

**SYMPOSIUM: THE FUTURE OF RIGHTS OF CONSCIENCE IN HEALTH CARE:
LEGAL AND ETHICAL PERSPECTIVES: ARTICLE: CONSCIENTIOUS
OBJECTION IN CLINICAL PRACTICE: NOTICE, INFORMED CONSENT,
REFERRAL, AND EMERGENCY TREATMENT**

Fall, 2010

Reporter

9 Ave Maria L. Rev. 81 *

Length: 15750 words

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Text

[*81]

Jane is a 15-year-old who became a patient of Dr. Jones several years ago. As she entered puberty, she no longer felt comfortable seeing the male pediatrician who had cared for her since birth. Jane and her mother chose Dr. Jones on a friend's recommendation after confirming that Dr. Jones was on their insurance plan. Jane is in good health and sees Dr. Jones periodically for attention deficit hyperactivity disorder for which she is treated with stimulants.

Jane and her boyfriend have been dating for several months. They are sexually active and use condoms for contraception. On Saturday night, during intercourse, their condom broke. On Monday morning at school, Jane shared her anxiety about becoming pregnant with her best friend Lily who told her about the "morning after pill." Jane frantically made an appointment with Dr. Jones for later that same day.

In the office, Jane explains her concerns to Dr. Jones who clarifies that post-coital contraception is effective if used within at least 72 hours. Dr. Jones, however, states that she believes it is morally equivalent to abortion and does not prescribe it. Jane asks where she can obtain a prescription and Dr. Jones replies that she cannot in good conscience refer either. Jane is very upset at what she perceives as Dr. Jones's lack of sympathy and unwillingness to help.

Jane texts Lily and they Google "emergency contraception." Using the Office of Population Research & Association of Reproductive Health Professionals' website <http://ec.princeton.edu>,¹ they find the **[*82]** address of the local Planned Parenthood clinic.² The clinician provides her with a prescription and offers her contraceptive counseling.

¹ The Office of Population Research at Princeton Univ. and the Ass'n of Reprod. Health Prof'ls, The Emergency Contraception Website, <http://ec.princeton.edu/get-ec-now.html> (last visited Feb. 7, 2011).

Jane's mother agrees that they should transfer to another practice. When calling to schedule a new patient appointment, Jane's mother confirms that all of the providers in the new office prescribe emergency contraception. While waiting the six weeks for the appointment, Jane runs out of her stimulant. Because it is a controlled substance, she does not have any refills and needs a new prescription.

* * * With increasing cultural pluralism and patient autonomy, clinicians have begun to assert the ability to refuse to participate in certain activities they consider immoral, such as the prescription of post-coital contraception, based on claims of conscience. The first part of this article will examine the conceptual foundations of such claims, their scope and limits. Claims of conscience should fundamentally be understood as claims to maintain personal integrity. Contrary to assertions that they are attempts to impose one's moral or religious beliefs on others, they should be understood in terms of the providers' liberty rather than paternalistic or moralistic violations of the patients' liberty. Concern over improperly contributing to another's immoral action, however, remains an important ethical consideration. Analysis of material cooperation relies on relative distinctions, which themselves can become claims of conscience. Having outlined a theory of conscience, the article will then examine the potential limits to the appeal to conscience, particularly in the medical profession. As a liberty claim, claims to conscience can be constrained by harm to others. In health care, such claims can also be limited by providers' fiduciary obligations to patients. There is not, however, a clearly distinct professional ethic that can be used to distinguish professional claims from personal or private claims and medically indicated treatment from treatment that serves broader social goals. The second part of this article will use this conceptual structure to identify providers' responsibilities in various aspects of the patient-provider relationship illustrated by the above hypothetical case. The aspects [*83] include the initiation of the patient-provider relationship, disclosure of alternatives in the informed consent process, referral and treatment during the transition process, and emergency care. Such analysis, however, should consider alternatives within the broader health-care system that may diffuse individual conflicts.

I. Conceptual Issues

A. Conscience

While there are a variety of conceptions of conscience, the dominant contemporary analysis focuses on integrity. Martin Benjamin identifies three main views of conscience: an inner self-validating sense of right and wrong; the internalization of parental and social norms; and an expression of integrity.³ The first understanding of conscience, an inner sense of right and wrong, has difficulty accounting for the putative self-sufficiency of claims of conscience.⁴ If an act is right solely because it is endorsed by one's conscience, the dictates of conscience appear arbitrary and there is no way to resolve conflict between individuals whose consciences disagree. If, on the other hand, conscience recommends an action because it is right, there must be an independent source of rightness. The problem of justification also undermines the second view of conscience, the internalization of social norms.⁵ Social norms only demand adherence if they can be independently justified. There are multiple examples of individuals with deformed consciences and social practices we now consider immoral.

Instead of focusing on the objective or universal rightness of an action, the third conception of conscience focuses on the relationship between a course of action and one's basic ethical convictions.⁶ Violating one's conscience is conceptualized as undermining one's integrity or wholeness and as resulting in guilt, shame, or loss of self-respect.

² The Office of Population Research at Princeton Univ. and the Ass'n of Reprod. Health Prof'ls, Search for an Emergency Contraception Provider, The Emergency Contraception Website, <http://eclocator.not-2-late.com> (last visited Feb. 7, 2011).

³ Martin Benjamin, Conscience, in *Encyclopedia of Bioethics* 469, 469 (Warren Thomas Reich ed., rev. ed. 2003).

