

Virtual Mentor

American Medical Association Journal of Ethics
March 2013, Volume 15, Number 3: 257-262.

OP-ED

The Limits of Conscientious Refusal: A Duty to Ensure Access

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What is the role of conscience in medicine? Some have argued that physicians who have conscientious objections to providing certain services have a responsibility to avoid entering specialties in which their objections would arise. Indeed, some argue more strongly that those who willingly enter a specialty knowing of conflicts have forfeited claims for protected refusal, since they would have been free to avoid the situation altogether by choosing another specialty [1]. After all, it is said, medicine is not just any business: it is a licensed monopoly, and with licensure comes heightened responsibilities.

Patients—especially those in rural areas or those in emergency situations—often lack the ability to choose who will care for them; and those who do have options should not have to face the burdens of finding—or suddenly shifting to—clinicians who can meet what the profession itself regards as a legitimate need. Given all this, fairness requires that patients be protected from the harms that clinicians' conscientious objections can engender by making provision of all services regarded as core by the specialty a condition of professional licensure.

We appreciate and applaud the desire to protect patients' access to important services, and we certainly agree that health care professionals have a responsibility to reflect on and explore ahead of time moral issues likely to arise in specialties when making career decisions. But we do not agree with such a stark interpretation of the terms of membership in a given area of practice. Medicine by its very nature intersects with some of the deepest matters in life about which good and reasonable people disagree. Provision of need through one lens is commitment of the gravest moral wrong viewed through another. We cannot expect to find canonical agreement on issues of perennial complexity; to limit the guild to those who concur with the full range of attributed rights of provision is, we believe, bad for medicine and the patients it aims to serve.

For one, it risks radically reducing the number willing to go into specialties that already face critical shortages [2]. Areas such as obstetrics and end-of-life care can ill afford to lose compassionate, talented, and skilled practitioners—some of whom have profound moral misgivings about interventions the profession as a whole endorses. Inclusion of such practitioners, moreover, is important to sustaining the field of medicine as a dynamic one, open to and benefiting from ongoing dialogue among its members about morally complex issues. Finally, patients who share moral objections to certain interventions may feel most comfortable being cared for by

like-minded practitioners. We risk alienating not just clinicians but patients with policies mandating that medicine be practiced only by those who are willing to act in accordance with a particular worldview.

Instead, we believe that society is best served by an approach that combines a progressive understanding of patients' needs, a nuanced determination of when those needs translate into claims of services from specific providers, stringent standards for genuine conscientious objection, and an approach that balances protection of minority views with the urgency of patients' needs.

When Do Patients Have a Reasonable Expectation of Provision?

The first factor in discussing issues of conscientious objection is determining when patients have what is called a reasonable expectation of provision. There are some services that, if valued by certain patients, are not among those we regard as core health needs. Further, even when we believe a service is one that patients deserve access to, this does not yet mean they have reasonable expectation to receive it from a given clinician. For example, it is now widely agreed that patients with life-limiting illnesses deserve access to medical care supportive of dying at home; but patients without access to hospice specialists have a complaint against the medical system, not a right to receive home-based palliative care from their particular internists.

Determination of reasonable expectation is complex, but includes consideration of the nature of care offered, the burdens that declining would impose on patients given reimbursement structures and the like, and the realities of patient vulnerabilities in ongoing clinical relationships.

To illustrate, consider the widely discussed cases of contraception and abortion. Many of us believe that a woman's access to control over reproduction, in the form of contraception and legal abortion, should be a core part of medical services available to women. Having the option to control whether to gestate, to give birth, to become a parent is of central importance to women in maintaining bodily integrity and authorship over their lives. Further, data show that access to medical means of reproductive control can have profound effects on health, outpacing the importance of such basics as access to antihypertensives in determining health outcomes and improving lives [3]. The fact that contraception and abortion are options not approved of or sought by every woman does not lessen their centrality to those women who do seek them. For those who seek it, access to contraception can be as fundamental to well-being as access to adequate pain relief; access to supportive and compassionate legal abortion as fundamental as access to medical support at the end of life.

From whom do women have reasonable expectation of contraception and abortion provision? We would argue that patients clearly have a reasonable expectation of contraception provision from those who provide well-woman care, given the centrality of contraception to many women's lives. If a clinic offers well-woman care, it would be strange, and more than incidentally burdensome to many, to find

that one cannot get a prescription for contraception as part of this care. A woman who goes to a well woman clinic—who may have saved scarce dollars, taken time off of work or found child care, arranged transportation to travel across town, or who has established a relationship and level of comfort with the clinic—has a reasonable expectation that one of the things she will be able to get if desired is counseling about and a prescription for contraception.

Abortion is more nuanced, especially in the context of prenatal obstetric care. Some obstetricians and midwives see their role as partnering with women in the enterprise of growing and delivering a baby. To such practitioners, a woman's decision to abort because she has changed her mind about becoming a mother, for instance, may be seen as ending that particular *obstetrics* relationship—ending the enterprise they were jointly engaged in—rather than as opting for a procedure she is entitled to receive as part of that relationship.

