

**SYMPOSIUM: THE FUTURE OF RIGHTS OF CONSCIENCE IN HEALTH CARE:
LEGAL AND ETHICAL PERSPECTIVES: ARTICLE: PROFESSIONAL
CONSCIENTIOUS OBJECTION IN MEDICINE WITH ATTENTION TO
REFERRAL**

Fall, 2010

Reporter

9 Ave Maria L. Rev. 189 *

Length: 17192 words

Author: T.A. Cavanaugh+

+ I gratefully acknowledge the very helpful comments of the participants at the BYU Law School's February 2010 Symposium on the Future of Rights of Conscience in Health Care. I thank BYU Law School and University Faculty for Life for sponsoring the Symposium. I particularly thank Professors Richard Myers and Lynn Wardle (the latter's hospitality while at BYU set an insuperable standard for all future conferences). I express gratitude to Professor Guy Micco, M.D. of U.C. Berkeley's School of Public Health for reading and commenting upon earlier versions of this article. I also thank participants in UFL's 2009 Life and Learning Conference who helpfully responded to an earlier version of this paper. I remain entirely responsible for its deficiencies.

Text

[*189]

I. Introduction

At the University of Notre Dame's 2009 commencement, President Obama proposed to "honor the conscience of those who disagree with abortion and draft a sensible conscience clause, and make sure that all of our health care policies are grounded not only in sound science but also in clear ethics as well as respect for the equality of women." ¹ This paper takes up the President's suggestion by addressing conscientious objection in medicine. In what follows, this paper presents the principal features of a sensible clause while elaborating upon the need to extend conscientious objection to include referral, a particularly controverted claim.

What is a sensible conscience clause? First, one needs to distinguish professional conscientious objection in medicine from conscientious objection in employment more generally. The former concerns those who have publicly, or *pro fateri*, said what they stand for: professionals. ² They have articulated and publicly stated an account of medical care that delimits what they take to be within and without the practice to which they commit themselves. Most importantly, this [*190] account includes their conceptions of themselves as medical practitioners and what constitutes a patient, a disease, health, and medical therapy. Physicians, nurses, and pharmacists are medical professionals; ultrasound, radiology, and surgical technicians are not. A sensible medical

¹ President Barack Obama, Commencement Address at the University of Notre Dame (May 17, 2009), in 39 *Origins* 33, 36 (2009).

² See Hugh Walters, *The Meaning of Words in the New Health Service*, 88 *J. Royal Soc'y Med.* 365, 366 (1995) ("The word profession comes from the Latin *pro fateri* which means "to bear witness on behalf of ...' ." (ellipses in original)).

conscience clause bears on the former. Conscientious objection in employment more generally would address the latter, just as it would address the issue of, for example, Islamic taxi drivers' religiously-based objections to transporting passengers carrying alcohol. ³ Thus, what follows concerns professional conscientious objection in medicine.

This account understands a profession to have an independent character autonomous from what law permits and society accepts. While there is pluralism within professions concerning particulars, and, therefore, disputes within the professions concerning their self-conceptions, a profession and professionals, as such, always stand for something more than the efficient use of skill. Put most generally, this something more amounts to their view of the good they seek and the bad they avoid, or, their ethic. With this distinction in mind, and noting that conscientious objection bears on otherwise legal patient requests, the following outlines a conscience clause for medical professionals. After delineating conscientious objection, this Article will present the obligations attending it.

[*191]

II. General Features of a Sensible Conscience Clause

First, the professional objects based upon her professed account of medicine. Her account is public, promulgated, graspable by others, and scientifically-grounded. The objector must be capable of giving reasons accessible to others, in contrast to asserting an entirely personal stance. These reasons must refer to empirically grounded concepts of health, disease, the subject of both (the patient), the goals of medicine, its capabilities, and its boundaries. So, for example, an obstetrician who objects to circumcising a healthy newborn male may do so based upon his account of bodily integrity and the proper functioning of organs. For similar reasons, a nurse may object to being involved in a sterilization post-caesarian section. A pharmacist in Oregon or Washington might object to a terminally ill cancer patient's legal request to fill a lethal prescription for physician-assisted suicide in terms of life not itself being a disease. An anesthesiologist might object to her participation in capital punishment by reference to her account of the very concept of a patient and of sickness. In doing so, each of these professionals offers a reason-based explanation available to others for objecting to the relevant request. Professionals offer such explanations not in terms of exclusively personal beliefs, but rather, in terms of accessible, albeit controverted, answers to the central questions of medical practice. Those questions include: What is medicine? What is a patient? What is a disease? What is health? And what goals can and ought medicine to serve? ⁴

Because a sensible conscience clause must be grounded in a professed account of medicine, it does not cover, for example, objecting to relieving a patient's pain based on one's religious belief in pain's redemptive value or one's

