

CONSCIENTIOUS OBJECTION IN THE HEALING PROFESSIONS

A READERS' GUIDE TO THE ETHICAL AND SOCIAL ISSUES

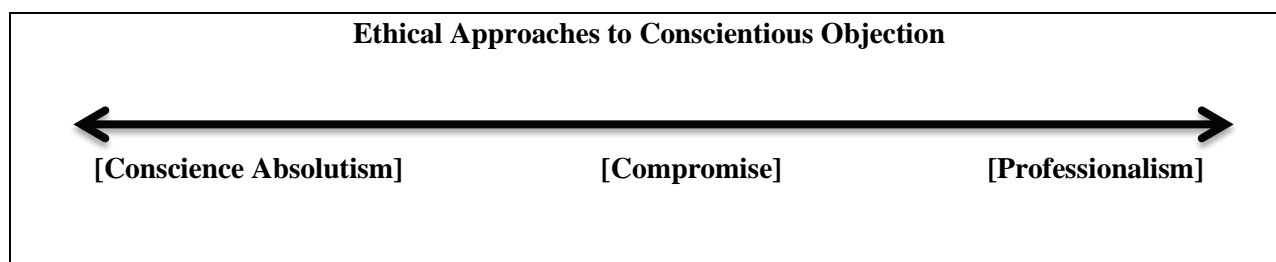
Ethical Analyses

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The medical profession has a long history of promoting ethical principles in order to benefit and protect the patient.¹ These principles include beneficence, “the duty to try to bring about those improvements in physical or psychological health that medicine can achieve” paired with nonmaleficence, “going about these activities in ways that prevent further injury or reduce its risk.”² Professionals are guided by these principles while also respecting autonomy, “the moral right of every individual to choose and follow his or her own plan of life and actions.”² In cases of conscientious objection, professionals may find that their understanding of how best to pursue beneficence and nonmaleficence may differ from that of their patients. At the same time a professional may find that respect for the patient’s autonomy must be practiced at the expense of their own autonomy, such as in cases where the physician’s personal moral and ethical values are in contention with the care the patient requires or requests. In these situations, both the law and medical ethics provide guidance; however, they do not offer a definitive solution for how physicians should ethically respond in order to provide the patient the best care while also preserving a sense of personal, moral integrity. This section presents an overview of ethical analyses of the practice of conscientiously objecting when the care the patient requests conflicts with the professional’s personal moral and ethical values.

Arguments for and against conscientious objection may be situated along a spectrum. At one end of the spectrum are those who argue for the respect of individual conscience in all cases, or, in Wicclair’s phrasing, *conscience absolutism*.³ At the other end of the spectrum, are those who argue for upholding professional norms and standards, or *professionalism*.³ In the middle are those who seek some way to balance a professional’s conscientious concerns with the need to protect the patient’s right to receive treatment. Thus, in the middle one may find attempts to forge a *compromise*—these arguments permit conscientious objection, but within limits.



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I. Conscience Absolutism

When a person feels forced to violate personal values, regardless of whether those values are informed by religious or secular world views, in order to fulfill the demands of their profession or to meet the needs of their patients, they are likely to experience significant moral distress. Should they be forced to meet the needs of the patient at the cost of their own integrity? Should they be required to find another job—one that does not conflict with their moral values? Analyses described here, under the heading of *conscience absolutism*, make the case that one should never compromise their core moral values and beliefs. In essence, conscience absolutism seeks to uphold a professional's right to object, because judgments of conscience are morally binding. In the religious context, this means that to act against conscience is to sin against God. Therefore, to force a professional to perform a service they find to be morally objectionable would cause them to violate their core beliefs—beliefs, in fact, which may have informed their decision to enter the healing professions.

