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PHILOSOPHICAL EXPLORATION

The Challenges of Conscientious Objection in Health care

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Abstract Conscientious objection (CO) is the refusal to perform a legal role or responsibility because of personal beliefs. In health care, conscientious objection involves practitioners not providing certain treatments to their patients, based on reasons of morality or "conscience." The development of conscientious objection among providers is complex and challenging. While there may exist good reasons to accommodate COs of clinical providers, the exercise of rights and beliefs of the provider has an impact on a patient's health and/ or their access to care. For this reason, it is incumbent on the provider with a CO to minimize or eliminate the impact of their CO both on the delivery of care to the patients they serve and on the medical system in which they serve patients. The increasing exercise of CO, and its impact on large segments of the population, is made more complex by the provision of government-funded health care benefits by private entities. The result is a blurring of the lines between the public, civic space, where all people and corporate entities are expected to have similar rights and responsibilities, and the private space, where personal beliefs and restrictions are expected to be more tolerated. This paper considers the following questions: (1) What are the allowances or limits of the exercise a CO against the rights of a patient to receive care within accept practice? (2) In a society where there exist "private," personal rights and responsibilities, as well as "civil" or public/shared rights and responsibilities, what defines the boundaries of the public, civil, and private space? (3) As providers and patients face the exercise of CO, what roles, responsibilities, and rights do organizations and institutions have in this interaction?

Keywords Ethics · Conscientious objection · System-based practice

The views in this paper are those of the author alone. They do not represent the views of the National Center for Patient Safety, the Veterans Administration, or the US Government.

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Introduction

Conscientious objection (CO) is the refusal to perform a legal role or responsibility because of personal beliefs (Berlinger 2008). In health care, conscientious objection can involve practitioners not providing certain treatments to their patients, and parents not consenting to certain treatments for their children. Citing moral reasons, many doctors refuse to perform or in other ways participate in abortions. Pharmacists have recently refused to fill prescriptions for emergency contraceptive medications and for birth control in general. Increasingly, states and municipalities have legislated "conscience clauses" giving providers, such as physicians and pharmacists, to refuse to provide health care services.

The development of conscientious objection among providers is complex and challenging. There are good reasons to accommodate COs of clinical providers. However, the rights and beliefs of the provider, when exercised, necessarily have a potential impact on a patient's health and/or their access to care. With this in mind, professional societies have made it incumbent on the provider with a CO to minimize, if not eliminate, the impact of their CO on the delivery of care to the patients they serve. Further, they should minimize the impact on the medical system in which they serve patients.

The increasing exercise of CO, and the impact it is having on large segments of the population, is recently made more complex by the provision of health care benefits to more people by private entities under a government program. This results in a blurring of the lines between the public, civic space, where all people and corporate entities are expected to have similar rights and responsibilities, and the private space, where personal beliefs and restrictions are expected to be more tolerated.

This paper will consider the following questions:

1. As a health care provider attempts to prevent himself or a patient from what is perceived as harm, what are the allowances or limits of the exercise a CO against the rights of a patient to receive care within accept practice?
2. In a society where there exist "private," personal rights and responsibilities, as well as "civil" or public/shared rights and responsibilities, what defines the boundaries of the public, civil, and private space?
3. As providers and patients face the exercise of CO, what roles, responsibilities, and rights do organizations and institutions have in this interaction?

History

A brief history of CO in health care is outlined elsewhere (Fiala and Arthur 2014). The original expression of CO was the refusal to participate in military services, motivated by an objection to killing. More recently, the concept has been used by people and corporations to refuse to provide services with which they personally disagree: assisted suicide, abortion, contraception, and other services.

Allowances for CO in health care exist in multiple nations with liberal democracies (Heino 2013): for example, Austrian law dating back to the 1970s states "No one may be in any way disadvantaged … because he or she has refused to perform or take part in such an abortion." Several of these laws exist with caveats: in France, the law attempts to allow for CO but requires that the exercise of such CO not impairs access to care: "A doctor is never

required to perform an abortion but must inform, without delay, his/her refusal and provide immediately the name of practitioners who may perform this procedure."

