Justified Conscientious Objection

Frank P. DeVita

Columbia University

December 2016

Introduction

Doctors and pharmacists are professionally and ethically obligated to provide healthcare services, and their doing so is a necessary condition for the possibility of a functioning of the healthcare system. If a doctor or pharmacist refuses to deliver care or dispense medication on grounds of "conscience," this means he or she puts their personal beliefs against the well being of the patient. Consequentially speaking, this creates a barrier to care or medication, which can be construed as both beneficial and detrimental. From a deontological point of view, refusal of service by doctors and pharmacists is problematic because it undermines the essential components of a working healthcare system, however, it may nevertheless be justified on a case-by-case basis. Ultimately, however, conscientious objection in healthcare is a barrier to access to healthcare services, and the value of prohibiting access must be justified in order to justify conscientious objection. In what follows, we will explore 4 different conscientious objection scenarios, consider points from the bioethical literature on conscientious objection in healthcare in order to articulate an "all things considered" point of view on conscientious objection by doctors and pharmacists.

Scenario 1

In Scenario 1, a pharmacist refuses to carry Plan B (emergency contraception, EC) and refuses to refer a patient seeking Plan B to any other pharmacist who will dispense the medication. In this case, it could be argued that the pharmacist has a right to refuse to stock or refer for EC, for example, if the pharmacist personally believes that dispensing EC is immoral and unethical because it eliminates the possibility of a human life. In favor of the pharmacist's refusal, one may argue that an individual is not required to compromise their fundamental personal beliefs for the sake of their professional role, nor are they obligated to take actions that will result in events that violate their beliefs or ethical constitution, and therefore that the pharmacist is not obligated to stock, dispense or refer for Plan B emergency contraception, nor is he or she obligated for referring a patient to another pharmacist who will dispense Plan B. This logic is largely consequentialist, protecting the pharmacist from being responsible for any Plan B-mediated prevention of new life.

Against refusal, we can realize that emergency contraception is mechanistically *not* an abortive measure (i.e. does not end a formed human life), but rather prevents fertilization, the event that can be rationally defined as the earliest possible beginning of a human life, and therefore that the pharmacist's position is unreasonable. The pharmacist may hold beliefs that contradict with their professional role, however the pharmacist must examine those beliefs against the pharmacology of the medication they refuse to dispense. Plan B works by (a) stopping the release of an egg from the ovary, (b) preventing fertilization of the egg or (c) preventing egg implantation into the uterus. In any case, the mechanism of action of Plan B does not directly abort a fertilized egg. Rather, it prevents fertilization or implantation. Therefore, refusal on grounds of "conscience" (i.e., personal beliefs) about the nature of conception and the ethics of emergency contraception is untenable.

Scenario 2

In Scenario 2, a pediatrician's office posts the following message:

> *Dear Parents: The physicians in this practice are deeply committed to the standard sequence of early childhood vaccinations (e.g., for smallpox, measles, mumps, whooping cough…) whose efficacy and safety have been scientifically proven. If you do not share this view, then our pediatric practice is not for you.*

In this case, the pediatrician's office posting of a commitment to the standard course of childhood vaccinations is a definitive statement on the office's commitment to scientifically proven medical practice. By making the statement public, they refuse to deliver non-standard, unproven pediatric care or, alternatively put, refuse to *not* deliver standard, clinically proven medical care. The pediatrician office's refusal to deliver non-standard care is supported by scientific and medical research and a scientific point of view, however, it also stands at odds with the office's obligation to deliver care to the patients who request it.

One argument in favor of the office's refusal may be based on the history, nature and conduct of medicine. Medicine is an art and a science. As such, its practice is driven by the creative and systematic application of scientific conclusions reached through experimentation, analysis and validation. As a practice, the pediatrician's office has decided to not assume the risks and put stock in the efficacy of a non-standard, non-vaccination approach to pediatric care. This is reasonable because there is not sufficient information available to properly weigh the risk and benefits of the course of care the office refuses to administer. Therefore, the pediatrician office's declaration is valid from medical and scientific perspectives. Moreover, vaccination practice is a public health measure that has eradicated deadly infectious diseases and curbed deaths and harm to individuals on a global

scale. Lastly, those seeking non-vaccinatory childcare are not asking for a healthcare service but rather the omission of one, further underscoring the office's right to refuse inaction. Vaccination has proven efficacy, and, again, there is not sufficient evidence to argue that pediatric care without vaccination is beneficial. The pediatrician office's refusal is therefore also bound up with a commitment to the greater good *qua* public health and deontologically sound.

