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Philosophy and Theology: Notes on Conscience Protections for Health Care Workers

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PHILOSOPHY AND THEOLOGY

An operating room nurse arrives at her weekend call shift. It is morning at Mount Sinai Hospital in New York City, and Cathy DeCarlo comes to her assignment desk just as she has countless times in her five years at the hospital. But this morning is different. Cathy is assigned to circulate in a room where a twenty-two-week D&E [dilation and evacuation] dismemberment abortion will be performed on a live baby. Cathy promptly calls for clarification, noting that the hospital has known her religious objection in writing based on her Catholic faith since the day she was hired. The pregnant mother is diagnosed with preeclampsia, but the hospital did not designate the case as requiring immediate surgery, and the patient is not on magnesium therapy. The patient later presents in the operating room in a stable condition with blood pressure that is not near crisis level. Cathy's supervisor, who is willing to participate in such procedures, is available to assist. And Mount Sinai, one of the top ranked medical centers in the United States, receives hundreds of millions of federal health dollars every year, which require the hospital not to discriminate against employees who choose not to assist abortions if it would violate their religious beliefs. Yet despite Cathy's tearful pleas, her supervisors tell her she must immediately assist in the late-term abortion or she will be charged with insubordination and patient abandonment, threatening her job and her nursing license. (M. C. Mattox and M. S. Bowman, "Your Conscience, Your Right: A History of Efforts to Violate Pro-life Medical Conscience, and the Laws That Stand in the Way," *Linacre Quarterly*, May 2010)

Much is at stake in the debate about conscience protection. The contemporary debate has only intensified as all sides hope to codify their views in law.

Mark Wicclair's article "Is Conscientious Objection Incompatible with a Physician's Professional Obligations?" should be required reading for everyone involved in the discussion about conscientious objection in medicine (*Cambridge Quarterly of Health Care Ethics*, January 2009). Wicclair critiques the "incompatibility thesis," namely, the view that "anyone who is not willing to provide legally and professionally permitted medical services should choose another profession." One thing to remember about the incompatibility thesis is that it is a thesis, a proposition that is far from

self-evident and needs a justification. Wicclair considers a wide array of different arguments for the thesis, and then points out that each argument fails to justify it.

Consequentialist arguments hold that the incompatibility thesis is justified because it leads to greater well-being overall, especially for women seeking abortion and contraceptives. But if likely overall consequences guide our decision making, it is far from clear that the incompatibility thesis is justified, especially if “well-being” includes the moral integrity of health care professionals and if other means are available to secure the desired services.

Wicclair’s argument is strengthened by several considerations he does not mention. Vast numbers of people oppose abortion and believe it seriously wrong, at least in most cases. If performance of abortion is made a mandatory part of the medical profession, many doctors will be forced from the practice of medicine and a great number of talented young people will decide not to enter the profession (Wicclair, “Conscience-Based Exemptions for Medical Students,” *Cambridge Quarterly of Health Care Ethics*, January 2009). As J. W. Gerrard notes in the *Journal of Medical Ethics*, “The pragmatic reason is that professions may have problems recruiting and retaining talented members in certain specialties if they do not find a way to accommodate divergent views” (“Is It Ethical for a General Practitioner to Claim a Conscientious Objection When Asked to Refer for Abortion?” October 2009). Since women are more pro-life than men, since Latinos are more pro-life than non-Latinos, and since people of faith are more pro-life than atheists, self-selection against the practice of medicine would work against diversity among medical personnel. A similar point can be made about pro-life hospitals, many of which will shut down if forced to perform abortions: “615 Catholic hospitals account for 12.5% of community hospitals in the United States, and over 15.5% of all U.S. hospital admissions.”¹ Shutting down these health care facilities will increase the cost of health care and put thousands of lives at great risk. Those who care about women’s health should consider not just women who want abortions, but also women (and men and children) who have a wide variety of health care needs that will not be met if conscience protections for pro-life physicians and institutions are struck down.

