
Conflicts of Conscience in Health Care

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Holly Fernandez Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise*

Conflicts of Conscience in Health Care

An Institutional Compromise

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A Primer on Conscience Clauses

For obvious reasons, conscience plays a major role in ethical endeavors, and those within the realm of bioethics are certainly no exception. Conscience frequently rears its head in bioethical decision making since these choices often raise deep questions about life and death, God and science, tradition and technology. Further complicating matters is the fact that doctors and their patients may hold widely disparate perspectives on these issues, but only one course of action can be chosen, which often cannot be taken back and which may have lasting consequences for either or both parties. For these reasons, some find it hard to believe that a physician's conscience is formally protected at all, while others are surprised to learn that this was not the case until about the time of the Supreme Court's landmark decision in *Roe v. Wade*. Then, the first refusal clauses began to make their way into responsive legislation.

A Brief History

Prior to that point in history, and even in response to a proper reading of *Roe*, there was no need for statutory protection of physicians. The law generally removed the sorts of choices that could have raised conflicts of conscience in the first place by banning controversial services like abortion and birth control. Additionally, since physicians generally wielded so much power in the doctor-patient relationship, conflicts of conscience were highly unlikely—or were at least unlikely to come to the attention of patients. Nevertheless, the recognition of a constitutional right against unduly burdensome state interference in a woman's personal decision about whether to carry her pregnancy to term sparked

fear among those opposed to abortion that this negative right would soon be transformed into a positive one, by which physicians and other health-care workers could be forced to provide these services against their moral objection.

This fear led Congress to pass the Church Amendment in 1973,¹ its ironically religious title having nothing to do with its content, but instead referring to the statute's sponsor, Senator Frank Church. This legislation, still in effect today, was a direct response not to *Roe*, but rather to a district court's injunction requiring a Catholic hospital to allow sterilizations to be performed on its premises over its religious objection.² The injunction was promptly dissolved in the wake of the statute's protection of institutions and individuals receiving federal funds from being forced to provide abortion or sterilization services if those services would be contrary to their "religious beliefs or moral convictions."³ The statute also forbids institutions receiving federal funds from discriminating against health-care employees based on their religious or moral convictions regarding these procedures.⁴ The vast majority of states quickly followed suit, passing a flurry of conscience clause legislation of their own, filling in the gaps and offering protection not dependent on any particular funding source.⁵

Of course, the negative right established in *Roe* has not evolved into a positive right, and in fact seems to be moving in the opposite direction. Yet reactive conscience clauses remain on the books and have even expanded. Today, forty-six states, the District of Columbia, and the federal government have statutes protecting physicians from an incredibly broad array of consequences for refusal to participate in abortion procedures,⁶ and Illinois,⁷ Mississippi,⁸ and Washington⁹ allow refusal of *any* medical service to which the physician is morally opposed. Several other states extend their conscience clause protection to contraceptive and sterilization services, assisted reproduction, human cloning, fetal experimentation, physician-assisted suicide, and withholding or withdrawing life-sustaining treatment. Further, many of these statutes reach beyond physicians to cover other health-care providers, such as nurses and pharmacists, as well as health-care institutions, such as hospitals and insurers.¹⁰

In addition to *Roe v. Wade*'s integral impact on the addition of conscience clauses to our legal landscape, the patient autonomy movement and increasing cultural pluralism have also played important roles in the historical evolution of this issue, but have received far less attention. Over the past several decades, physicians have witnessed a shift from widespread, unquestioned, doctor-knows-best medical paternalism to the opposite extreme of patient autonomy. For most of the history of medicine, patients followed the advice of their physicians without a dialogue regarding alternatives, risks and benefits, or the patient's goals. The doctor was the expert and the patient bore the dependent, vulnerable sick role.¹¹ Physicians introduced only those treatment options they deemed appropriate, which, of course, left very little room for conflicts, especially in an era when patients had almost no access to medical information on their own. Contrast that with today's patient, who is nearly bombarded with easily accessible, if not always entirely accurate, information on the Internet, commercials, and television medical dramas. For years, physician beneficence was treated as the supreme guiding principle of medical ethics, and that was not challenged until the 1960s, when patient autonomy began to be asserted as a principle of equal or greater weight.¹²

As the locus of decision making has shifted from the physician to the patient, the patient's right to refuse care, which was the original spark behind the patient autonomy movement, has developed into a demand to receive the care of one's choice and also to dictate the precise details of how that care is delivered.¹³ In many ways, we have moved from an era of physician paternalism to its polar opposite, in which physicians are viewed simply as the patient's agent and are expected to concede to patient demands without objection. For example, if parents want Ritalin for their child, they expect to get it; the physician's explanation that the child exhibits normal activity levels and does not suffer from ADHD may fall on deaf ears, for the parents have already made up their minds. If this doctor will not prescribe the desired drug, they can certainly find one who will. Similarly, if a patient has witnessed several friends taking a prescription drug with success, has viewed advertisements touting the drug's benefits, and has even researched the matter on the web, that

patient will likely be taken aback by the doctor's position that the drug is just not right for him. This result may be received no more favorably than a store clerk refusing to sell a customer a suit because, in her opinion, it does not fit well. While the phenomenon of well-informed patients certainly has its upsides, many physicians have begun to complain that they are forced to waste valuable time convincing patients that what they want is not what they need.¹⁴

At this extreme, the physician seems forced to abandon her own moral agency in order to fill a new role as the patient's "technical accomplice," now responsible for simply using her technical skill to accomplish anything desired by the patient, within legal boundaries, regardless of the physician's moral qualms.¹⁵ Clearly, the patient rights movement has created a serious, and not entirely beneficial, challenge to the autonomy of physicians. This at least partially explains why the physician's personal and professional beliefs about what is right are subject to greater attack today than ever before. Thus, protective conscience clause legislation can be viewed not only as a reaction to *Roe*, but also as a reaction to ever-expanding patient autonomy, a response through which the medical profession has attempted to reclaim some of its lost power.

