Virtual Mentor
American Medical Association Journal of Ethics
August 2010, Volume 12, Number 8: 622-627.

CONLEY ESSAY CONTEST 2009 WINNING ESSAY

Justice in Medicine—Conscience Must Not Undermine Patients' Autonomy and Access to Care

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Melanie was a patient at City Fertility Clinic, Inc. She had been trying to conceive for more than a year and had gone through two cycles of in vitro fertilization (IVF) and embryo implantation. Although neither effort had succeeded, Melanie had not given up hope. She had confidence in Dr. Boyles' professional competence. He had helped her arrange for sperm donation and implantation. Melanie decided to introduce him to her partner, knowing that it might be a surprise to him because, when she started treatment, it was as a single parent. Melanie was now happily in love with Bridget and they lived together. A baby would complete their household, she told Dr. Boyles, and they could share the parenting responsibilities.

A few days after the visit, Melanie received a letter from Dr. Boyles' office asking that she find another doctor and recommending other clinics. Dr. Boyles wrote that he could not, in conscience, help in bringing a child into a same-sex household and hoped she'd understand that these beliefs were deeply held and grounded in his religious faith. He thought that another physician could act in Melanie's behalf with greater understanding and enthusiasm than he could.

Shocked at what she read and angry at being abandoned by her physician, Melanie called his office. "I need to speak to Dr. Boyles," she told the receptionist. "I just got a letter telling me to find another doctor. How can Dr. Boyles dump his patient after more than a year? Just where am I going to find another clinic? You've got all my records. It will take weeks to sort this out. You can tell him that I'm reporting him to the state licensing board. This can't be legal. It's discrimination."

Response

It behooves every man who values liberty of conscience for himself to resist invasions of it in the case of others: or their case may, by change of circumstances, become his own.
Thomas Jefferson

In the United States there is a long tradition of legislation protecting physicians' right to opt out of providing medical services they find morally objectionable. For example, soon after the Supreme Court handed down its ruling in *Roe v. Wade* in 1973, the Church Amendments (named for the senator who introduced the bills) were passed to allow objecting physicians to opt out of participating in abortion [1]. Similarly, Oregon's 1997 Death with Dignity Act included a clause allowing doctors

to refuse to be involved in assisted suicide [2]. More recently, physicians have appealed to similar so-called "conscience clauses" in refusing to participate in other treatments they find objectionable, such as performing *in vitro* fertilization (IVF) or prescribing oral contraceptives.

Given the controversial nature of many recent medical advances, allowing physicians who have religious objections to opt out of participating in certain treatments appears to be a good compromise. As a society we applaud people who are willing to stand up for their moral convictions and act in accordance with their consciences. Striking a compromise also has practical appeal: if doctors were required to offer services they found objectionable, it is possible that many would choose other careers instead of joining the nation's ranks of health care professionals.

In recent years, however, a number of incidents have surfaced that underscore the problem this compromise poses to patients' access to care. One case involved a team of doctors in California who refused to artificially inseminate a patient because she was unmarried [3]. The government has recently become embroiled in the controversy surrounding conscience clauses: the California Supreme Court ruled in 2008 that the doctors who refused to inseminate their unmarried patient were not justified in withholding infertility treatment based on their religious beliefs [3]. Only hours before the conclusion of his second term, President Bush's Department of Health and Human Services (HHS) issued the Provider Refusal Rule, which allows any health care worker to decline to participate in any "health services or research activities that may violate their consciences" [4]. Soon after assuming office, President Obama moved to overturn this rule. This contentious debate warrants further examination of an important medical ethics issue: is it ethical for physicians to choose which nonemergent treatments to provide based on their religious beliefs?

It must be emphasized that this difficult question only becomes an ethical issue when practical measures fail. So long as objecting physicians can refer patients to other physicians who are willing to assume responsibility for their care, most problems can be avoided. As long as patients' access to care is not compromised, physicians' religious concerns can and should be accommodated. Rare cases do arise, however, in which willing professionals are not available, and, more troublingly, some of those who object have refused to refer patients elsewhere and have actively interfered with patients' attempts to get treatment from other professionals. One such case involved a pharmacist who not only declined to dispense oral contraceptives to a college student but also refused to tell her which pharmacies would fill her prescription and objected to giving the prescription back so she could take it elsewhere [5]. In such cases, the ethical question concerning professionals' duties to their patients must be confronted.

Physicians generally decline to provide services they find objectionable for two reasons: they either find the treatment *itself* to be morally troubling, or they object to treating a particular *patient*. The first category can be termed *treatment objections*. In accordance with the notion of respecting autonomy, an important value in medical

ethics, objecting physicians claim their choices should be protected. The obvious problem is that some objecting physicians claim that acting in accordance with their consciences requires refusing even to inform patients of their options or to refer them to other doctors, and this clearly undermines patients' access to care. Accommodating physicians' beliefs to this extent would thus deprive many patients of the ability to act in accordance with their own beliefs. Those physicians who want their own beliefs respected have an ethical obligation to ensure that patients' beliefs enjoy the same respect, thus all medical professionals who object to offering certain treatments are nevertheless ethically obligated to inform patients of their options and refer them elsewhere.

During the Bush administration, the Department of Health and Human Services framed conscience clauses as a matter of preventing religious discrimination, arguing that hospitals were punishing workers for their religious beliefs if they discipline providers who refused to be involved in certain procedures [4]. There is an important difference, however, between discriminating based on *beliefs* and holding professionals accountable for their *actions.* Clearly, it is unethical to refuse to hire people based on their religion or punish them for expressing their beliefs. Nevertheless, our society generally protects the right to express beliefs only up to the point at which doing so begins to harm others. Because the state licenses medical professionals and grants them sole authority to provide medical services to patients, physicians assume a positive obligation to provide these treatments to the public [6].