American culture, and law, has likewise long allowed for the exercise of religious liberty. Historically, there exist limits of expression of such liberties. In a 1985 case that defines, for most legal scholars, the landscape of the exercise of religious liberty in the USA, US Supreme Court stated "The 1st Amendment…gives no one the right to insist that, in pursuit of their own interests, others must conform their conduct to his own religious necessities."(Supreme Court of the US 1985) *The fundamental principle to be observed was that of "reasonable rather than absolute accommodation." (emphasis added).*

In health care in particular, the first federal compromises to Roe v. Wade were introduced in the 1970s. The Church amendments, named after Senator Frank Church (R-ID), directed that recipients of federal funding could not require health care professionals to perform or assist in abortion or sterilization procedures that were contrary to their religious or moral convictions (Appel 2005). The Church amendments also protected health care personnel who were equally compelled by their religious or moral beliefs to provide such services. During this same time, the number of states with conscience clause rules increased from 10 in 1972 to 40 in 1980.[1]

A key difference in the recent evolution of CO in health care was twofold. First, the exercise of CO began to be pursued by other professions, such as pharmacists. This was distinct in that, prior to the 1990s, there existed little legislative, legal, or professional history allowing for CO in such professions. Further, the exercise of CO by health care institutions, historically limited to clinical providers with a religious mission, proliferated to non-religious private organizations. Notably, Wal-Mart, a retail store with 3400 retail pharmacies, decided in 1999 that they would no longer sell Preven, a package of emergency contraceptive pills (ECPs) often called "the morning after pill" or "emergency contraceptive."[2] In April 1999, the Wal-Mart corporation stated,

> At this time Wal-Mart has made the business decision not to sell Preven. However, in the interest of serving and meeting the needs of our customers, our pharmacists will refer any request for this product to a pharmacy that does carry it. (New York Times 1999)

Several states ordered the Wal-Mart Corporation to stock and dispense ECPs, and the corporation ultimately reversed its policy in 2006. During this seven-year period, a number of pharmacies and pharmacists began to articulate a right to CO. This led, expectedly, to states responding either to the rights of providers or to the rights of patients. In 2013, the FDA made ECPs a "behind the counter" medication, not requiring a prescription. At the time of this publication, nine states adopted restrictions on ECPs, with 4 states explicitly directing pharmacists and pharmacies to "fill all valid prescriptions".[3]

As state and federal laws increased the number of conscience clauses, and the practice of CO became more widespread within and among professions, medical professional societies responded with statements reinforcing the responsibilities of health care providers to serve the interests of patients when exercising CO (American Medical Association House of Delegates 2013). Most follow the same line of the Council of Medical Specialty

[1] *The Trend in State Abortion Conscience Clause Rules,* Center for American Progress, www.americanprogress.org.

[2] http://www.religioustolerance.org/abo_walm.htm.

[3] http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf.

societies, which requires that "physicians resolve conflicts of interest in a fashion that gives primacy to the patient's interest."[4]

Most recently, as health care becomes more universal, the obligation or corporations to support patients' rights to selected medical services became a controversy. Private organizations, both religious and non-religious, have attempted successfully to exercise their right not to support employee health care, with recent cases ending in their favor in the supreme court.

CO, Provider and Patient Rights, and the Challenge of Achieving Balance

The topic of CO raises the question of how best to weigh the rights of the provider against that of the patient whom the provider serves. This question leads to a more general question of how to best reconcile the contrary rights of two individuals who do not share similar views on a topic—such as abortion or end-of-life care. How does a functioning civil society reconcile the discordant rights of two individuals?

A model for such reconciliation of liberty and equality is outlined in John Rawls's *Theory of Justice* (Rawls 1971). The relationship to Rawls's model to health care has been outlined elsewhere (Brody 2011). In general, a just, civil society can accommodate "considerable differences in citizens' conceptions of justice, provided that these conceptions lead to similar political judgements." This model of social justice, individual liberties, and shared civil responsibilities is built on a "social contract," that is largely unwritten, and limited to the "public space," which is "shared" by individuals: the town square, government facilities, and other public resources. On the other hand, there is no such contract in "private spaces," such as houses of worship, private organizations, and personal homes. In the public space, all individuals share rights and responsibilities: There is no such expectation of rights in the private space.

A challenge arises when there is a blurring of the boundaries between the public space and private space. This challenge is especially evident when the role of "public good," or services ostensibly available to all members of a just society, is being provided by a private entity that seeks to assert its own rights in the "public space." As different private entities, be they people or institutions, seek to assert their personal beliefs and restrictions based on conscience, the result will be increasing difficulty in finding those areas of overlapping consensus. When the overlapping consensus relates to key services, like medical procedures, professional counsel, or prescription medications, conflicts arise over the competing rights of the providers and those whom they serve, and where the rights of one ends and the other begins.