As a voice for the defense of conscientious objection, Edmund D. Pellegrino asserts that conscience clauses should be implemented to give legal status to objections based on moral claims. Pellegrino argues that the failure to offer legal protection to objection physicians creates a values and belief dichotomy “which is incompatible with moral integrity for a true religious person.”⁴ According to Pellegrino, even when the conditions under which conscience clauses will be applicable and their effectiveness is at issue, conscience clauses will “help at least to establish a right to dissent.”⁴

In addition to protecting physicians, Pellegrino stresses that conscience clauses should also protect patients, students, educators, and religious institutions. Pellegrino advocates that both Catholic physicians and institutions alike have the same “moral claim to exercise of conscience, as all other humans, even when the fruit of conscience is refusal and even resistance to accommodation of secular beliefs or the changing beliefs of their professional colleagues.”⁴

In order to avoid the potential conflict that may arise between health professionals and patients, Pellegrino argues that physicians have a duty to make their practice limitations publically known. Pellegrino recommends that in order to make practice limitations known in advance of a crisis, “individual physicians should prepare a leaflet outlining what they can, and cannot, in good conscience do.”⁴ Although advanced knowledge may not be possible in all situations, Pellegrino still asserts that “the Catholic physician cannot violate her conscience to provide a morally objectionable procedure or treatment.”⁴

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Brugger EC.⁶ Do health care providers have a right to refuse to treat some patients? *Christian Bioethics*. 2012;18(1):15-29.

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II. Professionalism

At the other end of spectrum are those who defend the norms of *professionalism*.³ Professional standards of health care impose duties on the providers of medical treatment. Professionals have obligations to provide patients with the fullest extent of care available within their field. According to those who argue for these norms, the obligations of the professional (whether they be a nurse, physician, pharmacist or assistant) to patients trumps person moral or ethical values. In other words, the value of respecting the patient's autonomy and protecting and pursuing the patient's well-being outweighs the professional's personal concerns. Those that argue for this position insist that when a person becomes a health professional, they should consent to and adopt the values and ethics of the profession. Advocates of professionalism assert that in order for medicine to be fair and consistent, all physicians should provide patients with the best, legally-permissible care.

Julian Savulescu, a prominent voice for professionalism, maintains "if people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."¹⁶ Savulescu opposes physicians' rights to conscientious object stating four major arguments:

- 1) "conscientious objection introduces inequality and inefficiency" because it forces patients to "shop among doctors to receive the service to which they are entitled";
- 2) allowing conscientious objection for moral or religious claims, while not allowing objections for self-interest and self-preservation creates inconsistency among the medical profession;
- 3) part of being a doctor is taking on certain commitments which include offering appropriate medical interventions that are "legal, beneficial, desired by the patient, and a part of a just healthcare system"; and
- 4) to treat religious values "differently from secular moral values is to discriminate unfairly against the secular."¹⁶

Although Savulescu strongly defends professionalism, he makes some room for compromise. Under Savulescu's view, conscientious objection can be accommodated when it can be exercised without compromising patient care. However, in cases where conscientious objection compromises the "quality, efficiency, or equitable delivery of a service, it should not be tolerated."¹⁶ All health care should adhere to its primary goal, which according to Savulescu is "to protect the health of its recipients."¹⁶

Although the majority of papers addressing conscientious objection in the health professions seek for ways to accommodate objectors, it would be a mistake to assume the majority of professionals and ethicists are similarly represented. In fact, it may be the case that those who believe that professional values are more important than personal values, do not feel the need to defend their position. If one's personal values align with the values of the profession, one is unlikely to encounter the motivating moral distress to address the topic, nor is one likely to adopt the vocabulary of "conscience."

