Illiberal Liberty: Analysing the Hidden Harms of Conscientious Objections in Health Care Provision

Peter West-Oram
Brighton and Sussex Medical School, University of Sussex, University of Brighton*

Abstract

The right to conscientious objection, and the extent of the entitlements it grants to rights holders, has become progressively more controversial due to the growing range of contexts in which the right is asserted or defended and the corresponding growth in the range of persons making, and affected by, such claims. In this paper, I examine the extent to which a right to conscientious objection in health care is compatible with the liberal pluralist commitments upon which the right allegedly rests. I focus on conscientious objections to duties to participate in the provision of abortion and contraception and argue that granting health care providers exemptions to duties to participate in the provision of such services causes wrongful harm to women, even under idealized conditions designed to preserve access to these health care services.

Keywords: conscientious objection; abortion; contraception; liberal pluralism; rights to health care; ideological freedom.

[A] INTRODUCTION

While rights are sometimes characterized as providing absolute guaranteed entitlements of enjoyment of particular goods, such enjoyment is instead typically contingent upon multiple factors, most often the impact that the exercise of a right will have on other people (Mill 1966: 100-101). This is the case even for rights seen as "basic" (Shue 1996) or otherwise fundamental, as Berlin notes when discussing the importance of restricting rights to personal freedom, for example (Berlin

* The author wishes to thank the Brocher Foundation, which supported them with a residential fellowship while writing an early draft of the paper, Alena Buyx and Adam Henschke for their thoughtful comments, and the participants of the 2024 SLSA "Health Care Law and Bioethics" conference, for a helpful discussion of the paper's core themes. I am also grateful to two anonymous reviewers, and the editors of this Special Section for their thoughtful and constructive feedback on this paper. All remaining errors are my own responsibility.

1971: 124). Thus, states are argued to be entitled, and even obliged, to establish institutions to limit the exercise of certain rights in order to promote their enjoyment more generally (Raz 1986: 417; Rawls 2005: 32). How states choose to do this, which rights they constrain, and which they do not, therefore reveals something significant about both the perceived value of the right in question and the perceived status of the people whose rights are and are not so constrained. In some cases, constraint is universal, and its burdens shared by all persons foregoing only relatively minor entitlements to act in ways which would impose significant harms upon other people. Speed limits constrain our freedom to drive as fast as we might like, for example, but in so doing protect us all from significant risk of harm (Mill 1966: 100-101; Makowsky & Stratmann 2011). In other cases, states must choose which persons' rights claims they will support or prioritize and which they will not. In some such cases, the decision to prioritize the fulfilment of one specific (type of) rights claim over another will simultaneously also affirm a decision about the status of the persons whose rights are not prioritized. This may not always be wrongfully discriminatory and may sometimes be necessary and appropriate, such as the decision not to fulfil one person's non-basic right claim because it would preclude fulfilment of another's basic right (Shue 1996; West-Oram 2026). However, in certain iterations of this kind of case, a state's decision to prioritize the fulfilment of one type of rights claim over another will wrongfully and harmfully erode the moral and political status of the person(s) whose rights are not prioritized. It is with this category of state decision that I am concerned here.

In this paper I examine the extent to which the right of health care providers to conscientiously object to duties to participate in the provision of contraception, particularly intrauterine devices (IUDs) and emergency hormonal contraception (EHC), and abortion[1] is compatible with the commitments of political liberalism upon which the right is

[1] As I discuss in section [H], while appeals to conscience are increasingly made in an ever-wider range of contexts, I focus on abortion and contraception here due to the ubiquity of objections to these health care services, and the increasing frequency with which they are made. Abortion and contraception are seen by some, despite their importance as basic health care services, as immoral because they are alleged to be equivalent to murder – the victim in this case being the foetus or embryo that is destroyed or prevented from implanting in the uterus by their use (Marquis 1989: 183; West-Oram 2013; West-Oram & Buyx 2016; West-Oram & Nunes 2021).

claimed to rest.[2] I argue that legislation granting health care providers "conscience based exemptions (CBEs)" (Neal & Fovargue 2016: 544) to duties to participate in the provision of such services both wrongs and harms patients, even under idealized, hypothetical conditions designed to preserve access (Brock 2008: 194). My goal is to show how, despite the importance of rights to freedom of conscience, such legislation is inherently harmful and wrongful when applied to the provision of certain kinds of health care regardless of whether access to these services is constrained in any way. In doing so, I also show how appeals to the right to conscientious objection are increasingly used to deny the moral status of already marginalized people and exclude them from the group of primary social and political concern. I argue, therefore, that the expansion of the right to conscientious objection thereby radically changes the nature of the relationships between patient and doctor, and between patients and their community. In each case, situating patients seeking abortion and/or contraception in a subordinate social, legal, and political role, in which they hold second-class status to their community and/or physician, both of which are elevated to hold moral authority over what the patient may decide happens to her body.

With this aim in mind, in the following section I first provide a brief overview of the recent legislative and jurisprudential history of the medical conscientious objection debate. Having done so, in section [C], I then explore the key arguments surrounding the significance and role of conscientious objection in its wider social and political context. I do so with reference to the core liberal–pluralist framing around which recent arguments in favour of broad rights to conscientious objection are constructed. In section [D], I consider these arguments in light of the significance of the kinds of health care services most often subject to conscience claims, most specifically contraception and abortion, and argue that these services represent essential components of the fulfilment of important liberty rights. In section [E], I outline and expand on one approach to resolving the apparent conflict between rights to freedom of conscience and rights to reproductive autonomy and bodily integrity—the "conventional compromise" (Brock 2008: 187). In sections [F] and [G], I consider the implications of perfect fulfilment of this enhanced "conventional compromise" and argue that, because of the significance

[2] Importantly, the author is a philosopher, rather than a lawyer, and this paper focuses on the moral and philosophical implications of current and proposed legislation, rather than the letter of the law itself. For this reason, I use examples from a range of legal jurisdictions in both North America and Europe to illustrate my argument. These jurisdictions were chosen as they ostensively share broadly similar liberal–pluralist foundations to their rights-based legal frameworks and because similarly grounded claims have been made in each jurisdiction about the supposed primacy of rights to conscientious objection over other rights claims.

of at least certain kinds of health care, conscientious objection to those services is incompatible with the liberal–pluralist principles upon which the right to conscientious objection is claimed to rest. Finally, in section [H], I note the increasingly broad range of ways that appeals to conscience are used in attempts to justify not merely refusal to provide contested services, but also active discrimination against members of a range of marginalized and stigmatized communities. In doing so, I note the expansion of appeals to conscience in the legislative and litigative domains and explain the ways that it is used to deny the moral status of targeted communities and exclude them from solidaristic concern.

[B] CONSCIENCE IN CONTEXT

In 2010, then United States (US) President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) 2010 into law, representing a paradigm shift in the landscape of American health care provision. While the PPACA fell short of enacting universally accessible, government-administered health care, it nevertheless imposed new standards on health insurance providers, with the intention of improving access to health care for poorer people and those with pre-existing health conditions (West-Oram 2013: 237-238). The PPACA did not, however, pass without controversy, with one of its most contentious aspects being the requirement that all insurance schemes had to provide coverage for prescription medicines, including birth control and emergency contraception (though importantly not abortion) (PPACA 2010, section 1302(b)(1); West-Oram 2013: 239). This was seen as particularly controversial, in part because it required employers and insurance scheme enrollees to contribute indirectly through payment of their insurance premiums to funding services which they may believe to be immoral. This controversy fuelled a range of lawsuits against the government, each of which sought to overturn, or allow exceptions to, these obligations on grounds of conscience, alleging that duties to participate in providing various forms of reproductive, sexual health, and gender-confirming care violated the rights of plaintiffs to freedom of religion (West-Oram 2013; West-Oram & Buyx 2016; Liberman 2017; West-Oram 2018).