³ In Minneapolis, Minn., approximately two-thirds of cab drivers are Islamic Somalis. According to certain Muslim clerics influential in Minneapolis, the Koran's prohibition against drinking alcohol extends to transporting alcohol. While other clerics dispute this interpretation, some Muslim cab drivers at the Minneapolis airport refused to transport passengers openly carrying alcohol from the duty-free airport stores. Stephanie Simon, *Where Faith and Work Collide*, L.A. Times, Mar. 27, 2007, at A10. In April of 2007, the Minnesota Airports Commissioners decided that a taxi driver must transport passengers with alcohol. *Dolal v. Metro. Airports Comm'n*, No. 07-1657 slip op. at 4 (Minn. Ct. App. Sept. 9, 2008). Now if a driver were to refuse a fare on any grounds, his work license is to be suspended for thirty days; a subsequent refusal is to result in a two-year suspension. Minneapolis, Minn., Metropolitan Airports Commission, Ordinance 106 § 3.1 (2007). The policy was appealed to the Minnesota Court of Appeals, which in September of 2008 ratified a lower court's ruling that it was legitimate because the taxi drivers did not suffer irreparable harm. *Dolal*, No. 07-1657, at 7-8. Although not the topic of this paper, this seems like an unenlightened, unimaginative resolution of the dispute. Given that there were typically more taxis than customers at the airport and that problems arose fewer than a dozen times a month, a variety of resolutions presented themselves, including having non-objecting drivers jump the taxi-line when an objection arose. *Id.* at 3-4. This, in conjunction with a policy that once a driver takes a fare he must bring the fare to her destination, would have resolved the conflict. *Id.*

⁴ Sixty years ago, practitioners widely shared a profession of medicine roughly corresponding to the Hippocratic ethic. Today, one finds numerous oaths, and, by implication, professions. For a study of the variety amongst oaths in all accredited U.S. allopathic and osteopathic medical schools as of 2000, see Audiey C. Kao & Kayhan P. Parsi, *Content Analyses of Oaths Administered at U.S. Medical Schools in 2000*, 79 Acad. Med. 882, 882-86 (2004).

experiential belief that pain builds character. It does not extend to an obstetrician who considers anesthesia during labor objectionable based upon his religious conviction that Genesis 3:16⁵ requires that labor be redemptively painful. Nor does it encompass the profane belief in pain as character-building. Sensible objection requires that one's grounds be both reason-based and medical. A religious belief in the redemptive value of pain is neither reason-based nor medical. Alternatively, a belief in pain as character-building may be reason-based, [*192] but not medical. Thus, such nonmedical, non-reason-based convictions do not ground professional conscientious objection.

The exclusion of profane, nonmedically based convictions does not significantly depart from current statutes concerning conscientious objection in medicine. However, ruling out exclusively religious convictions importantly differs from current federal conscientious objection statutes, which explicitly mention religious beliefs as a basis for conscientious objection.⁶ Accordingly, it requires comment. A sensible conscience clause for medical professionals does not extend to every instance of conscientious objection that society may be willing to grant to individuals. As noted, an employee may have a claim to conscientious objection in employment just as a citizen may have one to military-service or other forms of governmental-mandated action.⁷ These claims may be grounded in religion. These rights of objection extend to the employee as an employee in the context of employment, or to the citizen as a citizen in the context of citizenship. So also, the professional has rights to conscientious objection in the context of profession, which may materially differ from those of the employee and those of the citizen. Most significantly, the professional's actual profession (her view of health, sickness, patients, and the purposes of medicine) grounds professional conscientious objection.

As professions, medicine, law, and the clergy possess autonomy, literally of a self-lawed character. For example, the legal and clerical professions enjoy a virtually absolute degree of confidentiality not found elsewhere in social relations.⁸ Professional conscientious objection in medicine is an instance of the autonomy of the professions from what is simply legal.⁹ Professional conscientious objection differs from religiously grounded objection by being reason-based, and therefore, [*193] in principle, accessible to all. To highlight exclusively religiously-based conscientious objection to the neglect of professional conscientious objection renders conscientious objection a strange and alien phenomenon to the non-religious. More importantly, to do so erroneously suggests that the professional has no positions concerning the ethics of her own practice. The venerable Hippocratic Oath indicates otherwise.¹⁰ Regardless of one's judgment concerning the Oath, it points to a 2,400-year-old autonomous profession, as does professional conscientious objection more generally. Accordingly, we must distinguish professional from religious conscientious objection.

⁵ Genesis 3:16 (Revised Standard, Catholic Edition) ("In pain you shall bring forth children.").

⁶ See Health Programs Extension (The Church Amendment) Act of 1973, [42 U.S.C. § 300a-7](#) (2006) (referring to "religious beliefs or moral convictions").

⁷ See, e.g., [W. Va. State Bd. of Educ., 319 U.S. 624, 628-630 \(1943\)](#); [Newdow v. Rio Linda Union Sch. Dist., 597 F.3d 1007, 1014 \(9th Cir. 2010\)](#) (both cases discussing requirement that U.S. school children salute or pledge allegiance to the American flag).

⁸ In this respect, the defeasible confidentiality in medicine differs from its counterparts in law and religion, thus indicating differences within the professions.

⁹ From the legality of an intervention, one may not conclude that a professional must acquiesce to a patient's request for the intervention. The criteria, in terms of which one determines legality, have little to no bearing on the practitioner's profession concerning health, sickness, and the ends of medicine.

¹⁰ I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." Hippocrates, The Hippocratic Oath (c. 400 B.C.), in *Ancient Medicine: Selected Papers of Ludwig Edelstein* 6 (Owsei Temkin & C. Lilian Temkin eds., Ludwig Edelstein trans. 1987).

