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J. David Bleich

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The Physician as Conscientious Objector

Cover Page Footnote

Professor of Law, Benjamin N. Cardozo School of Law; Tenzer Professor of Jewish Law and Ethics, Yeshiva University; Professor of Talmud and Director of Postgraduate Institute for Jurisprudence and Family Law, Rabbi Isaac Elchanan Theological Seminary; Herbert and Florence Tenzer Professor of Jewish Law and Ethics, Yeshiva University.

THE PHYSICIAN AS A CONSCIENTIOUS OBJECTOR

*J. David Bleich**

I. ACCOMMODATION OF THE CONSCIENTIOUS OBJECTOR

Rabbinic lore relates an anecdote, probably apocryphal, portraying a lively student who flits from person to person in the study hall. To each one he says, *I have an answer. Ask me a question!* I do not claim to have a resolution to the dilemma posed when a conflict arises between a patient's rights and a physician's conscience, certainly not a facile one. My real task is to convince those in a position to implement a solution that a problem exists and that it merits serious consideration. Patient autonomy certainly deserves both moral respect and legal protection, but to demand of a physician that she act in a manner she deems to be morally unpalatable not only compromises the physician's ethical integrity, but is also likely to have a corrosive effect upon the dedication and zeal with which she ministers to patients.

Society has long recognized and been forced to come to grips with the conflict arising from a woman's right to terminate a pregnancy as announced by the United States Supreme Court in *Roe v. Wade*,¹ and the moral convictions of a health care practitioner that constrain her to refuse to participate in the extinguishing of nascent human life. A physician's belief that certain forms of assisted reproduction constitute a violation of natural law does not impact an infertile couple's right of procreation for the simple reason that a physician who espouses such views will choose another area of specialization. Yet, the issue of whether an employer who finds such forms of procreation to be morally offensive that must nevertheless include coverage of such forms of fertility treatment in health care insurance provided to employees represents an unresolved moral dilemma as evidenced by a recent debate in the

* Professor of Law, Benjamin N. Cardozo School of Law; Tenzer Professor of Jewish Law and Ethics, Yeshiva University; Professor of Talmud and Director of Post-graduate Institute for Jurisprudence and Family Law, Rabbi Isaac Elchanan Theological Seminary; Herbert and Florence Tenzer Professor of Jewish Law and Ethics, Yeshiva University.

1. 410 U.S. 113, 153 (1973).

New York legislature.² Finally, the courts in *Tarasoff v. Regents of the University of California*³ and its progeny have long since recognized and addressed the issue of maintaining professional confidentiality in the face of imminent criminal activity.

II. CONSCIENTIOUS OBJECTION VS. PATIENT AUTONOMY

There remain two areas in which conflicts do exist, but are largely ignored. First, is the treatment of the terminally ill, in both the broad sense of the term and the more narrow sense, the determination of the time of death at which continued treatment is regarded as inappropriate. The second is in the field of neonatology with regard to the institution of measures designed to assure the survival of an unborn infant suffering from a serious congenital anomaly. Contemporary society has long conscientiously subscribed to the tongue-in-cheek adage formulated by Arthur Clough: "Thou shalt not kill; but needs't not strive officiously to keep alive."⁴ However, there are individuals who sincerely believe that the preservation of life is a paramount value, and that the quality of life preserved is irrelevant to fulfillment of the moral imperative generated by that value. For these individuals, failure to provide aggressive treatment for even the most premature neonate, for instance the infant afflicted with spina bifida,⁵ or a severe chromosomal defect,⁶ is the moral equivalent of infanticide. Likewise, failure to intubate⁷ a terminally comatose patient, or even to

2. S. 936, 224th Ann. Leg. Sess. (N.Y. 2001); S. 7359, 225th Ann. Leg. Sess. (N.Y. 2002) (discussing acts to amend the insurance and health law in relation to health insurance and conscience clauses).

3. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976) (holding that therapist's special relationship to patient also applied to plaintiff, and that therapist had a duty to exercise reasonable care when he was aware that patient was going to harm victim).

4. Arthur Hugh Clough, *The Latest Decalogue*, in *THE OXFORD BOOK OF NINETEENTH-CENTURY ENGLISH VERSE* 205 (3d ed. 1974). These words, when quoted, are almost invariably cited in a literal sense. In actuality, the poet was not endorsing the moral position expressed in this couplet, but was engaging in irony. See MAURICE BENJAMIN STRAUSS, *FAMILIAR MEDICAL QUOTATIONS* 159b n.1 (1968).

5. Spina bifida is a condition, which results from defective development of the posterior wall of the spinal canal (neural arches) causing one or more vertebrae to remain incomplete. *THE OXFORD MEDICAL COMPANION* 918 (John Nicholas Walton et al. eds., 1994).

6. A chromosome is a thread-shaped structure consisting largely of deoxyribonucleic acid ("DNA") and protein. *Id.* at 138.

7. Intubation is the introduction and maintenance of a tube within part of the body, particularly an endo-tracheal tube to maintain an airway for artificial ventilation and administration of general anesthesia. *Id.* at 435.

administer cardiopulmonary resuscitation,⁸ when there is a realistic possibility of clinical success, constitutes passive euthanasia. These individuals would also consider employment of neurological criteria in pronouncing death nothing but a deceptive subterfuge designed to disguise an immoral act by means of semantic sleight of hand.

There have been a number of instances where hospitals have declined to honor a request for discontinuance of a feeding tube and other life supporting technology.⁹ However, such occurrences have been few and far between and have involved matters of institutional policy rather than an expression of the qualms of an individual physician or nurse. Solo practitioners are also confronted with this dilemma. A solo practitioner's isolation aggravates her dilemma because she must make a principled decision without the moral support of like-minded colleagues, and without the benefit of institutional legal talent or informational resources.

The first difficulty in generating awareness of the problem apparently lies in the relatively small number of health care practitioners who find themselves morally conflicted. The problems of the few seldom become the concern of the many. A more serious hurdle lies in the unwillingness of many medical institutions, as well as society, to recognize the existence of a genuine moral dilemma.