While simply *holding* a particular religious belief does not interfere with this duty, failing to *do* certain things—like answering patients' questions truthfully, obtaining informed consent for treatment, and keeping records confidential—undermines health professionals' ethical obligations and causes significant harm to patients. Practical measures must be put in place to ensure timely referrals so patients' access to care is not compromised if some physicians object to providing certain services. When practical measures are not sufficient to ensure reasonable access to care, hospitals may then be justified in disciplining or declining to hire any physician who refuses to perform the services necessary to fulfill the health professions' collective obligation to patients.

Doctors who are disciplined for refusing to perform procedures are not being discriminated against because of their religious beliefs; they are being held accountable for acting in ways that undermine the basic ethical duty of their profession to provide equal access to care. As Martin Luther King Jr. said, people who stand on principle must be willing to face the consequences [7]; physicians who decide not to participate in certain treatments must not force their patients to bear the burden of their choices [8]—if they have resolved to act in accordance with their beliefs at their patients' expense, they are ethically obligated to accept the ramifications.

Even though conscience clauses occasionally lead to grievous failures that harm patients, some physicians might argue that they are entitled to conscientiously object

to providing certain medical services, just as conscripts conscientiously objected to going to war. This line of reasoning neglects an important distinction between those drafted into military service against their will and physicians who choose their profession voluntarily. Aspiring physicians who are troubled by the ethical duties inherent in certain specialties should make one of two choices: either they should not go into those fields, or, if they do choose those fields, they should live up to their professional responsibilities by providing any legal, medically indicated services patients need and seek to change practices they find troubling only through the appropriate policy-level discussions [9].

Perhaps the most serious problem with conscience clauses is that their widespread application could lead to truly disastrous consequences. A flaw of many conscience clauses is their implication that religious beliefs deserve more protection than other deeply held, albeit secular, moral commitments. Paradoxically, the Provider Refusal Rule, which claims to prevent religious discrimination, ends up committing exactly this sort of discrimination when it treats religious beliefs as more worthy of respect than other moral convictions.

To be consistent, any conscience clause that allows, say, Christian physicians to refuse to perform abortions should also concede that it is ethically acceptable for vegetarian internists to refuse to prescribe any drugs that have been tested on animals, for surgeons troubled by blood transfusions to decline to provide them for their patients, and for pediatricians who object to vaccination to refuse to immunize children.

Indeed, as written, the Provider Refusal Rule must accommodate all these examples of treatment objections, since the rule says that *any* health care provider who conscientiously objects to *any* health service has a right to opt out of being involved [4]. Conscience clauses thus walk a precarious line: they must be infinitely vague about which conscientious convictions are to be protected in order to avoid discrimination, but in doing so they necessarily create an impossibly slippery slope that threatens to undermine patient care significantly.

Implementing practical measures to accommodate physicians' treatment objections unfortunately fails to circumvent all of the ethical minefields surrounding this issue. Some of the most controversial cases, it turns out, are not treatment objections at all. This second category of objections involves physicians who refuse to participate in patient care not because they object to the *treatment* in question but rather because they object to the *patient* receiving it. The scenario of Dr. Boyles, who has no objection to IVF in principle but strongly objects to helping Melanie, who is a lesbian, epitomizes a *patient objection*. These patient objections could be handled the same way as treatment objections—by accommodating objecting physicians via referral of patients to other doctors. This would be an egregious mistake, however, inasmuch as it would signal that it is ethical for health professionals to refuse to help people they find to be "unacceptable." Patient objections, such as Dr. Boyles' refusal to treat Melanie, clearly constitute wrongful discrimination.

Physicians like Dr. Boyles may argue that they cannot in good conscience treat patients they view to be living immorally. But it has long been established that doctors have a duty to treat *everyone* who is in need of medical assistance, even patients who arguably qualify as the most heinous of moral offenders, including convicted murderers and enemy soldiers [10]. Objecting providers may reply that, though they have a duty to provide lifesaving treatment to enemy soldiers, they are under no ethical obligation to provide nonemergency services to facilitate "lifestyle choices" they find objectionable.

Again though, given that the state grants physicians a monopoly on providing medical services like IVF, the health professions must fulfill their public obligation and uphold the ideal of providing equal access to care [6]. In addition to undermining the health professions' commitment to justice, bowing to providers' patient objections would also violate the other key principles of medical ethics [11]: accommodating these objections would unfairly restrict the autonomy of patients like Melanie, forcing them to shop for a doctor who finds them to be "acceptable."

Such a policy would almost certainly cause psychological harm to the patients who suffer discrimination at the hands of those whose stated mission is to come to their aid. Finally, accommodating physicians who object to treating certain patients would make it much more difficult for *all* doctors to act in their patients' best interests, since patients would most likely be more hesitant to reveal details about their personal lives out of fear that doing so could lead to their being abandoned by their doctors—just as Melanie was.

Nobody wants to see doctors, nurses, or pharmacists forced out of their jobs because they cannot in good conscience provide treatments they find morally troubling. Practical solutions can and should be implemented to accommodate professionals' treatment objections, but these accommodations must be circumscribed by a prior duty to ensure patients' access to care. Physicians who object to certain treatments, therefore, have an ethical obligation to inform their patients about the availability of legal medical services and to refer patients to other willing clinicians. Physicians who object to treating certain patients, however, are a different matter entirely. Physicians who choose to help "acceptable" patients while refusing to care for others fail to live up to their ethical duty as doctors, and within the medical profession such behavior must be actively discouraged.

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