Because the professed account of medicine must be empirically grounded, new information and technological changes influence it. It is scientifically grounded, not ideologically based. Accordingly, unlike ideology, discoveries can change it. For example, to consider one currently debated issue of conscience, some find emergency contraception (sometimes known as EC, the "morning after pill," or by its trade name Levonorgestrel¹¹) morally problematic.¹² They do so because they believe it to have at least two mechanisms of operation by which it prevents pregnancy: First, a contraceptive agency by which it prevents ovulation and, thereby, fertilization of an ovum, and second, an abortifacient mechanism by which it prevents the fertilized ovum from implanting in the uterus. All acknowledge the contraceptive mechanism. Dispute and some ambiguity attend the second, putatively abortifacient mechanism.¹³ If it were to be established that the currently favored emergency contraception, Levonorgestrel, had no abortifacient mechanism, or if an alternative pill were developed that acted solely as a contraceptive, then one who finds abortion professionally objectionable - while not objecting to contraception - could with a clear conscience prescribe, fill, or administer it. Whatever the case concerning this example, professional conscientious objection must be evidence-based.

[*194] This brings us to the second feature of the clause, which addresses a particularly difficult issue in determining the outlines of sensible conscientious objection. Namely, may objection refer to specifics about the patient or must it refer solely to a requested intervention?¹⁴ While there may be legitimate instances in which a professional objects to performing some intervention based upon characteristics of the patient - for example, a physician might prescribe contraceptives while objecting to doing so for minors - such cases ought to be regarded as exceptions to a general rule which focuses on objection to specific interventions. Generally, the professional ought to object to a requested intervention, not to the requestor. So, for example, if a fertility doctor does not object to in vitro fertilization in terms of his account of medical practice, he ought to provide it to all otherwise medically-qualified patients.¹⁵ Generally, objection ought not employ any nonmedical reference to the patient who makes the

¹¹ Frequently Asked Questions, Plan B One-Step, <http://www.planbonestep.com/plan-b-faq.aspx> (last visited Jan. 10, 2011).

¹² See Peter J. Cataldo, *The USCCB and Rape Protocols*, 29 *Ethics & Medics* 2 (2004), reprinted in 72 *Linacre Q.* 255, 255-58 (2005).

¹³ J.B. Stanford, *Emergency Contraception: Overestimated Effectiveness and Questionable Expectations*, 83 *Clinical Pharm. & Therapeutics* 19, 20 (2008).

¹⁴ This question resembles one encountered in discussions of conscientious objection to military service. Namely, to be granted conscientious objector status, must an individual object to all wars - be a thoroughgoing pacifist - or may he accept the justice of some wars while objecting to the justice of others - be a subscriber to just war theory, also called selective conscientious objection? Clearly, it is easier for society to administer the pacifist/non-pacifist distinction (object to all wars/not object to all wars) than to extend conscientious objector status to adherents of the just war theory (some wars are just while others are not). Indeed, the U.S. Department of Defense policy, and apparently, U.S. law do not accept selective conscientious objection. "An individual who desires to choose the war in which he or she will participate is not a Conscientious Objector under the law. The individual's objection must be to all wars rather than a specific war." Dep't of Defense, *Instruction Number 1300.06, Conscientious Objectors* § 3.5.1 (2007), available at http://www.fas.org/irp/doddir/dod/i1300_06.pdf.

¹⁵ See, e.g., *N. Coast Women's Care Med. Group, Inc., v. San Diego Cnty. Superior Court*, 189 P.3d 959, (Cal. 2008). A lesbian woman had sought and received fertility treatment. *Id.* at 963. While her doctors had no objections to prescribing medication to facilitate fertility nor to referring her to a non-objecting physician, the doctors did object to performing intrauterine insemination [hereinafter IUI]. *Id.* There was a factual dispute between the parties that was never settled at court: The plaintiff asserted that the physicians objected to performing IUI in light of her sexual orientation; the doctors claimed to object to inseminating a single woman. *Id.* at 969-70. In effect, the court ruled that the basis upon which the physicians did not provide the service was not relevant. *Id.* at 970. Their objection had the effect of discrimination based on sexual orientation, regardless of their motive for objection. *Id.* The court held that while one need not provide the relevant service, if one does offer it, it must be provided to all: "Defendant physicians can simply refuse to perform the IUI medical procedure at issue here for any patient of North Coast, the physicians' employer. Or, ... defendant physicians can avoid such a conflict by ensuring that every patient requiring IUI receives 'full and equal' access to that medical procedure though [sic] a North Coast physician lacking defendants' religious objections." *Id.* at 968-69 (quoting Unruh Civil Rights Act, *Cal. Civ. Code* §§51(a), (b), 52(a) (2009)).

request. ¹⁶ Rather, [*195] it solely considers the act requested. Medicine bandages the wounds of the wounded, regardless of creed, character, race, gender, sexual orientation, innocence, or guilt. Similarly, conscientious objection generally excludes scrutiny of the patient to whose request the doctor objects. ¹⁷

Third, conscientious objection extends from individuals to institutions. For institutions organically arise out of the association of individuals who often share a professed account of medicine. As Thoreau notes, "It is truly enough said, that a corporation has no conscience; but a corporation of conscientious men is a corporation with a conscience." ¹⁸ To prohibit the extension of conscientious objection to corporations or institutions is to thereby prohibit citizens from associating conscientiously. So, just as a pharmacist may object to filling a prescription for physician-assisted suicide, so also may a pharmacy. Indeed, in the case of small pharmacies, the pharmacy is often the pharmacist.