Law and morality occupy quite different arenas; nevertheless, law frequently gives expression to the moral values of society. Ostensibly, the decision handed down in *Employment Division, Department of Human Resources of Oregon v. Smith* was designed to establish the parameters of the Free Exercise Clause of the First Amendment.¹⁰ *Smith* establishes the principle that only religious worship enjoys absolute constitutional protection.¹¹ According to *Smith*, religious conduct does not enjoy any particular constitutional protection so long as the religious practice is not singled out in a discriminating fashion.¹² The result of this principle is that, even in the absence of a compelling state interest, statutes of gen-

8. Cardiopulmonary resuscitation ("CPR") is the "restoration of cardiac output and pulmonary ventilation following cardiac arrest and apnea, using artificial respiration and manual closed chest compression or open chest cardiac massage." *STEDMAN'S CONCISE MEDICAL DICTIONARY FOR THE HEALTH PROFESSIONS* 760 (John. H. Dirckx, M.D. ed., 3d ed. 1997).

9. See, e.g., *Cruzan v. Dir.*, Mo. Dep't. of Health, 497 U.S. 261, 268 (1990) (denying a court order for a third party to force a hospital to remove a patient's feeding tube and hydration equipment).

10. *Emp. Div., Dep't of Human Res. of Or. v. Smith*, 494 U.S. 872, 890 (1990).

11. *Id.* at 877-78.

12. *Id.*

eral applicability can be enforced against an individual even when conformity with the law compels compromise of religious scruples.¹³ Prior to *Smith*, religious practice was accorded deference on constitutional grounds so long as there was no countervailing compelling state interest.¹⁴ The *volte face* in constitutional law represented by *Smith* can only be explained by changing societal attitudes vis-à-vis religion in general and religious practice in particular.

While continuing to pay at least lip service to the role of religion in society, society simply does not take religion and religious scruples as seriously as it did in days gone by. The prevailing notion seems to be that religious preferences are precisely that, namely, preferences, but not mandates. Thus, just as recreational, aesthetic, or gastronomical preferences must bow to laws of general applicability, it is assumed that religious preferences must bow to the demands of the dominant culture that are enshrined in statute.

Such a socio-political stance not only fails to respect the role of religion in the life and value system of the religionist, but also fails to recognize the historical and pragmatic basis from which the principle of religious freedom developed. Indeed, although often overlooked, the Free Exercise Clause of the First Amendment¹⁵ was rooted, at least in part, on practical considerations.

The Framers of the Constitution of the United States made extensive use of the writings of John Locke, whose influence was most direct upon the First Amendment.¹⁶ Locke recognized that religious intolerance was inconsistent with both public peace and good government, and deemed religious rivalry and intolerance to be among the most severe political problems of his day.¹⁷ Civil strife and lawlessness, not to speak of war between nations, were regarded by Locke as the product of religious turmoil.¹⁸ In an essay written in 1689, Locke stated:

It is not the diversity of opinions, which cannot be avoided; but the refusal of toleration to those that are of different opinions,

13. *Id.* at 889.

14. *Id.* at 883; *see also* Scherbert v. Verner, 374 U.S. 398, 402-03 (1963) (holding that the conditions used for unemployment benefits infringed on the party's free exercise of religion).

15. U.S. CONST. amend. I.

16. Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 HARV. L. REV. 1409, 1430-31 n.7 (1990).

17. *Id.* at 1431.

18. *Id.*

which might have been granted, that has produced all the bustles and wars, that have been in the Christian world, upon account of religion.¹⁹

Elsewhere, decrying the futility of religious coercion, Locke wrote, "let divines preach duty as long as they will, 'twas never known that men lay down quietly under the oppression and submitted their backs to the blows of others, when they thought they had strength enough to defend themselves."²⁰

The way to avoid such strife is by assuring toleration and liberty of religious practice for all. Freedom of religious practice also enables a government to govern effectively. A populace that perceives its religious principles to be thwarted by the government will harbor deep resentment and disrespect for the ruling authority. Consequently, the government will be delegitimized in the eyes of those whose religious liberties are denied, thereby compromising respect for the government and its laws. Such considerations apply to matters of religious practice no less so than to matters of belief and worship.

There has been at least one case where a physician has testified that he would feel morally compelled to disobey a court order that would result in hastening the death of a patient.²¹ In *Grace Plaza of Great Neck, Inc. v. Elbaum*, Dr. Lester Corn, the medical director of Grace Plaza, testified that he would not remove artificial nutrition or hydration from a patient, even under court order.²² Dr. Corn testified that not only would he refuse to disconnect the patient from a feeding tube, but also that he would not allow access for that purpose to a physician not connected with Grace Plaza.²³ Dr. Corn apparently adopted that stance, not on the basis of religious conviction, but because of his perception of the ethical commitment of a medical practitioner.²⁴ Dr. Corn "further testified that he would not disconnect a patient from a feeding tube because

19. *Id.* at 1432 (quoting VI JOHN LOCKE, *Letters on Toleration*, in THE WORKS OF JOHN LOCKE 53 (Scientia Verlag 1963) (1823)).

20. See I H.R. FOX BOURNE, *THE LIFE OF JOHN LOCKE* 190 (1876).

21. See generally *Bouvia v. Super. Ct. of L.A. County*, 225 Cal. Rptr. 297 (Ct. App. 1983). See also George J. Annas, *When Suicide Prevention Becomes Brutality: The Case of Elizabeth Bouvia*, 14 HASTINGS CENTER REP. 20, 20 (1984). Although not cited in the decision, Dr. Donald E. Fish, chief of psychiatry at Riverside County General Hospital, "testified that he would have force-fed the patient with a nasogastric tube even if the court ordered him not to." *Id.*

22. *Grace Plaza of Great Neck, Inc. v. Elbaum*, 588 N.Y.S.2d 853, 859 (App. Div. 1992).

