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Conscience and its Consequences: Reconciling Practitioner and Patient Rights

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On December 19, 2008, the Bush administration issued last-minute regulations to strengthen existing federal "conscience clauses."[1] A conscience clause is a statutory provision that permits medical practitioners and institutions to refuse to provide medical procedures on the basis of religious or moral beliefs.[2] Several federal conscience clause laws exist which protect those in the healthcare field from taking part in abortion or sterilization procedures.[3] But arguably the broadest conscience clause statute already in existence provides that ''[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services'' if doing so ''would be contrary to his religious beliefs or moral convictions.''[4] This statute potentially applies to all health service programs and research activities.

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[1] Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory
Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88).

[2] Ascension Health, Healthcare Ethics, Conscience Clause, http://www.ascensionhealth.org/ethics/public/issues/conscience_clause.asp (last visited Apr. 16, 2009).

[3] *See, e.g.*, 42 U.S.C. § 300a–7(b)–(d) (2006).

[4] 42 U.S.C. § 300a–7(d) (2006).

Although these conscience clause regulations merely reinforce already-existing protections,[5] there is speculation that the Bush administration strengthened the rule because the Obama administration has pledged support for the Freedom of Choice Act, which would make it illegal for federally-funded health institutions to deny an abortion prior to fetal viability.[6] On January 15, 2009, a bill was proposed in the House of Representatives that would effectively repeal the Bush regulations.[7] On February 27, 2009, the Obama administration stated its intent to rescind the last-minute Bush regulations.[8] This flurry of legislative activity and the recent change in executive opinion make conscience clauses a timely issue worth examining in search of a compromise.

I. PRACTITIONER RIGHTS: SUPPORT FOR CONSCIENCE CLAUSES

Many health care practitioners hold moral or religious beliefs which may conflict with certain medical procedures or practices. In citing the nationwide shortage of healthcare practitioners, the last-minute Bush regulations from the Department of Health and Human Services note that the agency is "concerned about the development of an environment in sectors of the health care field that is intolerant of individual objections to abortion or other individual religious beliefs or moral convictions."[9] Such an environment could potentially discourage

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[5] Brian Montopoli, *Abortion Foes Warn of Hospital Closures*, CBSNEWS.COM, Jan. 28, 2009, http://www.cbsnews.com/stories/2009/01/27/politics/main4757890.shtml (discussing opposition to the Freedom of Choice Act proposed in Congress).

[6] Diana Sroka, *Hospitals Avoiding National Controversy*, NORTHWEST HERALD, Jan. 21, 2009, *available at* http://www.nwherald.com/articles/2009/01/21/09105338/index.xml; S. 1173, 110th Cong., § 1 (2007).

[7] Protecting Patients and Health Care Act of 2009, H.R. 570, 111th Cong. § 1 (2009), *available at* http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname=111_cong_bills&docid=f:h570ih.txt.pdf.

[8] Saundra Young, *White House Set to Reverse Health Care Conscience Clause*, CNN.COM, Feb. 27, 2009, http://www.cnn.com/2009/POLITICS/02/27/conscience.rollback/index.html.

[9] Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory
Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,073 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88).

persons with objections to certain medical procedures from pursuing careers in health care.[10]

The tenets of the Catholic faith, coupled with the religion's strong ties to medical care, serve as an illustrative example of the dilemma presented to certain healthcare practitioners. Catholicism's stances on "many crucial issues are distinctly and unapologetically ethically counter-cultural," and some of their positions are shared by other religious groups.[11] Despite the fact that the Catholic position on certain health issues often differs from mainstream opinion, one out of every six patients hospitalized in the United States receives care at a Catholic hospital.[12] Although administered by religious institutions, such hospitals "operate in the public sphere and they do so largely with public funding."[13] Catholics are implored by their religious leaders to conscientiously object to medical practices which contradict their faith.[14] Consequently, a practitioner is, in certain circumstances, essentially forced to choose between the tenets of her faith and the realities of her profession.[15] Conscience clauses serve to limit such pressures on health care practitioners, yet, as a result, the burden inevitably shifts to the patient.

II. THE EFFECTS OF CONSCIENCE CLAUSES ON PATIENTS' RIGHTS

Practitioners' religious beliefs "often conflict with accepted standards of medical practice and patients' right to self-determination."[16] Conscience clauses have the potential to place significant burdens on patients by creating obstacles to

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[10] *See id.*
[11] Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221, 225 (2002).
[12] Ben Arnoldy, *Catholic Groups Fear Abortion Rights Bill*, CHRISTIAN SCI. MONITOR, Dec. 5, 2008, at 3, *available at* http://www.csmonitor.com/2008/1205/p03s03-ussc.html.
[13] Susan Berke Fogel & Lourdes A. Rivera, *Saving* Roe *Is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 742 (2003-2004).
[14] *See, e.g.*, Pope John Paul II, Address to International Congress of Catholic Obstetricians and Gynecologists (June 18, 2001), *available at* http://www.lifeissues.net/writers/doc/doc_13_obstetandgynec.html.
[15] *See id.*
[16] Fogel & Rivera, *supra* note 14, at 727.

certain health care decisions and options.[17] Rural or medically underserved regions of the country may be especially affected by conscience clauses.[18] Many medical services, such as the prescription of emergency contraception, must be administered in a timely manner to ensure effectiveness.[19] A patient's ability to travel might be a determining factor in her outcome if the health care practitioner she visits first will not perform the requested procedure.[20] But low-income patients with limited mobility are not the only ones at the mercy of practitioners. In 2006, for example, a married lawyer and writer in Washington, D.C. contacted her doctor for a prescription for emergency contraception,[21] was refused by two providers and could not get an appointment with a third; the 72-hour period of effectiveness was about to expire, so she decided to take her chances and became pregnant.[22] The woman eventually underwent an abortion as a direct result of being refused emergency contraception.[23]

