CONSCIENTIOUS OBJECTION IN HEALTH CARE

Historically associated with military service, conscientious objection has become a significant phenomenon in health care. Mark R. Wicclair offers a comprehensive ethical analysis of conscientious objection in three representative health care professions: medicine, nursing, and pharmacy. He critically examines two extreme positions: the "incompatibility thesis," which holds that it is contrary to the professional obligations of practitioners to refuse provision of any service within the scope of their professional competence; and "conscience absolutism," which holds that they should be exempted from performing any action contrary to their conscience. He argues for a compromise approach that accommodates conscience-based refusals within the limits of specified ethical constraints. He also explores conscientious objection by students in each of the three professions, discusses conscience protection legislation and conscience-based refusals by pharmacies and hospitals, and analyzes several cases. His book will be a valuable resource for scholars, professionals, trainees, students, and anyone interested in this increasingly important aspect of health care.

MARK R. WICCLAIR is Professor of Philosophy and Adjunct Professor of Community Medicine at West Virginia University and Adjunct Professor of Medicine, Center for Bioethics and Health Law, University of Pittsburgh. He is the author of *Ethics and the Elderly* (1993).

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An Ethical Analysis

MARK R. WICCLAIR

CAMBRIDGE UNIVERSITY PRESS

CAMBRIDGE UNIVERSITY PRESS
Cambridge, New York, Melbourne, Madrid, Cape Town,
Singapore, São Paulo, Delhi, Tokyo, Mexico City

Cambridge University Press
The Edinburgh Building, Cambridge CB2 8RU, UK

Published in the United States of America by Cambridge University Press, New York

www.cambridge.org
Information on this title: www.cambridge.org/9780521514316

First published 2011

Printed in the United Kingdom at the University Press, Cambridge

A catalogue record for this publication is available from the British Library

Library of Congress Cataloguing in Publication data
Wicclair, Mark R., 1944– author.
Conscientious objection in health care : an ethical analysis / Mark R. Wicclair.
p. cm.
Includes bibliographical references and index.
ISBN 978-0-521-51431-6 (hardback) – ISBN 978-0-521-73543-8 (pbk.) 1. Medical ethics. 2. Conscientious objection. 3. Refusal to treat. I. Title.
[DNLM: 1. Ethics, Clinical. 2. Refusal to Treat – ethics. 3. Conscience. 4. Delivery of Health Care – ethics. WB 60]
R725.5.W53 2011
174.2–dc22
2010048731

ISBN 978-0-521-51431-6 Hardback
ISBN 978-0-521-73543-8 Paperback

For Lucy and David

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Preface

The subject of this book is conscientious objection in health care. Although conscientious objection historically has been associated with military service, it has become a significant phenomenon in health care. Some physicians, nurses, and pharmacists have refused to provide or assist in providing goods and services for reasons of conscience. Many of these conscience-based refusals are related to the perennial and sometimes controversial issues of sex/reproduction and death. Examples in the former category include abortion, sterilization, contraception, and assisted reproduction. Examples in the latter category include palliative sedation (the practice of sedating terminally ill patients to unconsciousness until death) and forgoing medically provided nutrition and hydration. Novel technologies, procedures, and therapeutic measures also have occasioned conscience-based refusals by health care professionals, and can be expected to do so in the future. Recent examples include conscience-based objections to participation in embryonic stem cell research, genetic testing and counseling, and donation after cardiac death (retrieving organs after life support has been withdrawn from patients who do not satisfy the neurological or whole brain criterion of death).

In this book, I offer an ethical analysis of conscientious objection in three representative health care professions: medicine, nursing, and pharmacy. There are several reasons for considering these three professions together. First, from the perspective of conscientious objection, the three professions are interdependent. On the one hand, physician conscience-based objections can affect the practice of pharmacists and nurses. On the other hand, conscience-based objections by pharmacists and nurses can affect physicians insofar as they rely on pharmacists to fill prescriptions and nurses to implement care plans. Second, many conceptual and ethical questions and issues related to conscientious objection are similar for each of the three professions. For example, no matter the profession, it is essential to understand what distinguishes refusals that are conscience-based from those that are not

and to identify the ethical reasons for accommodating conscience-based refusals. These are among the topics that I explore in Chapter 1. Third, since there is considerable overlap in the core professional obligations of physicians, nurses, and pharmacists, similar ethical guidelines apply to conscience-based refusals by practitioners in each of the three health care professions.

