SOUNDING BOARD

Physicians, Not Conscripts — Conscientious Objection in Health Care

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"Conscience clause" legislation has proliferated in recent years, extending the legal rights of health care professionals to cite their personal religious or moral beliefs as a reason to opt out of performing specific procedures or caring for particular patients. Physicians can refuse to perform abortions or in vitro fertilization. Nurses can refuse to aid in end-of-life care. Pharmacists can refuse to fill prescriptions for contraception. More recently, state legislation has enabled counselors and therapists to refuse to treat lesbian, gay, bisexual, and transgender (LGBT) patients,[1] and in December, a federal judge issued a nationwide injunction against Section 1557 of the Affordable Care Act, which forbids discrimination on the basis of gender identity or termination of a pregnancy.[2]

Health care conscience clauses are legislative tools that are used to insulate professionals from performing tasks that they personally deem objectionable. Legislative protection for conscientious objection in health care emerged at the height of conscientious objection to military service. Supporters of conscientious objection in health care explicitly referenced "the right of conscience which is protected in our draft laws" to justify and legitimate it.[3] Yet conscientious objection in health care diverges substantially from conscientious objection to war. We highlight the differences and argue that, in most cases, professional associations should resist sanctioning conscientious objection as an acceptable practice. Unlike conscripted soldiers, health care professionals voluntarily choose their roles and thus become obligated to provide, perform, and refer patients for interventions according to the standards of the profession.

THE HISTORY OF CONSCIENTIOUS OBJECTION TO MILITARY SERVICE

Conscientious objection initially emerged in the context of war. From the time of colonial militias to the Civil War, legislatures allowed recognized religious pacifists, such as Quakers, to avoid bearing arms by hiring substitute soldiers or paying substantial fines. The Selective Service Act of 1917 eliminated financial penalties and the hiring of substitute soldiers while demanding alternative service; those who refused noncombatant work faced imprisonment. By World War II, obtaining "conscientious objector" status no longer required membership in a peace church (i.e., a recognized pacifist religious organization or group), but it still demanded that the objector accept a noncombatant military role, such as that of a medic, or work in a Civilian Public Service camp or a psychiatric hospital. During the Vietnam War, the Supreme Court redefined conscientious objection to encompass nonreligious pacifists, but it forbade "selective conscientious objection" — that is, objection to particular wars or duties — and continued to require alternative service.[4]

Conscientious objection to military service has five distinctive characteristics: first, it objects to state-mandated conscription; second, it opposes an unchosen combatant role; third, it requires "all or nothing" (as opposed to selective) objection; fourth, it subjects the sincerity of the objection to external assessment; and fifth, it disciplines the objector by requiring the objector to perform alternative service or undergo imprisonment. Although the U.S. draft ended in 1973, the provisions for and regulation of conscientious objection remain intact for men who are required to register with the Selective Service System.

THE HISTORY OF CONSCIENTIOUS OBJECTION IN MEDICINE

As the Vietnam War waned, conscientious objection in health care accelerated. In 1973, in response to the legalization of abortion by the Supreme Court in *Roe v. Wade*, Senator Frank Church

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(D–ID) — who opposed the Vietnam War — sponsored the first federal health care conscience clause. Passed with bipartisan support, the Church Amendment allowed federally funded physicians, nurses, and hospitals to refuse to perform abortions or sterilizations on the basis of religious or moral convictions or policies.[4-6] Within a year after passage of the amendment, 28 states had enacted similar conscience clauses.[6] In 1974, the National Research Service Award Act allowed individual persons to recuse themselves from participating in federally funded research that would conflict with their religious or moral convictions.[6,7]

