of conscientious objection, it is an employee who *refuses* to perform a *legal* action *required* by their mandate, invoking that the performance of such action is contrary to their conscience.

The criteria differentiating an act of conscientious objection from one of civil disobedience are less univocal. Most of the scholars usually differentiate conscientious objection from civil disobedience on the grounds that the latter aims at changing the law targeted, while conscientious objectors only aim at being exempted from implementing the law in question (Childress, 1985, p. 68; Wicclair, 2011, p. 11). That is, civil disobedience aims at influencing political decisions, often in targeting enforced laws that the disobedient individual judges unjust, while conscientious objectors are conceptualized as individuals willing to be discharged from a specific task that they are required to do, on the basis that it contradicts their core values. It is also often added to that a related point concerning the public/private dimension of these acts. Indeed, civil disobedience is often described as a public act (scholars even state that there is a requirement of publicity in order that an act could be qualified as civil disobedience) while conscientious objection is often thought to be more private. Indeed, for instance, Brownlee differentiates civil disobedience from what she calls "personal objection" (but that is frequently labelled as "conscientious objection") on the particular point that the latter lacks the communicative dimension necessary to civil disobedience (Brownlee, 2015, p. 28). We can balance this point by saying that there can be a requirement to publicity for conscientious objection acts too, particularly in cases such as refusal to perform abortion, because of the impacts it can have on the implementation of the law, and also in order to avoid instrumental uses of the conscience clause.

Brock defines what he names "conscientious refusal" as "refusals to perform a[n] action or participate in a practice that is legal and professionally accepted but that the individual professional believes to be deeply immoral" (Brock, 2008, p. 188). He adds: "individual A could be justified in believing that actions of kind p are morally right and individual B justified in believing that they are morally wrong, though both of their beliefs cannot be true. But this means that even if A's judgement of conscience is justified, that is not sufficient to warrant imposing his view in public policy on B, who may be justified in holding an opposing view." (Brock, 2008, p. 189). This definition underlines the aspect of *private act* one is performing in order to ask for being exempted from one or several required tasks, for moral reasons; contrasting with the aim of civil disobedience at changing the law, based on revendications of justice.

Childress gives, for example, ideal types of civil disobedience and of conscientious objection to underline the differences between the two concepts:

- Civil disobedience: "public, nonviolent, and submissive violations of law in protest based on moral-political principles and designed to effect or to prevent social, political, or legal change (Childress, 1985, p. 68)
- Conscientious objection: "public, nonviolent, and submissive violations of law based on personal-moral, often religious, convictions and intended primarily to witness to those principles or values" (Ibid.).

However, as stated priorly, these are ideal types and Childress suggests that conscientious objection could be encompassed in the term of civil disobedience, making the differentiation between the two only marginal and thus recognizing as more important the aspect of opposition and contestation of specific laws. Nevertheless, in his book, *Conscientious Objection in Health Care*, *An Ethical Analysis*, Wicclair contests the characterization of conscientious objection as unlawful as he states that conscientious objection aims at render legal the exemption from a particular law that they may, at the moment break. Conversely, civil disobedience, he says, involves, intrinsically, a break of law (Wicclair, 2011, pp. 12–13). However, it can totally be argued that, in case of direct civil disobedience[4], the aim is also to change the law and therefore make legal the break of law currently committed by disobedients.

In a similar path, Ceva argues that, as well as civil disobedience, conscientious objection has a communicative dimension (Ceva, 2015, p. 30). This means that conscientious objection is to be considered as a *means* for minorities disregarded during the decision-making process to use their right to participate in the democratic decision-making process. According to Ceva, from a proceduralist account, conscientious objection has to be considered as a measure to palliate procedural inequalities occurring during the decision-making process in allowing the bypassed parties to voice their views afterwards (Ibid., p. 49). She then warns on two points: first that it does not follow that objectors must be exempted from the provision of the law, this would necessitate a "case-by-case evaluation [that] must be open to consequence-sensitive considerations concerning the impact that any given exemption could have on the rights of others" (Ibid., p. 48); and, second, that conscientious objection is a *moral* right and does not have to become a *legal* right. Nevertheless, according to Ceva, objectors should be

[4] For a classification of the type of civil disobedience as 'direct' or 'defensive' and 'indirect' or 'offensive', see (Cohen, 1969, pp. 224–226) and Rawls, 1991, p. 105

judged in taking into account a "conscientious defense" as "cultural defense" is used to judge culturally motivated crimes (Ibid.).

I shall now contrast this point by looking at Ceva's and Ferretti's 2014 article that concerning the misuse of a "conscience clause" that can lead to institutional corruption. In this article, Ceva and Ferretti explain how using conscientious objection in aiming at influencing the (non-)enforcement of democratically enacted laws can be described as institutional corruption, in the sense that it violates the principle of impartiality of public institutions and the political equality of the citizenry (Ceva & Ferretti, 2014, p. 133). The authors explicitly refer to the Italian context in which healthcare professionals, while invoking their right to conscientious objection, voluntarily obstruct the implementation of the democratically amended right to abortion (which is largely supported by the Italian people), directly, and/or indirectly, promoting a prolife agenda (Ibid.). The facing of these two conceptions of "conscientious objection" underlines the need for a clear separation between "conscientious objection" as a *moral*, but illegal, right and the *legal* recognition of conscientious objection under the form of a "conscience clause" that can lead to abuses of this *legal* right. It seems to me necessary at this point to propose a distinction of these two radically different views of "conscientious objection" in the form of a different concept to express the granting of legal right to oppose a legal decision because of its moral implication: "conscientious *exemption*"[5]. Thus, in our context, it is the concept of "conscientious exemption" that will be the one in use when health care professionals are granted the legal right not to perform abortion if it affects their personal moral.

Most of the disagreement resides, in the literature, in the modalities for granting a right to conscientious objection, or what we can call a right to "conscientious *exemption*", since it aims at legalizing the right for some health care professionals not to perform abortion for moral reasons; rather than looking at the fairness of granting them this right, should it be from the point of view of the consequences of the enforcement of such a right on minorities (mostly women) or taken from a "proceduralist account of political justification" (Ceva, 2015, p. 26): the fairness of a process that allows some not to perform tasks they are entailed to for professional reasons (health care professionals are also obliged to their colleagues, other

[5] See Ceva's differentiation of a moral right to conscientious objection which does not entail a *legal* right to be *exempted* from the provision of the law one is opposed to, arguing that it would be acting contrary to their personal moral (Ceva, 2015, p. 48).

professionals and employers (Wicclair, 2011, p. xii)). That will be the aim of the second part of my *mémoire*.

I will use Wicclair's definition of 'conscientious *objection*' as when health care professionals "(1) refuse to provide legal and professionally accepted goods or services that fall within the scope of their professional competences, and (2) justify their refusal by claiming that it is an act of conscience or is conscience-based" (Wicclair, 2011, p. 1). To sum up a concrete definition of "conscientious *exemption*" would be: X is an act of "conscientious *exemption*" if and only if: a) there is a legal statement granting the right for someone to be exempted from performing a specific action b) that contravenes to one's core values c) without undermining the patients' rights and d) the responsibilities the HCPs has towards their colleagues and employers.

Rights

I will now turn to a second exercise of conceptual analysis concerning the concept of "rights". Through the lens of conceptual analysis, I am aiming, this time, at underlining the concepts proximate and (traditionally) associated with rights, which is one of the function of the methodology of conceptual analysis (Olsthoorn, 2017, p. 167). After having exposed what is a "right" and differentiated legal and moral rights, I will thus look at the connections between the concept of "rights" and those of "autonomy", "liberty" and "equality". I will finally expand on professional rights and duties.

What are rights and why are they so important?