While the debate surrounding conscientious objection in the health care context is particularly fierce in the US, it is increasingly relevant in other countries. For example, in the United Kingdom (UK), a Bill intended to significantly expand the rights of health care workers to conscientiously object to participating in the provision of contested services passed its first and second readings and reached the committee stage of review in the House of Lords although it did not progress further and was not enacted

(Conscientious Objection (Medical Activities) Bill [HL] 2018; West-Oram & Nunes 2021). Also in the UK, two midwives were (after a lengthy court case) denied the right to exempt themselves from administrative duties tangentially connected to the provision of abortions (*Greater Glasgow Health Board v Doogan* 2014). In this case, the plaintiffs' opposition was not to having to answer telephones or complete paperwork *per se*, but rather to having any role at all in a causal chain which would lead to abortions being acquired. Here, the plaintiffs were unsuccessful (after multiple appeals) in their claim because it was held that accommodating their asserted right to conscientious objection would place unreasonable burdens on their colleagues. It was also noted in the judgment that the obligations to which the plaintiffs objected were not merely professional expectations, but also legal obligations (*Greater Glasgow Health Board v Doogan* 2014: paragraph 40). Similarly, in Sweden two nurses (unsuccessfully) sued their local health authorities on grounds of unfair discrimination because they were denied employment as midwives due to their refusals to participate in the provision of abortions (BBC News Online 2017; *Grimmark v Sweden* 2020; *Steen v Sweden* 2020). Notably, Sweden is relatively unusual in that it does not permit health workers a right to conscientious objection, instead handling requests for exemptions on a case-by-case basis (Munthe 2017; Clarke 2026: 514). The defendants in each case argued that the plaintiff was free to pursue alternative employment, but that as midwives they had professional and legal duty to provide abortions when requested by patients, which they each stated they would refuse to fulfil. The cases were eventually considered by the European Court of Human Rights, which rejected all claims made by the plaintiffs (BBC News Online 2017; *Grimmark v Sweden* 2020; *Steen v Sweden* 2020). It is notable that the court found in *Grimmark* that while Article 9 of the European Convention on Human Rights (ECHR) does guarantee a right to freedom of religion, that right is not absolute and can be restricted under certain circumstances (*Grimmark v Sweden* 2020: paragraph C).

The assertions of the right to conscientious objection discussed in this section are each grounded in the belief that liberal–pluralist commitments to liberty and equality entitle claimants to avoid, potentially even very distant, involvement in the provision or use of goods that they believe to be immoral. In each case, it was argued that to require such participation would deny claimants the right to act in accordance with their personal moral codes (Pellegrino 2002: 226, 239; LaFollette & LaFollette 2007: 251), unjustifiably restricting their autonomy, and denying their moral status as autonomous agents and equal members of society. Requiring

rights holders to "violate their personal moral or religious beliefs" (Stein 2005) in this way was argued to be discriminatory and constitute an unjustified restriction on an important personal freedom which liberal states are argued to have an obligation to preserve (Rawls 2005: xvi).

However, as I discuss in more detail in the following section, liberal–pluralism is not committed to allowing absolute freedom for all moral perspectives which do not align with legal or professional standards and expectations of behaviour, particularly when those perspectives lead to actions which impose on the ability of other persons to live free, autonomous lives (Mill 1966: 100-101; Berlin 1971: 124; Raz 1986: 417; Zohar 2003). As with other personal liberty rights, the right to conscientious objection is not absolute and does not trump all other considerations in all circumstances, some compromise is both inevitable and necessary. To illustrate this point, Julian Savulescu has argued that it is unlikely that we would accept as valid a physician's refusal to treat elderly patients because she believed that they had had a "fair innings" (2006: 295). Savulescu's point is that, while a commitment to the fair innings argument may be no less sincere than the opposition to abortion, this does not justify allowing physicians to refuse treatment to elderly people on grounds of conscience. Generally speaking, we simply do not take the right to conscientious objection to entitle us to opt out of any and all duties to which we assert an objection.[3] Indeed, the UK Equality Act 2010 prohibits discrimination on the grounds considered by Savulescu because such refusal is seen as inegalitarian and discriminatory. While liberal states typically do recognize and protect personal liberty rights, and freedoms from obligations to do things we believe to be immoral, these guarantees are not absolute, as I discuss in detail in the following section.

[C] LIBERAL–PLURALIST COMMITMENTS TO FREEDOM OF CONSCIENCE

The appeals to conscience discussed in the previous section are directly derived from a narrow definition of the basic principles of classical liberal–pluralism, the primary concerns of which are taken to be the preservation of the liberty of individual persons (Mill 1966: 101; Nozick 1999; Courtland & Ors 2026) and the recognition of their fundamental moral and political equality (Sandel 1998: 67-69; Young 2002: 39). As a consequence of this concern for the preservation and promotion of these

[3] For example, pacifists are not typically entitled to withhold that portion of their tax contributions which would normally be spent on the military.

goods, it has been argued that liberal states are committed to neutrality between incompatible or competing moral perspectives (Raz 1986: 110; Sandel 1998: 10; Rawls 2005: xvi). This neutrality is argued to ensure that citizens are able to live autonomous lives, and enjoy recognition as morally equal agents who are members of a shared community (Raz 1986: 110; McKinnon 2005: 60–61). The commitment to state neutrality is derived from the importance of autonomy (Berlin 1971: 126; Raz 1986: 413) and the liberal commitment to the preservation of individual liberty and equality (Berlin 1971: 171; Raz 1986: 373, 400), and is argued to thereby entail a right to freedom of conscience—a right to believe what one wishes and live according to those beliefs. For a state to fail to adhere to this commitment, by endorsing and enforcing compliance with a particular "comprehensive doctrine" (Rawls 2005: 39) is, it is argued, to fail to respect the autonomy of its citizens, unjustifiably restrict their individual freedom, and deny their equal moral status and authority to make private choices under the law (Sandel 1998: 10; Rawls 2005: 37; McKinnon 2005: 62). Such denials of autonomy, liberty, and equality are argued to constitute a significant harm to those denied these goods (McKinnon 2005: 67), which is sufficient to justify the requirement that states maintain a position of political neutrality between various incompatible moral doctrines (Raz 1986: 413, 425). Consequently, the liberal commitment to individual freedom and equality precludes the state (or any individual) from compelling adherence to any given "conception of the good life" (Raz 1986: 111). Liberal democratic states are therefore argued to be (or at least have an obligation to be) innately pluralist (McKinnon 2005: 68; Rawls 2005: xxxvi) and to have responsibilities to ensure that citizens are free to pursue their own conception of the good life (Raz 1986: 111; Rawls 2005: 30).

Despite (or perhaps, because of) the commitment to the promotion of individual freedom, it is important to acknowledge that liberal–pluralist understandings of justice do simultaneously support state responsibilities to establish political structures (Dworkin 2002: 141), or "basic institutions" (Rawls 2005: 39), which are necessary for the preservation of individual freedom and equality and which enable citizens to privately pursue a "valuable autonomous life" (Raz 1986: 417-418). The imposition of limits on personal freedom is thus an inherent feature of liberal–pluralism and enables adherents of different ideologies to achieve "their cherished goals without thwarting [each] other" (Lamprecht 1921: 232; Rawls 2005: 32). Refusal to accept such limitations, through asserting absolute rights to ideological freedom and personal liberty, can thus deny other persons their own rights to freedom of conscience (Berlin 1971: 124) and reject

the liberal–pluralist principles upon which rights to freedom of conscience are grounded. The imposition of reasonable limits on the freedom to live in accordance with freely held beliefs in the absence of state interference is thus intended to both maximize the ideological freedoms enjoyed by all persons and prevent the emergence of a quasi-Hobbesian context in which persons with competing ideologies are in a state of constant conflict (Lamprecht 1921: 234; Berlin 1971: 123; Zohar 2003: 126; Rawls 2005: 38; Eyal & Gosseries 2013).[4]

The importance of institutions which preserve liberty generally, and the need for mass participation in their delivery and preservation, has led some theorists to argue that liberal justice does not merely require passive toleration of the freedom of others to pursue lives of their own choosing, it can also require rights holders to actively cooperate with policies that they may oppose (Zohar 2003: 122; Rawls 2005: 16, 55). This "active cooperation" requirement is, according to Noam Zohar, a fundamentally necessary part of liberal, democratic politics and an essential feature of living in society with other persons (Zohar 2003: 128). Echoing the points above, ensuring that all persons are able to live according to their moral principles, and thus respect their equal entitlement to such freedoms, may require individual cooperation with the delivery of institutions which protect and promote such freedoms, even when we may hold that cooperation to be incompatible with our personal moral code (Rawls 2005: 39; Dworkin 2002: 141). In this way, for a state to allow a conscience exemption (that is, an entitlement to be released from an otherwise applicable professional or legal duty) in any given situation is for it to endorse it as within the realm of reasonable liberal discourse, the principles upon which it is grounded. It is worth emphasizing here that this is not a point about states legislating what people are allowed to think but, rather, about which professional or legal obligations people are permitted to refuse, based on what they think. For a state to legislate on what people believe is a very different, and arguably far more intrusive and concerning, thing than legislating on how people are permitted to behave based on what they think. I discuss this point in more detail in section [G]. First however, in the following section, I discuss the significance of the kinds of health care services often subject to conscientious objection claims in health care and explain their importance as fundamental components of important liberty rights.