23. *Id.* at 863.

24. *Id.* at 858.

to do so would be condemning the patient 'to death, which is in essence contrary to the dedication of medicine [to] the preservation of life and not the discontinuance of life.'²⁵ A physician who internalizes such values because of an objective to fulfill the divine mandate, "nor shall you stand idly by the blood of your fellow,"²⁶ rather than based on a subjective perception of the ethical commitment of a medical practitioner, can hardly be expected to be less tenacious.

Civil disobedience, if tolerated, can rapidly degenerate into anarchy. Yet, even upon taking note of that concern as a moral consideration, a person of abiding religious conviction may find that her conscience demands that she disregard the fiat of a secular state when she finds it to be in conflict with divine law. Locke sagaciously recognized that when such a conflict arises the state is inevitably the loser, regardless of how the conflict is resolved.²⁷ Civil disobedience, even in the name of religion, undermines respect for the law; coerced obedience to laws deemed to be repugnant to religious scruples breeds disdain for the state and its institutions. Locke's solution was to prevent such conflicts from arising in the first place.²⁸ The authors of the First Amendment were prompted by the recognition that strategic retreat in the face of a religious claim redounds to the interest of the state, at least in the absence of a countervailing state interest.

III. THE CONFLICT BETWEEN INDIVIDUAL AUTONOMY AND PRESERVATION OF LIFE

Both the religionist and the secular humanist regard individual autonomy and preservation of life as moral values. The problem occurs when the two come into conflict, i.e., when one cannot preserve one value other than by compromising another. When this conflict exists, it is not the case that the secular humanist always gives preference to individual autonomy over preservation of life. No one has argued that either consensual homicide or dueling is, or ought to be, constitutionally protected. At least to that extent, society recognizes the state's paramount interest in restraining conduct designed to compromise the value of human life even at the cost of curtailing individual liberty.

25. *Id.* at 863.

26. *Leviticus* 19:16.

27. McConnell, *supra* note 16, at 1496-97 n.7.

28. *Id.* at 1445.

Indeed, recent debate concerning a constitutional right to suicide, with or without physician assistance, has been limited to suicide on the part of the terminally ill or the seriously debilitated. The plaintiffs in *Washington v. Glucksberg* did not claim an untrammelled right to commit suicide, much less to assistance in doing so.²⁹ In a previous suit against the state of Washington, the plaintiffs asserted their right to “the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a *mentally competent, terminally ill* adult to commit physician-assisted suicide.”³⁰ In arguing that “the constitutional principal behind recognizing the patient’s liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice of *impending death* by consuming lethal medication,”³¹ the plaintiffs narrowed the issue to the determination of whether such rights could be advanced by a terminally ill patient. The district court and the court of appeals, relying on *Planned Parenthood of Southeastern Pennsylvania v. Casey*,³² took the same position when “determining ‘what liberty interest may inhere in a *terminally ill* person’s choice to commit suicide.’”³³

Despite an early decision in *John F. Kennedy Memorial Hospital v. Heston*, it is now well-established that even an otherwise healthy competent adult has the right to refuse medical intervention, even in life-threatening situations.³⁴ In *In re Quinlan*, the New Jersey Supreme Court determined that this right is based upon the constitutionally protected right to privacy, as well as the common law right to bodily integrity.³⁵ Later, in *In re Conroy*, the court relied upon the common law right of self-determination.³⁶ Although *Quinlan’s* emphasis on the constitutional privilege has been criticized by Justice Handler in *In re Jobes*,³⁷ as well as by Professor Lawrence Tribe,³⁸ the existence of both a constitutional and a com-

29. *Wash. v. Glucksburg*, 521 U.S. 702, 707-08 (1997).

30. *Compassion in Dying v. State*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994) (emphasis added).

31. *Glucksberg*, 521 U.S. at 725 (emphasis added).

32. 505 U.S. 833 (1992).

33. *Glucksberg*, 521 U.S. at 726 (emphasis added).

34. *John F. Kennedy Mem’l Hosp. v. Heston*, 279 A.2d 670, 674 (N.J. 1971), *overruled by In re Conroy*, 486 A.2d 1209, 1226 (N.J. 1985).

35. *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976).

36. *Conroy*, 486 A.2d at 1222-23.

37. 529 A.2d 434, 454 n.3 (N.J. 1987) (“The *Quinlan* court may have been mistaken in its choice to base the decision on constitutional grounds.”).

38. LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-11, at 937 (1978).

mon law basis for such a right has been acknowledged in numerous cases.³⁹

Less clear, and certainly debatable, is whether a healthy adult of clear mind has a constitutional right to passively commit suicide by refusing food and water.⁴⁰ The issue with regard to passive suicide is whether the state's interest in preventing the death of one of its healthy citizens trumps not only the would-be suicide's liberty interest, but also her right to bodily integrity. Although the courts consider the insertion and even the continued use of a feeding tube to be a medical procedure, which as such, may be refused by any person, they nevertheless appear to be willing to countenance such intervention in the face of refusal of food and water that might be ingested in a normal manner.⁴¹ The court's statement in *Superintendent of Belchertown State School v. Saikewicz* implies that the distinction between declining life sustaining medical treatment may not properly be viewed as an attempt to commit suicide.⁴² Refusing medical intervention merely allows the disease to take its natural course.⁴³ Even more explicit is Chief Justice Rehnquist's emphatic statement in *Cruzan*: "We do not think a state is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death."⁴⁴

It should then be hardly surprising that some members of society subscribe to a value system in which preservation of life is accorded

39. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (holding that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment); *Foody v. Manchester Mem'l Hosp.*, 482 A.2d 713, 717-18 (Conn. Super. Ct. 1984) (acknowledging that "[a]part from constitutional considerations, the individual right to self-determination has long been recognized at common law," and, "includes the right of a competent adult to refuse life-sustaining medical treatment." (citations omitted)).