In the 1990s, amidst the culture wars, a flurry of health care conscience legislation emerged anew.[7] The 1996 Coats Amendment allows physicians and students to abstain from abortion training and maintains accreditation of residency programs that do not provide abortion training.[6,7] The Balanced Budget Act of 1997 allows insurance companies to deny coverage, reimbursement, and referrals on the basis of religion or moral convictions.[5,6] The 2005 Weldon Amendment forbids funding "any institutional or individual health care entity" — ranging from clinicians to hospitals and insurers — that discriminates against those who refuse to perform, offer referrals to, or cover abortion services.[6,7] In January 2009, the Bush administration issued the expansive Provider Conscience regulations, which protected a person from mandatory participation in any treatment or research that was "contrary to his religious beliefs or moral convictions." The Obama administration curtailed these provisions to apply to only abortion and sterilization, as demarcated in the Church Amendment.[6] The Trump administration, including Secretary of Health and Human Services Tom Price, has declared an interest in expanding health care conscience regulations, though the exact forms remain unknown.[8]

Despite the temporal relationship of conscientious objection to the Vietnam War and conscientious objection to abortion, conscientious objection in health care differs from conscientious objection to military service in five important ways: first, it objects to professional practices, not state-mandated conscription; second, it occurs within the context of a freely chosen profession; third, it allows selective objection to professionally accepted interventions; fourth, it accepts objection without external scrutiny; and fifth, it shields the objector from all repercussions and costs. In addition, health care conscience clauses are one-sided, protecting only those who refuse to treat patients, not those whose conscience compels them to provide medically accepted but politically contested care.[9,10] In contrast, proponents of war could enlist before being drafted, a prerogative that continues today with the all-volunteer military.

THE VIEWS OF PROFESSIONAL SOCIETIES

Physicians, nurses, pharmacists, and therapists occupy different roles with distinct but complementary responsibilities. All their professional health care societies accept the same professional role morality: patients' well-being is their primary interest. Despite this ethical stance, guidance from professional societies regarding conscientious objection varies considerably, but all tend to accept rather than question conscientious objection in health care.

The American Medical Association (AMA) is internally inconsistent on conscientious objection. In its Code of Medical Ethics,[11] the AMA insists that "physicians' ethical responsibility [is] to place patients' welfare above the physician's own self-interest" (Opinion 1.1.1). Consequently, physicians must treat patients with human immunodeficiency virus (HIV) infection and AIDS (Opinion 1.1.2).[12] Likewise, the AMA forbids discrimination in selecting or rejecting patients on the basis of "race, gender, sexual orientation, or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care" (Opinion 1.1.2). Conversely, it permits physicians to refuse to treat patients who are seeking care that is "incompatible with the physician's deeply held personal, religious, or moral beliefs" (Opinion 1.1.2[a]). The AMA "Physician Exercise of Conscience" (Opinion 1.1.7) equivocates, asserting the ethical importance of "fidelity to patients and respect for patient self-determination" but then reversing itself by arguing that "physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs." This freedom is somewhat restricted; it should not "unduly burden" patients, does not apply in emergencies or to patients' end-of-life decisions, and cannot countenance discrimination or disregard for "basic civil liberties."[11]

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The American Pharmacists Association is similarly ambivalent. In 1994, it reinforced its view that "the well-being of the patient [is] at the center of professional practice."[13] In 1998, however, it approved "the individual pharmacist's right to exercise conscientious refusal."[14] The American Nurses Association likewise allows nurses to "refus[e] to participate on moral grounds."[15]

Other professional societies have upheld the primacy of the patient when care is being given. In 2007, the American College of Obstetricians and Gynecologists enunciated that "with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests." Thus, in the case of abortion, "conscientious refusals . . . should be accommodated only if the primary duty to the patient can be fulfilled" directly or through referral.[16] The American Psychological Association, which prohibits discrimination against patient populations, insists that when laws and professional ethics conflict, "psychologists must meet the higher ethical standard."[17]