[4] And, indeed, to prevent an anarchic context in which conscience claims are so common as to make the delivery of any social structures or public goods impossible (Zohar 2003: 128).

[D] CONTRACEPTION, ABORTION, AND INDIVIDUAL LIBERTY

Contraception and abortion enable women[5] to avoid, prevent, or terminate an unwanted or unsafe pregnancy (Estrich & Sullivan 1989: 130; Neff 1990: 327-328, 352; McDonagh 1998: 1074; Purdy 2006: 287; Shahvisi & Finnerty 2019), empowering them to protect themselves from the health risks, and restrictions on liberty, associated with pregnancy and childbirth (West-Oram & Buyx 2016: 337; Committee on Preventive Services for Women 2011; Sonfield & Ors 2013). Consequently, these goods should be considered basic health care services, since they help to manage and reduce serious health risks. Further, access to these goods should be acknowledged as a necessary prerequisite for women to enjoy their rights to reproductive autonomy and bodily integrity, each of which are fundamental liberty rights, since in the absence of rights to contraception and abortion the ability to control fertility and decide what happens to and in one's body is severely curtailed.[6] The right to bodily integrity is simply a right to control what happens to one's body (Estrich & Sullivan 1989: 126), while the right to reproductive autonomy is a right to freely make reproductive choices, based on one's personal moral commitments and life goals (Freedman & Isaacs 1993: 19; Purdy 2006: 287). These rights are closely related, and both are fundamentally important liberty rights, which add weight to arguments in favour of the accessibility of abortion services and contraception (Lindemann 2009: 43). This is not a new claim but it is worth noting this importance here as a foundation for the rest of my argument (Conscientious Objection (Medical Activities) Bill [HL] 2018).

The noted rights enable women to freely make reproductive choices (Purdy 2006: 287) and thus control what happens to their bodies (Lindemann 2009: 43). They are thus "fundamental to [women's]

[5] I recognize that the term "woman" relates to a specific gender, and that non-binary people and trans men may also become pregnant, and thus be affected by conscience-based refusals to provide contraception and abortion by health care providers, in addition to other forms of discrimination (as I discuss in more detail in section [H]). However, in the interest of brevity, and to reflect the literature, legislation, and jurisprudence surrounding the conscience debate, I use the word "woman" to denote the class of persons affected by such refusals, following Shahvisi and Finnerty (2019).

[6] While it might be argued that sexual abstinence would have the same result, this ignores the fact that to require abstinence as an alternative to pregnancy is simply to allow women's biology to impose a different set of restrictions on their autonomy. Namely, that the ability to become pregnant is sufficient grounds to limit what women are entitled to do with their bodies—it is to deny the freedom to have sex without risking pregnancy. Further, it is to ignore the fact, noted above, that some serious risks of pregnancy only become apparent during a pregnancy, meaning that abstinence would not protect women from the risks of a wanted pregnancy.

intellectual, psychological, and economical development. [They are] the foundation of individual control and self-determination" (Neff 1990: 353). Consequently, the freedom to control one's body is "a central condition of personhood" (Buchanan & Ors 2000: 216), meaning that actions which restrict access to contraception and abortion undermine liberty rights of fundamental importance to women's freedom and autonomy. Importantly, those without female reproductive systems, most notably cis gender men, do not live under the same constraints, meaning their need for medical assistance in controlling fertility is less extensive than that of women (Purdy 1990). Denial of these rights, and obligating women to continue pregnancies they may wish to end, thus reduces women to things which can be used by other people (Estrich & Sullivan 1989: 127; McDonagh 1998: 1061; McLeod 2002: 2-3), denies their status as citizens of equal moral standing (Sandel 1998: 67-69; Young 2002: 39), and restricts their ability to participate fully and freely in society (Thomson 1971; de Gama 1993: 117–118; Freedman & Isaacs 1993: 19; Wynn & Ors 2007: 254). Therefore, actions which restrict access to contraception and abortion do not merely impose restrictions on the availability of a commercial good; rather, they undermine liberty rights of fundamental importance to women's freedom and autonomy.[7]

This position has been articulated forcefully by Judith Jarvis Thomson, who argues that the rights to bodily integrity and reproductive autonomy entitle women to abortions, regardless of the moral status of the foetus (1971). This is because denying access to abortion imposes an obligation on pregnant women to incur the significant costs of allowing another "person" (the foetus, assuming it qualifies as a person) to use their body without their consent—a significant imposition on the liberty of pregnant women (Thomson 1971; Lindemann 2009: 43). Given that we do not acknowledge an obligation to donate the use of our organs or bodily tissue to persons who are currently physically independent of us but who are in need of the use of those organs to survive, it is unjustifiable to require women to grant the use of their organs to a foetus who is not physically independent of them, *even if* the foetus is a person (Thomson 1971: 48-49; de Gama 1993: 117). Consequently, Thomson argues that women cannot be required to carry a pregnancy to term against their will (Thomson 1971: 66). Requiring that they do so violates their rights to bodily integrity and reproductive autonomy, reduces them to things which can be used by other people (Estrich & Sullivan 1989: 127; Purdy

[7] It might be argued at this point that granting conscience exemptions to health care providers opposed to contraception and abortion does not restrict the accessibility of those goods. I discuss this claim below.

1990: 278; McDonagh 1998: 1061; McLeod 2002: 2-3), denies their status as a citizen of equal moral standing, and restricts their ability to participate fully and freely in society (Freedman & Isaacs 1993: 19; de Gama 1993: 117-118; Wynn & Ors 2007: 254; Lindemann 2009: 43). This argument also applies to contraception, arguably with even greater force, since contraception prevents pregnancy, and thus avoids even the potential for any conflict between the rights claims of foetus and woman (allowing for the sake of argument that foetuses can have rights).

The issue at the heart of the debate surrounding the right of health care providers to exempt themselves from duties to participate in the provision of contested services is therefore a conflict between two important liberty rights—to freedom of conscience and to the freedom to control one's body. Each of these rights guarantee psychological, cognitive, and/or physical freedoms and are thus central to the ability to live a life of one's own choosing. Resolving conflicts between these rights is challenging, since to prioritize either one over the other may appear to impose significant harms on the holders of those rights assigned lower priority. Therefore, it seems that it is not possible, if the claims of both providers and patients are accepted at face value, to adequately respect all competing liberty rights in the context of conscientious objection in health care—one party must inevitably have their liberties restricted. I discuss one possible response to the seeming intractability of this problem in the following section.

[E] A "CONVENTIONAL COMPROMISE"

One approach to resolving the tensions noted in the previous section is reflected in UK law governing abortion. Under the Abortion Act 1967 health care providers who assert a conscientious objection to abortion may exempt themselves from duties to participate in its provision, though cannot do so in circumstances where abortion is necessary to save the life of the pregnant woman, or to protect her from "grave permanent injury to … physical or mental health" (Abortion Act 1967, sections 4(1) and 4(2)). Correlatively, ethical guidelines provided by the British General Medical Council (GMC) allow physicians to conscientiously object to contested practices, but require them to inform patients (preferably in advance) that they do not provide the service, refer them to another provider, and ensure that patients are not left "with nowhere to turn" (2024: paragraph 15). Further, UK British Supreme Court's ruling in *Doogan* affirmed that rights to conscientious objection should be understood to only apply to direct participation in the provision of contested services, rather than the provision of wider "ancillary, administrative and managerial tasks" (*Greater Glasgow Health Board v Doogan* 2014: paragraphs 37-38), a

position also reflected in multiple other jurisdictions (Domenici 2021: 39-40).[8] This approach, wherein rights to exemption are conditional rather than absolute, has been described by Dan Brock as the "conventional compromise" (Brock 2008). Under this approach, consideration is given to establishing whether and to what extent granting conscience exemptions to objecting health care providers will impact on clients, non-objecting providers, and society as a whole. Where granting conscience exemptions will have relatively minor costs, they are often taken to be easier to justify (Kelleher 2010).[9]

This approach to granting rights to conscientious objection is argued to be a "moderate" solution to the problem of preserving freedom of conscience whilst also safeguarding rights to essential health care services (Kelleher 2010: 291). Ensuring the continued accessibility of contested services through duties to refer, and prohibiting exemptions where their assertion would cause significant harm, is thought to maintain state neutrality between incompatible moral perspectives, minimizes the extent to which objecting providers are required to participate in the provision of services which they believe to be immoral thereby respecting their right to freedom of conscience, and avoids the imposition of harms caused by material deprivations of contested services on clients (Kelleher 2010: 291). Costs are seemingly borne by both parties when the conventional compromise is enacted, but these are minimized significantly. This becomes especially clear when compared to the alternatives at either end of the spectrum—compulsory provision by providers (no right to conscientious objection at all), or no duty to inform or refer (an absolute right of conscientious objection).