It may also be argued that the pediatrician office's refusal to deliver non-standard care is unethical because it does not conform to the wishes of patients seeking non-vaccination pediatric care. One taking this position may contend that the pediatrician's office is a site of healthcare service delivery with the patients being its customers, and therefore is obligated to deliver care in the manner requested by the patient. (This becomes problematic if the wishes of the patient contradict the practice's preferred mode of healthcare delivery.) This position against the refusal of the physician office is further strengthened if the office is located in a rural area where there are few, if any, other medical practices locally available. If these conditions obtain, there is a strong argument against the office's right to refuse. That is, since they are they patient's primary site of medical care, it is logical on some view to hold that the office is obligated to cater to the wishes of their patients, or at least be open to some mutually acceptable compromise.

Scenario 3

In Scenario 3, a physician in Oregon has a patient who has gone through the procedures and protocols specified by Oregon's Death with Dignity Act and who is requesting a prescription for a lethal dose. The physician declines to comply with that request and refers the patient to another physician who is known to be willing to do so, provided the proper procedures have been followed. In this case, there is a sound argument for the physician's refusal to mediate euthanasia and referral

to a colleague. The refusing physician may hold a personal belief (like our pharmacist earlier) that it is impermissible to take a human life despite the wishes of its owner. Unlike the pharmacist however, the physician is willing to refer his patient to another willing party. This is in stride with the Hippocratic oath ("nor will I fail to call in my colleagues when the skills of another are needed"), and does not obstruct the delivery of care desired by the patient. Although the physician refuses to comply with the patient's request, he does not let himself become a barrier to care, upholds his own personal beliefs *and* remains committed to the wishes of the patient by providing a referral. This case is a paradigmatic example of the ethical challenge in medicine, and a doctor behaving as such (i.e., refusing to deliver care he or she is ethically opposed to but being willing to refer), is an archetype for the optimal course of action when dealing with a hotly controversial healthcare practice.

It may also be argued that although the physician in this scenario is willing to refer his patient seeking a lethal dose to another physician, provided all procedures and protocols are properly followed, that the physician's refusal to deliver the requested care is unethical. This is especially true if one holds an anti-paternalistic model of the physician-patient relationship to be true. In such a model, the patient dictates what care they desire and the doctor is obligated to cater to those wishes, despite his or her ethical qualms, personal beliefs or other variables that may underscore a refusal to carry out a particular procedure or prescribe a particular drug. If this model obtains, then it follows that the physician in this scenario is required to deliver the care requested by his patient, despite his opposition to it.

Scenario 4

In Scenario 4, a surgeon declines to perform an operation on the ground that the potential health-benefits are slight while the probability of the patient dying during the surgery is great. In this case, like the others, there is logical support for and against the refusal of the physician. An argument for refusal is that because of the low benefit compared to the high risk (i.e., death) of the procedure being requested by the patient, it stands to reason that the physician in is not obligated to deliver care that has a high probability of a negative outcome. The physician's duty is to preserve or maintain health, and performing a high-risk procedure with little to no probable benefit for the patient is a direct contradiction to this commitment. Therefore, the physician's refusal is ethically justified.

An argument against refusal is dubious, however can nevertheless be made. It's reasoning would mirror that applied to the argument against refusal in the euthanasia case above. One may argue that the physician is in an ant-paternalistic relationship with his or her patient, and is therefore obligated to deliver care as requested. However, this particular case has an additional variable—the high risk to low benefit ratio. In this case there is a high likelihood that harm will be done to the patient, so this argument becomes much harder to make, as it also conflicts with core bioethical principles, namely non-maleficence and beneficence. That said, one could still make the argument that patient autonomy generally takes absolute precedence in a healthcare setting. As such, one could (however unsoundly in my view) rationalize that, despite the high risk of the procedure in question, the patient should ultimately have full command over their life and healthcare, and it would follow that the physician's refusal to perform the high-risk procedure is unjustified.

The Case for Justified Refusal

In evaluating any ethical dilemma, we aim to reach a definitive conclusion about morality and right action. However, it is a practical reality that there will be ways to justify opposing points of view that precipitate from any moral problem. Therefore, often times the most reasonable solution for an ethical dilemma is an intermediate position. After exploration of the 4 scenarios above, the dialectics expounded for each make it clear that an intermediate position in which refusal *qua* conscientious objection is not justifiable in healthcare in some cases but justifiable in others may be the pragmatic a solution we seek.