Fourth, and this point closely follows upon that just made, the extension of conscientious objection to individuals in principle amounts to an extension of conscientious objection to the entire profession. For one professional after another may legitimately exercise conscientious objection to include the entire membership of the profession. Simply because the law endorses the use of a medical technology does not insure, and more importantly - given the profession's autonomy from the law - ought it to insure that medical professionals themselves agree with that use of their abilities.

This will understandably be a much-controverted claim, especially given concerns about access to interventions in rural areas where one typically finds fewer practitioners. Moreover, as some note, given [*196] that the medical professions enjoy monopoly-like control over the controverted procedures and technologies, ought one grant conscientious objection to the profession itself, that is, allow conscientious objection in principle to extend to all members? ¹⁹

In light of this monopoly-like control some who would grant conscientious objection to individuals would deny it both to institutions and to the profession in its entirety. However, as noted above, because professionals constitute a profession and individuals by association compose institutions, conscientious objection cannot be limited to individuals. To do so disregards the individual's associative nature, as Professor Lynn Wardle notes: "To exclude institutional health providers from conscience clause protection is merely an indirect way of denying the conscience and morality of the individuals whose will and purposes the entities were created to effect." ²⁰ Nonetheless, those who attend to the exclusive command the medical professions enjoy over the relevant matters have a point.

¹⁶ The medical versus nonmedical distinction is not an entirely bright one (and the above-mentioned "medically-qualified patient" does not remain free of ambiguity). Many would think it perfectly legitimate, perhaps even obligatory, for a fertility specialist to object to providing interventions for a woman well past child-bearing age or to a woman based upon the number of children she already has. In such cases, medical and nonmedical considerations overlap. To take a more controversial case, consider a fertility specialist who limits his practice to married heterosexual couples in light of his medical view that they alone suffer infertility. Such a professional might reasonably maintain that he treats reproductive systems, which systems are neither male nor female, but rather, the union of a male and a female. If he were conscientiously to object to treating a single woman (or man), he would not thereby be importing nonmedical reference to the patient. For fertility, and thereby, infertility, are medical characteristics of heterosexual couples. Again, while such cases might be justifiable and while society may be willing to accommodate them, they ought to be considered exceptions to the general rule in which one objects to performing a specific intervention, not to performing it for this patient.

¹⁷ See, e.g., [id. at 968-69](#); see also Wesley J. Smith, Pulling the Plug on the Conscience Clause, *First Things*, Dec. 2009, at 41, 43.

¹⁸ Henry D. Thoreau, *Civil Disobedience* (1849), reprinted in *On Civil Disobedience: American Essays, Old and New* 11, 12-13 (Robert A. Goldwin ed., 3d prtg. 1973) (1968).

¹⁹ For a discussion on the issue of monopoly and its bearing on conscientious objection see Elizabeth Fenton & Loren Lomasky, Dispensing with Liberty: Conscientious Refusal and the "Morning-After Pill," 30 *J. Med. & Phil.* 579, 579-92 (2005).

²⁰ Lynn D. Wardle, Protecting the Rights of Conscience of Health Care Providers, 14 *J. Legal Med.* 177, 186 (1993).

Medical professions and institutions cannot, on the one hand, exert sole control over technologies and, on the other, enjoy conscientious objection concerning those interventions that have been legalized. Thus, just as legislatures and voters may legalize the use of medical technologies in manners rejected by the medical profession,²¹ they may also legalize others to employ those interventions. Indeed, the medical professions ought not to impede, and, as much as is consistent with their professional ethic, ought to endorse nonmedical personnel being permitted to employ the relevant legalized technologies and interventions.

Consider a case requiring physician-and nurse-complicity in capital punishment in the State of North Carolina.²² The Supreme Court of North Carolina recently ruled that the North Carolina Medical Board, which licenses physicians in the state, cannot restrict physician participation in capital punishment to the physician being physically present at an execution.²³ Rather, in opposition to the Medical Board's (on the face of things, principled and balanced) stance, the [*197] legislature can, as it does in [N.C.G.S. §§15-190](#), require that a physician, "monitor the essential body functions of the condemned inmate and [] notify the Warden immediately upon his or her determination that the inmate shows signs of undue pain or suffering."²⁴ It could come about that all physicians object to this participation in capital punishment (as it could develop that all nurses and pharmacists also object). Indeed, in arriving at its stance, the Medical Board noted that, "physician participation in capital punishment is a departure from the ethics of the medical profession."²⁵ Additionally, the Medical Board cited the American Medical Association's Code of Medical Ethics opinion on capital punishment, which distinguishes the personal opinion of the medical practitioner concerning the morality of the death penalty from the ethic of "a member of a profession dedicated to preserving life when there is hope of doing so."²⁶ To protect conscientious objection and to insure accessibility to the legalized intervention, legislatures that mandate the use of medical technologies in capital punishment must extend authority over such techniques to nonmedical persons. Thus, the State of North Carolina, for example, ought to revisit the exclusive control of medical professionals over the relevant technologies. The same holds for other uses of putative medicine legislatures legalize.²⁷

Fifth, conscientious objection is a two-way street. That is, conscientious objection protects both those who regard certain patient requests as objectionable and those who consider providing the requested medical intervention to be legitimate or even required. One finds this admirable feature in the Church Amendment of 1973, which prevents discrimination against both those who perform abortions and sterilizations and those who refuse to do so.²⁸ A conscience clause [*198] recognizes that there are competing professed accounts of medicine and controverted interventions. As a two-way street, the conscience clause acknowledges the legitimacy of conscience at the level of

²¹ See, e.g., [N.C. Dep't of Corr. v. N.C. Med. Bd., 675 S.E.2d 641, 643-45 \(N.C. 2009\)](#).