"Right" is an important concept if we are to analyze social and institutional interactions. Indeed, as Rawls states in *A Theory of Justice*, the first principle of justice "[Its] main requirements are that the fundamental liberties of the person and liberty of conscience and freedom of thought be protected and that the political process as a whole be a just procedure. Thus, the constitution establishes a secure common status of equal citizenship and realizes political justice". (Rawls, 2005, p. 199). Rights are therefore fundamental in both the

construction of just institutions and in the exercise of law as Dworkin's rights thesis[6] states that judges are to distribute and to deny concrete (legal) rights between conflicting parties (Dworkin, 1991, p. 101). Furthermore, in characterizing citizens as equal "agents […] capable of self-legislation" (Ceva, 2015, p. 26) it is necessary to allocate them rights in order to "'ring-fence' areas of life within which they are free to act as they see fit" (Jones, 1994, p. 123) so they can be autonomous agents setting and pursuing their own goals in life. Rights are also important in order to legitimate political decisions. Indeed, democracy as a political system is favored by liberals because it gives the possibility to individuals to participate in the decisions that will be binding to them. Thus, political decisions can be legitimate only if they are taken through a democratic process of decision-making, which can be guaranteed only by giving citizens political rights. "In this argument, equal voting rights and the other equalities associated with democracy are important, not for what they contribute to the process of decision making, but as public acknowledgements of the equal status accorded to individuals. The wrong that would be done to individuals or groups who were excluded from the political process would be the failure to recognize them as people whose worth and standing were no less than those of others. People have a right not to be treated in that publicly humiliating fashion." (Jones, 1994, pp. 179–180).

Therefore, rights can serve as justifications to political decisions. Dworkin differentiates the arguments used as justification of political decisions as being of policy and of principle, the latter being the stronger (Dworkin, 1991, pp. 82–84), "Arguments of principle are arguments intended to establish an individual right; argument of policy are arguments intended to establish a collective goal. Principles are propositions that describe rights; policies are propositions that describe goals." (Dworkin, 2005, p. 90). Dworkin then underlines a common feature between political aims and individual rights. He defines a political aim as corresponding to the state of affairs taken to be desirable by a particular political theory. A political aim will guide political decisions in a way that promotes it. Thus, decisions perceived

[6] Following Dworkin's rights thesis, in order to reach a decision to discriminate whose rights must prime over the other's rights, we must determine what are the rights of both parties and from which principles those rights are derived. There can also derived from policies, but, according to Dworkin, deriving an argument from principle is stronger than when derived from a policy, because "[a]rguments of principle are arguments intended to establish an individual right; argument of policy are arguments intended to establish a collective goal. Principles are propositions that describe rights; policies are propositions that describe goals." (Dworkin, 2005, p. 90). Thus,if we hold a liberal conception of justice, we should be careful when referring to arguments of policy not to favor a conception of the good overs another (Dworkin, 1991, p. 274).

as leading to this aim are favored over decisions thought to endanger the aim (Ibid., p. 91). He then compares political rights to political aims at the scale of individuals, saying that:

> [a]n individual has a right to some opportunity or resource or liberty if it counts in favor of a political decision that the decision is likely to advance or protect the state of affairs in which he enjoys the right, even when no other political aim is served and some political aim is disserved thereby, and counts against that decision that it will retard or endanger that state of affairs, even when some other political aim is thereby served. A goal is a nonindividuated political aim, that is, a state of affairs whose specification does not in this way call for any particular opportunity or resource or liberty for particular individuals. (Dworkin, 2005, p. 91).

Both legal and moral rights can thus be raised while justifying a particular political justification. Now that we have established the fundamental importance of the concept of 'rights' both to the functioning and to our understanding of social and institutional relations, we have to distinguish legal from moral rights.

Legal and moral rights

Legal rights are the rights enacted in texts of law while moral rights are rights thought as being essential to human beings although not necessarily sanctioned by the law (it can be for intrinsic reasons or for belonging to a particular community). Legal rights can be thought of as the recognition of moral rights, thus moral rights are often broader and more general while legal rights concretely enact some aspects of moral rights (Jones, 1994, p. 120). Therefore, rights can be seen as titles one is entitled to[7] for being a human being (moral right) or for being legally entitled to them (legal right).

> Our rights are what, morally, we must be accorded. When we assert that we have a right to something […] [w]e are saying that we are entitled to it, that it is rightfully ours and that, morally, others are obliged to act in ways which respect that entitlement. In claiming our rights, we do not present ourselves to the world as supplicants begging for favours; we inform the world of what we are owed, of what is rightfully ours. To claim a right is to register the strongest kind of claim for which our moral language provides. Correspondingly, when we are denied our rights, we typically respond with indignation or outrage, rather than with mere disappointment; we conceive ourselves as the victims of an injustice rather as mere unfortunates who have been denied the milk of human kindness.
>
> That is the main reason why rights have been closely associated with ideas of human dignity and of 'personhood'. The clearest way to give moral standing to human beings, to respect them as persons, is to accord them rights. If we wish to stress their equal moral standing, we can do that by according them equal rights. (Jones, 1994, p. 49-50).

[7] (See 'Rights as titles' *in* Jones, 1994, pp. 36–39)

The concept of rights is thus central to the status of human beings as moral and autonomous agents. There are various rights thought of having primacy over other rights and moral considerations. However, legal rights are not necessarily absolute, otherwise it would lead to numerous conflicts between them, but they should still have some weight in order not to become too often overridden (see Ibid., pp. 191–194). A way to avoid eternal conflicts between legal rights is to conceive (some of) them as conditionals. That means that someone can be granted a particular right only if they meet the requirements necessary to be eligible to this particular right (that is often the case for socioeconomic rights), or only if they fulfill the conditions that give them access to this right (for example the rights someone has in virtue of having completed their share of a contract), or if the resources necessary to enact that right are met by the society in question (Ibid., p. 194). Rights can also be prima facie in the sense that "there may be circumstances in which that right would be justifiably overridden. Thus, if I have a 'prima facie' right to x, ordinarily it would indeed be wrong for me to be denied x but, extraordinarily, all things considered, that right may have to yield to some competing and more weighty consideration. That other competing consideration may be another right or it may be another sort of moral consideration." (Ibid., p. 195). However, Jones warns that "there is a difference between someone's having, prima facie, a right and their having a prima facie right" (Ibid., p. 197). Indeed, assuming that someone has, prima facie, a right signifies that, in the end, they actually do not have that right, while having a prima facie right signifies that people have a particular right that might, in some special circumstances, be overridden. In that case, they still hold that right but a weightier moral consideration makes it possible to override that right: it is thus an injustice but a justified injustice (Ibid.). Rights can thus be more or less binding, their bindingness being evaluated following the three degrees used in order to evaluate the strongness of moral considerations. All-things-considered rights are always binding, pro tanto rights are usually binding but could be suspended under special circumstances or in certain conditions, and prima facie rights are binding at first sight, but their bindingness may be questioned upon scrutiny.

Now that the difference between moral and legal rights is set, I will first focus on legal rights, and on their relation-based classification. Then, I will look at the concepts in which moral rights are grounded.