However, as I argue below, state endorsements of conscience exemptions to duties to participate in the provision of contraception and abortion impose hidden, yet significant, harms on women, and therefore violate the liberal commitment to state neutrality between competing moral paradigms. Importantly, this is the case *even if* the following additional counterfactual (and unrealistic) conditions hold in each case of conscientious objection:

[8] Though, as I discuss in section [H], this understanding is also explicitly rejected in other jurisdictions.

[9] It is important to note, however, that, given that the efficacy of EHC is dependent upon how quickly it can be taken, alternative systems of provision must be readily available to women, and must not entail significant waiting periods, if they are to qualify as imposing only minor costs on women.

1 Referrals will not impose *any* additional costs on either clients or non-client third parties, such as non-objecting providers, or the state.

2 Conscientious objectors will provide false, but plausible and believed, statements to justify why they "cannot" provide a good at a given time (that is, providers will lie about why they "cannot" provide a service to which they object).

These stipulations are both unrealistic and highly demanding. However, by specifying such counterfactual conditions of this enhanced conventional compromise (ECC), I aim to eliminate any overt or direct harm caused by protecting rights to conscientious objections of the kind endorsed by the objectors in the given examples. If alternative provision is *immediately* available, and access to the contested goods is not restricted, providers and clients both appear to get what they want, and costs of providing that care are not imposed on third parties. Equally, if clients remain unaware that they are being denied a service by a particular provider for discriminatory reasons, they avoid immediate, dignitary harms caused by expressions of discriminatory attitudes (McLeod 2002: 12). However, as I argue below, even assuming perfect fulfilment of the ECC, a significant wrongful harm is still inflicted upon women.

[F] STATE ENDORSEMENTS OF CONSCIENTIOUS OBJECTIONS—THE SOURCE OF HIDDEN HARMS

Under idealized circumstances in which the ECC is fulfilled perfectly, providers avoid direct involvement in actions they believe to be immoral, though they retain some responsibility to assist their clients (West-Oram & Buyx 2016: 341-342). Correlatively, clients retain the ability to access contested services and avoid the dignitary harms and additional costs associated with conscientious refusals. However, as I argue in the rest of the paper, significant wrongful harm is still inflicted upon women, even those who do not ever seek access to contraception or abortion, by state support for rights to conscientiously object to the provision of those services. This harm is independent of the dignitary harms of refusal and the "inconvenience" (Fenton & Lomasky 2005; McLeod 2010) of accessing alternative provision, which are each addressed by the ECC. Instead, the harm with which I am concerned is inflicted by the state's endorsement of the right to conscientiously object to duties to participate in the provision of abortion and contraception.

Elizabeth Fenton and Loren Lomasky argue that conscientious refusals by pharmacists to dispense emergency contraception only impose inconvenience on their clients, rather than inflicting actual harm (2005). In response, Carolyn McLeod argues that such refusals do in fact cause harm because, in a sexist and racist social context in which women must endure "inadequate protection from sexual assault and poor access to abortion services", permitting pharmacists to conscientiously object to providing emergency contraception expresses disrespect towards women, by "confirm[ing] to her that her society does not respect her ability to decide what happens to her own body" (McLeod 2010: 20). Given that women "have an interest in not feeling this way", McLeod argues that "[c]onscientious refusals that violate this interest harm women" (McLeod 2010: 20) by undermining their sense of security in being able to make choices about their bodies. McLeod also argues that conscientious refusals may also inflict additional dignitary harms upon women, potentially reducing use of emergency contraception. I do not discuss these dignitary harms further here as they would, as I stipulated above, be prevented by the ECC (Free & Ors 2002; Shoveller & Ors 2007; McLeod 2010: 16-18, 20).

McLeod does not go as far as to suggest that these harms are definitively *wrongful* (ie that they are a normative harm) (McLeod 2010: 17), adhering instead to Joel Feinberg's definition of harm as a "non-normative setback to interests" (McLeod 2010: 17). Consequently, she is open to the idea that it *may* not be wrong for pharmacists to cause these harms by refusing to dispense emergency contraception on grounds of conscience (McLeod 2010: 21). I broadly agree with McLeod's analysis of the *origins* of the harm caused by conscientious refusals to dispense emergency contraception (and by extension other forms of contraception, and abortion). However, I do wish to extend her argument here and show how the harms inflicted by conscientious objections to the provision of emergency contraception, and by extension to abortion and other forms of contraception more broadly, are in fact wrongful as well as harmful.

I argued in section [C] that when a state grants rights to conscientious objection in a given context it implicitly endorses as within the sphere of reasonable discourse the exemption, its costs, and the beliefs upon which the conscience claim is based. This is not to say that the state accepts that those beliefs are true, valid, or moral, but merely that they are not so outrageous or dangerous that respecting them, through the granting of conscience exemptions, would infringe upon respecting other important liberal values. For example, conscientious refusals to serve in the armed forces are typically permitted, but, in the UK at least, we do not

(yet?) allow racist, transphobic, homophobic, or misogynistic teachers to conscientiously object to duties to teach members of persecuted groups on grounds of conscience, precisely because such beliefs are incompatible with prior commitments of liberalism such as respect for equality and individual liberty (Equality Act 2010).

Conversely, rights to conscientiously object to duties to provide contraception and abortion are commonly granted. Given that rights to conscientious objection are conditional upon state approval, for a state to endorse rights to conscientiously object in this context is for it to endorse as within the realm of reasonable disagreement the principles upon which the claimed right is grounded. Therefore, since abortion and contraception are prerequisites for the fundamental liberty rights to reproductive autonomy and bodily integrity, for a state to grant conscience exemptions to the provision of these services is to accept as reasonable the belief that women do not or should not enjoy the same entitlements to these rights as men. It is also, therefore, to endorse as reasonable the belief that women should have a secondary or inferior, and significantly less free, status than men, and implies that the reproductive autonomy rights of affected clients are of less importance than the rights of providers to *actively* deny the entitlements of clients to have such rights.

This is the hidden harm that is caused by states' granting health care providers conscience exemptions to duties to participate in the provision of abortion and contraception. By granting such exemptions, states implicitly classify women's rights to control their bodies as being, at best, a secondary concern when compared to the rights of health care

professionals to opt out of voluntarily undertaken duties.[10] At worst, the actions of the state deny the fundamental moral status of women by implicitly accepting, as within the scope of reasonable pluralist discourse, the claim that women lack rights to control their own bodies and endorse this position as being compatible with the egalitarian commitments of liberal pluralism.

This harm is not merely a "non-normative setback to interests" *qua* Feinberg (McLeod 2010: 16) but rather a deep and lasting injury to its victims. Accepting as reasonable the belief that women should not have rights to control their bodies is to accept that they hold secondary moral status to men—a fundamental denial of their moral and political status, and a significant moral *wrong*. Further, and contrary to McLeod's claim, this hidden harm would occur even in the absence of systemic gender oppression because in and of itself it is a formal state endorsement of an inherently discriminatory and dehumanizing attitude. Even if women were not subject to systemic oppression and states established systems which meant that the exemptions granted to objecting providers would have no impact on the lives of their clients, the state would still be asserting that the conscience claims of the objecting providers are minimally compatible with liberal pluralism, in a way that racism, homophobia, or other forms of discrimination are not.