If performing abortions is made a mandatory part of being a doctor, some people who believe that abortion is the intentional killing of an innocent person would become doctors anyway. This development would also be bad for the medical profession, since people who violate their consciences about such an important matter will be more likely to violate their consciences about other matters—such as improperly filling out insurance forms, lying to patients, or otherwise acting against what they take to be ethical behavior. This would harm the entire medical field. The practice of medicine would be further diminished by the public perception that physicians—not just as a group, but as individuals—are willing to engage in practices that the majority of Americans find seriously morally wrong. This would reduce the prestige of the profession and undermine the trust that ought to exist between doctors and patients. These considerations suggest that an appeal to consequences does not justify the incompatibility thesis.

¹U.S. Conference of Catholic Bishops, *The Catholic Church in America: Meeting Real Needs in Your Neighborhood* (Washington, DC: USCCB, 2006), 12.

Another possible justification of the incompatibility thesis arises from the professional obligations of physicians for the well-being of their patients. The professional obligations of physicians are characterized in different ways. One view noted by Wicclair (in “Is Conscientious Objection Incompatible with a Physician’s Professional Obligations?”) “specifies the end of medicine as *healing* and . . . characterizes the physician–patient relationship as one between a professional committed to healing and a vulnerable patient who is ill and seeks help from the professional.” But the conscientious objector can reasonably claim that abortion is not an act of healing, since pregnancy is not a disease. Furthermore, as Wicclair points out, a physician can be committed to healing but decline to perform all the procedures that are sometimes used in healing. Some doctors focus on one kind of specialty (dermatology) and so do not offer other kinds of treatments (hernia operations). They may decline to provide certain procedures simply because they prefer to provide some kinds of treatments and not others. If such demurrals to provide treatments are already permitted for reasons of mere preference, how much more should they be permitted for ethical reasons.

Perhaps the incompatibility thesis is justified because the physician has an obligation to place the interests of patients before his own interests. However, as Wicclair argues, this duty is not absolute. Clearly, the physician should sometimes put the interests of the patient before his own. In the midst of surgery, the doctor should not leave to play a round of golf. But the doctor need not make house calls, cancel vacations, charge less or nothing at all, or offer night-time appointments to accommodate patients’ schedules, although all of these may be in the interests of his patients. Wicclair writes, “Any reasonable criterion would have to distinguish among interests according to their importance or significance and moral weight; and a physician’s interest in moral integrity is a very important interest that has substantial moral weight.”

Another justification for the incompatibility thesis rests on reciprocal justice: “Physicians enjoy certain rights, privileges, and benefits as professionals. These include a monopoly to provide certain services, self-regulation, subsidized education and training, and government support for research.” This justification holds that in virtue of these privileges, physicians must provide requested services even if it violates their consciences.

Wicclair contends that considerations of reciprocal justice also fail to ground the compatibility thesis: “It is arguable that a requirement to provide services even when a professional has a conscience-based objection to doing so is no more reasonable than a requirement that physicians treat patients no matter how high the risk of death due to epidemics or bioterrorism. It is also arguable that more reasonable reciprocity-based requirements would set limits to risks and would permit conscientious objection with procedural requirements to protect patients, such as advance notification and referral. In any event, the reciprocal justice account fails to provide an unequivocal basis for the incompatibility thesis.” One can accept that reciprocal justice entails that physicians have certain obligations to society and to its ill members without holding that doctors should be forced to perform abortions or refer for them.