40. See, e.g., *Bouvia v. Super. Ct. of L.A. County*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1983) (holding that patient who was mentally competent had a fundamental right to refuse such treatment). For a summary and analysis of that case, see Annas, *supra* note 21, at 20-21, 46.

41. *Cruzan*, 497 U.S. at 279 (finding that "forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest.").

42. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 423 (Mass. 1977).

43. *Id.*

44. *Cruzan*, 497 U.S. at 280. Earlier, in *Heston*, albeit in the context of a decision denying the patient's right to refuse certain forms of intervention, the New Jersey Supreme Court, in addressing the distinction between passively submitting to death and actively seeking it, declared, "[t]he distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug. If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the others." *John F. Kennedy Mem'l Hosp. v. Heston*, 279 A.2d 670, 672-73 (N.J. 1971).

virtually unqualified supremacy over other values. The problem is further compounded when the health care practitioner asserts not only that she regards preservation of life to be a more compelling interest than preservation of patient autonomy, but also advances her own liberty interest in the form of a claim to free exercise of religion.

It might be thought that one person's liberty interest, including the right to free exercise of religion, ends when it impinges upon the liberty interest of another. This notion is particularly compelling when that liberty interest is not only grounded in a common law right to be free from any unwanted intrusion, but also in an equally protected constitutional right of privacy. Nevertheless, in *Brophy v. New England Sinai Hospital, Inc.*, the Massachusetts Supreme Court ordered artificial maintenance of nutrition and hydration to be discontinued, and held that a medical facility must honor the substituted judgment of a patient in a persistent vegetative state.⁴⁵ However, the court also held that the medical facility treating the patient was fully entitled to remain loyal to its own moral convictions that constrained it from honoring the patient's wishes.⁴⁶ The remedy offered by the court was to authorize the patient's guardian to remove the patient from that hospital to the care of other physicians who were prepared to honor the patient's wishes.⁴⁷ Citing earlier cases where "maintenance of the ethical integrity of the medical profession" was recognized over a countervailing state interest,⁴⁸ the court agreed that the hospital and the medical staff "should not be compelled to withhold food and water to a patient, contrary to its moral and ethical principles, when such principles are recognized and accepted within a significant segment

45. *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 633 (Mass. 1986).

46. *Id.* at 639.

47. *Id.* at 640.

48. The earliest formulation of this consideration of a compelling state interest is in *Saikewicz*, 370 N.E.2d at 425. See also *In re Conroy*, 486 A.2d 1209, 1223-24 (N.J. 1985) (noting the state's interest in the preservation of life). In *Quinlan*, the court referred to the claimed interest of the state in the "defense of the right of the physician to administer medical treatment according to his best judgment." *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976). That concept may or may not be identical with the concept of the ethical integrity of the medical profession *Id.* at 668-69. In *Quinlan*, the court, in effect, rejected that argument by substituting its own judgment regarding a proper medical response for that of the physician who did not wish to remove the respirator. *Id.* at 665-67. It would have been more forthright for the court to have declared that the state has no interest in preserving a physician's autonomous judgment with regard to proper practice of medicine. *Id.* at 668. In any event, the court treated "the right of the physician" as being predicated upon medical practice rather than upon ethical principles. *Id.* at 668-69.

of the medical profession and the hospital community."⁴⁹ At the same time, the court found that so long as the hospital was itself not forced to participate in removing the gastrostomy tube, there was no violation of the integrity of the medical profession.⁵⁰

However, it should not be assumed that the *Brophy* court established a clear hierarchy of values in which the need to maintain the integrity of the medical profession serves to establish the primacy of the individual physician's ethical sensitivity. The court pointed to the existence of "substantial disagreement in the medical community" with regard to the propriety of withdrawal of nutrition and hydration as well as to the hospital's willingness to assist in a transfer of the patient to another facility where the desired effect could be achieved.⁵¹ The court emphasized that "[it] would be particularly inappropriate to force the hospital, which is willing to assist in a transfer of the patient, to take affirmative steps to end the provision of nutrition and hydration to him."⁵² Apparently for those reasons, and only because of those reasons, "[a] patient's right to refuse medical treatment does not warrant an *unnecessary intrusion* upon the hospital's ethical integrity in *this case*."⁵³

Less than a fortnight later, in *In re Requena*, a New Jersey court ruled that the right of a patient dying of amyotrophic lateral sclerosis to refuse feeding by nasogastric tube had priority over the hospital's policy against participating in the withholding of food or fluids from the patient.⁵⁴ The court ordered St. Clare's/Riverside Medical Center to remove the patient's feeding tube despite the Medical Center's willingness, and even demand, to transfer the patient to St. Barnabas Hospital for that purpose.⁵⁵ Nevertheless, the court conceded the Medical Center's proposal to be "a realistic alternative,"⁵⁶ and indeed an expedient one that "would seem to be an ideal solution to the problem presented by this case."⁵⁷

Requena is distinguishable from, and hence consistent with, *Brophy* by virtue of the fact that Beverly Requena was conscious of her surroundings, while Patricia Brophy was in a permanent veg-

49. *Brophy*, 497 N.E.2d at 639.

50. *Id.* at 638.

51. *Id.* at 639.

52. *Id.*; see also *Childs v. Abramovice*, 253 Cal. Rptr. 530, 535 (Ct. App.) (finding that no further right may be asserted when medical facility is willing to effect a transfer).

53. *Brophy*, 497 N.E.2d at 639 (emphasis added).

54. *In re Requena*, 517 A.2d 886, 893 (N.J. Super. Ct. Ch. Div. 1986).

55. *Id.* at 890.