The current debate surrounding these laws can also be understood as the latest manifestation of the struggles between religion and secularization in modern America.¹⁶ As pluralism and cultural diversity have increased alongside the introduction of technological innovations and new bioethical questions that often demand members of a pluralistic society to reach some level of consensus as to how to move forward, the potential for conflict has become increasingly apparent.¹⁷ Moral pluralism is a good thing, since, as Rawls noted, it indicates a genuinely free society in which individuals are permitted to pursue their own conceptions of the good.¹⁸ Nonetheless, in recent years, American society has attempted to avoid the seemingly inevitable conflict resulting from the breadth of cultures and beliefs coexisting in this nation largely by asking everyone to restrict their beliefs to their personal lives.

This sort of secularization is an apparent attempt to demonstrate tolerance for disparate perspectives, but in reality it is disingenuous, for tolerance is comfortable and painless when one is never forced to confront opposing views. Further, the segmentation of one's personality

demanding by secularization may be utterly impossible and can lead to widespread dissatisfaction, particularly considering the fact that it appears to “tell even devout people to treat religion as a once-a-week, private activity—in tension with the view that religion affords a complete way of life.”¹⁹ This has resulted in a backlash against secularization and the increasing presence of “private” views in the “public” sphere visible today. For example, in 2000, 70 percent of Americans wanted religion’s influence in this country to grow,²⁰ and further denunciation of secularization is evidenced by the political organization of the religious “right” and the increasing acceptability (or at least expectation) of religious discourse in politics.²¹

Combining the effects of the patient autonomy movement and pressure toward secularization, religious physicians, and those with deeply held moral beliefs, are beginning to feel marginalized. They see themselves as instructed to ignore the very beliefs that may have played a vital role in their choice to enter the noble healing profession, expected instead to concede all control to patients, whose beliefs are to be almost unconditionally respected. For some physicians, this one-sidedness seems far too much to ask.

Many claim that they are truly not attempting to impose their beliefs on anyone and are not even purporting to know better than the patient what is in the patient’s best interests. Instead, they are simply seeking protection of their *own* moral integrity in the face of increasingly questionable technological advances and patient demands.²² Others can do it—and perhaps others should do it—but they themselves cannot. In this regard, the expression of physician conscience need not be about power or necessarily about forcing one’s personal views on others.

Of course, not everyone is willing to accept these physicians as benign refusers, suggesting instead that their refusals, at least with regard to abortion and contraceptives, are based on a belief that women seeking these services are “promiscuous at best, and potential murderers at worst,” which in turn is rooted in deeper beliefs about the role of women in society and the family.²³ For these skeptics, refusal at its core is all about the control of others. This may in fact be an accurate portrayal of the motives of some physicians involved in the current debate, physicians who see their conscientious beliefs as expressing the revealed truth of

what is universally good for all based on divinely established categories of right and wrong. Not only will they not provide the service in question, but, these doctors argue, neither should anyone else.

Regardless of whether refusers view their conscience as a reflection of nothing more than their own idiosyncratic understanding of morality or as a reflection of God's absolute standards applicable to all,²⁴ the impact of their behavior on the patients dependent upon them for care may nonetheless have the same effect, and consequences are often what matter most. Avoiding these negative consequences of conscientious refusal will be the essential task for any acceptable compromise solution.

What Are Conscience Clauses Doing for Physicians?

While pharmacists and institutional refusers, such as hospitals and insurers, have received a great deal of attention in the current debate, it may seem odd that there has not been more significant discussion in the media, courts, and legislatures about physician refusals in particular. Surely doctors are not immune to these conflicts, but their stories are chronicled with far less frequency, though there is no clear explanation as to why that is the case. There is some notion that patients who are denied treatment rarely complain, perhaps because the situation feels too personal and humiliating to make public, and that when patients do make noise, things are often resolved quietly.²⁵ Of course, these theories are powerless to explain why pharmacists' refusals have garnered so much attention, particularly since those stories deal with similarly personal sexual issues.

Academic discussion of physician refusers has been somewhat more robust, but still not to the extent one might expect. Medical ethicists and philosophers have addressed the issue of conscience as applied to physicians, but even they have tended to focus more on other instantiations of the debate, and none has offered a convincing and feasible solution to conflicts of conscience that would protect both patients and their doctors. Further, the legal literature suffers from a surprising paucity of commentary evaluating the propriety of the pervasive laws that protect physicians from nearly any imaginable consequence of refusing to com-

ply with patient requests on moral grounds; discussion of refusals by pharmacists, hospitals, and insurers is far more widespread.