⁴ *Id.*

⁵ *Id.* at 470.

⁶ *Id.* See also Jeffrey Blustein, *Doing What the Patient Orders: Maintaining Integrity in the Doctor-Patient Relationship*, 7 *Bioethics* 289, 296 (1993); James F. Childress, *Appeals to Conscience*, 89 *Ethics* 315, 320 (1979); Mark R. Wicclair, *Conscientious Objection in Medicine*, 14 *Bioethics* 205, 213 (2000).

⁷ This third view allows one to both emphasize the importance of acting in accordance with one's conscience and acknowledge the **[*84]** fallibility of moral judgment. It is not contingent on specific religious beliefs and provides a reason to support others complying with their conscience even if you believe they are wrong. ⁸

Some opponents of conscience claims have asserted that those espousing claims of conscience are attempting to impose their moral or religious beliefs on others. ⁹ This misunderstands the nature of conscience claims. Jeffrey Blustein argues, "it is part of the logic of the concept of conscience that my conscience can only forbid me from acting in certain ways or instruct me to act in certain ways, not other people." ¹⁰ It would be incoherent to assert that, "if you did that, it would violate my conscience." Fundamentally, conscience claims should be understood as a kind of liberty claim. ¹¹ Liberty claims can be contrasted with paternalistic or moralistic claims, restricting another's liberty for his or her own good or because the action is immoral, to which the critics' objection more closely corresponds. ¹² Basic liberty has priority over paternalism and moralism, which require substantial justification. ¹³ In the case of paternalism, for example, the individual's decision must be impaired and disapproval of the good or end chosen is not sufficient to demonstrate impairment. ¹⁴

B. Cooperation

Nonetheless, the ways in which individuals' actions interact in complex social systems should be acknowledged. Proponents of conscience are concerned that their actions will improperly contribute to another's immoral action and thereby violate their own integrity. ¹⁵ **[*85]** The face validity of this claim can be illustrated by an example unrelated to the conscientious objection debate. Suppose Jane's older brother and his friends went out to hear a band at a local bar. Her brother drives his friend's car. Later that night, his friend, who is clearly intoxicated, asks for the keys back so he can drive home. If Jane's brother returns the keys and his friend kills another driver in an accident, Jane's brother cannot disclaim all moral responsibility in the accident and death. ¹⁶

A developed analysis of the morality of such interactions can be found in the Roman Catholic conception of "cooperation." ¹⁷ The analysis of cooperation involves a series of distinctions. The fundamental distinction is

⁷ Benjamin, *supra* note 3, at 470.

⁸ For a discussion of additional reasons for society to respect conscience, see Eva LaFollette & Hugh LaFollette, *Private Conscience*, *Public Acts*, 33 *J. Med. Ethics* 249, 249-54 (2007).

⁹ Rob Stein, *A Medical Crisis of Conscience: Faith Drives Some to Refuse Patients Medication or Care*, *Wash. Post*, July 16, 2006, at A1 ("As soon as you become a licensed professional, you take on certain obligations to act like a professional, which means your patients come first," said R. Alta Charo, a bioethicist and lawyer at the University of Wisconsin at Madison. "You are not supposed to use your professional status as a vehicle for cultural conquest.").

¹⁰ Blustein, *supra* note 6, at 299. See also Benjamin, *supra* note 3, at 470; Childress, *supra* note 6, at 318-19.

¹¹ Amy Gutmann & Dennis Thompson, *Democracy and Disagreement* 206, 237 (1996).

¹² *Id.* at 230, 248-49, 261; Blustein, *supra* note 6, at 289, 292, 313.

¹³ Gutmann & Thompson, *supra* note 11, at 230-31.

¹⁴ *Id.* at 261-68.

¹⁵ Stein, *supra* note 9 ("Think about slavery," said physician William Toffler of the Oregon Health and Science University in Portland. "I am a blacksmith and a slave owner asks me to repair the shackles of a slave. Should I have to say, I can't do it but there's a blacksmith down the road who will?" (quotations omitted)).

¹⁶ Another potentially more inflammatory example is an individual who discloses the location of his or her Jewish neighbors' hiding place to Nazi soldiers while the individual knows the neighbors will be killed. The potential need to provide an exculpatory reason - that the individual himself or herself might be killed - demonstrates the complicity.

¹⁷ Orville N. Griese, *Catholic Identity in Health Care: Principles and Practice* 373-74 (1987). See also Anthony Fisher, *Cooperation in Evil: Understanding the Issues*, in *Cooperation, Complicity and Conscience: Problems in Healthcare, Science,*

between formal and material cooperation. ¹⁸ In formal cooperation the secondary agent shares the intent of the primary agent, who performs the action's immoral goal; while in material cooperation the secondary agent does not share the primary agent's intent. Formal cooperation is always immoral while some forms of material cooperation are morally acceptable. The tradition contends that material cooperation that involves actual participation in the evil deed itself is equivalent to formal cooperation. ¹⁹ It is called immediate, in distinction from mediate, material cooperation. ²⁰ For mediate material cooperation to be justifiable there must be an independent and proportionately serious reason or set of reasons for cooperating. ²¹ In the medical context, these reasons must be over and above the medical reasons for performing the procedure. Such reasons might include keeping one's job or continuing in one's profession. The facilitating action must itself also be either good or indifferent. ²²