Yet another way to justify the incompatibility thesis is the promise model. On this view, a person entering a particular medical specialty has made a promise to future patients to provide the services that are typical and normal for the specialty: “In other words, individuals have a choice: become a member of a medical specialty

or subspecialty and promise to provide the corresponding normal range of services or, if providing any of those services violates one's ethical and/or religious beliefs, select another medical specialty or subspecialty or another profession (i.e., one that is compatible with the individual's ethical and/or religious beliefs)" (183). This justification, too, fails to provide unequivocal support for the incompatibility thesis: "Performing colonoscopies is a 'normal' or standard procedure within gastroenterology, but not all gastroenterologists perform colonoscopies; and delivering babies is a 'normal' or standard practice within obstetrics/gynecology, but not all obstetrician/gynecologists deliver babies. In neither case does a physician's failure to provide the service at issue constitute the breaking of a promise made upon entering her respective subspecialty." There are, of course, certain core services that various specialties provide, such as pelvic examinations in gynecology. However, it is implausible in a descriptive sense to claim that performing abortions is an essential element of being a gynecologist, since thousands of gynecologists have never and will never perform them. To claim that it is essential in an evaluative sense is to beg the question. It is also implausible in the extreme to hold that all obstetrician-gynecologists promise to perform abortions simply by virtue of becoming obstetrician-gynecologists, and if no promise has been made, then no promise is broken. Wicclair's article provides a telling critique of the case against conscience rights for health care workers.

Cases raised by Dan Brock challenge the view presented by Wicclair ("Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?" *Theoretical Medicine and Bioethics*, June 2008). Doctor A has deeply held racist beliefs and so refuses to treat persons of color who come into his practice. Doctor B becomes a Jehovah's Witness and refuses to perform blood transfusions even at the cost of a patient's life. Are such cases similar to conscientious objection to abortion or contraception?

Doctor A's case is not analogous, since it has to do with refusal to treat a certain kind of *person*, not a refusal to perform *certain kinds of procedures* for any kind of person. Discrimination against persons is morally different from discrimination against particular kinds of actions.

Neither is the case of Doctor B similar to conscientious objection to abortion and contraception. Aside from abortion to save the life of the mother (and as I have argued elsewhere, I know of no case where abortion properly defined—i.e., the intentional killing of the human fetus as a means or as an end—is necessary to save the life of the mother²), one difference between Doctor B and a physician who conscientiously objects to abortion is that a refusal to perform a transfusion leads to the death of the patient, but a refusal to perform an abortion does not lead to the death of a patient (either the mother requesting the abortion or the other patient, the unborn child). Likewise, not providing a prescription for contraceptives does not lead to the immediate demise of a patient, unlike a refusal to perform a blood transfusion. So it makes sense that a physician who refuses to perform blood transfusions should not be allowed to perform procedures in which blood transfusions may be

²Christopher Kaczor, *The Ethics of Abortion: Women's Rights, Human Life, and the Question of Justice* (New York: Routledge, 2011), 185–191.

necessary. Admitting this, however, does not mean that all doctors have a duty to facilitate abortion or contraception.

Brock holds that Doctor B should be told, “Transfusing patients when that is medically indicated is a central part of your role and responsibilities as an emergency physician. You freely chose that role knowing that this responsibility is an important part of it. If after doing so you have now adopted religious beliefs which prohibit you from carrying out this responsibility without violating your personal beliefs and moral integrity, then you must leave that role and the hospital would be justified in firing you if you do not.” To change the case slightly, for a gynecologist the choice would be to perform the abortion or find a new job.

In terms of abortion, this argument involves circular reasoning. Precisely at issue is whether performing abortions ought to be considered a central part of the role and responsibilities of the physician or health care provider. The question about what is and is not part of the role and responsibilities of health care providers is simply another way of putting the question about whether there is a duty to perform abortions. Those who argue for conscience protection claim that it is not a central part—indeed, that it is no part—of the role and responsibility of the physician to perform abortions; those who wish to override conscience protections in medicine say that it is. Appealing to the duties of physicians to care for patients merely begs the question rather than settling it one way or another.