The Hohfeldian categories of rights

The hohfeldian classification of rights is a way to categorize legal rights according to their types of "jural relation" into four categories (Jones, 1994, p. 12). These are known as claim-rights, liberty-rights, powers, and immunities, although these names do not exactly match the original one gives by Hohfeld (Ibid., pp. 12–13). Having a claim-right involves the establishment of a contract between two persons (A and B) concerning a particular duty. In that case, A has a claim over B to perform such duty, and conversely, B has a duty over A to do so (Ibid., p. 12). These duties can be in the positive or negative (as duty of non-interference) form as well as *in personam* or *in rem* (Ibid., p. 15). A liberty-right can be defined as the absence, for one, of any duty or obligation (Ibid., p. 17). This is a right not to have a duty to do something, such as a right to eat what one wants for dinner, or from not being coerced to do something, such as Hart's example of the right someone has to look at their neighbor's garden (Hart in Ibid., p. 19). Liberty-rights are related to claim-rights because the latter are often used as guidance to frame liberty-rights (Hart in Ibid., p. 20). To go back to the last example, I may have a right to look over my neighbor's fence, but they may decide to build a wall so I would be prevented from seeing them (they also have a liberty-right to do so) (Hart in Ibid., p. 19). However, they cannot shoot me because I have a claim-right not to be shot (Hart in Ibid., p. 20). Powers are rights in which someone is legally empowered to express their will (such as the right to marry or the right to vote) (Ibid., pp. 22-23) and immunities are rights to be exempted from the power of others (Ibid., pp. 24-25). We may cite conscience clause as an immunity-right because it renders someone immune from a decision they would have normally had to conform with. Therefore, as liberty-rights are linked to claim-rights, so too are immunities to powers. Indeed, as Jones puts it: "[t]o possess a liberty-right is to be free of another's claim-right; to possess an immunity is to be free of another's power" (Ibid., 1994, p. 24).

These types of rights thus stand in interactions between each other. Understanding these types of relations between rights is fundamental in order to set boundaries between rights, and between the own components of a right. It then helps in order to establish priority rules between rights and their components. Moreover, a same right can be broken down and categorized differently thus entailing different interpretations of this same right. This then lead to different conclusions regarding the repartitions of rights and duties to each of the parties involved.

Liberty and autonomy as the basis of moral rights?

Autonomy

> Thus the fundamental meaning of autonomy is self-rule; an autonomous person is one who, in some sense, rules himself, one who determines the course of his own life. (Jones, 1994, p. 124)

One of the basic rights granted to individuals by 'neutralists liberals' is autonomy. By 'neutralists liberals', I refer to Jones's definition:

> that is, with a view that the state should remain neutral on the question of the ends to which its citizens should devote their lives […]. They attempt to maintain a distinction between the 'right' and the 'good'. A conception of 'right' provides the framework within which individuals are to pursue their own conceptions of the 'good.' What constitutes the 'right' or 'just' framework is a question on which neutralists differ, but they remain united as neutralists by a shared belief that that framework should not be based upon any particular conception of the good. What conceptions of the good individuals should pursue is a matter of which should be left individuals themselves. (Jones, 1994, p. 133).

Because liberals conceive citizens as autonomous agents capable of defining their own conception of the good, they have to provide them rights so that they can make use of their agency in being "the authors of their own aims and aspiration". (Ibid., pp. 128–129). The entitlement to a right to autonomy results thus directly from their status as individuals. The following quotation from Jones shows even more precisely the necessarily required connection between the concepts of 'rights', 'autonomy' and 'agency': "[i]n thinking about how it is proper to treat human individuals and, more particularly, in thinking about what rights they possess, we must take full account of their nature as autonomous beings. Not to allow people the freedom to develop and to act upon their capacity for autonomous conduct is not to accord them the respect to which they are entitled." (Ibid., p. 128). Jones asserts that both the external (not to be impeded by others) and the internal (actual capacity to make own choice) dimensions of autonomy must be guaranteed (Ibid., pp. 124–126). That is why neutralist liberals cannot ground their theories of rights on a precise conception of the good; in doing so, they would risk to undermining individuals' autonomy in imposing on them a conception of the good in the name of their rights. (Ibid., p. 115). It is thus key to recognize and grant individuals what is alternatively termed as "the right to personal liberty" (Ibid., p. 122).

Despite their shared conception of autonomy as the grounding for granting basic liberties to individual agents, neutralist liberals differ on the set of fundamental rights that is to be granted to people (Ibid., p. 129).

Liberty

> Indeed we might suppose that the mutual compatibility of a set of rights must be a feature of a satisfactory theory of rights. If a theory yields conflicting rights, perhaps that indicates that there is something wrong with the theory. In a fully worked out moral or political theory all rights would be 'compossible' (Steiner in Jones, 1994, p. 200). (Jones, 1994, p. 200)

Liberals, among others, are often thought to favor liberty rights as fundamental rights and to cherish liberty in its "negative" form (Berlin *in* Dworkin, 1991, p. 266), which, according to Dworkin, causes them to be forced to take a side either for liberty or for equality, as these concepts are set in tension (Dworkin, 1991, pp. 266–267).

If we go back to Rawls's theory of justice as fairness, he says that liberty is the first and most important principle of his theory and that it implies that individual's basic liberties can be overridden only for the sake of protecting another basic liberty (Rawls, 2005, pp. 244; 302). Rawls never gives any precise account of what those basic liberties are, he rather says that it depends on the (institutional) context. If we focus on the (institutional) Western context, the set of fundamental rights includes, according to Rawls, freedom of thought and liberty of conscience, freedom of the person, civil liberties, and political liberty (Ibid., p. 201). In his interpretation of Rawls, Dworkin focuses rather on the middle term used in the formulation of the principle "of greatest *equal* liberty" (Ibid., p. 302 [my emphasis]). He states that "Rawls's most basic assumption is not that men have a right to certain liberties that Locke or Mill thought important, but that they have a right to equal respect and concern in the design of political institutions." (Dworkin, 1991, p. 182). In giving such a right to individuals, the point is no more to determine what are the basic liberties to be distributed and safeguarded for all individuals but rather to make sure that each and every individual is equally considered in the process of decision-making in order to produce just decision that can be binding on individuals (Ibid., p. 180). Furthermore, in distinguishing two acceptations to the term 'liberty', 'license' (as an indiscriminate concept) or 'independence' (as a discriminate concept) (Ibid., p. 262), Dworkin, following Rawls's theory, states a "liberal conception of equality" (Ibid., p. 273) as a way out of the classical opposition between equality and liberty. This focus on equality allows him to avoid the conceptual flaw of an irreconcilable incompatibility between liberty and equality, in

underlying how equality is intricated in the concept of liberty, or at least in its liberal conception as "independence" or "autonomy" (Ibid., p. 274).

Equality

> Government must treat those whom it governs with concern, that is, as human beings who are capable of suffering and frustration, and with respect, that is, as human beings who are capable of forming and acting on intelligent conceptions of how their lives should be lived. Government must not only treat people with concern and respect, but with equal concern and respect. It must not distribute goods or opportunities unequally on the ground that some citizens are entitled to more because they are worthy of more concern. It must not constrain liberty on the ground that one citizen's conception of the good life of one group is nobler or superior to another's. These postulates, taken together, state what might be called the liberal conception of equality; but it is a conception of equality, not of liberty as license, that they state. (Dworkin, 1991, pp. 272–273)

Dworkin's "liberal conception of equality" consists in granting a fundamental right to individuals, from which the repartition of other basic rights should derive. This fundamental right is twofold, it concerns both the right to be treated as an equal and, more importantly, the right to "equal concern and respect in the political decision about how these goods and opportunities are to be distributed." (Dworkin, 1991, p. 273)." Here is his definition of the fundamental and derivative rights (which is used only in special circumstances, if it follows from the fundamental right of treatment as an equal (Ibid.)) on which Dworkin thinks should be grounded the distribution of other basic rights:

> The fundamental right of *"treatment as an equal":* "the right, not to receive the same distribution of some burden or benefit, but to be treated with the same respect and concern as everyone else." (Dworkin, 1991, p. 227)
>
> The derivative right of *"equal treatment":* "the right to an equal distribution of some opportunity or resource or burden." (Ibid.)

This conception of equality as a basis for the distribution of rights allows to link concepts of "equality" and of "liberty" in creating a right to "equal liberty" that guarantees the respect of agents as equals as well as the equal consideration of their life plans.