On the litigation front, however, there has been some interesting case law directly involving physician refusals. For example, an ongoing case in California, which will be discussed in greater detail in chapter 6, involves the denial of reproductive services to an unmarried lesbian woman. The state supreme court will assess whether the physicians' behavior, allegedly based on their religious beliefs, was constitutionally protected, but the state's conscience clause is not directly implicated, since it covers only abortion services.²⁶

In 2004, a Pennsylvania court held a physician liable for medical malpractice not as a result of his refusal to perform an abortion, which was protected by statute, but rather due to his failure to provide full informed consent by not disclosing the dangerous situation facing the mother so that she might have chosen to seek the procedure elsewhere.²⁷ A much earlier case in Washington was similarly willing to allow a physician's refusal of services on moral or religious grounds, so long as the physician provided patients with all material information.²⁸ New Jersey courts have allowed physicians to refuse to participate in a course of treatment selected by the patient that the physician regards as inappropriate or disagreeable so long as the physician continues to provide basic care, reflecting the standard understanding of how a doctor can go about terminating a relationship with a patient.²⁹ Doctors have also been permitted to refuse bloodless surgery to Jehovah's Witnesses as a result of claimed medical standards without being held liable,³⁰ and have even been allowed to refuse care as a result of their personal economic beliefs, just as long as patients were notified of this policy in advance.³¹

Despite this breadth of cases, however, there has been a dearth of reported opinions specifically dealing with challenges to, or even addressing, conscience clause statutes as they apply to physicians. Why the silence? One explanation for this apparent anomaly is the simple fact that physicians are unlikely to enter a field where they will predictably face personally objectionable situations—a selectivity that is not available to generalists like pharmacists, insurers, and hospitals—thus eliminating opportunities for conflict and the pursuant litigation or discussion. Of course, as technology moves forward, selectivity in one's choice of

medical fields will likely be less effective in avoiding conflicts, particularly as embryonic stem cell therapies develop, impacting everyone from oncologists to endocrinologists to gerontologists.

Another part of the explanation involves important factors surrounding the creation of the doctor-patient relationship. Existing case law conveys the well-established rule that initiation of this relationship is entirely voluntary for both parties; the express or implied consent of the physician is required in the form of some affirmative action toward treating the patient.³² Thus, according to legal analysis, as well as statements of professional ethics adopted by the American Medical Association,³³ physicians are free to refuse to accept a prospective patient for any reason not prohibited by law or contract, and could therefore refuse to take on a patient with whom the physician foresees a conflict of conscience arising. Because physicians have no duty of care to nonpatients, prospective patients who are refused services based on a physician's moral beliefs have no basis on which to bring a lawsuit, offering physicians a level of protection completely outside the realm of conscience clause legislation. This effective preemption of claims may be responsible for preventing widespread discussion of conscientious refusal in medicine by the courts and the broader public, despite the fact that allowing physicians such vast discretion in patient selection fails to address potential access problems that could become quite problematic as grounds for conscientious refusal expand in line with technological developments.

Once a doctor-patient relationship has been established, patients are still unlikely to attain a successful remedy against a physician refusing to provide a service based on his or her personal moral objections. As a threshold matter, the patient may not even be aware that a refusal is occurring, particularly in light of evidence that a significant number of physicians consider it acceptable to withhold information about medical services they find objectionable.³⁴ That issue aside, establishing that a physician had a duty to initiate, or even to complete, a service may be quite difficult, since a physician can terminate an existing relationship at any time so long as he provides the patient with sufficient notice of his intention to do so.³⁵ Further, while patients may experience inconvenience as a result of a physician's conscientious refusal, they may not be so inconvenienced as to render the pursuit of a lawsuit or disciplinary

complaint worthwhile. Additionally, there is always the possibility that the patient disagrees with the physician's behavior, but nevertheless respects the physician's decision based on a recognition that the requested service is morally controversial and not everyone will be comfortable providing it.

More important, depending on the scope of a state's conscience clause, physicians' refusals may be protected with regard to the services they are most likely to refuse to provide, essentially eliminating any duty that could be used to form a malpractice case against them. The Illinois statute, for example, provides that "no physician or health-care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health-care service which is contrary to the conscience of such physician or health-care personnel."³⁶ As we will see shortly, these statutes are hardly amenable to legal attack, so affected patients have little incentive to launch a judicial challenge—they are unlikely to succeed in an attempt to invalidate the conscience clause, so they will also fail in any attempt to hold the protected refuser liable.

On the employment front, conscience clauses offer significant protection that might not otherwise exist. As we saw above, the federal Church Amendment protects individuals employed by institutions receiving federal funding from employment discrimination, discrimination regarding staff privileges, and discrimination in admission to training and study programs, while several state statutes offer an even broader shield.³⁷ In fact, aside from the end-of-life cases involving refusal to withhold or withdraw life-sustaining medical care, which are often suits against institutions,³⁸ most cases involving the conscientious refusals of individual providers have been employment law cases.

In these suits, the health-care worker sues his employer for firing or demoting him after he has refused to provide a given service for moral or religious reasons. The matter is resolved through reliance on either conscience clause statutes or Title VII, a part of the landmark Civil Rights Act of 1964 that prohibits discrimination on a variety of bases including religion.³⁹ This may at least partially explain why doctors have not traditionally been involved in lawsuits on these grounds and

why nurses and pharmacists deal with this problem far more frequently: doctors are quite often self-employed and are more often explicitly protected by state law from negative employment consequences or loss of privileges related to their refusals. In the end, the statutes create a cause of action for physicians (and possibly for other health-care workers), but eliminate one for patients, if they ever had one at all.