On Brock’s view, a physician is required to provide certain services to patients: “This level of services should include all legal and beneficial medical interventions sought by patients.” But the debate in the medical community is precisely about whether abortion is a beneficial medical invention for patients. Refusing to perform an abortion is fully consistent with the goals of medicine, namely, to preserve or restore health, since pregnancy is not a disease. By contrast, refusing to perform a blood transfusion may cause a patient’s death and so is not consistent with medicine’s goals. Those in favor of abortion consider it a beneficial medical intervention; those opposed do not, since they believe they are treating two patients, one or (in the view of some physicians) both of whom will not benefit from the procedure. The question is partly what counts as a benefit, but more importantly *whose* benefit counts—the mother’s alone or that of the developing child within her.

Illustrating the division in the medical community is the contribution of Dr. Robert Orr, who critiques his medical colleagues in the American College of Obstetricians and Gynecologists in “Medical Ethics and the Faith Factor: The Endangered Right of Conscience” (*Ethics and Medicine*, Spring 2010):

ACOG erroneously maintains that negative patient autonomy (the right to refuse a recommended treatment) and positive patient autonomy (the right to demand a treatment) are morally equivalent. It is a well-established and long-standing tenet of medicine that the patient’s right to refuse is nearly inviolable, but a patient’s right to demand a specific treatment is subject to physician discretion and veto. Were this not so, patients could demand unnecessary surgery, and they would not require prescriptions for antibiotics or narcotics. Society has supported such professional refusals of procedures or drugs the physician believes to be deleterious to the patient based on patient beneficence. Similarly, society has until recently supported physician refusal based on his or her right of conscience.

To hold that negative patient autonomy, the right to refuse a recommended treatment, is absolute is not to say that positive patient autonomy, the right to demand a treatment, is absolute. Clearly it is not. The right to refuse treatment, at least for patients who are mentally competent, admits no exceptions. The right to get requested treatments or services admits multiple exceptions, such as unnecessary surgery and prescriptions for antibiotics or narcotics. If we hold that a doctor has the obligation to do whatever a patient requests, regardless of the physician's medical judgment, then our idea of a physician is radically different from what virtually everyone accepts.

Finally, critics of conscience protections, like ACOG, argue that health care professionals should be obligated to tell patients about abortion and contraception to ensure informed consent. ACOG is not entirely consistent, however, about the importance of sharing information with patients. As Orr mentions, "Edmund Pellegrino, chair of the President's Council on Bioethics, has noted the irony of this provision, since ACOG has gone to court to fight laws requiring abortion doctors to offer informed consent information to patients on the risks and alternatives to abortion."³

Like ACOG, Thomas May and Mark P. Aulisio argue that "if we take informed consent seriously, we must limit conscience-based refusal to provide such information, since allowing refusal could deprive patients of even knowing what options exist" ("Personal Morality and Professional Obligations: Rights of Conscience and Informed Consent," *Perspectives in Biology and Medicine*, Winter 2009). It is logically possible that not mentioning the existence of contraception and abortion could—in some imaginary world—deprive patients of even knowing these options exist. In the United States, the percentage of adults capable of giving informed consent who are unaware that contraception and abortion are options is approaching zero, and among those few who are unaware of contraception and abortion as possibilities, most of these, I suspect, would not give informed consent to them anyway. The mentally handicapped may be unaware that abortion and contraception are options, but such persons cannot give informed consent. Children are unaware that abortion and contraception are options, but they too cannot give informed consent (unless we suppose that they cannot give informed consent for sexual intercourse but *can* give informed consent to using contraceptives in sexual intercourse). Indeed, virtually no prescription or procedure provided by doctors is better known than contraception and abortion are, so it is not plausible to argue that patients have a pressing need to be informed of either. Given that both contraceptive use and abortion are elective, consistency would demand that patients also be informed of other elective practices so as not to be deprived of informed consent. But no one holds that all doctors must inform all their patients of breast augmentation, Botox injections, rhinoplasty, or face-lifts. Since neither contraception nor abortion restore a woman's health (because neither fertility nor pregnancy are diseases), there is even less reason to inform women of these procedures than there is to inform them about other elective procedures, at least some of which would restore health.

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³*American College of Obstetricians v. Thornburgh*, 737 F.2d 283, 297-98 (3d Cir.1984).