This work is the culmination of a project that began about ten years ago when I wrote my first article on the subject of conscientious objection in health care (Wicclair 2000). My interest in the subject was stimulated by what struck me at the time as a paradox. Ethical guidelines on forgoing life-sustaining treatment issued by a number of recognized professional bodies such as the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983), The Hastings Center (Anonymous 1987), and the American Thoracic Society (American Thoracic Society 1991) stated that practitioners were not obligated to follow those guidelines if they did not accept them because of their personal ethical or religious beliefs. I observed a similar phenomenon in relation to hospital policies. When ethics committees on which I served formulated a policy, it was standard practice to grant an exemption to practitioners with conscience-based objections. At the time, I was puzzled by the seemingly inconsistent message about ethical standards and obligations. On the one hand, a guideline or policy might leave no doubt that option *x* (e.g. forgoing life-sustaining treatment) is the ethically right option in certain contexts. On the other hand, by allowing health care professionals to refuse to effect option *x* if they have conscience-based objections, the guidelines seemed to permit practitioners to refuse to do the right thing. If option *x* in a certain context is the ethically right option, then doesn't it follow that health care professionals are ethically obligated to bring it about? Shouldn't guidelines and policies insist that everyone – regardless of their personal ethical or religious beliefs – do the right thing?

I have come to recognize that this framing of the issue is overly simplistic. From an ethical perspective, option *x* may be the ethically right option for a patient. However, securing option *x* for the patient may not require that a particular health care professional effectuate it. For example, suppose the ethically right option for a patient is to withdraw medically provided nutrition and hydration (MPNH). Depending on the circumstances, however, effectuating that option and providing appropriate medical care may not require the attending physician to personally manage the withdrawal of MPNH and the subsequent care of the patient. All that may be required is

for the attending physician to refrain from providing inappropriate care, withdraw from the case, and facilitate a transfer of the patient to a physician who is willing to withdraw MPNH and manage the patient's subsequent care. Accordingly, it may be possible to achieve the ethically right outcome for the patient without compromising a practitioner's conscience. A key question, then, is whether accommodating health care professionals' conscience-based refusals when it does not prevent a patient from receiving ethically appropriate medical care from another practitioner is compatible with the professional obligations of physicians and other health care providers.

Conceptions of professional obligations in relation to conscience-based refusals fall within a continuum. At one extreme, advocates of what I refer to as the "incompatibility thesis" maintain that it is contrary to the professional obligations of physicians, nurses, and pharmacists to refuse to provide any legal good or service within the scope of their professional competence. At the other extreme, advocates of what I refer to as "conscience absolutism" maintain that health care professionals should be exempted from performing any action that is contrary to their conscience, including providing information and referrals. I criticize both of these extremes and defend a compromise approach that provides some accommodation for conscience-based refusals but only within the limits of specified ethical constraints. According to the compromise approach I advocate, when a health care professional refuses to provide or assist in providing a legal good or service within the scope of her competence for reasons of conscience, the refusal is compatible with the practitioner's professional obligations only if it does not present an excessive impediment to a patient's timely and convenient access to the good or service. I now believe that this compromise approach satisfactorily addresses the aforementioned paradox.

I consider several possible accounts of the professional obligations of physicians, nurses, and pharmacists in Chapter 2, and I argue that conscience absolutism is incompatible with most, if not all, of those accounts; none unequivocally supports the incompatibility thesis; and most, if not all, favor a compromise approach. I present and defend a compromise approach in Chapter 3. Practitioners within each of the three professions have core professional obligations that provide the basis for constraints on the exercise of conscience. These include an obligation to respect patient dignity and refrain from discrimination, an obligation to promote patient health and well-being, and an obligation to respect patient autonomy. These core professional obligations justify limitations on the exercise of conscience in relation to discrimination, patient harms and burdens, disclosing options,

referral and/or facilitating a transfer, and advance notification. Determining whether the corresponding ethical constraints are satisfied in particular cases is in part context-dependent. For example, whether or not a burden or harm is *excessive* depends in part on the seriousness and urgency of the medical condition and the timely availability of other providers. In Chapter 3, I illustrate the context-dependent nature of ethical constraints on the exercise of conscience by applying them to several cases.