This combination of factors offers a less-than-satisfying account of why public commentary specifically regarding physician refusals has not been more prevalent, since it seems that we should be talking more about whether conscience clauses applicable to physicians are appropriate or are in need of revision. But it does at least help to explain the state of existing case law. At first glance, the fact that doctors do not appear to be getting sued, fired, or disciplined for refusing to perform services on moral grounds might appear to indicate either that such refusals are not in fact a problem or that physicians do not actually need explicit protection of their conscience because it is available from some other source. However, that is emphatically not the case. While doctors may be able to avoid liability through careful rejection of potential patients and may glean some limited employment protection from Title VII, existing conscience clauses are doing something for physicians. Their most important role, however, may be concealed by the status quo.

The primary value of conscience clauses for physicians becomes visible upon consideration of the limitations on conscience that state licensing boards could feasibly impose in the absence of these statutes, which frequently prohibit licensing boards from discriminating against conscientious refusers. Under their police powers, states have broad authority to regulate the conduct of the medical profession, including the elements of training and capacity required for permission to engage in the practice of medicine. They have largely delegated this power to state medical boards, which determine the qualifications required to practice medicine in the state, including medical school graduation, postgraduate training, passage of various examinations, and the like.⁴⁰ Further, state medical practice acts authorize licensing boards to take disciplinary action against physicians engaging in unprofessional or dishonorable conduct, which the Federation of State Medical Boards suggests should be defined to include at least

(4) conduct likely to deceive, defraud or harm the public; (5) disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; ... (9) negligence in the practice of medicine as determined by the Board; ... (12) practice or other behavior that demonstrates an incapacity or incompetence to practice medicine; ... (35) violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation or agreement of the Board; (36) engaging in conduct calculated to or having the effect of bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board.⁴¹

Any one of these provisions could be read broadly to require a physician to provide even those medical services to which he or she is morally opposed. Physician refusal might conceivably be construed as unprofessional, likely to harm the public, disruptive behavior that interferes with patient care, negligence, incompetence to practice medicine, or conduct that could bring the profession into disrepute.

Without conscience clauses, licensing boards could take an even more direct route to limiting physician conscience. For example, in 1987 the New Jersey Board of Medical Examiners prohibited licensees from categorically refusing to treat a patient who was HIV+ or had AIDS when the physician possessed the skill and expertise to treat the condition presented.⁴² While this was a licensing requirement based on certain types of patients, absent any existing statutory protection against professional discipline resulting from conscientious refusal, it is possible that boards, prompted by patient access concerns, might demand that physicians provide certain services regardless of their moral objections as a condition for obtaining or retaining their license to practice. In fact, Nora O'Callaghan describes a hypothetical state law requiring all physicians licensed by the state to provide abortions without any basis for exemption, even on religious grounds, after a finding by the state that many of its counties lacked abortion facilities and that women were thus unable to avail themselves of their fundamental reproductive rights.⁴³

The question of whether such a statutory or regulatory obligation on individual professionals to provide abortion services (or any other medical care) upon request would survive a First Amendment challenge is a complex one, and it is largely fact based. The Supreme Court has

imposed various levels of scrutiny when reviewing claims that particular laws violate the First Amendment. In the free exercise context, it has upheld laws of general applicability that are neutral with regard to religion so long as the law has a rational basis. In *Employment Division v. Smith*, for example, the Court relied on precisely these grounds to reject a claim challenging a denial of unemployment benefits to plaintiffs who had been dismissed from their jobs as a result of religiously inspired peyote use.⁴⁴ In other First Amendment contexts, however, such as those involving laws apparently targeted at religion (rather than simply creating an incidental burden) and challenges based on the freedom of association or speech, the Court has engaged in a more stringent analysis, asking whether the law's restriction of a fundamental right is necessary to the accomplishment of a compelling government interest.⁴⁵

Because of the intricacy involved in First Amendment analysis, we cannot definitively conclude that O'Callaghan's hypothetical statute could withstand constitutional scrutiny,⁴⁶ particularly since it involves an affirmative requirement to do something rather than just a restriction on behavior that an individual might otherwise wish to undertake. What we can say, however, is that what she describes is a neutral law of general applicability that has the legitimate goal of improving patient care—the abortion service mandate would apply to all physicians and is not intended to target any particular religious group or practice, although it may have that secondary effect. We can also say that the government has a compelling interest in ensuring widespread access to reproductive medical services, although in light of the proposal explored in this book, we will see that it may become more difficult to argue that the goal of patient access could not be achieved by less restrictive means.⁴⁷

The fact-intensive nature of this area of law is demonstrated by a 2007 decision from the U.S. District Court for the Western District of Washington involving state pharmacy regulations, which will be discussed in more detail in chapter 4. For now, suffice it to say that these regulations do not explicitly bar pharmacists from refusing to fulfill legal prescriptions on grounds of conscience but preclude pharmacies from doing so. In the context of granting a preliminary injunction against enforcement, the court held that the regulations were neither neutral nor generally applicable, despite the facial satisfaction of both criteria.⁴⁸

Although the regulations apply to all pharmacists and pharmacies in the state, and to all types of prescriptions, the fact that they were explicitly prompted by religious refusals to dispensing “Plan B” emergency contraception led the court to conclude, somewhat questionably, that policymakers acted with the direct intent to burden free exercise rights. Additionally, although the regulations were overtly an attempt to improve access to a wide variety of prescriptions, a public welfare rationale that the court acknowledged could normally suffice to overcome the increased constitutional scrutiny leveled against laws intentionally and uniquely burdening religion, the court was not convinced that this was the true motivation here. Not only are there regulatory exceptions that allow continued inhibition of patient access on secular grounds, but the court also stressed that it had seen no evidence that access to care had truly been eliminated by the religious refusals of pharmacists. Thus, the court determined that on these facts, enforcement of the regulations would likely violate the First Amendment.