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III. Compromise:

Arguments defending absolutism and professionalism represent opposite ends of the debate about conscientious objection in the health care. In practice, however, most decisions about how and when (if at all) to accommodate conscience-based refusals tend to fall somewhere in the middle. Compromise solutions seek to permit conscience-based refusals, but within limits. Under this model, physicians are afforded an opportunity to object on moral or religious bases without the fear of retribution, while patients are still provided the care they need and desire. In order to avoid diminishing a patient's autonomy or disregarding a professional's moral integrity, the "compromise" solutions seek to establish rules and systems to address conflicts well in advance of a crisis. In addressing "absolutist" arguments against limits to conscientious objection, Dan W. Brock, provides the conceptual grounds for what he describes as the "conventional compromise."²⁵ According to Brock, a series of three conditions must be met in order for physicians to exercise conscientious objection: 1) The physician informs the patient about the service if it is medically relevant to their medical condition; 2) The physician refers the patient to another professional willing and able to provide the service; and 3) The referral does not impose an unreasonable burden on the patient.²⁵

In order to make accommodations for objectors while protecting the needs of patients, those who favor compromise have proposed practical models for preventing and resolving conflicts. These models focus on allowing professionals the right to conscientiously object without interfering with the patient's ability to obtain health care services. The following are provided as examples of these models:

The Lynch Approach:

In her book, *Conflicts of conscience in health care: An institutional compromise*, Holly Fernandez Lynch defends the role of conscientious objection in medicine, but concedes that there are times when physician refusals should not or cannot be accommodated.²⁶ Lynch argues that accommodating conscientious objection promotes a diverse profession and encourages physicians and other healthcare workers to seriously consider moral, professional and ethical obligations. Lynch, however, believes that conscientious objection should not be based on discrimination and that conscience-based refusals have no place in certain circumstances, such as life threatening emergencies. Lynch proposes that physicians should openly declare their conscientious objection status so that state medical licensing boards can ensure that a sufficient mix of physicians who reserve the right to conscientiously object with those that do not reserve that right is disbursed throughout various geographic areas.

The Wicclair Approach:

Rejecting both the "conscience absolutism" and "professional incompatibility" theses, Wicclair proposes a model of compromise in his book *Conscientious Objection in Health Care: An Ethical Analysis*.³ Similar to Lynch, Wicclair also defends the role of conscientious objection; however, Wicclair draws a clear line between when physicians have a right to conscientiously object and when they do not. In Wicclair's version, physicians maintain an unrestricted right to conscientiously object as long as their objections do not harm the well-being of patients. In essence, Wicclair proposes that in order for physicians to exercise conscientious objection, they must first ensure that the needs of the patient will be met.

According to Wicclair, there are three core professional obligations that physicians need to adhere to in order to ensure that patient needs are met. These obligations include: 1) respecting patient dignity and refrain from discrimination; 2) promoting patient health and well-being; and 3) respecting patient autonomy. In order to adhere to Wicclair's compromise model, a physician is free to object as long as he fulfills his duty to "inform the patient about care options and alternatives, or refer the patient for such information, so that the patient's rights are not constrained."³ Wicclair asserts that the current system

allowing for physician objection provides too much protection to individual conscience and does not protect positive duties, therefore rendering conscience clauses inadequate.

The Cantor and Baum Approach:

Julie Cantor and Ken Baum, in their article "The Limits of Conscientious Objection — May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?", assert that only three possible solutions exist to resolving the conscientious objection debate: "an absolute right to object, no right to object, or a limited right to object."²⁷ Although, they acknowledge the debates for both professionalism (no right to object) and absolutism (an absolute right to object), Cantor and Baum propose a solution to protect objections in certain circumstances. The guidelines they propose give practical limits to pharmacists with objections in order to protect the interests and needs of patients. These guidelines would, presumably, apply as well to professionals in other health care fields.

The Cantor and Baum approach to compromise requires several steps. First, providers who object must issue patients an alternative. This alternative includes ensuring that there is always a provider available that can offer the service to the patient. In cases where the provider does not have an alternative provider available, clear notice should be prominently displayed and patients should be referred elsewhere. For example, Cantor and Baum suggest in cases where emergency contraceptive will not be issued, a sign should be displayed that says, "We do not provide emergency contraception. Please call Planned Parenthood at 800-230-PLAN (7526) or visit Emergency Contraception Web site at www.not-2-late.com for assistance."²⁷

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