This discussion is relevant for the topic in the sense that it avoids getting stuck in an impossible choice between the right to abortion and the right to conscience, as Wicclair presented it in its demonstration of the rights-based theory incompatibility with a rejection of the right to conscientious objection for health care professionals (see Wicclair, 2011, p. 46) Indeed, here, in following Dworkin's way out, that is a conceptualization of the right to equal freedom as, primarily, a right to treatment as an equal, we shift the debate to looking at whether the parties were *equally* considered in the granting of a right to conscientious exemption for health care professionals. That is, rather than weighting one right against the other, we look at whether all agents were treated as equal within the process of granting such a right.

Then, the last consideration important to take into account in order to really grasp the right to conscientious exemption for health care professionals is the dimension of professional rights and duties. Indeed, in order to look at both right, it is important to look at to *whom* the right applies, under which status (citizen/officeholder for example) and therefore define the impact this can have on the justification to grant, or not, such a right. I will then employ the next section to conceptualize this dimension of professional rights and duties.

Professional rights and duties

I will now expand on a final consideration concerning the status of *professional* and how it can impact on one's rights. Indeed, in the case I am investigating along this *mémoire*, the involved rights concern both citizens and health care professionals. In this last section concerning rights, I will underline some worth considering aspects of this status difference. Another case-specific aspect is that it concerns professionals working in *public* institutions, thus submitted to the particular status of officeholder and involving specific rights and duties.

In their institutional role, officeholders acquire power mandates that are normative because they are "action-guiding for the officeholders as the occupants of institutional roles" (Ceva & Ferretti, 2022, p. 284). Power mandates thus change a citizen into an officeholder with special normative powers, or rights and duties, when acting in their institutional role. These powers can only be used as an institutional role occupant, and officeholders are to make sure that they use them in a way that corresponds to what their mandate requires.

Officeholders are also subjected to:

> [a] cluster of *secondary rules* describes the duties and the entrusted power attached to each institutional role designed for the implementation of public (primary) rules. Open violations of secondary rules are unlawful. […] For each institutional role, secondary rules describe, among other things, the areas in which discretion can be lawfully exerted. […] Also, there is a high degree of social confidence that institutional actors not only will comply with secondary rules, but that in the exercise of their functions they will keep up with the *spirit* of the (primary) public rules which they are entrusted with the power to implement." (Ceva & Ferretti, 2014). These considerations show that officeholders are subjected to special rights and duties when they act in their institutional roles, that differ and can impact on the rights and duties they bear as "bare agents (Ceva & Ferretti, 2022, p. 284).

The impact of these considerations on the case of granting a right to conscientious exemption for healthcare professionals is twofold. First, it shows that the right to conscientious exemption is granted to *professionals* while the right to abortion is granted to *individual citizens*. Then, *professionals* are entrusted with a mandate, which includes rights and duties, and that they should follow. In the case of health care professionals, it is necessary to look at their mandate and the powers of office attached to it in order to determine whether the granting of such a right does not undermine their accomplishment of the tasks they have to perform in virtue of their (elected) institutional role.

Assumptions and thesis

There are several points that I will take for granted throughout my argument, either because they are not closely related to the issue or are not necessary to develop for the sake of my argument, and because – and this is directly related to the first reason – I don't have the space to develop here an argument about these specific points, that are peripherical or in background of my argument.

I will assume that my reasoning concerns a democratic Western society in which the right to abortion for women* is legally enacted[8]. I am, thus, also taking for granted the moral right to abortion. Therefore, my *mémoire* is centered on the question of the moral justification of granting both a moral and a legal right to conscientious exemption to health care

[8] Therefore, I will not enter the debate of the morality and legality of the right to abortion. Nor will I enter the debate of whether foetuses have rights. My focus will be on the right to conscientious exemption regarding its interaction with the right to abortion, assuming that this latter right is legally enacted.

professionals. I am also assuming that it is a well-ordered society that broadly aims at following Rawls's principles of justice and where civil servants, process decisions, and law enforcement are thought as impartial (Ceva & Ferretti, 2014, p. 128).

My thesis is the following: there is neither legal nor moral right to conscientious exemption for health care professionals working in the public sector. I will now go through the process of wide reflective equilibrium in order to demonstrate my thesis.

Wide Reflective Equilibrium

What does a legal right to conscientious exemption for health care professionals involve?

In terms of legal rights, if we look at the Hohfeldian classification of rights, the right to abortion is a liberty-right, since it gives the choice to pregnant women to or not to abort. It means that they are at liberty to abort or not. It is also a claim-right in the sense that it implies that women* have a claim over health care professionals to assist them in performing abortion. On the contrary, the legal right to conscientious objection – or, as I stated before, of conscientious *exemption* – is an immunity, because it exempts someone to do something they would have otherwise been requested to do. In that case, it allows some health care professionals not to perform abortion on the ground that it contradicts with their conscience, even if they would have been required to perform it as a professional duty. As long as it renders immune someone from the power of a law, conscientious exemption – is an immunity right, which is often legally enacted on the form of a conscience clause. The moral relevance of rendering immune professionals from performing a duty they have been assigned with regard to their professional role needs to be justified.

What does a moral right to conscientious objection for health care professionals involve?

> The role of rights in moral reasoning is primarily to justify action and restraints upon action rather than to describe states of affairs. They figure as elements in an argument rather than as features of an institutional arrangement. (Jones, 1994, p. 48).

To grant a *moral* right to conscientious objection to abortion for health care professionals is to recognize the rightness of their claim on moral grounds, without implying a legal enactment. It thus implies that health care professionals should be legally punished for having infringed a law.

However, conscientious objection can nevertheless be viewed as a democratic tool. Ceva and Ferretti underline for example the use made of conscientious exemption by liberal democrats as "an instrument to reconcile the will of the majority, expressed through the decision-making process, and "the dissenting claims of some minority outvoted during decision making" (Ceva & Ferretti, 2014, p. 134). Furthermore, in a 2015 article, Ceva argues that

conscientious objection should be understood as a form of political participation for the holders of non-mainstream views (Ceva, 2015, p. 40). Indeed, she explains that due to the structural disadvantages held in some cases by holders of non-mainstream views during the democratic decision-making process, they should be allowed to express their view through "unlawful forms of protest" such as conscientious objection in order to guarantee the "principle of equal respect for persons demands in politics" (Ibid., pp. 45-46).

Regarding our particular context, a moral right to conscientious objection for health care professionals can be granted on various grounds, derived from both of the two instances explained beforehand.

Firstly, it can be argued that a moral right to conscientious objection should be granted to health care professionals in virtue of their agency/moral integrity/autonomy. Indeed, as treating individuals as moral agents is to allow them to act autonomously in following their own conception of the good, they should be granted some space in order to act accordingly to their conscience. Even more – and that is the second point – when it comes to a morally contested act, as it is the case for abortion.

On the other hand, the status of health care *professionals* implies various obligations both to their patients and colleagues and to citizens, as they are mandated to implement democratically taken decisions. Thus, they are not in a *position* to oppose a democratic decision, as they act as *officeholders*, not as citizens holding a non-mainstream view flouted by the decision-making process and willing to contest a democratic decision.

My judgement and relevant principles:

My judgement is twofold: it consists in saying, first that granting health care professionals a conscientious *exemption* (under the form of a conscience clause) cannot be morally justified and then, even more, that there is no moral right to conscientious objection for health care professionals.

I have now to establish a list of relevant principles and arguments to take into account to set up wide reflective equilibrium. The complete list I have obtained from the literature is as follows, (obviously, I will not develop each and every one of these points, but only the most relevants):

a. On a (legal) right to conscientious *exemption* (a conscience clause)

i. “Positive appeals to conscience”: it consists in saying that the conscience clause is misleading because it only grants protection for *negative* appeals to conscience, as opposed to *positive* appeals to conscience (Wicclair, 2011, pp. 219–222). A “positive appeal to conscience” is to be granted a right to perform actions or give medications that are not legally enacted but that the health care professional claims to have a “conscience-based obligation to *provide*” and that are professionally permitted. (Wicclair, 2011, p. 219).