The complete analysis of the acceptability of material cooperation is dependent on a series of secondary distinctions. One distinction is **[*86]** the relative seriousness of the immoral action. ²³ Within the Roman Catholic moral tradition, immoral acts can be characterized in terms of their relative severity. For example, the use of post-coital contraception is more serious than the use of condoms because post-coital contraception potentially prevents implantation rather than fertilization. ²⁴ A second distinction is how proximate or remote the secondary agent's action is in the causal chain leading to the primary agent's action. ²⁵ A third distinction is how necessary or unnecessary the secondary agent's action is for the primary agent to accomplish his or her intention. Greater proximity or necessity increases the moral complicity. ²⁶

A final consideration in the evaluation of material cooperation involves the potential effect of the secondary agent's action on third parties. ²⁷ The action would be problematic if it led third parties to believe falsely that the secondary agent endorsed the primary agent's action and subsequently encouraged the third parties to act improperly. One of Jane's classmates, for example, might erroneously believe that Dr. Jones's disclosure of the availability of post-coital contraception meant that Dr. Jones approved of it. Within the Roman Catholic tradition, this is called "causing scandal." ²⁸

Unlike the categorical distinction between formal and material cooperation, these subsequent distinctions are matters of degree. This increases the potential scope of disagreement between individuals of good faith about whether an act of material cooperation is immoral. A claim about cooperation can itself become a claim of conscience. An individual who believes a particular act constitutes illicit material cooperation may contend that performing the act would violate his or her integrity.

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C. Constraints on Conscientious Objection

Law and Public Policy 27, 28-64 (Helen Watt ed., 2005); David S. Oderberg, *The Ethics of Co-operation in Wrongdoing*, in *Modern Moral Philosophy* 203, 203-06 (Anthony O'Hear ed., 2004).

¹⁸ Griese, *supra* note 17, at 387-88.

¹⁹ *Id.* at 388.

²⁰ *Id.*

²¹ *Id.*

²² *Id.* at 388-89.

²³ *Id.* at 389-90, 398-402.

²⁴ See *id.* at 389-90.

²⁵ *Id.* at 389-90, 398-402.

²⁶ *Id.*

²⁷ *Id.* at 389, 410-12.

²⁸ *Id.* at 410-16.

1. Harm to Others

As a liberty claim, claims of conscience are appropriately limited by harm to others.²⁹ Conservatively, the risk of harm must be definite, substantial harm to identifiable individuals.³⁰ The harm must follow directly from the action in predictable ways.³¹ It must be a substantial physical or mental injury in contrast to the violation of a moral rule.³² Finally, the harm must be to identifiable individuals rather than to oneself or a general class.³³ While there also may be disagreement about the degree of directness or severity, at a minimum, significant direct harm to identifiable individuals is a legitimate basis on which to constrain liberty.

2. Fiduciary Obligations to Patients

In the domain of health care, claims of conscience may also be constrained by providers' fiduciary obligations to their patients. Providers have a general obligation to place their patient's interests before their own.³⁴ This obligation has a number of sources. There are knowledge and power differentials between patients and providers.³⁵ Patients' illnesses make them vulnerable to exploitation.³⁶ The relative monopoly created by state licensure also reinforces this obligation.³⁷ This obligation can entail personal sacrifice and risk.³⁸ Conversely, **[*88]** vulnerability creates the need for trust, which the lack of integrity undermines.³⁹

3. Intrinsic Morality of Medicine

Both proponents and opponents of claims of conscience in health care appeal to professional norms as a way to limit the debate. Opponents have distinguished professional norms from religious or moral beliefs and argue that providers may refuse to perform actions that violate their professional, but not personal or private, integrity.⁴⁰ On

²⁹ Gutmann & Thompson, *supra* note 11, at 233. Cf. Wicclair, *supra* note 6, at 218, 226 (2000) (emphasizing violating established rights to receive treatment rather than causing harm).

³⁰ Gutmann & Thompson, *supra* note 11, at 234.

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ Ezekiel J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* 14-15 (1991); Joel Frader & Charles L. Bosk, *The Personal Is Political, the Professional Is Not: Conscientious Objection to Obtaining/Providing/Acting on Genetic Information*, 151C *Am. J. Med. Genetics* 62, 65 (2009).

³⁵ Frader & Bosk, *supra* note 34, at 65.

³⁶ Emanuel, *supra* note 34, at 17-18.

³⁷ Holly Fernandez Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* 70-75 (2008).

³⁸ Frader & Bosk, *supra* note 34, at 65.

³⁹ Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, *Hastings Ctr. Rep.*, May-June 1995, at 8, 8-10. Cf. LaFollette & LaFollette, *supra* note 8, at 250, 254 (emphasizing the voluntary assumption of these duties), with Rebecca S. Dresser, *Freedom of Conscience, Professional Responsibility, and Access to Abortion*, 22:3 *J.L. Med. & Ethics* 280, 281-82 (1994) (discussing the fact that such duties may not have been explicitly disclosed, understood, or agreed to).

⁴⁰ See Frader & Bosk, *supra* note 34, at 65; LaFollette & LaFollette, *supra* note 8, at 249-50, 253 (while these authors initially contrast private and public in terms of an action's effect on others, they later contrast private or individual and professional); Wicclair, *supra* note 6, at 217-27 (2000).