[10] A potential way for states to avoid this kind of harm (for which I am grateful to an anonymous reviewer), might be argued to be for states to avoid granting formal, legal rights to conscientious objection, but to refrain from preventing employers and their employees from agreeing to contracts which include conscientious objection entitlements. In this hypothetical, the state is not involved in directly affirming any conscience claims, so arguably avoids inflicting the kind of wrongful harm discussed above. However, it does not seem obvious that this suggestion removes the problem with which I am concerned in this paper because, for an employer to be able to offer such contractual terms, it must have first been allowed to do so by the state. That is, in permitting contractual rights to conscientiously object (CRCOs) to the provision of contraception and abortion, the state has made the same affirmation here that it does when legislating for such rights—that women's rights to decide what happens to their bodies are (or can be made) contingent upon the discretion of health care workers and their employers. While it may be argued that this is a decision to be made between an employer and potential employee, without implying state endorsement of any agreement reached, this claim should be considered carefully. For a state to allow CRCOs to the provision of abortion and contraception (or another service) but not others, is for it to make a value judgement about the legitimacy of different kinds of objection and the principles on which they are grounded, and of the significance of the rights such objections affect—it seems just as implausible, for instance, to suggest that we should accept a CRCO in the example suggested by Savulescu (2006) above, of the doctor who wished to refuse treatment to older patients, as it does to suggest that we should legislate to permit that objection. While the state's infliction of wrongful harm is done here indirectly, it is of the same kind as that caused by direct legislative action by the state, which at least tacitly approves the authority of employers to contract in this way (and, of course, the employer then directly inflicts that harm). Of course, were a state to permit CRCOs in all cases, it may be possible to avoid this problem, but we would then run into the practical, Hobbesian anarchy problem discussed in sections [C] and [G].

Importantly, this denial of status occurs regardless of whether alternative methods of provision are immediately available, and to women who never seek access to the health care in question, because it occurs at the level of state *policy*, rather than provider *practice*. A similar claim was the basis for the decision reached by the US Supreme Court in *Brown v Board of Education*. This case ended the formal segregation of American public schools and was based on the argument that, even if the segregated schools available to African-American students were just as good as those available to their white contemporaries, segregation was inherently harmful. "Separate" the Court held, could not be taken to mean "equal" (*Brown v Board of Education* 1954). The decision in this case was not based on the availability, or relative quality, of segregated schools, but on "the effect of segregation itself on public education", and on the affected children (*Brown v Board of Education* 1954: 493). Alternative systems of provision of the substances of important rights, such as education in *Brown v Board of Education*, are innately harmful to the persons forced to make use of them. They humiliate and degrade affected persons by stating that it is more important to defer to the prejudices of providers, and to empower them to actively oppose the rights of their clients, than it is to respect their clients as equal members of society.

[G] ILLIBERAL INCOMPATIBILITY

In the previous section, I argued that the state's endorsement of the right to conscientiously object to the provision of contraception and abortion is innately harmful and wrongful. This is because it endorses as legitimate political discourse the belief underpinning assertions of the right, that women should not enjoy the same rights as men, thereby fundamentally rejecting their moral status as autonomous members of society. In response, it is sometimes argued that the objection to abortion and contraception is an objection to a service and not to the rights or status of the person seeking access to it, in contrast to the case of racism, homophobia and misogyny. Therefore, it is argued, conscientious refusals to dispense contraception and abortion do not discriminate against women in the way that expressions of racist or homophobic attitudes discriminate against their targets. However, as I discuss in this section, this defence lacks force (Bollinger 2021; West-Oram & Nunes 2021).

Assertions of the right to conscientiously object to duties to provide abortion or contraception are typically phrased in terms of an appeal to a negative right to avoid participation in activities which the objecting provider believes to be immoral, rather than a demand to have the positive freedom to discriminate against clients. Thus, Brock's moderate response

to the challenge of conscientious objection in medicine is argued to be a *compromise*, rather than a *concession*. It is premised on the understanding that when people assert the right to conscientious objection they are not harming their patients (if they adhere to the conventional compromise), but are merely not helping them. It may therefore be argued that the objector's personal opposition to abortion is compatible with a commitment to the rights of women to access abortion and contraception (and therefore their status as full and equal members of society) *as long as the objector herself does not have to directly provide them*. However, while this position is open to private citizens who are personally opposed to abortion, it is not possible for health care providers to object to duties to participate in the provision of contested reproductive health services, and yet to faithfully recognize the rights of women to use such services, due to their professional and/or legal roles as "gatekeepers" of those services (Alta Charo 2005: 2473; Wynn & Ors 2007: 254; West-Oram & Nunes 2021: 226-227). That is, it is coherent for a private citizen to oppose abortion and contraception morally, yet simultaneously maintain that they should be legal and accessible. This position is innately pluralist, since it asserts a moral stance which may conflict with those of other persons in their society, yet simultaneously acknowledges the rights of those other persons to hold their own beliefs and act in accordance with them (Lindemann 2009).

There are three features of health care providers which define the gatekeeper status which renders the "anti-abortion-pro-choice" position unavailable to them. First, health care providers have legal and/or professional duties to participate in the provision of health care to their clients—this is the core professional function of health care providers (Arras 1988: 15). Second, they are also the appropriate persons to whom these duties should be assigned, because of their training and expertise—physicians, nurses, and pharmacists undergo training to be able to provide appropriate care, such as abortion and contraception, effectively and safely. It is true that alternative arrangements *could* be made, and responsibility for providing contested services *could* be assigned to different agents than those to whom they are currently assigned. However, the third feature of the agents who currently hold these responsibilities weakens the argument that existing systems should be changed to accommodate objectors—they have incurred these duties voluntarily, by choosing to join the profession to which these responsibilities are rightfully assigned. These duties are not, therefore, the product of a coercive imposition of responsibility by the state. Instead, objecting providers have chosen,

freely, to undertake a career of which the performance of certain actions is a central part (Rhodes 2006; LaFollette & LaFollette 2007: 259).

Collectively, these features define the class of agents to whom the duty to guarantee access to reproductive health care services has rightfully been assigned by the state—members of this group are therefore the people to whom we do, and should, turn when in need of access to abortion or contraceptive services. This is particularly true of midwifery and obstetrics and gynaecology, specializations which are each closely connected to health issues relating to "the female reproductive system" (Royal College of Obstetricians and Gynaecologists 2026). People in these specialisms have the authority, training, and/or responsibility to provide such services, and they have become so voluntarily. Further, in the case of abortion and many forms of contraception, such as IUDs, persons outside of the gatekeeper group are prevented by law from providing these services—another reason to require fulfilment of duties to provide such services by gatekeepers (Abortion Act 1967, section 1.1). Consequently, Rita Alta Charo argues that for health care providers with this gatekeeper status to demand an "unfettered right to personal autonomy" in the provision of important health care services is an "abuse of the public trust" (Alta Charo 2005: 2473).

Notably, it was suggested in the aftermath of the *Grimmark* and *Steen* decisions (as discussed in section [B]), that abortion should or need not be considered a core professional responsibility of midwives and that conscientious objections should therefore be permitted (Brzozowski 2021: 313; Domenici 2021: 37). This argument might also be extended to other health care professions that may be involved in abortion, such as obstetricians and gynaecologists. However, this ignores the fact that, in Sweden at least, abortion simply is part of the midwife's core role, and as the European Court of Human Rights ruled, there is a legitimate interest in it remaining so. It is important for patients to be able to enjoy guaranteed access to abortion (and contraception), and Sweden has decided that midwives play a key role in achieving that goal. Both Grimmark and Steen were already working as nurses and had made a deliberate decision to seek employment as midwives, knowing that they would refuse to fulfil all aspects of that role. They did so voluntarily and could have avoided the conflict by simply recognizing that the requirements of the role were incompatible with their moral commitments and staying in their current nursing roles. While we must avoid discrimination, for the plaintiffs to expect to be permitted access to the midwifery profession while refusing to fulfil one of its core obligations is, to borrow a vivid example from Ronald A Lindsay, "analogous to allowing a Quaker to volunteer for the

military, honoring his request to command a tank division, and then leaving it to his discretion to decide, without penalty, whether the division will be deployed for combat" (Lindsay 2007: 26). The expectations in both cases, of the prospective midwives and the Quaker tank commander, are simply unreasonable and incompatible with the effective delivery of an important state aim.

Of course, given that the specific duties of *any* given professional role are the product of choices which could have been made otherwise, rather than innate, unchangeable ontological commitments, it might perhaps be tempting to conclude that the responsibilities of midwives could and perhaps should be rewritten to accommodate objectors. However, health care infrastructure is enormously complex and organized in a way to best meet the needs of patients. Restructuring the complex and interconnected organizational structures that deliver care to accommodate objectors is likely to be both extremely challenging and costly. There are medical specialities and professions that would permit objectors to avoid involvement in the provision of services to which they assert objections, so it is unclear why we should incur the costs of restructuring to accommodate their ideological commitments. Doing so is likely to be highly costly and may generate new sources of potential conscientious objections—if we must restructure reproductive health care to accommodate the demands of people with one particular set of objections, we expose ourselves to the demand that we do so for other types of objection, potentially creating the kind of organizational anarchy discussed in section [C] that would preclude the delivery of any health care whatsoever (Zohar 2003: 126; Eyal & Gosseries 2013).