While this preliminary opinion of a lower court should not be given much weight, the case does at least indicate that the language, breadth and intent of an imposition on licensed health-care professionals to provide certain services can make all the difference. However, it certainly does not go so far as to suggest that any such service requirement would be inherently constitutionally impermissible.⁴⁹ In fact, the Court of Appeals of New York has upheld a law somewhat similar to that described by O’Callaghan, albeit one regulating institutions rather than individuals, that requires all employers who choose to provide insurance coverage for prescription drugs to also provide coverage for contraceptives, unless the employer’s organizational purpose is to spread religious beliefs, it primarily employs persons sharing those beliefs, and it qualifies as a nonprofit organization. This second condition prevents many faith-based organizations from falling within the statutory exemption, but the court found that the law is nonetheless permissible under both the federal and state constitutions since it is facially neutral and its primary (and genuine) purpose is to improve women’s health rather than to constrain religious activity.⁵⁰ The court also relied heavily on the fact that the plaintiffs were not required to provide prescription drug coverage at all, so they were not actually required to violate their religious beliefs.⁵¹

In this vein, it is essential to recognize that the courts have generally been less sympathetic to religious freedom claims made by those engaged in voluntary commercial activity, such as the practice of medicine, as opposed to directly religious activity, since the religious person could have theoretically made different professional choices that would not burden his or her beliefs at all.⁵² For example, while a person could not be excluded from a state-licensed profession simply because he or she belongs to a particular religious group, the Supreme Court refused to invalidate a requirement that those wishing to practice law in a particular state take an oath to support the state's constitution, despite the fact that the oath included an indication of willingness to perform military service.⁵³ If that was not a violation of federal constitutional protections of religious freedom, there is significant reason to believe that an analogous demand of willingness to perform certain medical services could also be a permissible imposition on physicians.

While this sort of care mandate would likely face political difficulties in state legislatures, the growing public dissatisfaction over refusals by health-care professionals to satisfy reasonable patient requests suggests that the adoption of such a requirement is not entirely unlikely. After all, physicians' general freedom to choose their patients and decide when to terminate their relationships is already constrained by laws and regulations prohibiting discrimination and otherwise protecting patients. These restrictions could likely be expanded to add conscientious objection to the list of unacceptable physician behaviors.

Beyond this apparent *permission* to avoid conscience clause protection, however, some argue that it *must* be avoided. These commentators claim that the coupling of conscience clauses with state licensure of health-care professionals should be regarded as impermissible state action in the denial of the constitutional right to be free from state interference in reproductive choices.⁵⁴ However, similar arguments have been largely rejected by the courts in other contexts. For example, the Supreme Court has held that heavy regulation of a private utility company and provision of a partial monopoly by the state were insufficient to render the utility a state actor,⁵⁵ and also that regulatory oversight by a state liquor board did not render the discriminatory actions of a private club state action.⁵⁶ Because conscience clauses simply allow professionals

to choose for themselves, but do not actually prohibit the choice to provide legal medical services, they are distinguishable from impermissible affirmative actions by the state to restrict reproductive autonomy or other protected freedoms. Notably, over the several decades of their existence, no state or federal conscience clause has been struck down as unconstitutional.

Whereas extant conscience clauses protect physicians from patients and employers, and most especially from licensing boards that might otherwise be able to exclude refusers from the practice of medicine entirely, we have now seen that these laws can be changed. Conscience clauses appear to be neither constitutionally mandated,⁵⁷ nor constitutionally prohibited, leaving state legislatures with ample room to strike a balance between the interests of both physicians and patients. Unfortunately, current conscience clause policy strikes the wrong balance—in fact, it offers hardly any balance at all, allowing physicians to refuse in too many situations without exception and without concern for the patient’s ability to access medical services. Of course, legislatures should not move to the other extreme, imposing the sorts of blanket requirements on physicians described above, but instead should seek an appropriate middle ground. Thus, the crux of this book is about finding that middle ground, and the policy it proposes is unlikely to run into constitutional resistance.

When *should* physicians have a duty to satisfy patient requests, when *should* they be able to refuse, and how *should* access concerns most appropriately be addressed? These are the crucial questions, but to answer them, we must first dispel some important misconceptions.

Where the Conscience Clause Debate Has Gone Astray

The battle lines have been clearly drawn, but unfortunately, responses to the conscience clause controversy tend to suffer from several fundamental problems. First, much of the existing discussion has inappropriately narrowed the issue to a focus on religious beliefs and associated objections. It often fails to recognize other important types of conscience, such as secular moral beliefs or, more important, understandings of professional ethics that also have a crucial role to play in the clinical

encounter between doctor and patient—and have the same, if not greater, potential to create access problems. A much broader conception of conscientious refusal is needed, one that will include refusals grounded in values that are widely held within the profession and have even been accepted as clinical standards, but that are not based exclusively on the profession's technical and scientific expertise.