This analysis suggests both a general reason for recognizing appeals to conscience in medicine and a condition that such appeals must satisfy to have significant moral weight. The reason is to nurture, encourage, and promote moral integrity among

the other hand, proponents have distinguished medical interventions from interventions which serve broader social goals, such as physician-assisted suicide or elective abortion, and argue that providers are only obligated to provide medically indicated treatment. ⁴¹ Both claims rely on the ability to clearly distinguish medical from nonmedical claims in a manner that is independent of contested moral claims.

[*89] Efforts to develop an essentialist internal morality of medicine have been generally unsuccessful. ⁴² Such efforts attempt to identify the morality of medicine from the nature of medicine itself rather than from the application of pre-existing moral systems. ⁴³ Edmund D. Pellegrino's work exemplifies this effort. ⁴⁴ It is essentialist because it views illness and healing as universal human experiences rather than as social constructions. ⁴⁵ He argues that medicine is oriented to the good of the patient's well-being or health. ⁴⁶ Even if health cannot be achieved, clinicians can seek to restore harmony or physiological and psychological function. ⁴⁷ He argues that the other helping professions, such as law, education, and ministry, have a similar structure: each deals with individuals in compromised states who are, therefore, exploitable. ⁴⁸ They all offer help and invite trust. The other helping professions, however, differ from medicine in their ends. They respectively seek justice, knowledge and truth, and spiritual good. ⁴⁹ This structure engenders specific moral obligations including insuring the moral agency of the patient and virtues such as suppression of self-interest. ⁵⁰

A fundamental shortcoming of this enterprise has been the failure to develop a consistent definition of health or disease. ⁵¹ The most robust effort to defend a naturalist definition of disease has been that of Christopher Boorse. ⁵² He defines diseases as follows: "In general, **[*90]** deficiencies in the functional efficiency of the body are

physicians. The condition is that an appeal to conscience has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine.

Id. at 217. Wicclair's assertion requires the ability to sharply differentiate these sources of moral identity. He refers to "an Orthodox Jew who happens to be a physician." Id. at 225. Cf., Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, [30 Fordham Urb. L. J. 221, 239-41 \(2003\)](#) ("For Catholics, Orthodox Jews, and Moslems, the teachings of the Gospel, Torah, or Koran take precedence in their lives and indeed inspire their healing vocations.").

⁴¹ Cf. Farr A. Curlin, et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 *New Eng. J. Med.* 593, 597 (2007), with Lainie F. Ross & Ellen W. Clayton, *Letter to the Editor, Religion, Conscience, and Controversial Clinical Practices*, 356 *New Eng. J. Med.* 1889, 1890 (2007).

⁴² John D. Arras, *A Method in Search of a Purpose: The Internal Morality of Medicine*, 26 *J. Med. & Phil.* 643, 645, 651 (2001).

⁴³ See id. at 643-51 (discussing the types of internalism).

⁴⁴ Edmund D. Pellegrino, *The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions*, 26 *J. Med. & Phil.* 559, 560 (2001) [hereinafter *Internal Morality of Clinical Medicine*]; Edmund D. Pellegrino, *Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness*, 4 *J. Med. & Phil.* 32, 32-33 (1979).

⁴⁵ *Internal Morality of Clinical Medicine*, supra note 44, at 560, 563.

⁴⁶ Id. at 563-66.

⁴⁷ Id. at 568.

⁴⁸ Id. at 573.

⁴⁹ Id. at 573-75.

⁵⁰ Id. at 575-76.

⁵¹ For other critiques emphasizing the importance of an internal morality of medicine but also noting its inadequacy for comprehensive medical ethics, see Emanuel, supra note 34, at 19-22, 27-29; Miller & Brody, supra note 39, at 9-12; Franklin G. Miller & Howard Brody, *The Internal Morality of Medicine: An Evolutionary Perspective*, 26 *J. Med. & Phil.* 581, 582-84, 595 (2001).

diseases when they are unnatural, and they may be unnatural either by being atypical or by being attributable mainly to the action of a hostile environment." ⁵³ Given the loss of a conception of a designer's intention, the function of species is determined by empirical analysis. Boorse introduces the concept of a hostile environment to account for diseases, such as dental carries, which are statistically normal. ⁵⁴

This proposal is problematic because environments change and evolution has supported adaption to the prior environments. ⁵⁵ In the current environment, atypical functioning may produce health such as resistance to emerging infectious diseases. ⁵⁶ In addition, humans rapidly change their environment, exacerbating the gap between the current environment and the environment where they previously evolved. ⁵⁷ Deciding whether to attribute disease to the body or the environment is a value-laden choice. ⁵⁸ More broadly, one characterizes problems within major social institutions, such as medicine, law, and religion, each with its own explanatory models, value judgments, and interventions. Such choices are frequently indeterminate and contingent on value considerations. ⁵⁹

Two examples may help clarify these issues. Individuals on both sides of the debate commonly assert that providers are not obligated to provide antibiotics for viral infections. ⁶⁰ This assertion generally oversimplifies the clinical situation by assuming diagnostic certainty. Suppose Jane came into Dr. Jones's office complaining of fever, cough, and a runny nose. Dr. Jones notes diffuse crackles when she listens to Jane's lungs. Some of these findings are consistent with an atypical pneumonia but the runny nose suggests a viral infection. Jane is concerned about missing school and getting behind in her work. Testing and treatment choices include supportive care, viral testing, radiographic studies, and empiric antibiotic therapy. While Dr. Jones's training allows her to understand this range of options and their **[*91]** relative benefits and detriments, it cannot tell her that a low likelihood of an untreated bacterial infection outweighs the risk of Jane worsening and falling behind on her school work. ⁶¹