56. *Id.*

57. *Id.* at 889.

etative state.⁵⁸ This distinction is significant because the *Requena* court declined to honor St. Clare's demand of transfer despite the fact that Beverly Requena's physician was also a member of the St. Barnabas' staff; that, as the court acknowledged, the facilities and treatment skills available at St. Barnabas were equal to those of St. Clare; and that the transfer to St. Barnabas located in the same geographical area could be safely and easily accomplished.⁵⁹ Rather, the court based its decision on its finding that it would be "emotionally and psychologically upsetting"⁶⁰ for the patient to be forced to leave the facility in which she was being treated, and that her removal "would also have significant elements of rejection and casting out, which would be burdensome for Ms. Requena."⁶¹

Nevertheless, it would be extremely naïve to assume that these two decisions do not fundamentally disagree. One can accept the assertion of the presence of an emotional and psychological burden at face value, and still question how such a burden borne for a short time could overcome and negate a state interest in maintaining the integrity of the medical profession. Quite clearly, the *Requena* court recognized no such state interest; indeed, it did not deign to acknowledge that other courts have recognized such an interest. Hence, absent acknowledgment of such an interest, the court should not have had mixed feelings in reaching its decision. Every moment that a court allows a feeding tube to remain in place represents a bodily intrusion and the invasion of a constitutionally protected right to privacy, as earlier defined by the United States Supreme Court in *Cruzan*.⁶² Accordingly, the court should have forthwith issued an order directing removal of the feeding tube.

Although the court did not label it as such, St. Clare's hospital asserted that preservation of the medical facility's ethical integrity was a matter of constitutional concern.⁶³ The Hospital spoke of "the wrongness of denying food or water to a patient,"⁶⁴ and of "the need for all patients and potential patients of the Hospital to be absolutely assured that they would not be harmed by the Hospital or any of its personnel while undergoing care."⁶⁵ That assertion was contemptuously rejected by the court with the rejoinder that

58. Compare *id.*, with *Brophy*, 497 N.E.2d at 627.

59. *Requena*, 517 A.2d at 889.

60. *Id.*

61. *Id.*

62. *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 279 (1990).

63. *Requena*, 517 A.2d at 892.

64. *Id.* at 891.

65. *Id.*

honoring the patient's request "is not denying her anything," and that, "[p]roperly understood it has no adverse implication for general patient care or for public confidence in the Hospital and its staff."⁶⁶

The issue requiring clarification is the meaning of the "maintenance of the ethical integrity of the medical profession"⁶⁷ as constituting a state interest sufficiently compelling to overcome a patient's right of privacy. The *Brophy* court found that asserting a claim of an obligation to treat a patient gives rise to a state interest in supporting that claim despite "substantial disagreement" among members of the profession with regard to the existence of such a claim under that case's circumstances.⁶⁸ In *Brophy*, the interest is treated as an ethical consideration in the classic sense of the term, i.e., as an assertion of a value, and hence a matter that might be individual or subjective in nature.⁶⁹ The *Saikewicz* court, which first enumerated "maintaining the ethical integrity of the medical profession" as one of four "countervailing state interests" that might serve to negate a right to refuse medical treatment, apparently took a diametrically opposed position.⁷⁰ That court categorized the "force and impact" of the state's interest in the maintenance of the profession's ethical integrity as "lessened by the prevailing medical ethical standards."⁷¹ Accordingly, since "[r]ecognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing mores,"⁷² it follows that in withholding such measures there is no threat to the integrity of the medical profession. As stated by the *Saikewicz* court, a state interest lies only in supporting a practitioner's judgment that is "in accord with the generally accepted views of the medical profession."⁷³ Thus, the expressed interest appears to be preservation of the integrity of medical *practice*, rather than of the ethics of the profession. However, if that statement is understood as meaning that the state's interest does indeed lie in maintaining ethical integrity, it is nevertheless clear that the *Saikewicz* court would limit

66. *Id.* at 892 (emphasis added).

67. *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 634 (Mass. 1986).

68. *Id.* at 639.

69. *Id.* (arguing that the state should not force medical professionals to take active measures "contrary to their view of their ethical duty toward their patients.").

70. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977).

71. *Id.* at 426.

72. *Id.*

73. *Id.* at 427.

that interest to preservation of only those ethical judgments that garner a consensus of medical opinion.

It is remarkable that both the *Brophy* and the *Saikewicz* courts (assuming that the *Saikewicz* court was also concerned with *ethical integrity*) focus upon the ethical integrity of the medical profession rather than of the practitioner. Both courts were willing to allow the medical profession's own practice *ipso facto* to serve as the standard for establishing an ethical norm. Such deference to the medical profession is misplaced. Physicians are not and should not be required, or even permitted, to become arbiters of ethical standards. Physicians, by virtue of training and experience, are acknowledged experts in medical science and clinical practice; they are also uniquely qualified to determine the prognosis of a malady and to assess the efficiency of alternative therapies. However, there is nothing in their training or experience that qualifies them as ethicists. As an individual, the physician's ethical values are entitled to the same respect as any other citizen, but also to no more deference than those of any other citizen. Moreover, even the cumulative value of all members of the profession is not entitled to greater protection than that of any other aggregate of individuals.

If the "maintenance of ethical integrity of the medical profession" constitutes a compelling state interest, it must be because society has a pragmatic interest in maintaining the norms that have historically been the hallmark of the medical profession. Society has a need for physicians who are healers, not "thanatologists."⁷⁴ Physicians can best protect society if such conduct is in the nature of a Pavlovian response by intuitively and instinctively seeking to actively prolong the life of a patient. Permitting a physician to withdraw a feeding tube—particularly when she does not wish to do so—serves to interfere with what hopefully is an instinctive reflex and desensitizes the physician's compelling urge to preserve life. St. Clare's Hospital well understood the meaning of, and the need for, "public confidence in [its] Hospital and its staff."⁷⁵ It also had a firm grasp of the meaning of "ethical integrity of the medical profession"⁷⁶ as a cognizable consideration in constitutional jurisprudence.

74. Thanatology, from the Greek word for death, is the "branch of science concerned with the study of death and dying." *STEDMAN'S MEDICAL DICTIONARY* 1793 (26th ed. 1995).