²² *Id.*

²³ [Id. at 651](#).

²⁴ *Id.* (alteration in original).

²⁵ [Id. at 644](#).

²⁶ [Id. at 645](#) (quoting Am. Med. Ass'n, Code of Medical Ethics: Current Opinions with Annotation § 2.06: 20 (2008-2009 ed. 2008)).

²⁷ [Id. at 647](#) ("Executions are not medical procedures..."). The logic of the prevailing position being that, if executions are not medical procedures, then when the law requires medical doctors actively to participate in them, the medical board has no jurisdiction. For, according to this line of thinking, the physicians do not act in a professional capacity. What ought one make of such a tortuous and, thereby, torturous line of reasoning? One possible implication would be that the Department of Corrections and a majority of justices of the N.C. Supreme Court recognize the autonomy of the medical profession in their very attempt to suborn it. For our purposes, if a legislature wants to use medical expertise for a purpose medical professionals do not share, the legislature does well to make alternative provisions in light of that fact.

²⁸ See [42 U.S.C. § 300a-7\(c\)](#) (2006).

institutions, while preventing institutions and individuals from discriminating against those whose consciences differ. So, for example, a Catholic hospital that objects to the performance of abortions or sterilizations on its premises may not deny privileges to an obstetrician who does so elsewhere. Conscientious objection considers one's own conduct, not that of another. While a Catholic hospital might prefer to have unanimity on this controverted matter amongst those who practice within it, the hospital must extend to others the very protection afforded to it and to those practitioners sharing its account of medicine.

Sixth, conscientious objection encompasses more than simply not performing the controverted intervention while in certain instances, requiring some cooperation with the patient in his attempt to achieve what he seeks. Working out the boundaries of conscientious objection may be the most difficult task in reaching some political consensus concerning what a sensible conscience clause looks like. Most importantly, conscientious objection encompasses referrals. Because some would permit professionals to object to performing the controverted interventions while requiring referral, this merits greater consideration.²⁹

In order to discuss the extension of conscientious objection to referral, a number of distinctions are in order. First, we must distinguish two cases: Namely, that of a patient with whom the professional has no preexisting relationship and that of the patient with whom there is a relationship prior to the controverted request.³⁰ Second, we must distinguish the act of referral from what we may call full disclosure. By full disclosure, I refer to the need to inform fully the patient of legally and medically available interventions. In my consideration of the obligations attending conscientious objection, I will attend to the obligation of the objecting professional to discuss alternative options with the patient. Referral and full disclosure differ. [*199] The objector need not refer, but he must disclose. Putting this distinction aside for the moment, let us consider the issue of referral with respect to the two aforementioned cases.

Before considering these two cases, a prior question arises: Why regard referral as at all objectionable? Given that professionals refer for those interventions they do not perform, it is, at least on the face of things, natural to suppose that an objecting professional would refer. For, just as the internist refers ingrown toenails to a podiatrist, so also would the objecting practitioner refer for physician-assisted suicide. Moreover, the internist would refer in both cases for the same reason; namely, because he does not perform the requested procedure. This understandable, yet ultimately mistaken, view proposes that referral ought to occur if one does not perform the relevant act, regardless of the basis for not doing that act. This view fails to note, however, that by referring one endorses the relevant act. The internist referring to the podiatrist thereby approves of and, indeed, recommends the podiatrist's act to the patient. In the case of objection, since the professional does not consider the relevant request to be consonant with his own professed account of health, sickness, and the ends, capabilities, and limits of medicine, he could not consistently refer the patient to another. To do so would be to contradict one's very objection to the request in the first place. A professional ethic cannot coherently regard some act as out of bounds while referring to another professional for the performance of that act. While a patient might be gratified by an objecting professional's referral, he would rightly be puzzled by such a view of an ethical principle. For those who apprehend the concept of a restrictive ethical principle understand it as prohibiting both one's own act and one's promotion of another's so acting.³¹ Thus, from the very nature of allegiance to an ethical principle, conscientious objection extends to referral.³² In light [*200] of this, return to the two above-mentioned cases. For the extension of

²⁹ See, e.g., Adrienne Asch, Two Cheers for Conscience Exceptions, *Hastings Ctr. Rep.*, Nov.-Dec. 2006, at 11, 12.

³⁰ As I employ the phrase, a preexisting relationship requires an encounter between professional and patient: The more such encounters, the more significant the relationship and the greater the claims the patient has upon the physician. Simply having an appointment or calling in a prescription to one rather than another pharmacy does not establish a preexisting relationship.