This conflict over competing rights and overlapping consensus with regard to health care services can be considered by asking several questions:

- *What comprises public, shared resources that are due to all individuals as a right?* Are all individuals due the rights of education, social services, and health care, or are these entities "privileges?" If we agree that health care is a right, are all aspects of health care rights, or just some? How are these rights decided in a civil society?
- *When core civic functions, owed by civil society to individuals as rights, are assumed by private entities, does the private entity assume the role of public space?* When the "town square" where most citizens congregate happens to be a private space, like a privately owned shopping mall, what are the responsibilities of the mall to freedoms of

[4] http://cmss.org/policies-positions/ethics-statement/.

expression, assembly and association? Does the mall take on the obligation of allowing free assembly on its private premises?

- *If a private entity assumes the role of the public space, what happens when the rules of the public space conflict with those of the private provider of those services?* If a private entity, such as a church, performs a civic service, like performance of marriage or adoption, and it does not wish to provide these services to people who do not accept key doctrines of its faith, what rights does it maintain and concede in such situations? Does the private entity forgo all, some, or no rights of conscience in such situations?
- *If a private entity is allowed to withhold core civic services from individuals, and the rights of the recipient of those services are now not being met, who assumes those responsibilities?* When a patient wishes to undergo an abortion, and the only provider licensed to do one refuses, what rights does the patient have on society to be provided abortion services without inconvenience, cost, or other barriers? What added impositions can be placed on the patient as reasonable, and what impositions should not be allowed to be placed on the patient?

Within health care, these questions have been largely asked and answered. It is generally accepted that when physicians enter practice, they voluntarily accept a set of core professional obligations. While controversies over the obligations of physicians might exist among lay people, politicians, and other non-medical professionals, clarity over physician obligations to patients can be found in the professional societies that govern best practice, develop guidelines, and provide overall direction to the practice of medicine for most providers. Professional societies have addressed these questions through professional statements. Most follow the Council of Medical Specialty Societies statement on ethics, which states the following:

- *The Physician's primary, inviolate role is an active advocate for each patient's care and well-being.* Most professional societies agree that when a conflict arises between the goal of patient health and any other goals—including existential threats to the moral code of a physician—primacy is given to the goal of patient health. A challenge, however, might arise when a physician's CO is asserted in the language of protecting the patient's health and well-being.
- *The physician's commitment to patients includes health education and continuity of care.* This statement commits the physician to two aspects of care that often are contrary to a CO: A physician is obligated to share all medical options, including those options which a physician has a CO to. Further, if the patient expresses the desire to pursue those options, the physician has an obligation to continue to care for the patient, and provide those options of care. If the provider is unwilling to provide those procedures because of a CO, they should facilitate the patient obtaining requested services in a timely and competent manner.
- *Physicians should resolve conflicts of interest in a fashion that gives primacy to the patient's interests.* This general statement serves as a simple, powerful reminder of the professional obligation of physicians. The most compelling constraint on accommodating COs is to protect patients from harm that results from not receiving a requested medical service. To that end, all conflicts, when they arise, should resolve in favor of the needs of the patient.
- *Physicians have a responsibility to serve the health care needs of all members of society,* and *physicians have an ethical obligation to preserve and protect the trust bestowed on them by society.* These two statements acknowledge that health care, while arguably not a right, is clearly a public good that can be dispensed only by those individuals licensed to do so. To protect patients from potential harm that might arise from this monopoly of sorts, professional societies charge physicians with the

obligation to provide their expertise to all members of society. To that end, physicians cannot restrict their practice based on gender identity, sexual orientation, religion, or other reasons, except when defined by their specialty and scope of practice (for example, an adult physician caring for an infant).

The Evolution of Systems-Based Practice and its Effects on the Exercise of CO

Over the last 20 years, the practice of medicine has changed substantially. More physicians are employed (American Hospital Association Annual Survey data 2010), by either large group practices or hospitals, and more hospitals are part of larger systems (American Hospital Association Annual Survey data 2010). Between 2005 and 2011, over 400 hospital mergers and acquisitions were announced, involving over 1300 hospitals (Irving Levin Associates, Inc. 2012).

The practice of medicine has likewise changed, with interdisciplinary care teams forming the basis of care. While physicians are a key member, often the leader, of that team, they are only one member. Their behavior not only is subject to scrutiny of peer physicians, but is now considered in the context of a team comprising other professionals, each with their own codes of conduct and behavior.