For example, consider the surgeon who refuses to accept a patient unless that patient first agrees to undergo a screening procedure that carries some significant risks of its own in order to rule out greater risk factors that could severely complicate the surgery. That doctor is only looking out for the patient's safety,⁵⁸ but what he or she is effectively saying is “regardless of the risks you as a patient are willing to accept, I cannot in good conscience impose those risks on you.” This behavior is likely in accord with professional standards, and those standards are what drive the physician's refusal, rather than some religious objection to the surgery itself. However, that other doctors would also refuse does not diminish the fact that the refusal is nonetheless based on ethical beliefs about the level of acceptable risk that the patient may not share, rather than on some objective, indisputable determination as to which risks are too great.⁵⁹ Therefore, this is a conscientious objection, albeit one made at a professional level and labeled as an issue of professional integrity or the internal morality of medicine. The fact that it is made by a group rather than by an individual does not necessarily suffice to render it acceptable, and as we will see, may make it even less so. But this is precisely the sort of refusal that would evade consideration under the narrow, stricter understanding of conscience that has prevailed over most of the existing debate.

In other ways, the matter of conscience has been treated too expansively. As Martha Swartz notes, more than one-third of U.S. conscience clauses fail to state what constitutes acceptable grounds for refusal, and some are drafted so broadly or ambiguously that they could “equally protect the right of a health care professional to refuse to participate in a medical treatment because the procedure was scheduled too early in the morning or because the procedure was controversial.”⁶⁰ These grounds for refusal are likely already protected by the laws governing the doctor-patient relationship discussed previously and may in fact be

important, given that the ability to select one's patients and to define the scope of one's practice are both crucial freedoms that contribute to the establishment of a personally fulfilling career. However, Swartz is right to point out that they are not true expressions of conscience and should be dealt with separately—but how exactly can we differentiate conscientious refusals?

The sorts of refusals that appropriately fall under this heading may in fact be quite broad, and conscience itself is a slippery concept that has been defined as the ethical tug toward doing the right thing that becomes a central, dominating feature of one's motivation and self-identity.⁶¹ It is “the interior, quintessentially human voice that speaks to us of goodness and duty, the voice we must obey if we are to keep our integrity.”⁶² Descriptions of conscience often boil down to fuzzy claims that a person could not be convinced to do the thing in question for any price and to notions that if a person did some act, he just could not live with himself, look himself in the mirror, or fall asleep at night. However, there may be different intensities of true conscience that these descriptions do not seem to recognize.

Note that some commentators attempt to draw a further distinction between objections rooted in general moral grounds and objections truly based on conscience. For example, Kent Greenawalt describes a nurse who believes that plastic surgery is inappropriate because it is materialist and superficial, encourages cultural denial of aging, and wastes valuable resources. He suggests that she may have “moral reasons not to help in such operations, but the reasons do not amount to a conscientious objection, and they might not render her assistance an act against conscience.”⁶³

While this reasoning appears to focus on how deeply held the personal beliefs in question are, perhaps in an effort to address the intensity issue raised above, the line Greenawalt attempts to draw is not self-evident and, in fact, seems to get things wrong. Acting contrary to these beliefs *would* damage the nurse's integrity, though maybe less significantly than participating in some action that she considers to be an even greater wrong. Perhaps more importantly, even if not a crucial, inviolable part of her self-identity, this sort of objection contributes to the critical moral debate regarding the proper ends of medicine, the value of which is

discussed in detail in chapter 3. Thus, for our purposes, the phrase “conscientious refusal” ought to be defined broadly to include nearly every *normative* ground for objection to a medical service, even if philosophical definitions of conscience have traditionally been more restricted. However, we will see that not every type of conscientious refusal should be protected simply by virtue of being defined as such.

In contrast, refusals on *non-normative* grounds, such as personal convenience, accommodation of popular opinion merely to avoid controversy,⁶⁴ economic considerations regarding which services are reimbursed at the highest rates, or mere aesthetic distaste,⁶⁵ do not satisfy either of our criteria for conscientious refusal. They would not involve regret or self-loathing if the physician was forced to act, nor do they necessarily contribute to the important social debate about whether medicine is veering into ethically troublesome territory. Thus, two irksome cases can be excluded from our discussion entirely: the distasteful or inconvenient service and the difficult patient.

If a physician who finds abortions to be terribly boring but not morally objectionable has to perform one,⁶⁶ he may be disappointed or even frustrated, but he would not feel guilty about what he had done and would certainly not lose any sleep over it. Potentially more telling: if that physician were offered enough money, he might be tempted to make abortion procedures the entirety of his medical practice. Further, he is not making any socially valuable statement about whether abortions are good or bad, right or wrong, admirable or deplorable—instead, his conscience is morally neutral. Similarly, an obstetrician who just hates to get up in the middle of the night might opt only to perform cesareans or induced births that he could schedule according to his plans, but could assist in an unscheduled birth without compromising his moral integrity.

Likewise, a doctor faced with a particularly belligerent patient who misses appointments, chastises staff when he does show up, and generally detracts from the quality of care available to other patients, could choose to end the relationship because it is just too challenging. For example, in *Payton v. Weaver*, a California court held that a physician had no obligation to continue providing dialysis treatment to a patient who

was disruptive and uncooperative in a way that affected other patients and staff.⁶⁷ Nevertheless, continuing to provide such a patient with care would not necessarily be *wrong* from the doctor's perspective, and thus would not violate his conscience. In fact, refusing to treat such a difficult patient may be more ethically troublesome for the physician, particularly if he worries that the patient may not be able to access needed care from anyone else.⁶⁸

These nonmoral reasons are important and may in fact explain far more refusals of care (and potential access problems) than what can properly be understood as conscientious refusal, even on the broadest account. Whether or not they are valid and appropriate is an open question, but they are distinguishable from conscientious refusals and thus present unique questions that will not be addressed here.