Conversely, Dr. Jones treats Jane for attention deficit hyperactivity disorder with stimulants. Peter Conrad notes that while the paradoxical effect of stimulants on some children was recognized in the 1930s, "hyperkinetic impulse disorder" was not conceptualized until the late 1950s and hyperkinesis did not become widely diagnosed and treated until the 1960s. ⁶² He argues that

by focusing on the symptoms and defining them as hyperkinesis we ignore the possibility that behavior is not an illness but an adaptation to a social situation. It diverts our attention from the family or school and from seriously entertaining the idea that the "problem" could be in the structure of the social system. ⁶³

⁵² Christopher Boorse, On the Distinction Between Disease and Illness, 5 *Phil. & Pub. Aff.* 49, 49-69 (1975); Jozsef Kovacs, The Concept of Health and Disease, 1 *Med., Health Care & Phil.* 31, 31 (1998).

⁵³ Boorse, *supra* note 52, at 59.

⁵⁴ *Id.*

⁵⁵ See H. Tristram Engelhardt, Jr., *The Foundations of Bioethics* 199-203 (2d ed. 1996); Kovacs, *supra* note 52, at 31-39.

⁵⁶ Kovacs, *supra* note 52, at 32.

⁵⁷ *Id.* at 32.

⁵⁸ *Id.* at 34.

⁵⁹ *Id.* at 35.

⁶⁰ Allan S. Brett & Laurence B. McCullough, When Patients Request Specific Interventions: Defining the Limits of the Physician's Obligation, 315 *New Eng. J. Med.* 1347, 1347-51 (1986).

⁶¹ Cf. Jeffrey P. Burns & Robert D. Truog, Futility: A Concept in Evolution, 132 *Chest* 1987, 1987-93 (2007) (discussing an alternative example - the failure to establish a clear definition of "futility").

⁶² Peter Conrad, The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior, 23 *Soc. Probs.* 12, 12-14 (1975).

Conrad acknowledges that the medicalization of hyperkinesis produces benefits and detriments.⁶⁴ While medicalization results in less condemnation and stigmatization, it also places the condition almost exclusively under expert control.⁶⁵ A lack of conscientious objection to prescription of stimulants suggests that medicalization per se is not objectionable but only certain forms of medicalization. These objections are contingent on secondary normative assumptions.⁶⁶

To summarize, claims of conscience are important because of the value of integrity. Claims of conscience should be understood as liberty claims - not only an exemption from performing an action one considers immoral, but also from not meaningfully contributing to other's immoral action. Such claims are constrained by direct harm to an identifiable other and by the role responsibilities of health-care [*92] providers. Professional norms do not, however, unequivocally validate or constrain claims of conscience in health care. These general principles can be used to consider various aspects of the provider-patient relationship including establishing the relationship, obtaining informed consent, referring, and providing emergency treatment. In analyzing these components it is important not to inordinately focus on the relationship itself but also to recognize the wider system in which it exists.⁶⁷ This wider focus may provide ways to resolve individual conflicts.

II. Clinical Practice

A. Notice

An individual's ability to select his or her provider varies. At one end of the spectrum is the unconscious victim of a motor vehicle accident being taken by ambulance to the nearest hospital and at the other is a wealthy individual in a fee for service system selecting a primary-care provider in a large metropolitan area. Even within managed care systems, individuals maintain some choice of their primary-care provider. In such contexts, it is reasonable to suggest that providers have obligations to disclose interventions they refuse to provide on the basis of conscience to both prospective patients and employers.⁶⁸

A provider's conscientious refusal to provide a particular intervention may be a reason either for or against choosing the provider. In Jane's case, Dr. Jones's refusal to prescribe emergency contraception [*93] might have been relevant to Jane and her parents' decision. Notice could take a variety of forms including brochures, posters, and verbal communication. Providers should not assume patients understand the implications of a provider being

⁶³ Id. at 19.

⁶⁴ Id. at 17.

⁶⁵ Id. at 17-18.

⁶⁶ Cf. Jeffery Sobal, *The Medicalization and Demedicalization of Obesity*, in *Eating Agendas: Food and Nutrition as Social Problems* 67, 81-84 (Donna Maurer & Jeffery Sobal eds., 1995); Virginia W. Chang & Nicholas A. Christakis, *Medical Modeling of Obesity: A Transition from Action to Experience in a 20th Century American Medical Textbook*, 24 *Soc. of Health & Illness* 151, 167 (2002) (discussing an alternative example - the demedicalization of obesity).

⁶⁷ See Rebecca Dresser, *Professionals, Conformity, and Conscience*, *Hastings Ctr. Rep.*, Nov.-Dec. 2005, at 9, 10 ("Institutional responses are needed to prevent patients from bearing the burdens of excusing professionals from performing their customary services.").

⁶⁸ See, e.g., Brad Mackay, *Sign in Office Ends Clash Between MD's Beliefs, Patients' Requests*, 168 *Canadian Med. Ass'n J.* 78, 78 (2003). As part of his settlement of professional misconduct charges with the College of Physicians and Surgeons of Ontario, Dr. Stephen Dawson agreed to post a sign in his waiting room. Id. The sign reads:

As a Christian physician, the prescription of birth control pills to unmarried women is contrary to the dictates of my conscience and religion. Similarly, arranging for abortions and the prescription of Viagra to unmarried men is contrary to the dictates of my conscience and religion... . In accordance with my Christian beliefs and the Canadian Medical Association's Code of Ethics, I am setting out my policy so that you are informed in advance of my beliefs and practice.