   An example of “positive appeal to conscience” is to provide abortion to a pregnant woman* that wishes so for professional reasons while the law only allows to do so in cases of rape or incest. TM Pope explains that the distinction between negative and positive appeals to conscience can be ambiguous insofar as some negative claims can be positive claims of the reverse. He gives the example of the refusing to withdraw a feeding tube that can be seen as a positive appeal to continue treatment. (see endnote n°5 in Pope, 2010, p. 163).

ii. “Moral distress” is claimed by Morton and Kirkwood to describe the effect that not recognizing a right to conscientious objection for health care professionals may leave on them (Morton & Kirkwood, 2009, p. 361).

   However, Wicclair differentiates moral distress from conscientious objection in three ways: moral distress is more pervasive than conscientious objection (Wicclair, 2011, p. 9); while moral distress arises when a professional norm is violated, conscientious objection arises when a health care professional is needed to violate a personal moral belief in order to comply with a professional duty (Ibid., p. 10). Whereas acts of conscientious objection are refusals to perform an action, moral distress involves the feeling of being constrained to perform an action that is thought to be contrary to professional, clinical and/or personal moral standards (Ibid.).

iii. Health care professionals are required to act on their conscience in their everyday practice. They may be reprimanded or even imprisoned if they act “without conscience” (Morton & Kirkwood, 2009, p. 358). It would

thus be inconsistent to refuse to grant them a right to conscientious objection. (Ibid., pp. 358-359).

iv. LaFollette and LaFollette insist on the need to plan a cost or a burden in order to be granted a right to conscientious objection (LaFollette & LaFollette, 2007, p. 251).

Indeed, they take the example of conscripted soldiers who refuse to go to war and thus have to perform "alternative service" that is often judged more burdensome, such as serving as a medic, in some "charitable setting outside the military", etc (Ibid.). On the same model, they ask for health care professionals to prove their sincerity and their "commitment to democracy, tolerance and the common good" in having a burden in order to be granted a right to conscientious *exemption* (Ibid.).

Ceva and Ferretti evoke the problem that the costless, and even beneficial, granting of conscientious *exemption* can provoke a rarefication of non-objectors that can thus lead to an inability for women* to abort in certain regions (Ceva & Ferretti, 2014, pp. 136–137).

Therefore, if a right to conscientious *exemption* is granted to health care professionals, it should be counter-balanced by a cost they are ready to pay in order to prove their sincerity and their "commitment to democracy" (LaFollette & LaFollette, 2007, p. 253).

v. Employers and other health care professionals will experiment some burden when attempting to accommodate objector health care professionals within the organization.

First, employers may be confronted with the necessity to hire a non-objector professional in order to compensate for objector health care professional's objection to perform certain services provided by the institution (it can be hiring another pharmacist who will agree to deliver abortion pills or a nurse who agree to assist a non-objector physician on abortion, etc) (Wicclair, 2011, p. 119). It can be totally accommodable but there may be ways in which the accommodation can become difficult. Wicclair gives the example of a pharmacy in which the majority of the staff conscientiously objects to fill prescription for abortion pills (Ibid., p. 122). Brock presents the case of an emergency

physician who conscientiously objects transfusion (Brock, 2008, pp. 190–191). He argues that they should not be accommodated, and thus not being granted a right to conscientious exemption, as transfusion is a central part of their work (Ibid., p. 191). This means that the granting of a conscientious exemption may also depend on how central to the mandate is the task one is willing to be exempted on the grounds of conscience. These two instances are cases of "undue hardship" for employers. This term is furthermore legally employed in order to set the limit of the accommodation of conscientious objectors in health care. (Wicclair, 2011, p. 121). However, the law does not provide concrete redlines that makes a case of "undue hardship" (Ibid.).

Second, the objectors' colleagues may also experiment a significantly increased workload in order to accommodate them, as well as other health care professionals who depend on them (eg: a pharmacist who refuses to fill the prescription a physician made to her* patient on the grounds of conscience, preventing her from undergoing abortion). Therefore, there are also limits to be set in order not to impose an excessive burden on the conscientious objector's colleagues and other health care professionals (see Ibid., pp. 126-127).

vi. The argument of a preselection of ethically insensitive people derives from the idea that if the profession does not accommodate conscientious objection, then it may discourage people with a strong sense of ethics to become health care professionals while privileging people "who are ethically insensitive". (Wicclair, 2011, p. 29).

vii. Brock proposes a "conventional compromise" that aims at granting a right to conscientious exemption without undermining the access to health care for patients and without putting excessive burden on employers (Brock, 2008, p. 194). According to Wicclair, this is an attempt to reach a middle-ground between the tenants of "conscience absolutism" (who claim an unconditional and all-things-considered right to conscientious exemption for health care professionals) and the tenants of the "incompatibility thesis" (who think that a right to conscientious exemption is incompatible with health care professionals' duties) (Wicclair, 2011, pp. 32–33).

b. For a moral right to conscientious objection

i. I will expand on the principle of "moral integrity" below. Broadly speaking, it is the capacity one has to act on their core moral values, it is linked to conscientious objection as to betray one's conscience too often may result in becoming morally insensitive (Wicclair, 2011; Wicclair 2000 p. 213-17, Brock p. 189).

ii. The principle of "autonomy" as defined by Beauchamp and Childress is composed of both conditions of "(1) *liberty* (independence from controlling influences) and (2) *agency* (capacity for intentional action)" (Beauchamp & Childress *in* Wicclair, 2011, p. 28). The exercise of the conscience clause is part of the exercise of the agent's autonomy in the sense that acting on conscience is for one to follow their on view and thus to act autonomously. The reasoning is that as long as acting autonomously should be respected, so too should be acting on conscience and thus having a conscience clause granted to be allowed to act autonomously. (Wicclair, 2000, pp. 212–213, Beauchamp and Childress *in* Wicclair, 2011, pp. 27–28)

iii. The principle of toleration of moral diversity in health care is held by Morton and Kirkwood as a way to accommodate conflicts in a "multi-cultural and multi-faith society" (Morton & Kirkwood, 2009, p. 361). However, Wicclair explains that such a view cannot account for a right to conscientious objection for three reasons. (Wicclair, 2000, p. 211).

First, an intolerant health care professional should not be tolerated. Thus not all instances of moral diversity can be tolerated (Ibid.).

Second, it can only account for cases where there are "contentious issues" (Ibid.). Wicclair cites the case of abortion as contentious but, in the end, this argument cannot be extended to defend a broad right to conscientious objection in health care as there are conventional rules regulating medicine (such as confidentiality, informed consent, etc.) (Ibid.).

Third, it does not answer the question of why conscientious objection in health care should be recognized, but instead replaces it by

the question of why moral diversity should be tolerated (Ibid.). (see also Wicclair, 2011, p. 28).