Aside from these issues of scope, another significant problem with much of the existing commentary is that despite the fact that conscience clauses have expanded their reach in the decades since *Roe*, the debate has unfortunately never shed its abortion roots. In fact, several observers have labeled the issue a mere proxy for the quintessential culture war that is the long standing abortion controversy, noting that several of the main arguments have simply been recycled and are thus similarly destined for stalemate.⁶⁹ However, it is simply not the case that opponents of abortion will always be proponents of protecting conscientious refusal or that those who are pro-choice will be resistant to allowing doctors to avoid the provision of certain services. For example, a physician could be wholly opposed to withdrawing life-sustaining treatment from a patient in a persistent vegetative state, since he may feel compelled to save lives whenever possible, rather than to permit death. Nevertheless, the same physician may have no moral objection to abortion, perhaps because he does not believe that a fetus has personhood rights such that the procedure is still in line with his understanding of his professional obligations. A doctor could also foreseeably refuse to provide hormonal stimulation to an infertile woman who will not agree to selective reduction of high multiple pregnancies should that occur—that doctor would be refusing not to abort. This clearly demonstrates the difficulty with the proxy approach, for the arguments surrounding conscientious refusal and abortion will not always run parallel to one another.

The abortion focus is inaccurate and misleading in other ways as well, at least in part because it underestimates the nature of the problem. It may be the case that the archetypal image conjured in the minds of most people on hearing the phrase “conscientious objection” applied to the medical context is the physician (valiant or derelict, depending on one’s view) who refuses to perform an abortion. However, directing attention exclusively to that type of refusal will obscure a variety of other important breeding grounds for conflict. What about the physician who objects to assisted suicide or euthanasia should those acts be widely legalized or who objects right now to the withholding or withdrawal of life-sustaining care,⁷⁰ who refuses to satisfy a patient’s request for care that he believes would prove futile, or who will not operate on a patient who rejects blood transfusions because without them the surgery would be too dangerous? What of the doctor who will not supervise the lethal injection of prisoners or who refuses to monitor political detainees to ensure that they can continue to be tortured without dying?

These examples are only the tip of the iceberg, for technologies derived from embryonic stem cell research, procedures involving genetic manipulation, assisted reproduction, enhancement technologies, and other medical advances will greatly expand the breadth of procedures that physicians find morally objectionable. As Martha Swartz has noted, the combination of new technologies entering the medical scene and the increasing diversity of health-care providers has the potential to create a perfect storm: “It is likely that at least *some* health-care providers may object to the application of *some* technology to *some* patient on the basis of *some* religious or moral belief.”⁷¹ The bottom line is that more doctors and more patients are likely to find themselves affected in the relatively near future.

Thus, the stakes are high, and limiting the debate to tired abortion rhetoric could be quite dangerous if it prevents meaningful discussion of the broader propriety of physician refusals. Without a doubt, abortion is intricately involved in this issue, but it is essential that the conscience clause debate extract itself from that tangle. Otherwise, true compromise will remain impossible as both ideological extremes continue to shout past one another; indeed, that is precisely what we have seen so far. Instead, the debate can be more appropriately recast as an

issue of professionalism focused on clearly defining professional obligations, nothing more and nothing less.

While the myopic focus on abortion is a serious flaw hindering progress in this area, by far the biggest problem confronting the current debate over conscientious refusal in medicine is its uncritical, almost sensationalist, framing of the issue as one of competing rights.⁷² Patient advocates talk about their right to access desired, legal medical services, while those supporting the cause of some health-care professionals focus on their right to exercise personal conscience even while wearing their professional hats.⁷³ While it is unclear whether these arguments are referring to legal rights, as opposed to moral rights that could be far broader in scope, an unfortunate consequence of this competing-rights language is that it makes it quite difficult to reach any resolution.

When the debate is focused solely around rights, it is difficult to avoid the problem of rights as trumps—both sides of the debate claim important rights that defeat those of the other simply by virtue of the fact that they are rights.⁷⁴ As Jeremy Waldron and Thomas Hobbes have eloquently noted, “for people to demand that we treat *their* theory of rights as the one that is to prevail is ‘as intolerable in the society of men, as it is in play after trump is turned, to use for trump on every occasion, that suit whereof they have most in their hand.’”⁷⁵ Of course, this leaves no room for reasoned argument, explaining the all-or-nothing nature of many proposed solutions to the conscientious refusal dilemma.