Id. (ellipses in original). See also Frader & Bosk, *supra* note 34, at 66; Wicclair, *supra* note 6, at 225-26.

affiliated with a Roman Catholic health-care facility.⁶⁹ In addition, providers have an obligation to inform their employers or the facilities in which they work so that they can provide reasonable accommodations. It should be acknowledged that individual's beliefs may change over time and, therefore, notice is an ongoing obligation.

B. Informed Consent

Informed consent is a fundamental constituent of contemporary medical practice. This requirement rests on protecting autonomous choice,⁷⁰ a claim that proponents of conscientious objection should recognize.⁷¹ Informed consent requires a patient to intentionally authorize a treatment or intervention with substantial understanding and without inordinate control by others.⁷² While disclosure may be excessively emphasized, it is an important element of informed consent.⁷³ Providers are generally obligated to disclose a variety of types of information including "those facts or descriptions that patients or subjects usually consider material in deciding whether to refuse or consent to the proposed intervention" ⁷⁴ There are limited exceptions to the rule of informed consent such as emergency, incompetence, waiver, and, more controversially, therapeutic privilege.⁷⁵ **[*94]** None of these exceptions generally apply in the cases under discussion. Notice is insufficient to waive the obligation to provide informed consent.⁷⁶

If Jane had gone to her doctor with another concern, such as the prevention of a sexually transmitted infection, she might not have been aware of the availability of post-coital contraception if Dr. Jones did not present this option. This lack of knowledge could result in direct harm such as an unintended pregnancy. Dr. Jones cannot reasonably claim that Jane is depressed, emotionally drained, or unstable and that disclosing this information would harm her.

As the patient has not formed an intention until the informed consent process is complete, the provider cannot object that providing an adequate informed consent represents illicit cooperation. In addition, a succinct statement that the provider believes the intervention is immoral, without necessarily elaborating the reasons unless requested, would make the provider's intention explicit.⁷⁷

⁶⁹ Belden Russonello & Stewart, Res. & Comm., Religion, Reproductive Health and Access to Services: A National Survey of Women 2-3 (2000), <http://www.brspoll.com/Reports/CFFC-cons%20clause%20report.pdf>.

⁷⁰ Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics 118 (6th ed. 2009).

⁷¹ See Gutmann & Thompson, *supra* note 11, at 52-55 (discussing reciprocity and mutual respect of persons); Benjamin, *supra* note 3, at 471.

⁷² Beauchamp & Childress, *supra* note 70, at 119.

⁷³ *Id.* at 132-35. Disclosure also touches on another element of informed consent - voluntariness. Voluntariness is acting without being under the control of another's influence. *Id.* at 132-33. Influence can vary by degree from persuasion, to manipulation, and coercion. Persuasion is influence by appeal to reason while coercion is the intentional use of a credible and severe threat of harm or force. Both coercion and some forms of manipulation are controlling and incompatible with autonomy. *Id.* at 133-34. Manipulation includes informational manipulation: "a deliberate act of managing information that nonpersuasively alters a person's understanding of a situation and motivates him or her to do what the agent of influence intends." *Id.* at 134.

⁷⁴ *Id.* at 121.

⁷⁵ *Id.* at 124. The therapeutic privilege allows for a physician to legally withhold information that would "potentially harm a depressed, emotionally drained, or unstable patient." *Id.*

⁷⁶ Lynch, *supra* note 37, at 222.

⁷⁷ Cf. Curlin, *supra* note 41, at 597 ("Patients who want full disclosure from their own physicians might inform themselves of possible medical interventions - a task that is not always easy - and might proactively question their physicians about these matters.").

There is an ongoing debate about the scope of interventions that should be disclosed in the informed consent process. Opponents argue all legally available interventions should be disclosed,⁷⁸ while proponents contend only medically indicated treatment need be disclosed.⁷⁹ The legal stand is too broad and does not provide meaningful guidance. There are very few interventions, such drugs and devices that the Food and Drug Administration has not approved for any indication, some late-term abortions, and female circumcision or genital mutilation, which are illegal.⁸⁰ Conversely, the argument in section I.B.3 has demonstrated the difficulty in demarcating the scope [*95] of medically indicated interventions.⁸¹ The existing reasonable person standard provides some guidance.⁸²

Some authors have emphasized the need to provide accurate and unbiased information.⁸³ Independent standards for accuracy and bias are difficult to identify. For example, there is a substantial debate over the mechanisms of post-coital contraception and whether it is abortifacient. Post-coital contraception delays or inhibits ovulation. Some evidence suggests that it may also have a post-fertilization effect possibly by altering the endometrium or uterine lining, and therefore impairs implantation. Unlike mifepristone or RU-486,⁸⁴ it does not dislodge an implanted embryo. Some, defining the beginning of a pregnancy as implantation and abortion as the disruption of an established pregnancy, argue it is not abortifacient.⁸⁵ Others, defining abortion as the inhibition of the development of a fertilized egg, contend it is.⁸⁶ This is a complex argument about interpreting data and defining terms.⁸⁷ Broader social consensus may be needed to determine the relevant information, which should be disclosed for specific interventions. Some investigators have attempted to develop uniform consent processes for treatments like gallbladder surgery.⁸⁸

⁷⁸ Julian Savulescu, Ethics: Conscientious Objection in Medicine, 332 *Brit. Med. J.* 294, 294-95 (2006) ("If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.").