Practice as an employed physician and as part of a multidisciplinary team introduces new questions and opportunities when considering the exercise of CO. When considering physician practice in isolation, CO is arguably easier to manage. Physicians can more easily transfer care over to another provider with less interruption or inconvenience to the patient. More important, physician employers introduce to the physician new restrictions and expectations on professional behavior. A result of physician employment arrangements is a practice-specific supervision and scrutiny on physician professional behavior

Some specialty societies acknowledge this new element in physician practice: The role of the institution is noted in recently published guidelines on CO (Lewis-Newby et al. 2015). Recently published guidelines on CO direct institutions with the following:

- Rather than *ad hoc* management by individual clinicians, CO is best managed by institutional mechanisms. Health care institutions should develop and implement CO policies in advance of actual cases. COs should be anticipated and prospectively managed. The process of CO management should also consider unanticipated COs and include steps to manage them without compromising patient safety or quality of care.
- The institution should accommodate physician COs, so long as three criteria are met:
    1. The accommodation will not impede a patient's timely access to medical services or information,
    2. The accommodation will not lead to excessive hardships for other clinicians or for the institution, and
    3. The CO is not based on invidious discrimination.
- A clinician's CO to providing medical services should not be considered justification to forgo the treatment against the wishes of the patient. The institution should have in place a process-based mechanism to resolve such disputes, which should include a path for the clinician to request a personal exemption from providing a particular service.

- The institution should generally foster a culture that respects, and to the best of its ability, accommodates, diverse values.

Put more simply, other societies state that doctors whose personal beliefs require them to deviate from standard practices can deny treatment only if they give prior notice of their moral objections, refer patients in a timely manner to another doctor, and provide any necessary care in an emergency.[5] These obligations require a "community of physicians," ready to take over for a physician exercising a CO. The use of group practices, employed physician models, and integrated health care systems is a logical one in this context.

These statements recognize the reality of physician–patient relationship, which existed for years but until recently, remained unacknowledged: that physician practice is not in a vacuum, and physician and patient decisions have an impact on and are affected by a number of people and institutions (Fig. 1). CO guidelines today are clear: that to best accommodate CO and not jeopardize care to patients, COs are best considered in advance of actual cases. Processes and procedures should be in place to maintain competent, timely care to patients without imposing compromises of CO by providers or substantial burdens on the health care institution of other providers working to continue patient care and accommodate the CO. To that end, the institution has its own obligations: to consider the presence of potential COs among its providers, and to make efforts toward culture that invites providers to express their COs and submit them for careful consideration and inclusion in institution operations.

This leaves several questions unanswered: How do two providers, and an institution where they both work, reconcile individual COs that are in conflict with one another? What if two physicians are unable to reconcile their COs? What if one of the providers, a devout atheist, has a CO to accommodating faith-based COs? What if the CO crosses specialties or clinician practice? A pharmacist might refuse to dispense a medication ordered by a physician; a nurse refuse to participate in a procedure ordered by a physician; or an anesthesiologist might refuse to assist in a surgical procedure. What if there are no alternative providers, or available time, to accommodate a CO? One might imagine an emergent case with an acutely sick patient, in need of an immediate procedure, or a procedure that can be performed by only one physician, and no ability to transfer the care of the patient to another institution where such care can be reasonably provided. In such situations, the proverbial "devil is in the details" that might make such cases a challenge to manage. These situations, however serious, are rare events that can be considered in advance using methods such as health care failure modes and effects analysis (HFMEA) to anticipate situations that might be unlikely but of substantial impact to a patient if they occur.[6]

Unanswered Questions and Challenges to Accommodations and Restrictions on CO

Additional layers of complexity to CO and the physician–patient relationship can be added, leaving challenging, unanswered questions:

[5] "The Limits of Conscientious Refusal in Reproductive Medicine," American College of Obstetricians and Gynecologists Committee on Ethics opinion, November 2007.

[6] Healthcare Failure Mode and Effect Analysis (HFMEA), accessible at www.patientsafety.va.gov.