Cantor and Baum (2004) state, "most people can agree that we must find a workable and respectful balance between the needs of patients and the morals of pharmacists," (p2010) and discuss that there are three possible solutions conscientious objection by pharmacists: an absolute right to object, no right to object and a limited right to object. They go on to discuss many of the points made in analysis of the scenarios above, for instance that an absolute right to object respects the autonomy of healthcare providers but diminishes patient autonomy. Cantor and Baum point out also state that same inequality exists in the absolute restriction condition in the other direction, i.e. that no right to object undermines the professional autonomy of the healthcare provider, and that this means we should articulate an intermediate position that allows for pharmacists to object. Their solution is that objecting pharmacists should be able to object, provided they are willing to provide referrals for patients to access the care they seek. That is, the value in the referral solution expressed by Cantor and Baum is that objecting providers remove themselves from the causal chain involving the patient and the service or medication that they are ethically opposed to delivering. This position seems ethically ideal, as it accommodates both the beliefs and ethical constitution of the provider as well as the wishes of the patient.

Card (2007) states that the intermediate position involving accommodation of the pharmacists' right to object and the solution of referrals to a non-objecting pharmacist articulated by Cantor and Baum is "reasonable on it's face, [but] problematic on closer inspection." (p9) He explains that the referral solution proposed by Cantor and Baum may not be possible in rural and underserved areas, making conscientious objection a non-trivial barrier to healthcare. He continues with this argument on access, expounding that the role of the pharmacist is to facilitate access to medications and ensure their safe use, not to morally evaluate the patient's decision to use a particular medication. Card also makes the point that there is no net causal difference between cases in which a pharmacist objects and refers versus the pharmacist refusing and not referring because the pharmacist remains involved in the causal chain of dispensing the medication in question in wither case, just one degree removed. Card's objection to the intermediate position advanced by Cantor and Baum based on this problem of access is a strong case against the position, and his additional argument from causation is an even stronger case against the intermediate solution. Card's point is that the referral solution actually does not remove the objecting provider from the causal chain, as they become the entity through which the patient will ultimately gain access to the drug or service they seek, which puts the intermediate solution in dire straits despite its ethical desirability.

Julian Savulescu (2006) takes a strong line against conscientious objection by doctors and pharmacists, generally stating that, "doctors cannot make moral judgments on behalf of patients." (p294) He goes on to offer several reasons why a medical professional's personal beliefs are not proper grounds for conscientious objection in healthcare, including concerns about inefficiencies resulting from objecting providers, inconsistent care patterns, the nature of being a physician and discrimination. Regarding inefficiencies, certain healthcare services become difficult to obtain if providers have a right to object, which create a barrier to care. Similarly, only select groups of patients may receive care if a physician refuses to treat certain patients or certain conditions,

resulting in imbalanced access to healthcare and further (unnecessary) barriers. Moreover, he points out that physicians commit themselves to caring for patients' illness (which also applies to allied health professionals), and this care should not be impeded by the nature of the patient's illness or the physician's personal beliefs. Savulescu's position addresses conscientious objection on a higher, more sociological level than the granular explorations of pharmacist objection detailed by Card, Cantor and Baum, however his points do drive home the case against conscientious objection in general as they supplant the personal beliefs of providers with concern for patient welfare, which should always take precedence in any healthcare scenario. As such, the intermediate view is exposed as problematic because it also generates a dialectic with arguments in favor and against that could be leveraged differently across an array of possible scenarios.

The three authors discussed above all offer interesting ideas that can contribute to arguments for an against the intermediate position on conscientious objection in healthcare, i.e. that refusal on grounds of conscience is not justifiable in certain cases but justifiable in others. Cantor and Baum offer the template intermediate solution of objection followed by referral, however their solution is problematic because it is not universally applicable. An integral component to their intermediate solution is that referrals are possible. However, referrals are not possible in rural or underserved areas, as emphasized by Card. This means that the intermediate solution they expound is not compatible with a significant percentage of healthcare scenarios. Nevertheless, the intermediate position offered by Cantor and Baum is an elegant solution for conscientious objection problems in developed areas with robust healthcare resources because it allows the provider to remain committed to their personal beliefs, but does not impede access to care or medication because it leverages the referral system. This way, the health of patients is not adversely affected, and the patient experiences continuous uninterrupted care. Therefore, we can conclude that the best position is indeed that conscientious objection in healthcare is justified in certain cases but not in

others. The variables that will help determine whether objection is justifiable or not will come from specific scenarios, which implies that the problem of conscientious objection may be insoluble generally and best evaluated per individual case.