⁷⁹ Farr A. Curlin, Ryan E. Lawrence, & John D. Lantos, Authors Reply, Religion, Conscience, and Controversial Clinical Practices, 356 *New Eng. J. Med.* 1891, 1891-92 (2007).

⁸⁰ Lynch, *supra* note 37, at 123-24.

⁸¹ See Griese, *supra* note 17, at 387-416; Gutmann & Thompson, *supra* note 11, at 33-34; Wicclair, *supra* note 6, at 205, 218-21.

⁸² See Beauchamp & Childress, *supra* note 70, at 122-24 (comparing the professional practice, reasonable person, and subjective standards).

⁸³ The Limits of Conscientious Refusal in Reproductive Medicine, ACOG Committee Opinion No. 385 (*Am. C. Obstetricians & Gynecologists, D.C.*), Nov. 2007 at 1-5.

⁸⁴ Mifeprex (mifepristone) Frequently Asked Questions, Danco Laboratories, http://www.earlyoptionpill.com/section/health_professionals/health_professionals_faq#How_does_Mifeprex_work (last visited Feb. 7, 2011).

⁸⁵ James Trussell & Beth Jordan, Editorial, Mechanism of Action of Emergency Contraceptive Pills, 74 *Contraception* 87, 87 (2006).

⁸⁶ Nicanor Pier Giorgio Austriaco, Is Plan B an Abortifacient? A Critical Look at the Scientific Evidence, 7 *Nat'l Cath. Bioethics Q.* 703, 704 (2007) (quoting Thomas J. Euteneuer, Plan A: Keep "Plan B" Out of Catholic Hospitals, *Spirit & Life: Hum. Life Int'l Newsletter* (Hum. Life Int'l, Front Royal, Va.), Oct. 5, 2007, available at <http://www.hli.org>).

⁸⁷ Cf. Comm. on Gov't Reform-Minority Staff Special Investigations Division, 109th Cong., False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers (2006) (discussing the risks of abortion, their relative frequency, and their magnitude); Charlotte Ellertson, History and Efficacy of Emergency Contraception: Beyond Coca-Cola, 22 *Int'l Fam. Plan. Persp.* 52, 52 (1996) (discussing various terms for post-coital contraception).

⁸⁸ See Elfriede Bollschweiler et al., Improving Informed Consent of Surgical Patients Using a Multimedia-Based Program? Results of a Prospective Randomized Multicenter Study of Patients Before Cholecystectomy, 248 *Annals of Surgery* 205 (2008).

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C. Referral

Referral has been a significant component of the conscientious objection debate, with different sides supporting or denying the duty to refer.⁸⁹ Referral generally provides patients with access to another provider to obtain services that the initial provider cannot or does not provide. For example, if Jane presented to her general pediatrician Dr. Jones with signs and symptoms of appendicitis, Dr. Jones would refer her to an emergency department to be evaluated by a surgeon. Referral can involve a variety of activities. In this case, simply telling Jane's mother to take her to the emergency department may be sufficient. If Dr. Jones had a preference among surgeons, she might direct Jane's mother to a specific emergency department and, as a courtesy to her colleagues, call ahead. Central to the debate is the direct communication with a willing provider. Such contact may be necessary for a variety of reasons, for example, the insurance company may require a referral for payment, the patient may not be able to obtain an appointment in a timely manner without his or her provider's assistance, or the patient may not be able to identify the relevant type of or best provider without assistance.

Referral generally involves cooperation and in some cases failure to refer may result in harm, which should be characterized from the patient's point of view.⁹⁰ As a result of the informed consent process, the patient has formed an intention that the provider may consider illicit. Assisting the patient to accomplish this goal involves at least material cooperation and the degree of cooperation may be immoral depending on the nature of the assistance.⁹¹ Claims of complicity should not, however, be sufficient to justify refusal of remote involvement such as transfer of medical records.⁹² In many instances refusal to refer does not produce harm; patients have sufficient time, knowledge, and resources to identify a willing provider. This claim is not, however, universally true. If Jane presents toward the end of the [*97] period during which post-coital contraception is effective and she cannot identify and access another provider in a timely manner, she could be harmed. Providers, therefore, have a limited duty to refer.

While there are occasions when the refusal to refer may result in harm to patients, it may be possible to transfer the responsibility to refer to other aspects of the health-care system. Health insurance companies and hospitals maintain lists of providers and can serve as referral sources.⁹³ In addition, third parties have developed referral mechanisms, such as toll-free telephone hotlines or websites, to refer for specific services such as prescribing and dispensing emergency contraception.⁹⁴ The efficacy of such mechanisms is, however, dependant on news

⁸⁹ Compare ACOG Committee Opinion No. 385, *supra* note 83, at 2-5, with Response from the Am. Ass'n of Pro-Life Obstetricians & Gynecologists to the ACOG Ethics Committee Opinion #385, "The Limits of Conscientious Refusal in Reproductive Medicine" 2 (2008).

⁹⁰ Cf. Patrick O'Connell & Jacques Mistrot, Letter to the Editor, Religion, Conscience, and Controversial Clinical Practices, 356 *New Eng. J. Med.* 1889, 1891 (2007) ("If we truly believe that a given procedure violates patients' intrinsic human dignity, then our responsibility to our patients mandates that we not help them procure that procedure.").