Patients, like the one in the previous example, do not usually consider their practitioner's beliefs before seeking care. In fact, the common perception among patients is that even if they seek care at a religious institution, they will be able to receive their requested treatment, even if it goes against the institution's religious teachings.[24] Even if a willing provider can be found, the patient is

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[17] *See id.*
[18] *See id.* at 729.
[19] *See, e.g.*, Plan B®: Frequently Asked Questions, http://www.go2planb.com/plan-b-faq.aspx (instructing the user that if the drug is taken within 72 hours of unprotected sex, it can significantly decrease the chance of pregnancy).
[20] *See* Fogel & Rivera, *supra* note 14, at 733.
[21] Emergency contraception has since been made available on an over-the-counter basis for persons 18 years of age and older. *See* Press Release, FDA, FDA Approves Over-the-Counter Access for Plan B for Women 18 and Older Prescription Remains Required for Those 17 and Under (Aug. 24, 2006) (on file with author), *available at* http://www.fda.gov/bbs/topics/news/2006/new01436.html. However, the dispensation of emergency contraception is still an issue at doctors' offices (for minors) and at hospitals. *See* Reena Singh, *New Barriers to Emergency Contraceptive Access for Rape Victims: A Report from Connecticut*, WOMEN'S HEALTH ADVOC. (Nat'l Women's Health Network, Wash., D.C.), May 1, 2007, http://www.nwhn.org/newsletter/article1.cfm?newsletterarticles_id=135. For example, rape victims in the emergency room may have no other access to emergency contraception. *See id.*
[22] Dana L., *What Happens When There Is No Plan B?*, WASH. POST, June 4, 2006, at B1, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2006/06/02/AR2006060201405.html.
[23] *Id.*
[24] *See* Fogel & Rivera, *supra* note 14, at 740-41.

presumably forced to pay, whether out-of-pocket or with insurance, for the first visit to the refusing practitioner as well as the second visit where the procedure was performed. In such a scenario, the practitioner's moral burden becomes a financial burden to the patient.

III. BRIDGING THE GAP BETWEEN PRACTITIONERS AND PATIENTS

Although it is unknown whether existing conscience clause rules will remain intact or whether they will be limited by the Obama administration, patient rights can still be expanded within current conscience clause provisions. Perhaps most importantly, disclosure to patients is crucial. The Bush regulations, while strengthening the practitioner's right of refusal, stress that there should be "open communication between [practitioner and patient] so patients can be confident that the care they seek and receive is endorsed by their health care provider."[25] Even Catholic scholars who favor conscience clauses have suggested that "physicians must make their positions publicly known," so that patients will have advance knowledge and an opportunity to find another practitioner.[26] For example, if all of the health care practitioner's objections are disclosed when a patient schedules an appointment, the patient has early notice and, if necessary, can look elsewhere for care without spending money on a wasted visit.

Yet, the reality is that advance knowledge of a practitioner's beliefs is often impossible to attain. Therefore, another way to protect both practitioners and patients is to require that institutions have a non-objecting practitioner available on the premises at all times.[27] However, in practice, this compromise would be particularly complex when it comes to hospitals affiliated with the

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[25] *See* Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory
Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,073 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88).
[26] Pellegrino, *supra* note 12, at 243-44.
[27] *See* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. ON ETHICS, COMMITTEE OPINION NO. 385, THE LIMITS OF CONSCIENTIOUS OBJECTION IN REPRODUCTIVE MEDICINE 5 (2007), *available at* http://www.acog.org/from_home/publications/ethics/co385.pdf [hereinafter ACOG Opinion].

Catholic church, which limit medical services that conflict with Catholic teachings.[28] Specifically, the individual practitioners at the hospitals do not necessarily have any discretion in the matter.[29]

Some critics of conscience clauses take a stricter stance. The Committee on Ethics of the American College of Obstetricians and Gynecologists published an advisory opinion in 2007, stating that in an emergency, a professional has a duty to provide a service, even if he or she objects, when no other provider is available and the patient's physical or mental health is at risk.[30] Others believe that instead of going so far as to require the practitioner to perform the requested service, the practitioner should instead be required to counsel the patient and ensure that the patient receives a referral to a willing practitioner.[31] Consequently, such a duty would effectively guarantee that the patient receives the service anyway. It is not difficult to imagine that some objecting practitioners would not be satisfied with this compromise.

IV. CONCLUSION

The Hippocratic Oath implicitly and famously tells physicians to do no harm when treating patients, and the modern version of the Oath instructs physicians to not "play at God." [32] Yet, today's society has created numerous circumstances in which the practitioner and patient have different perspectives on what constitutes "harm" and what "play[ing] at God" really means. Healthcare practitioners undeniably serve a valuable and necessary role in our society, and conscience clauses serve as effective tools in shielding practitioners from retribution for their beliefs. However, individual medical care is also a deeply personal matter for patients, and the law should not unreasonably hinder patients from getting the care they desire. Compromises will be necessary, especially in

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[28] *See* Fogel & Rivera, *supra* note 14, at 732.
[29] *See id.*
[30] ACOG Opinion, *supra* note 28, at 5.
[31] Fogel & Rivera, *supra* note 14, at 747-48.
[32] Louis Lasagna, The Hippocratic Oath - Modern Version (1964), *available at* http://www.pbs.org/wgbh/nova/doctors/oath modern.html.

the case of federally-funded religious healthcare institutions, in order for the rights of patients to be adequately protected.