75. *In re Requena*, 517 A.2d 886, 892 (N.J. Super. Ct. Ch. Div. 1986).

76. *Saikewicz*, 370 N.E.2d at 427.

Requena is rather unique in that St. Clare's Hospital explicitly presented what was, in effect, a First Amendment argument.⁷⁷ A Roman Catholic religious order of nuns controlled St. Clare's Hospital who refused to accede to the withholding of artificial feeding because such conduct would conflict with its "pro-life" values. The court could quite well have entered into an analysis of the limitations of the rights conferred by the Free Exercise Clause and, most particularly, upon the availability of a free exercise claim in face of a countervailing constitutionally protected right to privacy. Instead, it inappropriately proceeded to correct the good sisters' "mistaken"⁷⁸ assessment of Catholic teaching:

I suspect that part of the Hospital's insistence on what it perceives as a pro-life position in this case is a mistaken fall-out from the abortion controversy which is ongoing in our society. The Hospital, whose values are premised as they are on the loving care of people, naturally (and, I think, properly) views abortion as a terrible evil. But abortion involves the active, direct, intentional termination of life by interfering in the processes of nature. The life taken is usually perfectly healthy. The fetus does not in any sense consent to what is done to it. None of those elements are present in Mrs. Requena's case. There is no sensible comparison to be drawn between the two situations.⁷⁹

Catholic morality is for Catholic moralists, not secular courts, to decide. Moreover, it is well-settled that not only are courts precluded from inquiring into the basis of doctrinal matters, but that the First Amendment protection extends to matters that are erroneous, inconsistent, or even illogical. In *Thomas v. Review Board of the Indiana Employment Security Division*, the Supreme Court declared that "religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection."⁸⁰

Neither is unanimity among Catholics a prerequisite for assertion of a Free Exercise claim by a Catholic or by Catholic institution because "[i]ntrafaith differences . . . are not uncommon among followers of a particular creed . . . and the guarantee of free exercise is not limited to beliefs which are shared by all of the members of a religious sect."⁸¹

77. *Requena*, 517 A.2d at 892 (noting the impact of the hospital's affiliation with the Roman Catholic Church).

78. *Id.*

79. *Id.*

80. *Thomas v. Review Bd. of Ind. Employment Sec. Div.*, 450 U.S. 707, 714 (1981).

81. *Id.* at 715-16.

In a concluding homily that strikes as offensive to both the letter and spirit of the First Amendment, the court noted that the Hospital “rejoices in its specifically Christian heritage,”⁸² and admonishes its health care workers “to recall the beautiful words of Jesus: ‘Come to me, all you who are weary and find life burdensome, and I will refresh you.’”⁸³ The fact that ecclesiastic officials of the order responsible for the administration of St. Clare’s Hospital—as well as other scholars whose moral views are more consistent with those of the court—would find this an egregious misinterpretation of Scripture is irrelevant. The Devil may or may not have divine license to quote Scripture to suit his own purpose; a judge most assuredly does not have constitutional license to do so.

Pursuant to an accelerated appeal, the appellate division affirmed the lower court’s decision, but apparently only on the basis of a supplemental consideration. The appellate court declared:

An equitable consideration here is that Beverly Requena had no notice of St. Clare’s policy against withholding artificial feeding or fluids until July of 1986. The balance to be struck here is between the hospital’s right to enforce its regulation and fundamental rights of the patient. Under the circumstances we find no waiver or estoppel against Beverly Requena who had no notice of the regulation prior to her admission or for 15 months thereafter.

Viewed in this light, it is clear that Judge Stanton has not made a legal decision invalidating the hospital regulation but rather factual findings that have substantial support in the record, and he has balanced the equities in not applying that regulation to Mrs. Requena.⁸⁴

It may certainly be argued that the appellate court chose to misread Judge Stanton’s decision, but, if so, the appellate court was assisted by Judge Stanton in that misreading of his opinion. Ostensibly, Judge Stanton totally negated the hospital’s claim and did not at all predicate his decision upon the absence of prior notice to Mrs. Requena.⁸⁵ Nevertheless, if St. Clare could not assert a right to continue treatment under any circumstances, there was no reason for the lower court to engage in a balancing of relevant considerations. Be that as it may, the appellate court’s decision certainly affirms the principle that, at least in some circumstances, i.e., upon

82. *Requena*, 517 A.2d at 893.

83. *Id.* (quoting *Matthew* 11:28).

84. *Id.* at 870.

85. *Id.*

proper notice to the patient of the question of such a policy, a medical facility may persist in keeping a patient alive against her wishes.⁸⁶

Some months later, the finding of the appellate division was adopted, albeit somewhat equivocally, by the Supreme Court of New Jersey in *In re Jobes*.⁸⁷ The issue in *Jobes* was similar to that in *Requena* in that Nancy Jobes's husband brought suit seeking removal of a life sustaining nutrition system from his comatose wife who was a patient in a nursing home.⁸⁸ Yet, unlike the situation in *Requena*, there was no other readily identifiable facility that was willing to admit the patient for that purpose.⁸⁹ Hence, the court ruled that the nursing home could not refuse to participate in the withdrawal of the patient's feeding tube.⁹⁰ Regardless of the decision, it is of crucial significance that the court's judgment was predicated upon the absence of prior notice. This is most explicitly illustrated in the court's statement that, "[w]e do not decide the case in which a nursing home gave notice of its policy not to participate in the withdrawal of artificial feeding at the time of a patient's admission. Thus we do not hold that such a policy is never enforceable."⁹¹ Accordingly, the decision of the *Jobes*' court is consistent with that of *Requena* in recognizing a hospital's right to adhere to such a policy subject to a requirement that hospitals provide proper notice to the patient.