Therefore, toleration of moral diversity is not a convincing approach to defend the right to conscientious objection for health care professionals.

iv. Ethical relativism designates the fact that "(1) ethical statements have truth-value only in relation to some moral framework or other, and (2) there are several different moral frameworks, and when two or more clash, none is "privileged"" (Wicclair, 2000, p. 210). Following this statement would mean that any claim of conscientious objection should be tolerated as long as it respects the definition of conscientious objection and thus proceeds from one's core moral beliefs. Wicclair however contrasts that, since there are professional guidelines, some views must prevail over others (Ibid.). In the case of conscientious objection to abortion, it is necessary to look at the core values one mobilizes in order to be granted a right to conscientious objection and to see whether they are compatible with the one promoted by professional guidance, in order to balance their claim to conscientious objection.

c. Against a moral right to conscientious objection

i. One of the major end-state arguments against the right to conscientious objection for health care professionals is that it can jeopardize equal access to health care (Brock, 2008, pp. 190–191; LaFollette & LaFollette, 2007, p. 249; Pope, 2010, p. 164; Savulescu, 2006, pp. 295–296). Savulescu states that "[…] when conscientious objection compromises the quality, efficiency, or equitable delivery of a service, it should not be tolerated. The primary goal of a health care service is to protect the health of its recipients." (Savulescu, 2006, p. 296). This statement shows scholars' preoccupation regarding the impact of granting a right to conscientious objection to health care professionals on the just implementation of health care policies. I have briefly referred beforehand to Ceva's and Ferretti's description of the Italian case, where, in some central and southern regions, 90% of physicians are objectors of conscience to abortion (Ceva & Ferretti, 2014, p. 135). They

then allude to the US situation where "87% of US counties have no abortion provider" (Waxman *in* Ibid.). These figures are for the least worrisome as concerns the equal access to abortion for women*, even more as it occurs in countries in which the right to abortion is legally enacted since the nineteen-seventies.

d. Deontological arguments
    i. LaFollette and LaFollette argue that since they have voluntarily *chosen* to enter the profession, health care professionals should not ask for a right to conscientious objection (LaFollette & LaFollette, 2007, p. 250). As I have already explained, they compare the right to conscientious objection for health care professionals to the one of conscientious objectors to war (Ibid.). Their reasoning is as follow: it is in part in virtue of their *conscripted* status that draftees are granted a right to conscientious objection (professional soldiers are not granted such a right) (Ibid.). Concerning health care professionals, they voluntarily entered the profession and thus must accept what is required for them to do as professionals (Ibid.). This reasoning is similar to the one of professional duties.
    ii. Professional duties are duties attached to someone in virtue of its mandate. Performing abortion can be one of the professional duties required by certain health care professionals. In that case, some scholars argue that professional duties should prime (LaFollette & LaFollette, 2007, p. 251; Savulescu, 2006, p. 295) while others ask for a compromise (Brock, 2008, pp. 190–191)
    iii. LaFollette and LaFollette claim that if a right to conscientious objection is to be granted to health care professionals, other professionals may also require it, which could lead to awkward situations, such as "electricians who do not want to make repairs at an abortion clinic" (LaFollette & LaFollette, 2007, p. 251). In the case of health care professionals, they furthermore are institutional actors. Thus, the granting of a right to conscientious objection to *some* officeholders creates inequalities among officeholders and the granted of a right to conscientious objection to *all* officeholders may not be the best solution to resolve it, as they are mandated to implement democratically taken decisions, not

to decide which decision can or cannot be implemented depending on their own conscience.

e. As a background theory, I will follow the theory of institutional corruption, as theorized by Ceva and Ferretti (Ceva & Ferretti, 2014, 2021). I will first develop their argument of a corrupt use of the conscience clause by health care professionals (Ceva & Ferretti, 2014). Based on their arguments and on the communicative dimension of conscientious objection (Ceva, 2015), I will finally conclude on the wrongness of granting a right to conscientious objection to health care professionals even if it is not used in a corrupt manner.

The principle of "moral integrity"

The literature presents the exercise of conscience by health care professionals as important firstly because of its link to "moral integrity" (see Wicclair, 2011, p. 25-26; Brock, 2008, p. 189). Wicclair explains that "[a] person of moral integrity has: (1) a set of core moral (i.e. ethical or religious) beliefs and (2) a disposition to act in accordance with those core beliefs" (Wicclair, 2011, p. 25). Wicclair then points out the conceptual connection between moral integrity and the exercise of conscience. He concludes that "[t]o maintain one's moral integrity, a person must refrain from performing actions that are against her conscience (i.e. actions that violate her core moral beliefs). Thus, the exercise of conscience is essential to maintaining and protecting one's moral integrity." (Ibid., p. 26). Maintaining moral integrity is, according to Wicclair, capital in multiple ways. Apart from its implication on the objector's well-being and mental health, failure to maintain moral integrity can result in a loss of the person's moral character, which can be particularly problematic for health care professionals (Ibid.).

Morton and Kirkwood further advance the argument in saying that it would be inconsistent not to let health care professionals following their conscience regarding the performance of acts they think are wrong, when they are asked to act on their conscience in their everyday practice and while acting "without conscience" may lead health care professionals to be subject of reprimands and even to imprisonment (Morton & Kirkwood, 2009, p. 358). This argument is backed by the consideration that the right to conscientious objection for health care professionals is grounded on the right to freedom of conscience, which is widely recognized as one of the basic freedoms, at least for liberals (Rawls, 2005, p. 61), and

on the concept of autonomy (Beauchamp and Childress *in* Wicclair, 2011, pp. 27–28). In basing himself on Beauchamp's and Childress's argument, Wicclair states that "[t]he exercise of conscience (e.g., a conscience-based refusal to dispense EC[9]) is an autonomous action and constraints on the exercise of conscience also are constraints on autonomy. […] Insofar as respect for autonomy requires permitting individuals to act on their personal values and beliefs, it provides a reason for not restricting the exercise of conscience by health care professionals." (Wicclair, 2000, p. 28).

The concept of autonomy is indeed used as a basis for numerous theories, including liberal and utilitarian theories (Jones, 1994, pp. 127–129). As I have underlined in the "Rights" part of my *mémoire* theoretical framework, autonomy is central for the conception of the liberal agent capable of pursuing their own view. However, in applying it to health care professionals, Wicclair does not (yet[10]) counterbalance it with the professional duties that should be assumed by health care *professionals*. Indeed, in that case, they are not acting as mere agents but as officeholders in charge of implementing a policy legally enacted and, presumably, democratically accepted during the decision-making process. I will go back to this argument later on, as I will firstly underline the first line of consequentialists arguments used to justify limiting the use of conscientious objection for health care professionals. Before doing so, I will add a last argument that fuels the moral integrity argument an important condition. Indeed, in order to be granted a right to conscientious objection, most of the literature agrees on the fact that objectors have to provide a strong justification concerning their use of conscientious objection. Some scholars argue that objectors must prove that their core values prevent them to perform abortion. LaFollette and LaFollette, Brock, and Wicclair for instance state that these core values should be fundamental to the individual's moral integrity and thus to their identity in order to be eligible to a claim to conscientious objection (Brock, 2008, p. 189; LaFollette & LaFollette, 2007, p. 252; Wicclair, 2000, p. 214).

[9] EC means "emergency contraception" (Wicclair, 2011, p. 6). Similar arguments to the one to conscientiously oppose to perform abortion are used by pharmacists in order to be granted a conscientious exemption to provide emergency contraception (see Wicclair, 2011).

[10] Wicclair, as well as the majority of scholars, hold for a compromise way that both guarantee a moral right to conscientious objection for health care professionals and the least possible burdens for patients, citizens, society, and the other health care professionals (see both Wicclair, 2000, 2011)

The consequentialist argument of a risk to undermine the (equal) access to health care

First, apart from the tenants of "conscience absolutism"[11], scholars agree on the fact that objector health care professionals should, at least, inform the patient of the possibility of abortion, of their own status as objector, and provide them (for the least) with the contact – or a list of contacts – of non-objector colleague(s) or clinic(s) ((Brock, 2008, p. 189; Savulescu, 2006, p. 296; Wicclair, 2011, pp. 103–109; 115), this in order to guarantee (1) equal access to health care for citizens and (2) the implementation of the legal right to abortion. Moreover, such requirements are also legally enacted in governmental regulations across Europe and the US (Ceva & Ferretti, 2021, p. 134; Wicclair, 2000, pp. 208–209). Some scholars even ask for additional workload to compensate for the granting of a right to conscientious objection and to prove that their commitment to a moral value is sufficiently strong (LaFollette & LaFollette, 2007, p. 253). They state that, through implementing such a process, the number of objectors should fall (LaFollette & LaFollette, 2007, p. 251).