³¹ For a comparable view, see Michael D. Bayles, A Problem of Clean Hands: Refusal to Provide Professional Services, 5 *Soc. Theory & Prac.* 165, 165-81 (1979). Bayles notes, "The argument against referring ... appears consequentialist... . The consequentialism involved is inescapable in morality, for it is the 'consequentialism' of claiming that it is better that wrongful conduct not occur, that one ought not to assist in it The arguments are drawn from the inescapable consequentialism of having moral principles." *Id.* at 168.

conscientious objection to referral in the two cases differs. If no pre-existing relationship exists, the professional need not refer for the reasons noted above. However, if the professional has a preexisting relationship, he does have an obligation to insure that his patients are aware of his stance. If he has failed in this respect and an existing patient reasonably assumes him to be willing, the professional has an obligation to refer if the patient so insists.³³ For, absent notification to the contrary, the patient has the reasonable belief that the professional will perform or refer for the requested act. Moreover, the patient has justifiably developed reliance upon the professional. Were the professional not to refer, he would thereby violate the patient's honest dependence to which he contributed by not adequately communicating his objection. Accordingly, as will be noted subsequently, professionals must scrupulously inform relevant parties of their positions lest they create obligations based upon others' reasonable reliance upon them.³⁴ With the above exception in mind, an objector need not refer.

While in the noted cases, conscientious objection encompasses referral, it does not extend to nonprofessional, logistical tasks such as the forwarding of medical records, or the return of a prescription from a pharmacy.³⁵ In an instance of conscientious objection, but for the loss of time and the opportunity costs, the patient emerges no worse off from the interaction with the objecting professional.³⁶

[*201] Yet, some who have recourse to conscientious objection might object: Is not to acquiesce in the forwarding of medical records, the release of prescriptions, and fully to disclose legal and medically-accepted options provided by other practitioners tantamount to a referral or to moral complicity in the satisfaction of the requested intervention? By so limiting conscientious objection has one given with one hand and taken away with the other? No. Performing an intervention, referring a patient to another to do the same, filling a prescription, or communicating the contents of the same to another so that it may be filled intimately involves one in the relevant matter. One thereby acts with the purpose of ensuring the performance of the act. The achievement of the disputed goal shapes and informs one's own act. Accordingly, one thereby becomes an accomplice to the act to which one objects. For example, a referral must be to another capable and willing to fulfill the contested request. That desideratum structures one's act of referral and, thereby, violates a well-formed conscience. Transferring medical records or returning a prescription does not, however, so deeply implicate one in the objectionable act. One need not thereby intend or deliberate about how to achieve the wrong to which one objects. The objectionable act itself does not shape and determine those acts, which incidentally advance its achievement. While such acts make it easier for the

³² Notably, this is one of the ways in which an ethical principle can differ from a religious obligation. Consider a few religious observations. For example, on certain days, practicing Catholics do not eat meat. Yet this religious duty does not prevent them from selling, providing, preparing, recommending, and in general promoting the eating of meat by others who do not share their religion. Similarly, on the Sabbath, observant Jews refrain from certain activities. This religious commitment does not prevent them, however, from accepting the performance of such acts on their behalf by a volunteer who does not share their beliefs. So, for example, while an observant Jew may not carry bottled water on a hike on the Sabbath, others may offer to do so for him.

³³ Here, patients may correctly assume that medical professionals legally can and do provide an intervention they desire. Thus, an objecting professional has an obligation to inform his patients of his conscientious objector status, lest they develop reasonable reliance upon him.

³⁴ Some might point this out as inconsistent with the previous argument that objection encompasses referral. In the envisioned case, the professional has gotten herself into a moral dilemma where she will either violate her conscience by referring or violate her obligation to the patient who has reasonably come to rely upon her. In either case, whatever she does will be ethically problematic. By promulgating her stance to relevant parties, she can avoid this dilemma. Others might object that referral when a preexisting relationship exists does not adequately satisfy the obligations created by reliance. In such cases, if competent, ought not the professional perform the relevant intervention? The answer to this question depends upon particulars of the case such as how much of a burden referral poses to the patient, the elective character of the intervention, and how grave a violation of her profession does the physician regard the requested intervention in comparison to the wrong of reneging on her patient's reliance.

³⁵ Absent reliance, however, and for reasons comparable to those already noted concerning referral, a pharmacist need not call another pharmacy and communicate the contents of a prescription.

³⁶ Of course, the patient incurs no charges for the refusal.

patient to satisfy his request, they have only a modest determination to that goal. Moreover, they are not necessary to insure its success. For example, if prior to the objection, the patient incurred an insurance copayment, one would reimburse the same. It is immaterial to conscientious objection that the patient can use that same copayment to procure the relevant request elsewhere. Absent the return of the copayment, or return of a prescription, or transfer of medical records, the patient could still secure the controverted intervention.³⁷ In any case, conscientious objection does not extend to preventing the patient from achieving what he seeks. Rather, it insures that the professional need not violate her profession of medicine in her practice. To transfer a medical record, to return a prescription, or to disclose legal options that other professionals offer is not, thereby, to violate a well-formed [*202] conscience. Thus, a professional may not invoke professional conscientious objection for such matters.

Seventh, conscientious objection extends to practitioners and to those becoming practitioners. In terms of her chosen profession, a student may object to learning medical interventions she regards as incompatible with it. As yet to be professed and as one still learning the relevant profession, the student must ensure that she has a proper understanding of her chosen vocation and that her account has sufficient bases in reason and in medicine. She does well to recognize the plurality of views concerning what amounts to medical practice. Moreover, the aspiring medical professional ought to confirm the soundness of her view of medicine and its implications by seeking out experienced practitioners and reflecting upon her views in the light of their practice.