⁹¹ See Bernard M. Dickens, Ethical Misconduct by Abuse of Conscientious Objection Laws, 25 *Med. & Law* 513, 516-18 (2006).

⁹² Pellegrino, *supra* note 40, at 240.

⁹³ See, e.g., Intermountain Healthcare, <http://intermountainhealthcare.org/providers> (last visited Feb. 7, 2011); University Health Care, <http://healthcare.utah.edu/FindaDoc> (last visited Feb. 7, 2011).

⁹⁴ James Trussell et al., Call 1-888-Not-2-Late: Promoting Emergency Contraception in the United States, 53 *J. Am. Med. Women's Ass'n* 247, 247 (1998) [hereinafter Call 1-888-Not-2-Late]; James Trussell et al., Evaluation of a Media Campaign to Increase Knowledge About Emergency Contraception, 63 *Contraception* 81, 81 (2001) [hereinafter Evaluation of a Media Campaign].

coverage and public education media campaigns.⁹⁵ The use of such services might obviate the provider's role or make it more remote.

In the absence of notice, refusal to provide an intervention based on claims of conscience may disrupt the trust essential to a provider-patient relationship. Providers should provide ongoing uncontested care during the transition to a new provider. Doing so does not entail complicity and failing to do so may result in harm to patients. In Jane's example, stimulants are a controlled substance and new prescriptions must be written for them each time. It may take weeks to months for Jane to obtain a new patient appointment with her new provider and it would be inappropriate for the new provider to write the prescription without first obtaining a history and performing a physical examination. Dr. Jones should refill her prescription in the interim.

D. Emergency Treatment

Providers generally have an obligation not to abandon their patients; providers must provide adequate notice to afford patients **[*98]** the opportunity to seek another provider.⁹⁶ In a true emergency, transfer of care is not an option. It is an open question how frequently such situations arise in actual clinical practice. A common example in the literature is when a direct abortion is necessary to save a woman's life.⁹⁷ In such situations, treatment would result in moral complicity. Performing the procedure would entail formal cooperation - the provider must deliberate about how best to perform the procedure.⁹⁸ The principle of the doctrine of double effect does not necessarily alleviate this conflict because it prohibits using an immoral means to achieve a good end.⁹⁹ Given the way the hypothetical case of the emergency is constructed, failure to perform the procedure would harm the patient. The provider does not contest that death is a significant harm. If such a situation truly existed, the provider by virtue of his or her professional role has a duty to provide treatment within the provider's scope of practice.¹⁰⁰

The relevant considerations are how to prevent such situations from occurring and how to regard providers who nonetheless refuse to treat. Disclosure should serve as the basis of creating reasonable accommodations to prevent such situations from arising. Central questions are what costs colleagues, employers, or systems must bear,¹⁰¹ and when refusal constitutes a legitimate disqualification for the position.¹⁰² In addition, it should be acknowledged that there are individuals who will refuse to treat in such situations.¹⁰³ State licensing boards should consider what types of penalties are appropriate in such circumstances.

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III. Conclusion

Protecting both providers' integrity and patients' access are important concerns in the health-care system. While formal cooperation is a legitimate basis for conscientious objection, more causally remote or less necessary forms

⁹⁵ Call 1-888-Not-2-Late, *supra* note 94, at 247; Evaluation of a Media Campaign, *supra* note 94, at 81-82.

⁹⁶ Am. Med. Ass'n, Code of Medical Ethics: Current Opinions with Annotations § 8.115: 261-63 (2008-2009 ed. 2008).

⁹⁷ See, e.g., Michael Clancy, Nun at St. Joseph's Hospital Rebuked over Abortion to Save Woman, *Ariz. Republic*, May 19, 2010, at A1 (describing a situation in which urgent abortion was required to save the life of a woman with pulmonary hypertension).

⁹⁸ Griese, *supra* note 17, at 388.

⁹⁹ Cf. Dickens, *supra* note 91, at 516, with Lynch, *supra* note 37, at 225-26.

¹⁰⁰ Lynch, *supra* note 37, at 223-28.

¹⁰¹ See, e.g., Alan D. Schuchman, The Holy and the Handicapped: An Examination of the Different Applications of the Reasonable-Accommodation Clauses in Title VII and the ADA, [73 *Ind. L.J.* 745, 745-46 \(1997-1998\)](#).

¹⁰² Cf. LaFollette & LaFollette, *supra* note 8, at 253, with Lynch, *supra* note 37, at 64-65.

¹⁰³ See Pellegrino, *supra* note 40, at 243.

of material cooperation may be morally permissible. Individuals' claims of liberty may be appropriately constrained by harm to others. This general claim is bolstered in the provider-patient relationship by the provider's fiduciary obligations to their patients. Both notice and informed consent have strong moral justifications and are necessary for the health-care system to function properly. Neither represents a morally impermissible degree of material cooperation. There is a limited duty to refer based on the degree of harm and residual obligations such as transfer of medical records. There is also a strong duty to provide emergency treatment if failing to treat would result in the patient's death or serious disability. Alternatives such as referral hotlines and scheduling accommodations should be considered to discharge the duty to refer and to prevent conflicts over emergency treatment. Jane's situation could have been different if Dr. Jones notified all new patients of her objections or if the front office staff, upon hearing Jane's reason for the appointment, had informed her of Dr. Jones's beliefs and made a referral.

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