As said, the risk to undermine the (equal) access to health care for citizens in granting a right to conscientious objection to health care professionals is a widely shared concern among the literature. It is furthermore empirically proven:

> [i]n a survey I conducted several years ago, around 80% of clinical geneticists and obstetricians specialising in ultrasonography believed termination of pregnancy should be available for a normal 13 week pregnancy if the woman wants it for career reasons. However, only about 40% were prepared to facilitate it. This implied that less than half of doctors whose primary job is to deal with termination of pregnancy would facilitate a termination at 13 weeks if the woman wanted it for career reasons. (Savulescu, 2006, p. 295).

This instance underlines a twofold problem of equality. Indeed, if we go back to Dworkin's distinction between "equality as a right" and "equality as a policy" (Dworkin, 1991, p. 226), we see that both the latter (because the policy will be enforced differentially depending on the doctor one is consulting) and the former (thus, some women* will not have their basic right one should have over one's own body respected) are flawed. Therefore, even when

[11] Wicclair distinguishes three main position regarding the right to conscientious objection for health care professional: the "incompatibility thesis" which is opposed to granting a right to conscientious objection to health care professional, "compromise" and "conscience absolutism" (Wicclair, 2011, pp. 32–33). "According to conscience absolutism, in addition to not having an obligation to provide a good or service that violates a health care professional's conscience, the professional is not obligated directly or indirectly to participate in its provision or facilitate patient access to it." (Ibid., p. 34). For reasons of space I will not expand on "conscience absolutism" as one can easily see the incompatibility between asking for conscience exemption on the ground of respect for one's core moral beliefs while, in the meantime, refusing to acknowledge and respect others' core moral beliefs in refusing them to exercise their agency.

sticking with a right-based theory[12], granting a right to conscientious objection to health care professionals still contains a risk to violate one's basic rights.

Concerning that risk, the literature has often mentioned that, as long as there are enough health care professionals willing to perform abortion, and thus presumably no impact on the access of women* to abortion, the right to conscientious objection is unproblematic, or, at least, less problematic (Savulescu, 2006, p. 296; Wicclair, 2000, p. 219), as long as it does not cause significant burdens on non-objector health care professionals (Wicclair, 2011, pp. 126–127).

I have summarized here a consequentialist argument that goes against an all things considered right to conscientious objection for health care professionals who object performing abortion on the grounds of conscience. However, I will now present a series of deontological arguments that question the right to conscientious objection for health care professionals.

The argument concerning the *professional* status of health care professionals

A recurrent issue in the literature on conscientious objection is whether conscientious objection can take place in a context of choice. That is, can someone who has chosen to be in a position in which they know they can be asked to perform actions that are in counter of their core value be an objector? LaFollette and LaFollette oppose the case of a *conscripted* soldier who refuses to go to war because it would clash with their core values, and thus they become an objector and the case of a pharmacist who refuses to give contraceptive on the grounds that it clashes with their core values (LaFollette & LaFollette, 2007, p. 250). The authors' argument is that, as long as the pharmacist has voluntarily entered their professional role, knowing that it would be in their tasks to give contraceptives, they cannot become an objector, contrary to a *conscripted* soldier who did not choose to enter the military. (Ibid.).

Brock opposes this argument in differentiating the professional obligations and the rights and duties of professional agents. He states that the profession should provide "the public competent level of service" to its citizens and that in virtue to its monopolistic place and its state contract, it cannot be eligible to a conscience clause (Brock, 2008, pp. 192–193). However, concerning professional *agents,* Brock proposes a "conventional compromise" that aims at guaranteeing a right to conscientious objection for health care professionals under the

[12] "What will distinguish it as a rights-based theory is that, in its order of argument, rights will appear before duties and goals, and rights will provide the foundation for duties and goals." (Jones, 1994, p. 57)

condition that they respect some principle that should guarantee a least impact on patients. It consists in respecting the following three conditions:

> 1. The physician/pharmacist informs the patient/customer about the service/product if it is medically relevant to their medical condition
>
> 2. The physician/pharmacist refers the patient customer to another professional willing and able to provide the service/product
>
> 3. The referral does not impose an unreasonable burden on the patient/customer
>
> (Brock, 2008, p. 194)

However, it must be said that this "conventional compromise" stays a consequentialist answer to the risk of granting a conscience clause to health care professionals may have on patients. That is to say, from a deontological argument, that it does not provide a fair justification to the exemption for *some* professionals of *some* of their duties. Indeed, as LaFollette and LaFollette state, there would be no reason not to grant other professionals a conscience clause too. They take several examples, among them the case of "a construction worker [who] is opposed to building an amunitions *(sic)* factory because she thinks that in doing so she facilitates something immoral" (LaFollette & LaFollette, 2007, p. 251). It seems indeed difficult to find an argument that explains such a discrimination between professional fields.

Wicclair attempts to look at this discrimination between professionals in a justified way in saying that, "in contrast to many other professions and occupations, medicine is a `moral enterprise'. There are at least two respects in which it might be claimed that medicine is a moral enterprise: (1) Physician decision-making should be guided by a consideration of obligations to patients rather than the physician's self-interest. (2) Physician decision-making should be informed by ethical values and professional standards (e.g., standards of `professional integrity'), and physicians should not act as mere `technicians' who will perform requested services on demand." (Wicclair, 2000, p. 215). But that should be the case for all officeholders since the State appoints them in order to serve citizens. I will go back to this point in the next section. However, I will first continue with an objection Wicclair anticipates: "However, it can be objected that when medicine is said to be a moral enterprise, the implication is not that physicians should be guided by their personal values, irrespective of their content. Rather, the implication is that physicians should be guided by the goals and values of medicine" (Ibid., p. 216). Wicclair directly counters this argument in saying that, indeed, the values mobilized in

order to be granted an exemption should be coherent with and familiar to the field of medicine. He gives the example of an internist who refuses to provide pain treatment to a patient on the ground that pain is a sign of flaw and is therefore deserved. In that case, the justification is grounded on values foreign to the field of medicine and thus unwarranted (Ibid.). Conversely to the case of a physician who refuses to continue to care for a patient willing to forego cancer treatment on the ground that it is opposed to their ethical obligation as a physician to prevent, as far as they can, death. (Ibid). In that case, Wicclair argues, the value they claim are related to the one promoted by medicine, i.e.: life and health (Ibid). Now, going back to the case of abortion, is it possible to infer that the values handed by objectors are the same as the ones of medicine?

We could argue that one could refuse to perform abortion on the ground that it does not enter their conception of what "*healing*" is, as it implies killing a fetus. Wicclair himself acknowledges that "healing" is a broad concept that can encompass multiple conceptions (Wicclair, 2000, p. 50). But let us say that a health care professional's justification to conscientious objection to abortion is grounded on the fact that it does not correspond to their conception of healing. "Healing" is indeed a recognized value promoted by medicine. But even if we concede this possibility[13], there are conflicting values and core professional obligations that oppose this defense. Indeed, as Wicclair has done a survey of professional codes of conduct for physicians, nurses, and pharmacists in which three core professional obligations towards patients recur in the three professions, "[t]hese are an obligation to respect patient dignity and refrain from discrimination, an obligation to promote patient health and well-being, and *an obligation to respect patient autonomy*." (Wicclair, 2011, p. 88 *[my emphasis]*). Thus, at least the last professional obligation cited by Wicclair conflicts with the right to conscientious objection based on the shared value of "healing", if we suppose that they have equal weight. This consideration can be completed with Wicclair's other statement in which he explains the commonly (and legally) accepted duty of health care professional to honor the wish of their patient, while a right to conscientious objection can be granted to lift this duty, under certain conditions (Wicclair, 2000, p. 208). Wicclair himself acknowledges in his 2000 article the difficulty to weight competing moral considerations (Wicclair, 2000, p. 227) but he nevertheless states that the best agreement would be a transfer of the patient to a non-objector health care professional (Ibid., p. 226), which can be burdensome, as explained before. Another

[13] Although it implies recognizing that abortion is "killing a fetus", which is a controversial claim based on no scientific evidence (and even more if we take into account the legal timelapse in which abortion is permitted).

consideration regarding competing values is Savulescu's claim of paternalism from health care professionals willing to impose their view on patients while they should follow their professional obligations to implement required policies (Savulescu, 2006, p. 295). It resonates with LaFollette's and LaFollette's statement that the case of civil servants who will work under several governments without agreeing with all governments nor with all policies and laws but will nevertheless have the *duty* to implement these policies (LaFollette & LaFollette, 2007, p. 253). I will further investigate these claims in the next section by looking at the conscience clause misuses by conscience clause by healthcare professionals.