While objecting providers may argue that they are not claiming that clients do not enjoy a right to reproductive health care, this is implausible. Having voluntarily become a member of the group to which duties of provision are rightfully assigned, to conscientiously object to those duties, and to thus deny their existence *as duties*, is to define an important women's liberty right as a mere privilege, only available at the discretion of a given provider and, thus, to declare that women lack equal status as full and free members of society. It is irrelevant to say that one would also refuse to provide abortion to cis gender men and, therefore, that one does not discriminate against women because cis gender men would never need an abortion in the first place. If one refuses to provide a service that is needed by only one class of person, one is effectively discriminating against that class of person and denying them their status, even if you would hypothetically deny that service to members of another class if

they were ever to need it. It is discrimination against, and denial of the status of, the affected group with one additional step (at most).

One possible objection (for which I am grateful to an anonymous reviewer) here is that it is possible that there are health workers who would deny any contraception to anyone. Such health care workers would refuse condoms and sterilization to men, just as they would deny abortion, EHC and IUDS to women. Universal refusals of this kind, it might be argued, would not dehumanize or treat as a second class of citizen the persons refused care because *everyone* would be refused access to the means to control fertility and there would be no group who enjoyed greater control over their fertility than another. This is I think an interesting question, which deserves more attention than it is possible to give in this paper. Briefly, however, I think my argument does still apply to this case.

It is first worth noting that it does seem at least plausible that a health provider who conscientiously objected to the provision of all contraceptive and abortion care to all people regardless of *gender* may not be guilty of gender discrimination specifically. Second, and importantly, the stakes for men in this scenario are significantly less severe than they are for women. Further, for the time being at least, conscience-based refusals of service to men are far less frequent than similar denials to women, while the legislation and litigation discussed throughout this paper overwhelmingly focuses on health services typically only required by women. Finally, the burden of contraception typically falls disproportionally on women, meaning that women are more likely to experience refusals of service by health care providers, even if those providers would also refuse service to men (Kimport 2018; Lévesque & Ors 2024). Thus, while the objection raises an interesting question, it is one that is likely to apply to a minority of cases amongst the domain of conscientious objection in health care provision, and to cases for which the consequences are likely to be relatively less severe due to the fact that pregnancy happens within women's bodies, and because of the privileged social position and lower contraceptive expectations typically enjoyed by men relative to women.

However, the wrongful harm on which my argument is grounded in this paper emerges from the state's endorsement as within the realm of reasonable political discourse the principle behind the conscientious refusal. What is at stake therefore, is not the immediate impact of refusals themselves, or the (in)accessibility of treatment (both of which I stipulated away via the ECC), but rather the relative weight officially assigned to different rights claims and the unjustified prioritization of the rights of health workers over those of patients (women seeking abortion

and contraception in my original argument, people of all genders in this expansion).

Therefore, while in reality the impacts on men are significantly lesser than they are on women, the wrongful harm is analogous. The state has prioritized the right of health care workers to refuse to fulfil a voluntarily undertaken professional and legal duty over the rights of their patients to access services to which they have rights and which support their ability to control their fertility and protect themselves from harm. Thus, in those cases where refusal of service is/would be universal rather than gender-specific, women *may* not be classified as holding a secondary status to men *per se*, but they would be classified as holding a secondary status to the objecting health care provider (as would men similarly denied service). Consequently, while refusals in the universal objection case *may* not be grounded in gender discrimination, they nevertheless deny the authority of clients to control what happens to their bodies, which is inherently dehumanizing. State endorsements of the right to refuse service in such cases thus follow the same pattern as those of gender-specific refusals. In both kinds of case, the rights of objecting health workers are prioritized over their patients, the rights of whom are defined by the state's endorsement of rights to conscientious objection as being of secondary status, conditional upon health workers choosing not to exercise their own rights which have been assigned greater priority.

There is significant nuance to the noted objection, which I do not have space to fully explore here. More detailed examination could explore the relevance of the significantly wider accessibility of contraceptives such as condoms compared to abortion (many supermarkets sell the former for example), or the relative impacts of refusals of the two health services for instance. However, as argued throughout the paper, my key concern is the extent to which health providers are granted permission to refuse service on non-medical grounds to people who are entitled to access these important health goods. In this way, what matters is not the health and social impacts of refusals themselves, but rather of the endorsement by the state of the right to refuse and the principles upon which that right is grounded. Thus, the ethical significance of the two cases is closely analogous, given that, in each case, the health worker's freedom is prioritized over that of their patients.

To justifiably allow exemptions to a duty which has rightfully been assigned to a particular group, and voluntarily undertaken by members of that group, the state requires especially compelling reasons which respect other important commitments of political liberalism. Private, personal

beliefs should not qualify as such when they conflict with the provision of services which are essential to the wellbeing and fundamental autonomy rights of other people, because objecting members of the gatekeeper group could have easily avoided the contentious duties by not becoming members of that group in the first place (LaFollette & LaFollette 2007: 250; West-Oram & Buyx 2016).

[H] CONSCIENCE CREEP

The key focus of this paper has been conscientious objections by health care providers to the provision of contraception and abortion. In part, this is due to the ubiquity of objections to these health care services and the increasing frequency with which they are made. Correlatively, and of greater significance, is the impact that refusals of service, and of state endorsements of rights to do so, have on the wellbeing and status of women. Abortion and contraception have for decades been the particular focus of political campaigning against the interests of women. However, conscience is now frequently used as a political tool in an increasingly broad range of contexts, providing an increasingly broad range of entitlements for objectors, and expanding the category of persons entitled to assert rights to conscientious objection (*Burwell v Hobby Lobby Inc* 2014; West-Oram & Nunes 2021). As I argue below, this expansion also increases the number of people harmed by the endorsement and exercise of this increasingly broad right.

Multiple US states have passed legislation which grants health care providers (broadly defined) conscience-based exemptions (Neal & Fovargue 2016: 544) to otherwise applicable obligations under Federal Law (Medical Ethics Defense Act 2025; Bollinger 2021; Ronan & David 2021; West-Oram & Nunes 2021; DeMillo 2021; Hansen 2022; Graf 2023). The Trump administration has also explicitly referenced protection of freedom of conscience in an Executive Order which defined sex as an "immutable binary biological classification" (Dawson 2025) and denied the existence of transgender people (Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government 2025), effectively laying the ground work for health care discrimination against transgender people (Raifman & Galea 2018; Michelson 2025; Perry 2025). Equally, ten US states have now passed legislation which allows health care providers to conscientiously object to the provision of any health care services on the basis of the sexual orientation of their patients (Tran & Ors 2025; Movement Advancement Project 2026). This is particularly significant because this legislation does not merely allow conscientious objection to the provision of a particular service, but to the

provision of services to a particular class of persons. While I argued above that appeals to this distinction in the case of contraception and abortion were unsustainable (West-Oram & Nunes 2021: 226-227), those earlier objections were at least framed in a manner which attempted to conceal their discriminatory nature. Here, by contrast the right to discriminate is overt and has already caused significant harms to the health of affected patients (Tran & Ors 2025).

The increasingly broad range of contexts in which rights to conscientious objection are asserted expose an ever-widening range of persons to real and significant harm. In doing so, they reveal a shrinking of the boundaries of the group deemed by the state to hold equal solidaristic, moral, or political status. The conscientious objection claims discussed in this paper all rest on a belief that the patients that they affect should not have access to the same rights and/or services as other people. In some cases, this claim is hidden, framed in obscuring language, and may not be recognized even by those who assert it, as discussed in section [F]. In other cases, such as those discussed in this section, the discriminatory attitudes are explicit, written into laws intended to overtly dehumanize often already marginalized people. In each case, the rights of providers (broadly defined) to refuse to provide care are prioritized over the rights of patients to access it. As argued above, even if alternative sources of care are immediately available, state endorsement of the right to refuse, accepts as reasonable the belief that the rights, and therefore status, of patients are secondary to those of providers.