It should be noted that, in a dissenting opinion, Justice O'Hern implicitly accepted the existence of a countervailing state interest that should in all instances take priority over a patient's right to self-determination. Justice O'Hern found "it difficult to understand how one can order nursing professionals with an abiding respect for their patients to cease to furnish the most basic of human needs to a patient in their care."⁹² However, he immediately tempered that assertion with the tantalizing suggestion that, presumably, because the patient has not explicitly issued an advance directive, the physician is entitled to make a determination of the

86. *Id.* (suggesting that upon proper notice to the patient of a hospital's policy against withholding life sustaining treatment the court might balance the equities in favor of the hospital).

87. *In re Jobes*, 529 A.2d 434, 451 (N.J. 1987).

88. Compare *id.* at 438, with *Requena*, 517 A.2d at 888.

89. See *Jobes*, 529 A.2d at 450 (finding that "[t]he evidence indicates that at this point it would be extremely difficult, perhaps impossible, to find another facility that would accept Mrs. Jobes as a patient.>").

90. *Id.* at 451.

91. *Id.* at 450.

92. *Id.* at 464 (O'Hearn, J., dissenting).

patient's interests on the basis of her own value judgment.⁹³ Of course, the majority adopted a doctrine of substituted judgment rather than a best interest standard.

The position of the New Jersey Supreme Court as enunciated in *Jobes* was adopted by the United States District Court for the District of Rhode Island in *Gray v. Romeo*.⁹⁴ The health care professionals associated with Rhode Island Medical Center were "unanimous in their adamant opposition to the [removal of] nutrition and hydration" from Mrs. Gray.⁹⁵ These individuals opposed such action for various reasons. They regarded such removal as "tantamount to euthanasia, inconsistent with the physician's role as safekeeper of his or her patient's [well-being]," and they were concerned for the reputation of the hospital.⁹⁶

The district court found that Mrs. Gray had a constitutional right to forego artificial nutrition and hydration. In addition, the court, citing *Jobes* as precedent, held that "Marcia Gray and her family had no reason to believe that they were giving up her right to determine her course of care by entering the Rhode Island Medical Center."⁹⁷ Accordingly, the court ruled that Rhode Island Medical Center must "accede to her request" unless she could be "promptly transferred to a health care facility that would respect her wishes."⁹⁸

Moreover, the district court's decision in *Gray* is significant for an entirely different reason. Unlike the argument presented in *Jobes*, the healthcare facility in *Gray* raised a religious objection that the court seriously entertained.⁹⁹ Although the court's formulation of the argument can be hardly described as a model of clarity, it apparently distinguishes between providing unwanted care by means of initiation of an act of bodily intrusion and mere failure to

93. *Id.* (O'Hearn, J., dissenting). Justice O'Hearn stated, "I do not believe that such an order is essential to the Court's decision, and it may impinge upon the privacy rights of those nursing professionals. . . . [This] is a case in which the health care providers firmly believe the treatment is adverse to the patient." *Id.* (O'Hearn, J., dissenting).

94. 697 F. Supp. 580, 585 (D.R.I. 1988).

95. *Id.* at 583.

96. *Id.*

97. *Id.* at 590.

98. *Id.* at 591 (noting that unless she could be promptly transferred the hospital would have to respect her wishes).

99. *Id.* at 590 (stating that if 42 U.S.C. § 300 (1994) applies, then "a person associated with a health care facility may refuse on moral or religious grounds to participate in an abortion or sterilization procedure," but holding that this did not apply because the health care facility in question was not funded by the Secretary of Health and Human Services).

withdraw a foreign object already in place.¹⁰⁰ If so, the underlying assumption must be that refusal to allow the introduction of nutrients and liquids into the feeding tube is not constitutionally protected, but that refusal of the tube itself is protected. Such a distinction would be consistent with the care the court exercises in an earlier section of its decision to categorize use of a gastrointestinal tube as a medical procedure entirely analogous to use of a respirator.¹⁰¹ The *Gray* court would apparently refuse to recognize a constitutional right enabling even a patient *in extremis*, but capable of normal ingestion of food, to commit suicide by starvation.¹⁰² Thus, it reasons that, although a patient may make medical decisions affecting himself free from unwarranted governmental intrusion, "the government is under no *constitutional* obligation to provide resources to enable an individual to take full advantage of his or her rights."¹⁰³

Thus, absent legislation, a physician has no obligation to assist a patient in asserting her right to have the feeding tube removed. The court then proceeds to note that Rhode Island legislation explicitly guarantees a patient the right to refuse medical care, which the Court impliedly assumes includes the right to forego use of an existing feeding tube to provide life-sustaining nutrition and hydration.¹⁰⁴ The right to refuse delivery of certified nutrients through an existing feeding tube is apparently regarded as suicide, and is not constitutionally protected, but at least in Rhode Island, the right to such refusal is guaranteed by statute.

In that context, the court proceeded to address the religious objection, not from the perspective of a Free Exercise claim, but from the vantage point of Rhode Island statutory law.¹⁰⁵ The defendant argued that the principle reflected in Rhode Island General Laws section 23-17-11 (1985), which states that a person associated with

100. *See id.* (asserting that "the Constitution rarely commands an affirmative obligation on the government's part.").

101. *Id.* at 587 (finding that "if a person has the right to decline life on a respirator," then a person has the equal right to decline a gastrostomy tube) (citations omitted).

102. *Id.* at 589 (noting the "distinction between deliberately ending a life by artificial means and allowing nature to take its course") (citations omitted).

103. *Id.* at 590 (citing *Harris v. McCrae*, 448 U.S. 297, 317-18 (1990)) (holding that freedom from government interference in abortion decisions does not include the facilitation of funds necessary to exercise that right)).

104. *Id.* (stating that Rhode Island legislation guarantees a patient the right to refuse medical care).

105. *Id.* (dismissing the constitutional argument in favor of a statutory and Canon law approach).

a health care facility may refuse on moral or religious grounds to participate in an abortion procedure, should apply for withdrawal of treatment as well.¹⁰⁶ The extension of that statutory provision to withdrawal of a feeding tube is summarily dismissed by the court on the grounds that the “statute is clearly limited to procedures involving abortion and sterilization [and as such] does not apply to the circumstances of this action.”¹⁰⁷ Fair enough—at least insofar as disposition of the case before the United States District Court for the District of Rhode Island is concerned.