Conscientious objection and institutional corruption

We can go further in underlining the wrongness that can be caused by the use of the conscience clause in referring to a background theory: the theory of institutional political corruption. Indeed, in a 2014 article, Ceva and Ferretti interpret as corrupt cases of wrong uses of the conscience clause by health care professionals. This section is mainly based on their 2014 article.

As I have aforementioned in the theoretical framework of my *mémoire*, and based on Ceva's and Ferretti's work, professionals working in public institutions are called *officeholders* and they must act according to their *mandate*. It is their interrelated actions that form the institutions, they thus have to exercise their *power mandate* in a way that follows the institution raison d'être via the letter and spirit of their mandate (Ceva & Ferretti, 2014, 2021). The three features necessary for an abuse of the conscience clause to enter the definition of institutional corruption are:

> (i) the bending of public rules (ii) for the sake of private benefit and to the detriment of others (iii) perpetrated by someone who occupies an institutional position, either in violation of the secondary rules governing the exercise of the power associated with that position, or by misusing the discretion attached to that position, or by acting in ways contrary to the spirit of the rules to implement. (Ceva & Ferretti, 2014, p. 136).

In their article, Ceva and Ferretti identify three kinds of healthcare professionals' misuses of the conscience clause that can be qualified as instances of political corruption (Ceva & Ferretti, 2014, p. 137).

One of them is the "illegitimate but lawful use for reasons other than moral conviction, notably opportunistic considerations (e.g. to enhance one's own career prospects)" (Ibid.). Indeed, because of the strength of pro-life lobbies in the Italian health care system, advantages

can be perceived if one is to refuse to perform abortion. Conversely, there are "pressure to conform" (Ibid., p. 139), practices of mobbing and lesser career prospect for those willing to practice abortion in Italy. (Ibid., p. 140)

Another one is the "illegitimate and unlawful use either by professional categories that are not covered by the conscience clause (e.g. hospital administrative personnel) or for services excluded by the law (e.g. referral, post-abortion care)" (Ibid., p. 139).

Eventually, the one that interests us most: the "illegitimate but lawful use by health care professionals with pro-life convictions that is collectively planned with a view to undermine the implementation of the abortion regulation" (Ibid. , p. 139). This one usage is particularly worrisome as it is a violation of the political equality of citizens in that it allows some people to have further political influence in a way that is foreclosed to others which leads to "surreptitiously undermine[s] the implementation of the abortion regulation by sidestepping the democratic decision-making process" (Ibid., p. 139). In doing so, it undermines "the rationale of the liberal public order [which] is the constitution of an impartial framework within which individuals may pursue their different conceptions of the good, on a baseline of equality, and the conflicts possibly emerging between them can be settled." (Ceva & Ferretti, 2014, p. 133). Finally, I will argue that, even in respecting both the spirit and the letter of the conscience clause, health care professionals are, in appealing to conscientious objection, undermining the democratic decision-making process.

Why, even if not wrongly used, is the right to conscientious objection unjust?

Trying to go further, we should ask whether an institutional role occupant can use their *personal* beliefs in the exercise of their *public* mandate, in a way that undermines their capacity to fulfill the spirit or the letter of their mandate. Indeed, in the present case, a health care professional who refuses to perform abortion on the ground of their conscience while they are required to do so because of their professional career choice seems puzzling. Indeed, as I have already underlined, both the status of *officeholder* and the fact that it is a *chosen position* make a case against the use of conscientious objection by health care professionals.

Second, as I also have previously evoked, the blending of *private* or *personal* beliefs with *public* mandate is somewhat disturbing. Even more if other professionals cannot be granted such an immunity. This issue could be linked with Creationist teachers willing to teach their beliefs in place of the official curriculum decided in a democratic decision-making

process. The issue at stake with both of these examples is the contamination of the citizen action *within* the officeholder mandate. This means that while an officeholder should act respectively to its mandate in order to guarantee the impartiality of an institution and thus the possibility for its citizens to follow their own rationale, if they act on their personal beliefs, there is a risk of undermining (1) the impartiality of the institution, and (2) political equality among citizens. Indeed, while citizens can express their wills in *some particular places*, at *some particular moments*, and in *some particular forms*, an officeholder acting on their personal beliefs is participating politically a second time. Thus, this is my main concern with granting a right to conscientious objection to officeholders. Indeed, we can interpret officeholders conscientiously opposing the right to abortion as a form of vetoing the implementation of a democratically enacted decision via their special position of institutional actor. Even though they are not aiming at doing so, they are still not complying with their mandate of office. Therefore, we are in a situation where equality among citizens is undermined. Moreover, considering Dworkin's "liberal conception of equality", we can conclude that in granting a form of decisional power to officeholders, the fundamental principle of *"treatment as an equal"* (Dworkin, 1991, p. 227) is undermined, because tenants of the right to abortion are not equally considered as the opponents.

Furthermore, in the context of a well-ordered society, granting a moral and legal right to conscientious objection to abortion for health care professionals cannot be justified because they are acting as institutional agents and thus have the duty to assist citizens in following their own life plans, as long as they comply with the two basic principles of justice. Thus, as institutional agents, they cannot act on *their own* conceptions of the good but they should (1) follow the conception of justice, that guarantees the "greatest equal liberty" for all (Rawls, 2005, p. 302); and therefore (2) assist citizens in pursuing *their* conceptions of the good. As abortion is a legal right for citizens, as institutional agents empowered with both (1) the necessary knowledge and (2) the power (and duty) to perform this specific task, they *have to* provide them this service if they are willing to, even if themselves, as *personal agent*s, are opposed to this practice.

Conclusion

To sum up my reflexion, along this *mémoire* I have argued all-things-considered against a moral and legal right to conscientious objection.

Firstly, I have given a conceptual definition of "conscientious objection" and differentiated it from "conscientious *exemption*", which corresponds to the claim for a *legal* recognition of conscientious objection. This distinction has allowed me, during the remainder of the *mémoire*, to argue both against a *moral* right to conscientious objection and against a *legal* right to conscientious *exemption*.

Through Ceva's and Ferretti's theory of institutional corruption, I have been able to underline that granting a right to conscientious objection to health care professionals is to take the risk to see them participate politically twice: once as a *private agent* during the process of decision-making and a second time as an *institutional actor* during the (non-)implementation of the law. This is problematic not only for their potential *patients*, who will not be granted a legal service, but for *citizens* at large because they are not treated as equals, which is a basic liberal principle.

What was a stake for my reflexion was to demonstrate that the status of *institutional actor* is different from the one of *private agent*, and that so too must be the powers and duties attached to them. In following this argument, it is thus logical to ask institutional agents not to act as they would have acted as private agent, but to act as they are required to by their mandate. In this sense, institutional actors should refer to professional norms and values rather than to their own personal beliefs and values.

The added-value of my *mémoire* is to argue all-things-considered against a right to conscientious objection for health care professionals on the grounds of institutional corruption. The literature is indeed reluctant to reject at all the right to conscientious objection for health care professionals. In the actual context of threat against the right to abortion, as I have underlined in the Introduction, it is important that such debates continue to take place in order not to let insidious measures erase this right.

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