Finally, a sensible conscience clause does not take an ad hoc approach to objection by singling out specific currently and widely-recognized controverted interventions such as abortion and physician-assisted suicide.³⁸ Rather, it attempts to establish an acknowledged forum for the exercise of conscience in a milieu increasingly characterized by dissensus. In this respect, such a clause would differ from the currently existing federal clauses.³⁹ For these current federal laws almost exclusively refer to abortion.⁴⁰

A number of reasons recommend not so limiting protections of conscience to specific interventions. First, by itself not singling out any one controverted matter, the clause treats all parties equally. All recognize that they may have recourse to the exception made for conscience, if not now, perhaps at some future date. It does not require [*203] an overly active imagination, extensive reading of *Antigone*, or that one become a scholar of Anne Hutchinson's trial to conjure up conditions in which a majority regards as legitimate some intervention one considers abhorrent.⁴¹

³⁷ In cases of professional objection, and even more widely, the patient enjoys moral, and, in some jurisdictions, legal, claims to copayments, prescriptions, and medical records. For example, "Oklahoma explicitly states that a patient has a 'property right' in his or her prescription" Jill Morrison & Gretchen Borchelt, Don't Take "No" for an Answer: A Guide to Pharmacy Refusal Laws, Policies and Practices 8 (2007), <http://www.nwlc.org/sites/default/files/pdfs/donttakeno2007.pdf>. See *Okla. Stat. Ann. tit. 59, § 354* (West 2010).

³⁸ For polling data concerning abortion, see Americans Split on Covering Abortion in Insurance Plans that Use Federal Subsidies, Angus Reid Public Opinion (Jan. 14, 2010), http://www.visioncritical.com/wp-content/uploads/2010/02/2010.01.14_abortion_usa.pdf; Lydia Saad, The New Normal on Abortion: Americans More "Pro-Life," Gallup (May 14, 2010), <http://www.gallup.com/poll/128036/new-normal-abortion-americans-pro-life.aspx>. For polling data concerning physician-assisted suicide, see generally Americans Split over Euthanasia and Assisted Suicide, Angus Reid Public Opinion (Feb. 10, 2010), http://www.visioncritical.com/wp-content/uploads/2010/02/2010.02.10_euthanasia_usa.pdf; Joseph Carroll, Public Divided over Moral Acceptability of Doctor-Assisted Suicide, Gallup (May 31, 2007), <http://www.gallup.com/poll/27727/public-divided-over-moral-acceptability-doctorassisted-suicide.aspx>.

³⁹ For the relevant federal protections of conscience, see *42 U.S.C. § 300a-7* (2006); Coats/Snowe Amendment of 1996, *42 U.S.C. § 238n* (2006); Consolidated Appropriations Act, H.R. 2764, 110 Cong. § 508(d) (2008).

⁴⁰ But see *42 U.S.C. § 300a-7(c)(2)* (2006) (addressing nondiscrimination in federally-funded research towards those who perform or refuse to perform "any lawful health service or research activity," including sterilization).

⁴¹ See R.C. Jebb, *Sophocles: Plays: Antigone* (P.E. Easterling ed., Bristol Classical Press 2004) (1900); Winnifred King Rugg, *Unafraid: A Life Of Anne Hutchinson 160-70* (1930). Or, the converse: One regards as obligatory something the majority considers heinous. For the purposes of this paper, medical conscientious objection concerns objections to acts one regards as

Consider, for example, the aforementioned case from North Carolina of legislatively mandated physician-and nurse-participation in administering capital punishment,⁴² the prospect of military physicians being asked to participate in torture, or the mundane request that a pediatrician circumcise a healthy infant male so that he "fits in" or "looks like Dad." In light of such cases, many can realize that they have need of and, thereby, can welcome a conscientious objection clause.

Second, by not singling out any debated issue, the conscientious objection clause itself avoids unnecessary controversy. The heat surrounding discussions of conscience derives entirely from that associated with abortion. The important debate concerning abortion ought to be entirely distinct from that concerning conscience. To confuse the two equates to thinking that the legitimacy of a Quaker's recourse to conscientious objection depends upon the legitimacy of the specific war in which he would otherwise serve. On the contrary, the reason for extending to him a right of objection has nothing at all to do with the justice or injustice of any particular war. Rather, it has to do entirely with the relation between the individual and a legitimate state. Enlightened individuals who regard war as legitimate realize that the state might demand other acts of them to which they object. Thus, they realize that they might have recourse to conscientious objection just as the Quaker does. So also, distinguishing conscientious objection in medicine from any one controverted issue allows those who regard the profession as something more than a technique for the provision of legally permitted acts to see the need for conscientious objection. For the need arises simply from the autonomy of the profession [*204] from the political and social fora in which it operates. Third, by not limiting the clause to any one intervention, one makes room for responses to unforeseen developments⁴³ and less widely yet still controverted matters.⁴⁴

Fourth, and finally, all of the above aspects of a general conscience clause strengthen the inherent fairness of such a clause and, thereby, the political case to be made for it. For people can see that while they may enjoy liberty in their invocation of conscience, they may also incur costs when others with whom they differ invoke conscience in refusing an intervention they request. So, for example, those who oppose abortion may realize that a non-specific conscience clause, which does not require them to perform or refer for abortion, will also enable physicians who regard futile care to object to its provision. Moreover, once legislated, it will be less likely to suffer the constant tug of war fought over intervention-specific clauses. It will come to be seen, as it ought to be, as part of the nature of medicine as an autonomous profession with its own ethics.

III. The Duties of the Conscientious Objector

The above represent the outlines of a sensible clause that respects claims to conscientious objection. Associated with rights are obligations. What duties accompany conscientious objection? To sum up what follows: The obligations to the patient remain unchanged, but for the denial of the contested request.