Nevertheless, the district court has provided a mechanism for assuring that religious objection to withdrawal of treatment will be honored. The legislature of any state may simply enact legislation to that effect.¹⁰⁸ Since the court declared that, had notice been given of the hospital’s policy prior to the admission of Mrs. Gray to that facility, the court would not have ordered withdrawal of the feeding tube, the purpose of such legislation would be to obviate the need for explicit notice.¹⁰⁹ It may also be presumed that such legislation would create a right of refusal affecting even already admitted patients. Since, according to the *Gray* court, the government has no constitutional obligation to assist the patient in asserting a right to have the tube removed, all peripheral issues are subject to statutory regulation.¹¹⁰

At present, Indiana’s Health Code, Title 16, Article 36, chapter 4, section 13, provides that, “[i]f the attending physician, after reasonable investigation, finds no other physician willing to honor the patient’s declaration, the attending physician may refuse to with-

106. *Id.*

107. *Id.*

108. *Id.* (noting that the Rhode Island legislature enacted similar legislation with respect to abortions and sterilization procedures; specifically the right of health care facilities to refuse to participate on mutual or religious grounds).

109. *See id.* at 590-91.

110. Indeed, in a footnote the court refers to the applicability of 42 U.S.C. § 300a-7(d) (1994), which provides that:

[N]o individual shall be required to perform or assist in the performance of any part of a health service program . . . funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program would be contrary to his religious beliefs or moral convictions.

Id. at 590 n.6 (emphasis omitted). The court found that provision inapplicable because Marcia Gray was not receiving treatment through a federally funded health service program or in conjunction with a federally funded research activity. *Id.* The court thus acknowledged that, when treatment is provided in connection with such federally funded programs or activities, such a statutory right does indeed exist. *Id.*

hold or withdraw life-prolonging procedures.”¹¹¹ In light of existing federal case law, assertion of a right of refusal to withhold life-prolonging procedures in the sense of refusal to withhold a respirator, or refusal to refrain from insertion of a feeding tube, is of dubious constitutional validity (unless, as will be noted later, the patient had been given prior notice). However, refusal to withdraw a respirator or a feeding tube seems to be fully consistent with the decision issued in *Gray*.¹¹²

Despite the federal district court’s endorsement of the doctrine formulated in *Jobes*, at least one New York court has ruled that a medical facility has no duty to participate in the removal of a feeding tube in violation of its medical-ethical judgment despite the apparent absence of prior notice of such a policy. However, in that case, *Elbaum v. Grace Plaza of Great Neck, Inc.*, the court did rule that the medical facility might be required to permit a physician retained by the patient or by the patient’s family to enter its premises in order to remove the tube.¹¹³ In an earlier related action, the court in *Grace Plaza of Great Neck, Inc. v. Elbaum* declared that, “[t]here never has been a court order issued in this State commanding a particular physician to do an act which is directly contrary to the physician’s own medical ethics.”¹¹⁴ In the latter decision, the court found that “[a] patient who wishes to abstain from life-saving medical treatment may have the right to do so, but he has no right to force a physician to assist, actively or passively, in what the physician himself might regard as the equivalent of suicide.”¹¹⁵ In addition, they unequivocally declared, “we do not recognize any right to force a health provider to render treatment which is contrary to his or her own conscience.”¹¹⁶

Medical institutions or individual physicians who, for reasons of conscience, do not wish to withdraw a ventilator, nutrition, or hydration from a patient in situations where such withdrawal would otherwise be required by law would be well advised to make sure that patients are informed of such a policy. Although the matter is

111. IND. CODE § 1-36-4-13 (1993).

112. See *supra* notes 103-110 and accompanying text. The Indiana statute does not require that the physician’s referral be predicated upon religious or moral grounds. IND. CODE § 1-36-4-13. Based on the analysis presented herein no such claim should be required in order to protect the statute from constitutional challenge.

113. *Elbaum v. Grace Plaza of Great Neck, Inc.*, 544 N.Y.S.2d 840, 848 (App. Div. 1989).

114. *Grace Plaza of Great Neck, Inc. v. Elbaum*, 588 N.Y.S.2d 853, 859 (App. Div. 1992).

115. *Id.* at 858.

116. *Id.* at 859.

not explicitly addressed in *Gray*, such notice should logically establish a physician's right not only to refuse to remove a ventilator or feeding tube, but even to introduce such life-preserving mechanisms contrary to the wishes of the patient. Of course, the patient retains the right to seek transfer to another facility; thereby, terminating her contract with the physician. The patient may also accomplish the same end by seeking the ministrations of another physician within the same facility, but prior notice would then have the effect of protecting the new physician for the duration of the existence of a contractual relationship. Although the patient has a constitutionally protected right to refuse treatment, agreement to be treated pursuant to such notice would constitute a waiver of that right, and perhaps even a contractual undertaking to permit the physician to fulfill her perceived duty to treat even in such circumstances.

Jobes and *Gray* certainly serve as precedents for protection of the moral integrity of a physician who cannot in good conscience accede to the wishes of her patient. Nevertheless, in *Childs v. Abramovice*, despite its incorporation of a reference to *Gray*, the California Appellate Court remarked that, "[the] issue of whether a court could compel physicians to act contrary to their ethical views is too profound for gratuitous discussion in a dictum. Its resolution must await an appropriate case."¹¹⁷

Legislative action would certainly be beneficial in removing lingering legal doubt and in reassuring conflicted physicians. Moreover, legislation would afford an opportunity either to enshrine a notice requirement or, alternatively, to adopt the policy enunciated by the *Grace Plaza* court and reflected in the Indiana statute, and to accord a physician greater protection by omitting such a requirement.

117. *Childs v. Abramovice*, 206 Cal. App. 3d 304, 312 (1988).