In previous work with Alena Buyx, we argued that the US Supreme Court decision in *Burwell v Hobby Lobby,* which granted private corporations rights to conscientious objection, was a worrying expansion of an already problematic concept (West-Oram & Buyx 2016). One of our central concerns was that, far from protecting people from state overreach, the understanding of the right to conscientious objection affirmed by the Court granted undue power to objectors to "dictate the terms of the social contract to their benefit" (West-Oram & Buyx 2016: 342-343). Our concern was that the precedent established in *Burwell v Hobby Lobby* was likely to set the terms of debate surrounding how we provide important health and welfare services and the ways that we ensure our obligations to one another are fulfilled. In the years since that decision, legislation and litigation has granted objectors ever-greater power to redefine the social contract still further. In doing so, an increasingly narrow range of privileged actors have been empowered with greater and greater authority and freedom to deny an ever-wider range of services to an ever-wider range of people. Consequently, the entitlements granted to objectors

do not merely represent respect for the right to freedom of conscience and protection from state overreach. Rather, they provide conscientious objectors in an increasingly wide range of circumstances with special status, enabling them to deny care to patients due to their "unreasonably broadly defined right to freedom of conscience" (West-Oram & Buyx 2016: 342-343). Appeals to the right to conscientious objection have typically and historically been framed as appeals to protection from state overreach. In recent years, the reality of conscientious objection has largely seen it used as a weapon to marginalize, dehumanize, and exclude from the group of political and solidaristic concern (West-Oram 2026: 155-156; West-Oram 2021) those deemed inferior by a small group of politically powerful persons.

[I] CONCLUSION

In this paper, I have argued that when states grant health care providers rights to conscientiously object to participation in the provision of contraception and abortion they both harm and wrong those to whom care is denied. Importantly, I argue that this wrongful harm is imposed even in contexts in which there is no impediment nor additional cost to accessing these health care services. This is because, as I argued in sections [F] and [G], in enacting policy which grants rights to conscientious objection in certain contexts, states implicitly endorse as within the sphere of reasonable discourse the objection, its costs, and the beliefs upon which the conscience claim is based. In the kinds of case which have been the main focus of this paper, those beliefs are that women and other people who can become pregnant are not and/or should not be entitled to enjoy rights to reproductive autonomy or bodily integrity—rights which are of significant moral and political significance. Consequently, state endorsement of claimed rights to conscientiously object to the provision of abortion and contraception is simultaneously endorsement as reasonable the belief that women and other people who can become pregnant should have a secondary, and significantly less free, status than men. This endorsement is what makes rights to conscientious objection to the provision of contraception and abortion incompatible with the liberal–pluralist foundations upon which they are claimed to rest and is what causes the increasingly less-than-hidden harm with which I am concerned in this paper.

As discussed in section [H], the legislative and jurisprudential focus of conscientious objection in health care has until relatively recently focused on objections to the provision of services which safeguard, respect and promote the autonomy rights of women. More recently, however, just as

the harms which are my primary focus in this paper are becoming more overt, the range of persons affected by conscientious objection legislation and jurisprudence is increasingly broad, representing an arguably deliberate restriction of the range of persons deemed by the state to hold equal moral, political and social status. This should rightly be seen as an extension of the long history of conscientious objection being used to restrict access to abortion and contraception and thereby undermine the status of women. However, where those restrictions were often couched in obscuring language which concealed the impact of conscientious objection, more recent legislation and jurisprudence has made the denial of status to certain categories of person, particularly trans people, overt. In so doing, it has highlighted the social, moral, and political stratification, and denials of equal status, imposed on affected persons by state endorsements of rights to conscientiously object to the provision of certain kinds of care to certain demographic groups. It has also provided a stark warning about the expanding scope of the relational harms caused by increasingly broad guarantees of rights to conscientious objection.

As I have argued, the mere availability of alternative systems of provision does not eliminate the harm associated with granting overly broad rights of conscientious objection. Indeed, the provision of alternative systems of service provision can actually exacerbate the harms associated with denials of service—by including within the realm of reasonable disagreement, and thus normalizing, the anti-egalitarian beliefs upon which conscience claims are grounded. Seventy-two years ago, in *Brown v Board of Education*, the US Supreme Court recognized that "separate [was not] equal" (*Brown v Board of Education* 1954: 483). Today, we forget this when we treat the establishment of alternative methods of the provision of contraception and abortion as adequate compensation for deference to discriminatory attitudes. The mere availability of an alternative source of contraception and abortion does not undo the harm done to women and other marginalized and victimized people by a state's endorsement of misogynistic social norms.

About the author

Peter West-Oram *is Associate Professor in Bioethics at Brighton and Sussex Medical School, University of Sussex and University of Brighton. His work focuses on core questions in applied philosophy and bioethics theory and practice, with a particular focus on the origin, nature and extent of our obligations to other people. Recent work includes examination of the role of solidarity in global, public, and individual health, and the entitlements of migrant health care workers and refugees in their countries of residence.*

Email: p.west-oram@bsms.ac.uk.

References

Alta Charo, R. "The Celestial Fire of Conscience—Refusing to Deliver Medical Care." *New England Journal of Medicine* 352 (2005): 2471-273.

Arras, John D. "The Fragile Web of Responsibility: AIDS and the Duty to Treat." *The Hastings Center Report* 18 (1988): 10-20.

BBC News Online. "Swedish Anti-Abortion Midwife Sues Officials in Job Claim." Europe: *BBC News*, 26 January 2017.

Berlin, Isaiah. *Four Essays on Liberty*. Oxford: Oxford University Press, 1971.

Bollinger, Alex. "Ohio Governor Signs Bill with Exemption That Could Allow Doctors to Refuse LGBTQ Patients." *LGBTQ Nation*, 6 July 2021.

Brock, Dan W. "Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?" *Theoretical Medicine and Bioethics* 29 (2008): 187-200.

Brzozowski, Wojciech. "The Midwife's Tale: Conscientious Objection to Abortion after Grimmark and Steen." *Oxford Journal of Law and Religion* 10 (2021): 298-316.

Buchanan, Allen & Ors. *From Chance to Choice: Genetics and Justice*. Cambridge: Cambridge University Press, 2000.

Clarke, Steve. "A Consequentialist Case for Permitting Conscientious Objection in Healthcare." *Journal of Medical Ethics* 52 (2026): 512-518.

Committee on Preventive Services for Women. Clinical Preventive Services for Women: Closing the Gaps. Washington DC: Institute of Medicine of the National Academies, 2011.

Courtland, Shane D, Gerald Gaus & David Schmidtz, "Liberalism." In *Stanford Encyclopedia of Philosophy*, edited by Edward N Zalta & Uri Nodelman. Stanford CA: Stanford University Press, spring 2026.

Dawson, Lindsey. "The Trump Administration Executive Order on Gender Continues to Reverberate." *KTF*, 14 October 2025.

de Gama, Katherine. "A Brave New World? Rights Discourse and the Politics of Reproductive Autonomy." *Journal of Law and Society* 20 (1993): 114-130.

DeMillo, Andrew. "Arkansas Governor Signs Medical Conscience Objections Law." *AP News,* 26 March 2021.

Domenici, Irene. "Antigone Betrayed? The European Court of Human Rights' Decisions on Conscientious Objection to Abortion in the Cases of Grimmark v Sweden and Steen v Sweden." *European Journal of Health Law* 28 (2021): 26-47.

Dworkin, Ronald. *Sovereign Virtue: The Theory and Practice of Equality*. Cambridge MA: Harvard University Press, 2002.

Estrich, Susan R & Kathleen M Sullivan. "Abortion Politics: Writing for an Audience of One." *University of Pennsylvania Law Review* 138 (1989): 119-155.

Eyal, Nir & Axel Gosseries. "Obamacare and Conscientious Objection: Some Introductory Thoughts." *Ethical Perspectives: Journal of the European Ethics Network* 20 (2013): 109-117.

Fenton, Elizabeth & Loren Lomasky. "Dispensing with Liberty: Conscientious Refusal and the 'Morning-After Pill'." *Journal of Medicine and Philosophy* 30 (2005): 579-592.

Free, Caroline, Raymond M Lee & Jane Ogden. "Young Women's Accounts of Factors Influencing their Use and Non-Use of Emergency Contraception: In-Depth Interview Study." *British Medical Journal* 325 (7377) (2002): 1393.

Freedman, Lynn P & Stephen L Isaacs. "Human Rights and Reproductive Choice." *Studies in Family Planning* 24 (1993): 18-30.

General Medical Council. *Personal Beliefs and Medical Practice*. London: GMC, 2024.

Graf, Carly. "'Conscience Bills' Let Providers Opt Out of Care." *Clinical Advisor*, 22 August 2023.

Hansen, Victoria. "SC Law Lets Health Care Providers Refuse Nonemergency Care Based on Beliefs." *NPR*, 21 June 2022.