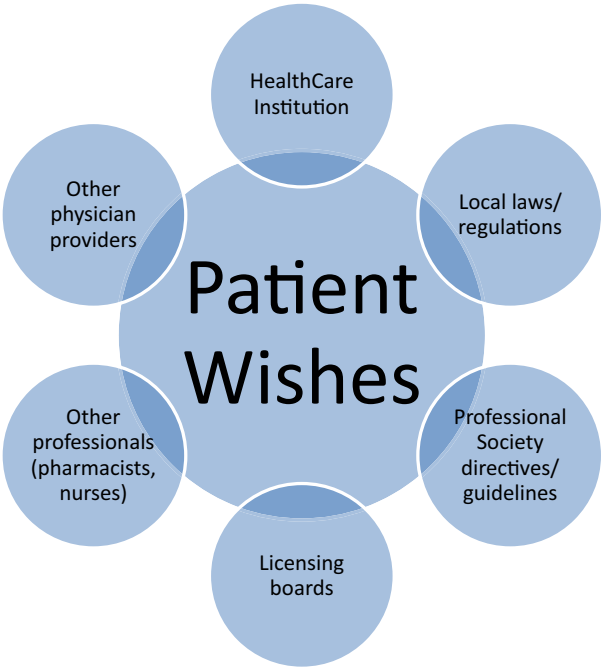

Fig. 1 Components of the Physician-Patient Relationship

What if the CO is exercised, not by the individual physician or other medical professional, but by the institution itself? This question arises in a new context. Since 1999, two religiously affiliated health systems were established,[7,8] with a current total of 220 hospitals and over 2000 clinics across 30 states. Both health care systems follow—and require that their providers and staff follow—the *Ethical and Religious Directives for Catholic Health Care*. Their practice, in effect, is guided by "the moral tradition of the church." Catholic health care institutions "must adopt these [official Church] directives as policy," and "require adherence to them within the institution as a condition for medical privileges and employment." (Ethical and Religious Directives for Catholic Health Care 2009) Health care providers have, if only occasionally, chafed at these restrictions.[9] Institutional COs placing restrictions on the provider have not been fully considered by professional societies or medical regulations.

What if the exercise of CO leaves the patient without options to get the care they need and request? While not due to CO, restrictions on abortions in some states currently force patients to travel over 1000 miles to the nearest health care facility, at substantial personal cost.[10] There are multiple reports of patients left unable to get medications because of expressions of CO by pharmacies and pharmacists (Fiala and Arthur 2014)

[7] http://www.trinity-health.org/.

[8] http://www.ascensionhealth.org/.

[9] "A Medical Crisis of Conscience: Faith Drives Some To Refuse Patients Medication or Care." Washington Post 7/16/2006.

[10] *The cost of driving to an abortion,* Accessed at http://www.theatlantic.com/health/archive/2014/10/the-cost-of-driving-to-an-abortion/381985/.

In cases where there is disagreement over a medical plan based in CO, how are disputes on the medical aspects of the case reconciled? If a physician or pharmacist is obligated to provide care "in a life-threatening situation," what happens when the provider states their belief that the medical case is not life-threatening?

If institutions and providers are unable to reconcile and accommodate COs, can providers be fired for them? To date, a cursory search reveals no cases where a physician was forced to quit, or was fired, over a conflict based on CO. The legal and ethical ramifications of an inability to accommodate a CO are broad and possibly unprecedented: On what basis would the physician be removed from practice? Would this be reportable to the National Practitioner Database?

Can a point be reached where the accommodation of CO becomes unsustainable? One might imagine in a diverse society where COs exist to accommodate not only physicians, but respiratory therapists, prehospital providers and paramedics, pharmacists, nurses, and even non-clinical staff involved with billing and coding. While only theoretical, the system of care could be reasonably be brought to a standstill as health care is paralyzed by attempts to accommodate an excess of individual providers, each with their own CO, and a patient stymied by a Kafkaesque system and unable to get the health care they need.

Conclusion

As American society, and American health care, becomes more diverse, there will be increasing heterogeneity among patients, providers, and institutions. Clinicians have potentially coercive power, with a monopoly on knowledge, skills, and resources (such as the ability to prescribe restricted medications). Recognizing this power, medical societies have attempted to dictate norms of professional behavior: They agree that protecting the moral integrity of physicians and providers, while important, is secondary to the needs of the patient. To that end, providers and the systems where they practice should anticipate COs and put in place processes to best protect patient rights for quality, safe medical care, and, to the best of their ability, accommodate COs. While there might be operational challenges to achieving this normative goal, and potential risks to doing so, the goal of accommodating clinician COs deserves attention.

Compliance with Ethical Standards

Conflict of interest None.

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