Beyond their obligations to patients, health care professionals have obligations to colleagues, other professionals, and employers. I also examine these obligations in Chapter 3; they justify additional ethical constraints on the exercise of conscience by physicians, nurses, and pharmacists.

Conscience-based refusals have not been limited to individual practitioners. Pharmacies and health care institutions (e.g. hospitals) have also cited ethical and/or religious beliefs to justify refusing to provide a good or service. For example, pharmacies and hospitals have refused to stock and dispense emergency contraception (EC), and hospitals have refused to permit abortions, sterilization procedures, and forgoing MPNH. I examine refusals by pharmacy licensees and hospitals in Chapter 4, and I argue that such refusals also are subject to context-dependent ethical constraints.

Students of medicine, nursing, and pharmacy and residents can object to participating in educational activities for reasons of conscience. In Chapter 5, I present reasons for offering conscience-based exemptions to students and residents. I also identify several ethical constraints on such exemptions.

The primary focus of the book is on ethics. Accordingly, with the exception of the final chapter (Chapter 6), I do not address the legal rights and obligations of health care professionals in relation to conscientious objection. In that chapter, I consider so-called "conscience clauses," which offer legal protections to health care professionals who refuse to provide goods or services for reasons of conscience. Somewhat paradoxically, I argue, conscience clauses offer both too much and too little protection of conscience. They offer too much protection insofar as they do not apply the ethical constraints that I present in Chapter 3. They offer too little protection insofar as they protect only conscience-based *refusals* and do not accommodate health care professionals who believe that they have a conscience-based obligation to provide a good or service that is prohibited by legal and/or institutional rules.

Given the importance of the issue and the interest it has sparked, it is not surprising that there is a substantial amount of literature in each of the three professions on conscientious objection. However, my primary aim is to offer a sustained account of a justifiable approach to conscientious refusals

by physicians, nurses, and pharmacists, and not to provide a comprehensive review of the conscientious objection literature in each profession. Accordingly, uncited works do not reflect a judgment that they are unimportant or without merit. Rather, their omission reflects my judgment only that citing them would not significantly advance the primary objective of the book.

Many people have given me valuable advice, assistance, and support. I am deeply grateful to the following persons for providing helpful comments on all or part of a draft of the book: Thomas Mappes, David Barnard, Pamela Grace, Mary Elizabeth Happ, Arthur Jacknowitz, Daniel Shapiro, Jessica Wolfendale, Matthew Talbert, Ralph W. Clark, Ernani Magalhaes, and Nathan Placencia. For their generous and helpful responses to my requests for references to pertinent literature and other information, I would like to thank David Brushwood, Kathy Cerminara, Gabriella Gosman, Pamela Grace, Mary Beth Happ, Arthur Jacknowitz, Anne Drapkin Lyerly, Alan Meisel, Valerie Satkoskie, Keith Voogd, and Douglas White. I also am grateful to Thomasine Kushner for giving me an opportunity to present preliminary drafts of sections of the book at several yearly International Bioethics Retreats.[1] Beyond these opportunities, she has been a consistent source of support and encouragement. I also appreciate Farr Curlin's invitation to participate in a conference on Conscience and Clinical Practice at the University of Chicago MacLean Center for Clinical Medical Ethics.[2] Chapter 2 grew out of my presentation for that conference. I am grateful to West Virginia University, and in particular, the Eberly College of Arts and Sciences, the Philosophy Department, and Sharon Ryan, the Department Chair, for a sabbatical leave to enable me to work on the book and for additional support. I also have benefitted from the support of the University of Pittsburgh Center for Bioethics and Health Law and its director, Alan Meisel. Finally, I want to thank Hilary Gaskin at Cambridge University Press for encouraging me to write this book.

[1] Revised versions of two presentations were published in the *Cambridge Quarterly of Healthcare Ethics*: (Wicclair 2009: 14–22), and (Wicclair 2010: 38–50).

[2] A revised version of my presentation was published in *Theoretical Medicine and Bioethics*: (Wicclair 2008: 171–85).