THE PROFESSIONAL ROLE MORALITY OF HEALTH CARE PROVIDERS

Health care providers have a primary interest: to promote the well-being of patients.[11,13,15-19] As the AMA "Principles of Medical Ethics" states, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."[11] Thus, as with attorneys and other professionals bound by fiduciary duties, health care professionals — when providing care — must subordinate their self-interest and personal beliefs to patients' well-being and professional decision-making (AMA Code of Medical Ethics, Opinions 1.1.3[d] and 1.1.4).[11] When financial conflicts of interest surface, patients' needs supplant physicians' monetary gain (Opinion 11.2.2).[20] Similarly, the AMA argues that physicians should not participate in executions, even if they personally accept the morality of capital punishment (Opinion 9.7.3).[21] Physicians also must care for wounded enemy soldiers and refuse to participate in torture, regardless of their personal political allegiance (Opinion 9.7.5).[22-24]

The profession, rather than the individual practitioner, elucidates the interpretation and limits of the primary interest (AMA Code of Medical Ethics, Opinion 1.1.1[11]); it does so through a process that the philosopher John Rawls characterized as reflective equilibrium.[17,25] Professionals debate issues until there is consensus but not necessarily unanimity. The locus of ethical discussion centers not on the effectiveness of interventions but on the appropriateness of professional involvement: should health care professionals provide or refuse specific interventions? Certain interventions, such as the provision of antibiotic agents for bacterial infections or treatments for accidental poisoning, are uncontroversial. Others, such as homeopathic interventions, are considered to be outside the province of professional medicine.[26] Still others, such as assisted suicide and the medical use of marijuana, are currently controversial and subject to debate about whether they are medically appropriate.[27,28] In a vibrant profession that is constantly gaining new knowledge and developing new interventions, there will always be disputes. But these debates focus on medical value and suitability, not political or cultural acceptance. As with all humans and human institutions, including the Supreme Court, professional societies can make mistakes. In the past, the medical profession sanctioned eugenics and classified homosexuality as a disease. But the profession also uses reflective equilibrium to self-correct. This dynamic process establishes professional obligations for health care providers regardless of their personal beliefs.

No one is forced to be a physician, nurse, pharmacist, or other health care professional or to choose a subspecialty within their larger field. It is a voluntary, individual choice. By entering a health care profession, the person assumes a professional obligation to place the well-being and rights of patients at the center of professional practice. This obligation is not unlimited, but exemptions are reserved for cases in which there are substantial risks of permanent injury or death.[12]

In a professional context, personal religious convictions are secondary. Thus the Jehovah's Witness surgeon cannot refuse to allow blood transfusions during the surgery. The Jewish pharmacist cannot withhold pills that are made with nonkosher gelatin. The Mormon nurse cannot refuse to treat alcoholics. Indeed, Sweden, Finland, and Iceland do not allow public health care professionals to deny "a legal medical service for reasons of [conscientious objection] when the service is part of their professional duties."[29]

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PROFESSIONAL ROLE MORALITY AND CONSCIENTIOUS OBJECTION

Health care professionals are not conscripts, and in a freely chosen profession, conscientious objection cannot override patient care.[30] No matter how sincerely held, objections to treating particular classes of patients are indefensible — regardless of whether the objections are based on race, gender, religion, nationality, or sexual orientation (AMA Code of Medical Ethics [Opinion 1.1.2]).[11] A health care professional cannot provide medical services for a white, heterosexual person and conscientiously object to providing the same services to a Hispanic, Muslim, or LGBT person.

Objection to providing patients interventions that are at the core of medical practice — interventions that the profession deems to be effective, ethical, and standard treatments — is unjustifiable (AMA Code of Medical Ethics [Opinion 11.2.2][11]).[29-32] Making the patient paramount means offering and providing accepted medical interventions in accordance with patients' reasoned decisions. Thus, a health care professional cannot deny patients access to medications for mental health conditions, sexual dysfunction, or contraception on the basis of their conscience, since these drugs are professionally accepted as appropriate medical interventions. To distinguish mental health, sexual health, and LGBT health as nontherapeutic realms of medicine, or as medicine in service of "lifestyle" choices, is to substitute cultural and political judgments for professional medical knowledge. The pathophysiology of psychiatric conditions is not fully understood, but the profession accepts that addiction, depression, and schizophrenia have physiological origins.