Specifically, what do these obligations entail? First, following from the very meaning of professing - and to develop a point previously mooted - full disclosure imposes the obligation to promulgate to the relevant parties one's conscientious objection. This includes one's prospective and current patients, colleagues, employers, and relevant institutions, for example hospitals and insurance companies. With respect to patients, this bears on informed consent and patient autonomy. Considering the recent referendum legalizing physician-assisted suicide in the State of Washington,⁴⁵ absent an internist's [*205] noting his objection to the procedure, a current or prospective

violating one's profession of medicine (not prohibitions concerning medical acts one regards as obligatory - a positive obligation to act). The latter might include the authorities - due to fear of losing a practitioner in low supply during a plague - forbidding a physician from treating a patient suffering from a highly contagious potentially lethal disease. Such cases are not the concern of this paper, nor do they typify actual cases of medical conscientious objection. They do, however, belong to the topic; a complete treatment would address them. I am inclined to think that the lineaments of conscientious objection concerning positive obligations differ from those regarding refraining from acting.

⁴² See [N.C. Dep't of Corr. v. N.C. Med. Bd., 657 S.E.2d 641, 645-47 \(N.C. 2009\)](#).

⁴³ For example, new technologies.

⁴⁴ For example, routine infant male circumcision or the provision of what one regards as futile interventions.

patient might mistakenly assume that her doctor would agree to her request for physician-assisted suicide at some future date. Were he to inform her of his objection to doing so, she would have the opportunity to make alternative arrangements, perhaps developing a physician-patient relationship with a doctor whose views are more consonant with hers. Moreover, by promulgating one's conscientious objector status, one avoids the previously noted problem of a moral dilemma resulting from a patient's reasonable reliance, which would require referral.

Second, conscientious objector status obliges the relevant professional to explain her reasons for her objection to those patients who request further information. That is, conscientious objection itself involves its own version of full disclosure based upon a patient's informed consent. This does not mean that the patient must consent to the practitioner's objection. Rather, it means that the patient is due the offer of an explanation. This does not, however, amount to the professional's having a right to pontificate concerning the relevant matter. Rather, the interested patient ought to receive some answer to the question as to why the professional objects. Certainly, not all patients will be interested to know why. Those who are not interested ought not to be treated as captive audiences; those who do want to know ought to receive a considerate and considered answer. In discussion of one's conscientious objection, full disclosure requires that one note the controverted nature of the matter concerning which one objects. One must bring to the patient's attention that not all medical professionals agree with one's own view. As noted, if no previous relationship exists, this does not require referral. It does, however, require that one puts one's own account of medicine into the larger context that includes other, disagreeing professionals, in virtue of which disagreement one resorts to conscientious objection. The patient ought to emerge having a sense both of one's grounds for objecting and of the pluralism found in medicine regarding the controverted matter. This constitutes the analogue of informed consent for non-controverted medical care. A professional would have failed in this respect were a patient to emerge from the interaction thinking that the medical profession as a whole rejected the requested intervention. ⁴⁶

[*206] Third, conscientious objector status bears exclusively on the patient's contested request; it does not relate to the other care the physician, nurse, or pharmacist provides for the patient. If a relationship exists with the patient, then the obligation of non-abandonment mandates that prior to alternative arrangements being in place for the controverted intervention, the physician, nurse, or pharmacist must provide care to which she does not object. So, for example, the internist who objects to her terminally ill patient's considered request for physician-assisted suicide does not thereby abdicate her responsibility to care for that patient otherwise until the patient finds an alternative physician.

Fourth, conscientious objector status requires the continued maintenance of confidentiality, particularly with respect to the fact that the professional objects to something the patient requests. For example, a woman who requests emergency contraception at the counter of an objecting pharmacist does not thereby forfeit any of her claims regarding discretion and confidentiality concerning that very communication with the pharmacist. Indeed, because such situations are fraught with potential for embarrassment and the untoward interest of others, the professional must strenuously and scrupulously protect the patient's privacy specifically concerning the patient's request and the practitioner's conscientious objection.

Finally, as earlier noted, while conscientious objection does not require referral to a third party who will abide by the patient's request, it does require transfer of relevant documents, returning a prescription, and, more generally, acts which, while they may result in the act to which one objects, do not require one to aim at that act.

⁴⁵ See Washington Death with Dignity Act, [Wash. Rev. Code Ann. §§70.245.010-70.245.904](#) (West 2009); Jacob Goldstein, Washington Passes Initiative 1000, Legalizing Physician-Assisted Suicide, Wall St. J. Health Blog (Nov. 5, 2008 8:46 AM), <http://blogs.wsj.com/health/2008/11/05/washington-passes-initiative-1000-legalizing-physician-assisted-suicide>.

⁴⁶ If a patient does not wish to discuss the professional's conscientious objection, the professional still must attempt to insure that the patient leaves the clinical encounter realizing the legality of the requested intervention and that other professionals might not object to it.

Professional conscientious objection finds its basis in medical practitioners' ancient practice of publicly expressing their accounts of health, sickness, caring, and curing for which they stand. A sensible conscience clause recognizes both the privileges and responsibilities attending such a profession.

Ave Maria Law Review
Copyright (c) 2010 Ave Maria Law Review
Ave Maria Law Review

End of Document