But in truth, matters quickly get more complex. As seasoned practitioners know, factors can emerge within the obstetrics relation over the course of even a strongly desired pregnancy that may shift a woman's thoughts about the wisdom or desirability of continuing the enterprise as initially envisioned: a prenatal diagnosis of significant fetal abnormality; the development of health complications for the woman; tensions between the interests of one and the other with obstetrical complications, such as threatened endometritis at the threshold of viability. Some women who enter a pregnancy sure they would never terminate may decide differently when deliberating in the context of a vividly specific difficulty. Having partnered with her obstetrician to that point—having shared hopes, fears, questions, and concerns, having agreed to monitoring and screening tests—a patient faced with devastating news might well have a reasonable expectation that that caregiver would be by her side through a safe and compassionate abortion, if not by performing it, then by assuring it through partnership with physicians identified ahead of time.

What Are the Standards—and Limits—of Conscientious Objection?

There are, then, many services that patients have reasonable expectation that a given clinician or clinic will provide. To say that a patient has a reasonable expectation of access either by direct provision or responsible assurance, though, is not yet to say that the patient has *right* of provision. Instead, it establishes a presumption of access to the service from the clinician, strongly limiting the kinds of reasons that are acceptable for declining. Mere preferences, or considerations of cost, are not sufficient basis. Instead, declining requires meeting the very high bar of genuine conscientious objection.

In our view, conscientious objection is a category that is often poorly understood, used broadly to refer to any sense of distaste or moral unease. If conscientious objection is to serve as a legitimate counter to reasonable expectations, though, it must be a category that brings with it stringent, specific, and compelling standards. In our view, conscientious objection should reflect a *deeply considered* position, not merely a gut feeling; based on a *scientifically accurate* view of the facts, not

assumptions about them; that provision or assurance would be a *grave wrong*, not just an ethical compromise. Further, that conclusion should be based on a moral position that can be accorded *respect*, even by those who disagree. This last is a substantive issue; its determination is as difficult as it is inescapable in a pluralist society and something that evolves with society's understanding of the contours of fundamental needs and rights.

Genuine conscientious objection, in short, is not something that can be lightly invoked. It brings with it a strong burden of reflection, exploration, and assessment, including cognizance of the diversity of views on the subject within one's moral or faith tradition. It carries with it responsibilities to confirm one's scientific understanding—for instance, of the causal pathways by which Plan B contraception actually works. Its legitimate exercise, moreover, brings very strong obligations in its wake. Those who would claim objector status take on strong and proactive efforts of disclosure, so that patient burdens are minimized and implied judgments about a specific patient's circumstance avoided.

Finally, we believe that there are limits to protection of even the most deeply grounded conscientious objection. One such limit is a requirement to provide accurate medical information. Patients have not just a reasonable expectation, but a right, to receive accurate information and counseling on all legal and medically safe options from their clinicians. The reason is a simple one. Core to medical communication is a fundamental asymmetry of knowledge between physician and patient; crucially, this is increased by a lack of knowledge on the patient's part about what she does not know. Patients are thus not in a position to be able to assess the import or implications of a clinician's disclosure that there is information their conscience precludes them from sharing. Medical professionals do not have the right to curtail the patient's knowledge or exploit its limits based on their moral worldviews.

Protection of conscientious objection, in our view, should also be limited by the urgency of an individual patient's situation. Consider, for instance, maternal-fetal medicine specialists (MFMs). Such physicians will predictably encounter women for whom continued pregnancy is literally as likely as not to lead to maternal death. One cannot reasonably become such a specialist, we believe, unless one is willing, at least, to assist patients in seeking abortions. Far stronger than mere referral, responsible assurance requires identifying ahead of time a willing and qualified physician who can provide timely and compassionate care. If the MFM cannot in conscience perform an abortion, he or she has an obligation to direct patients to qualified and willing physicians when pregnancy termination is chosen, assuring that they are well cared for in the process.

Or again, consider obstetricians on call in labor and delivery or emergency departments. A pregnant woman who goes to a hospital hemorrhaging badly at 20 weeks has not just a reasonable expectation but a right to be induced if she so desires and not wait hours—with its attendant risks of emotional trauma, infection,

transfusion—while a willing physician is searched for. If an obstetrician knows she will be the only qualified clinician in a situation, particularly such an emergent situation, he or she needs to be willing to perform medically indicated abortions with care and compassion or not place him- or herself in the position of gatekeeper.

Finally, disclosure of conscientious objection requires a model of the clinical encounter that is infused with compassion and respect. Communication of conscientious objection should be, first and foremost, a statement about the physician, not the patient or her circumstances. Discussions should be compassionate, respectful, and resolutely first-personal: for instance, “Based on my own faith tradition, I am not able to help you with that. What I can do is answer any medical questions you might have about the procedure, and give you information about its availability.” After all, a core premise for protecting conscientious refusal is that the issue at hand is one on which deeply good and reasonable people disagree. The clinician can indicate what her conviction disallows her from doing without questioning the integrity or moral stature of the patient.

The requirements for and limitations to conscientious objection are surely complex, shaped by myriad factors including how high the stakes are for the patient, how robust the provider’s grounds of objection, how predictable the conflict, to name just a few. Our point here is not to fully arbitrate the scope of the limits, but to argue that medicine will perforce need to confront them. For needs in medicine intersect with conflicts over values not just incidentally or occasionally, but deeply and persistently. Those conflicts, as vexed as they are, need to be faced with care—and mutual respect.

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