All Things Considered

In his *Nichomachean Ethics,* Aristotle explores the nature of goodness and concludes that something is good if it performs its function in accordance with virtue. He uses the example of a lyre player, explaining that we can differentiate a good lyre player from a bad one because the good lyre player performs his function, playing the lyre, well. We therefore learn from Aristotle that something is called "good" because it functions well, and we can apply this principle to many other contexts to evaluate a broad spectrum of moral questions.

The function of any healthcare system is to deliver care to its patients. This function is dependent on the proper functioning of its parts. The proper functioning of a healthcare system's parts, in turn, is dependent on the individuals occupying the professional roles that perform the actions required to deliver care and medicines to a patient, i.e. the function of the healthcare system. In requesting a healthcare service, a patient engages the healthcare system and as such, the component parts of the system must function well for the patient to receive their requested service. Therefore, those individuals in the various professional roles that facilitate healthcare delivery are necessary conditions for the possibility of patient care, and, in my view, are therefore obligated to cater to their patients.

The doctor takes an oath to "apply, for the benefit of the sick, all measures [that] are required… prevent disease whenever [they] can…remain a member of society, with special obligations to all my fellow human beings…[and above all, to] not play at God." The pharmacist

takes a complementary oath to, "consider the welfare of humanity and relief of suffering as [their] primary concerns…assure optimal outcomes for [their] patients and hold [themselves] and [their] colleagues to the highest principles of [their] profession's moral, ethical and legal conduct." Assuming a role that exercises proximal control over clinical care and medication delivery under an oath, the doctor and pharmacist are both interfaces through which the patient directly receives dispensed medication and are therefore integral components to a properly functioning healthcare system. A counterfactual reinforces this as true: If all pharmacists and doctors refused to deliver care or dispense medications to patients, then the healthcare system would fail. In this condition of refusal, the intent of healthcare generally, and therefore the well being of the patient, are fundamentally compromised. Therefore, doctors and pharmacists cannot rightly refuse to provide a service requested by a patient on grounds of "conscience" because if this were to happen universally, the healthcare system would crumble. However, this is not to say that that healthcare providers are always obligated to grant their patients' wishes. They can use information, probability of outcomes, risk and moral judgment to rationally inform their actions in particular ethical dilemmas they may encounter when caring for patients to determine the best course of action on a case-by-case basis.

My view is that conscientious objection is problematic in healthcare for deontological, epistemological and practical reasons. Nevertheless, it may be justified in some cases such as the high-risk surgery scenario presented above. In such situations, it is irrational to put a patient in danger of death or other negative outcome that undermines their health generally. If we consider the action of conscientious objection as the act of refusal to deliver care to a patient based on personal beliefs, then transform this into a universal imperative (i.e., imagining the condition in which all healthcare providers could refuse service based on personal beliefs), then it becomes clear that the delivery of healthcare in general becomes dependent on the personal beliefs of healthcare

providers and not on the illnesses of patients. If providers base their objections on information and facts, then this problem dissolves, as information-based healthcare decision-making and rational refusal supported by evidence is, in my view, a perfectly reasonable state of affairs. Epistemologically speaking, the condition of conscientious objection implies that one system of beliefs (of the provider) takes precedence over another (that of the patient), which again removes illness and health from the equation and turns the dynamics of healthcare into a battle of beliefs between provider and patient. This is untenable because while healthcare is a compassionate enterprise, its possibility is conditioned by scientific conclusions and community consensus. Pragmatically speaking, the function of a healthcare professional is to deliver health care responsibly, and it is naïve to assume that assuming this type of role in society will always be ethically comfortable. Considering all these ideas, we can only safely assume that there will be some scenarios in which objection will be justified, however in my view, the justification should not come from conscience, but rather from information and rationality.

References

Cantor J and Baum K. The Limits of Conscientious Objection: May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception? *The New England Journal of Medicine* 351;19:2008-2012.

Card RF. Conscientious Objection and Emergency Contraception. *The American Journal of Bioethics* 2007;7(6):8-14.

Savulescu J. Conscientious objection in medicine. *British Medical Journal.* 2006;332(7536):294-297.