More problematic, if patient advocates are using the term in the legal sense, is that American patients actually have very few rights that they can demand from health-care providers, rendering the rights-based argument insufficient to vindicate the sort of broad patient claims that have characterized the debate thus far. There seems to be some misconception that simply because something is legal (i.e., not prohibited), we must have a right to it. However, this sort of analysis proves far too much and is based on a failure to differentiate between positive and negative rights. If we understand positive rights to impose correlating duties or responsibilities on others to ensure that those rights can be exercised, then claiming a positive right to all that is legal cannot work. For example, it is legal for you to purchase your favorite orange juice, but if the company that manufactures that juice goes out of business or your

local grocer no longer sells the product, you have not been denied any right, for no one owes you any obligation to provide that particular orange juice. Legality on its own simply does not mandate universal availability.⁷⁶

If refusing physicians are in fact violating patient rights, something else must be at play, though, as we will see, it cannot be found in any legal source. First, patients have no clear constitutional rights to any affirmative care,⁷⁷ and certainly no right to affirmative care from any particular health-care provider.⁷⁸ Whether normatively appropriate or not, we saw previously that a woman has absolutely no positive right to abortion, but instead has only a negative right against unduly burdensome state interference in the choice to seek an abortion. Private behavior is not implicated at all,⁷⁹ and courts have repeatedly held that public institutions are not required to facilitate abortion in any way, including by offering or paying for it, and can even try to persuade women to choose other options.⁸⁰ Therefore, a physician's refusal to perform an abortion based on his or her own moral objections to the procedure violates no constitutional rights of the patient. Similarly, *Griswold* establishes no positive right to contraceptives, but rather provides a more restricted negative right against state laws prohibiting their use or sale.⁸¹ Finally, while patients do have constitutional rights to refuse medical treatment,⁸² they have no positive right to demand that any individual physician be the one to terminate treatment that has already been initiated.⁸³ As demonstrated by these examples, virtually all constitutional rights, especially when it comes to medicine, are "freedoms from" rather than "freedoms to." Thus, they cannot provide sufficient support for claims of patient rights against conscience clause protection for physicians.

Of course, the Constitution is not the only source of rights, and several statutes do provide patients with positive entitlements. However, these are relatively uncommon and certainly not pervasive enough to support a right against conscientious refusal. For example, the existence of Medicaid and Medicare benefit schemes creates positive entitlements to certain services for eligible individuals, but these entitlements are not physician-specific given that doctors are free to opt out of the programs. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) offers another positive right, and requires hospitals that have

emergency departments and participate in the Medicare program to provide medical screening and stabilizing treatment to all emergency room patients in a nondiscriminatory manner.⁸⁴ However, EMTALA does not extend beyond hospitals, and only questionably applies to individual physicians in covered emergency rooms.⁸⁵ Further, most states have no duty-to-rescue, or Good Samaritan, statute,⁸⁶ so that physicians not covered by EMTALA have no legal obligation to aid a patient in need of medical care absent a preexisting relationship between them.⁸⁷ Therefore, patients lack any legal right to emergency care from a particular physician, although most codes of professional ethics encourage physicians to provide emergency treatment and many state conscience clauses exempt emergency situations from the ambit of protected refusals.⁸⁸

Patients do have a common-law right to demand that physicians obtain their informed consent before embarking on any particular course of action,⁸⁹ and this right has been codified in many states.⁹⁰ Patients also have a common-law right of referral when their physician knows, or should know, that he lacks the requisite skill, knowledge, or facilities to treat the patient's ailment properly,⁹¹ although it is unclear that a conscientious refusal can be categorized in such a way. Finally, patients have a common-law right to be treated in reasonable accord with the standard of care and not to be abandoned by their physician once a doctor-patient relationship has been established, but have no legal claim on any physician before that point.⁹² Further, abandonment liability does not apply to a patient not in current need of continuing medical care, and even if the patient does require further medical attention, as alluded to earlier, the objecting physician must only ensure that the patient has sufficient notice of the physician's intention to terminate the relationship such that the patient herself can procure other medical attention.⁹³

The bottom line is that despite the arguments of conscience clause opponents who allege that refusers are violating patient rights of access, no such legal right exists. In fact, the lack of positive patient rights to health-care services is one of the major criticisms of the American health-care system. And because patients have so few legal rights, health-care professionals have a great deal of open space in which to exercise their own consciences even if they have no express legal right to do so.

However, while nearly all states have some statutory protection for physician conscience, creating a true legal right in those protected contexts, the current analysis must ignore such statutes because the propriety of their very existence is one of the major issues analyzed in this book. More important, we saw previously that legislatures have constitutional latitude in this area and could likely eliminate conscience clause protection altogether. Further, while doctors do have a federal statutory right against employment discrimination on the basis of their religious beliefs rooted in Title VII,⁹⁴ that right is extremely constrained, requiring no more than *de minimis* accommodation,⁹⁵ and is of no use to secular refusers. Therefore, while physicians currently have at least more *de facto* protection than patients, it is on at least somewhat shaky ground. In the end, it becomes clear that the “practice of medicine is a privilege . . . not a natural right of individuals.”⁹⁶

As should now be obvious, the legal rights starting point often used by both sides of the current debate does not provide solid, consistent, reliable protection of either party. It simply cannot do the work that is being asked of it, and a different paradigm for solving this dilemma is required. An alternative analysis of legal duties clearly will not get us very far, since if there are no legal rights, there are no legal duties. However, if we approach the problem in light of the *moral* obligations of professionals, as some commentators have done,⁹⁷ we will begin to understand what ought to be the case, rather than relying on what currently is, and can also avoid the problem of trumping. These moral duties will illustrate what moral rights both doctors and their patients can legitimately claim, which in turn will inform the analysis of what conscience clauses should really look like, and even whether they should exist at all. There are many conflicting and complementary understandings of a physician’s professional responsibilities, but once we recognize that the obligations of the profession as a whole may not precisely correspond to the obligations of the profession’s component members, we are on the road to an appropriate compromise.