Kelleher, J Paul. "Emergency Contraception and Conscientious Objection." *Journal of Applied Philosophy* 27 (2010): 290-304.

Kimport, Katrina. "More than a Physical Burden: Women's Mental and Emotional Work in Preventing Pregnancy." *Journal of Sex Research* 55 (2018): 1096-1105.

LaFollette, Eva & Hugh LaFollette. "Private Conscience, Public Acts." *Journal of Medical Ethics* 33 (2007): 249-254.

Lamprecht, Sterling P. "Some Political Implications of Ethical Pluralism." *Journal of Philosophy* (1921): 225-244.

Lévesque, Sylvie, Alexandra Toupin & Maude Pugliese. "Contraception: A Gendered Burden? A Mixed Methods Exploration of Experiences around Contraception Responsibility." *Canadian Journal of Human Sexuality* 33 (2024): 236-248.

Liberman, Alida. "Wrongness, Responsibility, and Conscientious Refusals in Health Care." *Bioethics* 31 (2017): 495-504.

Lindemann, Hilde. "'… But I Could Never Have One': The Abortion Intuition and Moral Luck." *Hypatia* 24 (2009): 41-55.

Lindsay, Ronald A. "When to Grant Conscientious Objector Status." *American Journal of Bioethics* 7 (2007): 25-26.

Makowsky, Michael D & Thomas Stratmann. "More Tickets, Fewer Accidents: How Cash-Strapped Towns Make for Safer Roads." *Journal of Law and Economics* 54 (2011): 863-888.

Marquis, Don. "Why Abortion Is Immoral." *Journal of Philosophy* 86 (1989): 183-202.

McDonagh, Eileen L. "My Body, My Consent: Securing the Constitutional Right to Abortion Funding." *Albany Law Review* 62 (1998): 1057.

McKinnon, Catriona. *Toleration: A Critical Introduction*. London: Routledge, 2005.

McLeod, Carolyn. *Self-Trust and Reproductive Autonomy*. Cambridge MA: MIT Press, 2002.

McLeod, Carolyn. "Harm or Mere Inconvenience? Denying Women Emergency Contraception." *Hypatia* 25 (2010): 11-30.

Michelson, Melissa R. "Trump's Anti-Transgender Executive Order Claims to Protect Women, but Will Lead to Real Harms for Transgender People, Women and Men." *American Politics and Policy*, 24 January 2025.

Mill, John Stuart. *On Liberty*, edited by John Stuart Mill & John M Robson. London: Macmillan Education UK, 1966.

Movement Advancement Project. "Religious Exemptions." *Movement Advancement Project,* 2026.

Munthe, Christian. "Conscientious Refusal in Healthcare: The Swedish Solution." *Journal of Medical Ethics* 43 (2017): 257-259.

Neal, Mary & Sara Fovargue. "Conscience and Agent-Integrity: A Defence of Conscience-Based Exemptions in the Health Care Context." *Medical Law Review* 24 (2016): 544-570.

Neff, Christyne L. "Women, Womb, and Bodily Integrity." *Yale Journal of Law and Feminism* 3 (1990): 327-353.

Nozick, Robert. *Anarchy, State, and Utopia*. London: Blackwell, 1999.

Pellegrino, Edmund D. "The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective." *Fordham Urban Law Journal* 30 (2002): 221-244.

Perry, Sarah Parshall. "Sorry Democrats, but Trump's 'Two Sexes' Executive Order Is Constitutional." *Heritage Foundation*, 20 March 2025.

Purdy, L. "Women's Reproductive Autonomy: Medicalisation and Beyond." *Journal of Medical Ethics* 32 (2006): 287-291.

Purdy, Laura M. "Are Pregnant Women Fetal Containers?" *Bioethics* 4 (1990): 273-291.

Raifman, Julia & Sandro Galea. "The New US 'Conscience and Religious Freedom Division': Imposing Religious Beliefs on Others." *American Journal of Public Health* 108 (2018): 889-890.

Rawls, John. *Political Liberalism*. New York: Columbia University Press, 2005.

Raz, Joseph. *The Morality of Freedom*. Oxford: Oxford University Press, 1986.

Rhodes, Rosamond. "The Priority of Professional Ethics over Personal Morality." *British Medical Journal* 332 (2006): 294-297.

Ronan, Wyatt & Alphonso David. "Arkansas Legislature Sends Broad Medical Refusal Bill Harmful to LGBTQ People to Gov Hutchinson's Desk." *Human Rights Campaign*, 18 March 2021.

Royal College of Obstetricians and Gynaecologists. "FAQs from Women and the Public." London: RCOG, 2026

Sandel, Michael J. *Liberalism and the Limits of Justice* 2nd edn. Cambridge: Cambridge University Press, 1998.

Savulescu, Julian. 2006. "Conscientious Objection in Medicine." *British Medical Journal* 332 (2006): 294-297.

Shahvisi, Arianne & Fionnuala Finnerty. "Why It Is Unethical to Charge Migrant Women for Pregnancy Care in the National Health Service." *Journal of Medical Ethics* 45 (2019): 489-496

Shoveller, Jean & Ors. "Identifying Barriers to Emergency Contraception Use among Young Women from Various Sociocultural Groups in British Columbia, Canada." *Perspectives on Sexual and Reproductive Health* 39 (2007): 13-20.

Shue, Henry. *Basic Rights: Subsistence, Affluence, and US Foreign Policy*, 2nd edn. Princeton NJ: Princeton University Press, 1996.

Sonfield, Adam & Ors. *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*. New York: Guttmacher Institute, 2013.

Stein, Rob. "Pharmacists' Rights at Front of New Debate." *The Washington Post*, 28 March 2005.

Thomson, Judith Jarvis. "A Defense of Abortion." *Philosophy and Public Affairs* 1 (1971): 47-66.

Tran, Nathaniel M & Ors. "Association of State Conscientious Objection Laws and Sexual Minority Population Health." *Sexuality Research and Social Policy* (2025).

West-Oram, Peter. "Solidarity as a National Health Care Strategy." *Bioethics* 32 (2018): 577-584.

West-Oram, Peter. "Solidarity Is for Other People: Identifying Derelictions of Solidarity in Responses to COVID-19." *Journal of Medical Ethics* 47 (2021): 65-68.

West-Oram, Peter. *Justice, Solidarity, and Global Health: From Globalisation to Collaboration*. London: Routledge, 2026.

West-Oram, Peter & Alena Buyx. "Conscientious Objection in Healthcare Provision: A New Dimension." *Bioethics* 30 (2016): 336-343.

West-Oram, Peter G N. "Freedom of Conscience and Health Care in the United States of America: The Conflict Between Public Health and Religious Liberty in the Patient Protection and Affordable Care Act." *Health Care Analysis* 21 (2013): 237-247.

West-Oram, Peter G N & Jordanna A A Nunes. "Conscience Absolutism via Legislative Amendment." *Clinical Ethics* 17 (2021): 225-229.

Wynn, L L & Ors. "Harm Reduction or Women's Rights? Debating Access to Emergency Contraceptive Pills in Canada and the United States." *Studies in Family Planning* 38 (2007): 253-267.

Young, Shaun P. *Beyond Rawls: An Analysis of the Concept of Political Liberalism*. Lanham MA: University Press of America, 2002.

Zohar, Noam J. "Co-Operation despite Disagreement: From Politics to Healthcare." *Bioethics* 17 (2003): 121–41.

Legislation, Regulations and Rules

Abortion Act 1967

Conscientious Objection (Medical Activities) Bill [HL] 2018

Equality Act 2010

European Convention on Human Rights 1950 (Europe)

Executive Order: "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government" Pub L Nos 2025–02090, 8615: 2025.

Medical Ethics Defense Act, §§ 63-1-901 (2025) (Tennessee, USA)

Patient Protection and Affordable Care Act 2010 (PPACA) (Compilation of Patient Protection and Affordable Care Act: Including Patient Protection and Affordable Care Act Health-Related Portions of the Health Care and Education Reconciliation Act of 2010) Public Law 111-148 974 (USA)

Cases

Brown v Board of Education, 347 US 483 (The Supreme Court of the United States of America 17 May 1954)

Burwell, Secretary of Health and Human Services, et al v Hobby Lobby Stores, inc, et al 573 US 682 (The Supreme Court of the United States of America 2014)

Greater Glasgow Health Board (Appellant) v Doogan and Another (Respondents) (Scotland) [2014] UKSC 68

Grimmark v Sweden (2020) App no 43726/17 ECHR

Steen v Sweden (2020) App no 62309/17 ECHR