Similarly, distinguishing interventions for established medical conditions from interventions for "lifestyle choices" is untenable. If gluttony leads to type 2 diabetes, are glucose-lowering agents lifestyle interventions? If sloth contributes to heart disease, are statins lifestyle interventions? Lifestyle plays a role in these conditions, but few people would deny that diabetes and heart disease are medical conditions that require medical management by health care professionals — and still fewer people would accept conscientious objection as a reason to withhold treatment for diabetes and heart disease, even if these conditions arise from the "deadly sins" of gluttony and sloth. Mental health, LGBT health, and sexual health are no different. To classify addiction, gender reassignment surgery, or the use of contraception as "lifestyle choices" that merit conscientious refusal is to allow personal moral judgment to masquerade as medical practice.[29-33] In their private lives, health care professionals may condemn alcohol, gender dysphoria, or nonprocreative sex along with gluttony and sloth, but in their role as health care professionals, they must provide the appropriate interventions as specified by the medical profession.

There is, however, a specific role for conscientious objection. It provides limited recourse in professionally contested interventions — that is, interventions about which the health care community is debating whether participation is appropriate or not. For example, physician-assisted suicide is currently legal in five states, and whether physicians should participate in it is at the center of a robust ethical debate among health care professionals.[27] (Conversely, although abortion is politically and culturally contested, it is not medically controversial [AMA Code of Medical Ethics (Opinion 4.2.7)].[11] It is a standard obstetrical practice.[34-36]) Health care professionals who conscientiously object to professionally contested interventions may avoid participating in them directly, but, as with military conscientious objectors, who are required to perform alternative service, they cannot completely absent themselves from providing these services. Conscientious objection still requires conveying accurate information and providing timely referrals to ensure patients receive care.

In emergency situations, health care professionals must provide medically indicated services in spite of personal objections (AMA Code of Medical Ethics [Opinion 1.1.1]).[11] This well-accepted duty also illustrates the difference between professionally disputed and personally contested interventions. The obligation to treat a woman who is at risk for tubal rupture and hemorrhaging from an ectopic pregnancy, for example, shows that ending some pregnancies is a standard, undisputed medical procedure.

Health care professionals who are unwilling to accept these limits have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession. To invoke conscientious ob-

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jection is to reject the fundamental obligation of health care — the primary duty to ensure patients' continued well-being. It places a professional's personal beliefs above professional standards. It is a conflict of interest, albeit a nonfinancial one. And, as with all choices, there are consequences. The military conscientious objector faced real penalties — fines, imprisonment, or alternative service — for resisting conscription. The health care professional who wants to prioritize personal values over professional duties must choose a less personally fraught occupation. Making this choice constitutes a substantial penalty. However, it emphasizes that physicians' personal commitments cannot outweigh the interests of patients, and it underscores that, unlike a conscripted soldier, no one is forced to enter the health care profession.

Health care professionals work within a matrix of legal, institutional, and professional constraints and obligations, but the primary commitment to patients remains the foundational responsibility of health care. Thus, collectively, the profession — not politicians, judges, or individual practitioners — sets its contours. Defending professional integrity means limiting conscientious objection to professionally disputed interventions and rejecting conscience clauses that target patient populations.

CONCLUSIONS

The proliferation of conscientious objection legislation in health care violates the central tenet of professional role morality in the field of medicine: the patient comes first. Although this legislation ostensibly mimics that of military conscientious objection, it diverges considerably. Viewing conscientious objection in health care as analogous to conscientious objection to war mistakes choice for conscription, misconstrues the role of personal values in professional contexts, substitutes cost-free choices for penalized decisions, and cedes professional ethics to political decisions.

Although the political process may continue unabated, and courts may deem conscience clauses to be legal, it is incumbent on professional societies to affirm professional role morality and authoritatively articulate the professional ethical standards to which all licensed health care professionals must adhere. Laws may allow physicians, nurses, pharmacists, and other health care workers to deny patients treatment or to refuse to care for particular populations, but professional medical associations should insist that doing so is unethical.

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Cascade

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