Virtual Mentor
American Medical Association Journal of Ethics
May 2007, Volume 9, Number 5: 362-364.

Health law
Duty to treat: conscience and pluralism
by Kayhan Parsi, JD, PhD

It's a shibboleth in Anglo-American jurisprudence that one has no duty to rescue. This may seem callous or even immoral, but, indeed, absent a fiduciary relationship, individuals typically have no legal duty to help others [1]. This was the holding in the early 20th-century case *Hurley v. Eddingfield* which wound its way to the Indiana Supreme Court [2]. In this case a pregnant woman, Mrs. Hurley, sought the services of her family physician, Dr. Eddingfield. Although no other physician was available, Dr. Eddingfield refused to see Mrs. Hurley and she eventually died. Did the court find that, because of Dr. Eddingfield's commitment to a Hippocratic ethic, he had an affirmative legal duty to treat this patient? Hardly. Rather, the Indiana Supreme Court stated that, "The [state licensure] act is a preventive, not a compulsive, measure. In obtaining [a medical license] the state does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept" [2]. The Supreme Court of Indiana was merely following the prevailing norms of the day—that a licensed physician had no legal duty to treat a patient who requested his or her services.

If we survey the development of 20th-century health law, we observe certain challenges to this laissez-faire approach to the practice of medicine. As legal scholar Sara Rosenbaum has noted, there have been significant challenges to the historical no-duty-to-treat rule, principally in the form of EMTALA (Emergency Medical Treatment and Active Labor Act) and various civil rights laws (notably the ADA [Americans with Disabilities Act]) [3]. Yet the AMA's *Code of Medical Ethics* states in principle VI that "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care" [4]. Physicians, then, in nonurgent settings, have the freedom to choose whom they wish to treat and the environment in which they provide medical treatment. What does this mean for the issue of conscience, something that has recently received great attention from the media as well as from various academics and bioethicists?

A 2007 article by Farr Curlin and colleagues, in the *New England Journal of Medicine* reported physicians' attitudes on this question [5]. The authors mention the flurry of legislative activity, especially the Illinois Health Care Right of Conscience Act, which protects health care professionals who exercise their moral convictions in the practice of medicine—even when doing so conflicts with their professional duties. Moreover, their study findings suggest that about 40 million Americans are

treated by physicians who believe they are not obligated to discuss treatment options they find morally objectionable, and nearly 100 million Americans are treated by physicians who do not believe they have an obligation to refer patients to physicians who may be able to accommodate their requests.

Recall that the AMA's principle VI states that a physician may choose whom he or she wishes to treat. Opinion 9.12 of the *Code*, however, states that "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination" [6]. Legally, physicians have no general duty to treat. Yet, it's clear that civil rights laws have made discrimination based on factors such as race or national origin invidious.

How do we balance a physician's sincere commitment to a certain moral belief with a patient's right to receive legal procedures or therapy (say, oral contraception) to which the physician is opposed? Should a pluralistic society allow individuals the freedom to express their conscience when doing their work? Consider the research scientist engaged in developing weapons. Can that research scientist opt out of weapons research based on his moral convictions? Or, can members of religious organizations (say, Jehovah's Witness or Quakers) be excused from military service if their conscience or religious tradition forbids it?

When one is working in health care, a number of professional, personal, religious and cultural norms come into play. When do we decide that one's moral convictions may excuse him or her from professional obligations? Although this may seem to call for ad hoc decision making, it does require a more systematic approach. Is one's objection based on well-recognized values in that religious tradition? Or should this even matter? Can one develop a sincere objection based on conscience that has no rooting in any religious values at all? We might expect that a pluralistic culture such as ours would tolerate and respect a wide range of views regarding specific kinds of health care procedures. Yet such tolerance must be balanced with patients' access to legally sanctioned procedures. The approach taken by some professional organizations seeks to strike a balance—allowing health care professionals to opt out of specific procedures but also requiring that they refer patients to another health care professional [7], thereby accommodating the conscience of individual health care professionals while allowing patients access to health care procedures that are legally available.

One last point deserves mentioning. It is possible that some professional roles may demand engagement in behavior that one believes is unethical. Take the example of the lawyer who works with criminal defendants. Would it be a valid exercise of conscience for a lawyer to habitually state that he or she did not wish to work with certain kind of defendants (sex offenders, say) on the basis of moral convictions? Or can an emergency physician consistently decline to treat patients who engage in sexual practices he or she find morally objectionable? We would be loathe to open the floodgates for professionals to opt out of their work roles whenever they had to

do something distasteful or even offensive to them. Rather, it's important for students considering professional careers to reflect upon the nature of their work. Can they, in good conscience, do the work required of their profession? If the answer is that the work itself creates such an internal conflict, perhaps the student should consider another specialty where such conflict does not readily arise.

References

1. The legal term "fiduciary relationship" connotes the highest duty of care, typically flowing from guardian to ward, agent to principal or attorney to client. *Black's Law Dictionary*. St. Paul, MN: West Group; 1999:640. Apparently, the Indiana Supreme Court did not believe such a relationship existed between Hurley and Eddingfield.
2. *Hurley v Eddingfield* 59 NE 1058 (Ind 1901).
3. Rosenbaum S. The impact of United States law on medicine as a profession. *JAMA.* 2003;289:1546-1556.
4. American Medical Association. Principles of medical ethics: principle VI. *Code of Medical Ethics*. Chicago, IL: American Medical Association; 2006:xlvii. http://www.ama-assn.org/ama/pub/category/2512.html. Accessed April 11, 2007.
5. Curlin FA, Lawrence RE, Chin MH, Lantos JD. Religion, conscience, and controversial clinical practices. *N Engl J Med*. 2007;356:593-600.
6. American Medical Association. Opinion 9.12 Patient-physician relationship: respect for law and human rights. http://www.ama-assn.org/ama/pub/category/8546.html. Accessed April 11, 2007.
7. Cook R, Dickens B. The growing abuse of conscientious objection. *Virtual Mentor*. 2006;8:337-340. http://www.ama-assn.org/ama/pub/category/16185.html. Accessed April 13, 2007.

Kayhan Parsi, JD, PhD, is an assistant professor at the Neiswanger Institute for Bioethics and Health Policy at the Loyola University Chicago Stritch School of Medicine. He is the graduate program director of an online master's program in bioethics and has taught courses on biomedical ethics and the law and justice and health care. He is a co-editor (with Myles N. Sheehan) of Healing as Vocation: A Medical Professionalism Primer *(Rowman and Littlefield).*

Related articles

Legal protection for conscientious objection by health professionals, May 2006

The growing abuse of conscientious objection, May 2006