

Dignity

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Inside:

Protecting the Health Care Provider's Right of Conscience

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In Alaska, the state supreme court has opined that private hospitals receiving state or federal funds must make their surgical suites available for the performance of elective abortions, due to their having become (according to state constitutional law) "quasi-public" institutions upon receipt of such funds. While the Court has not yet been directly presented with the question of whether religiously affiliated hospitals are encompassed by the ruling, statements in the opinion suggest that the ruling does apply to such hospitals.

In Texas, a jury found a private hospital liable for an excess of \$42 million for disregarding parental objections and providing life-sustaining care to an infant born after twenty-three weeks of gestation. Only through the intervention of the appellate courts was the hospital relieved from this liability.

In California, a physicians' group has been sued for violating state anti-discrimination laws due to a doctor's refusal to artificially inseminate a patient involved in a lesbian relationship. Dr. Brody, a Christian and an employee of the group, had agreed to treat the patient for infertility; however, the doctor had clearly stated from the outset that she was unwilling to artificially inseminate the patient. The patient concurred with this plan, and the treatment began. Subsequent circumstances resulted in the patient obtaining care from other providers and ultimately conceiving and giving birth to a baby boy. Nonetheless, the patient sued Dr. Brody, as well as the physicians' group, for violating California law prohibiting discrimination on the basis of sexual orientation. The trial court dismissed the case, finding that it was subject to the Employee Retirement Income Security Act ("ERISA") since the medical care was to be administered pursuant to an employer-provided

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health care plan. The intermediate appellate court reversed the decision, however, on the basis that ERISA was not meant to preempt claims of discrimination in the provision of medical care. The matter is now awaiting trial.

The common thread running through these cases is the insistence that health care providers comply with patient demands, regardless of the nature of the requests—and regardless of any conflicting demands of the health care providers'

consciences. In addition to the cases described above, patients or patients' representatives have, at various times, insisted that artificially administered nutrition and hydration be removed from patients who appear to have no hope of regaining

their health. Patients or their representatives have also sought to require Catholic hospitals to permit obstetricians to perform sterilizations of women immediately after giving birth and have demanded that Catholic hospitals provide "emergency contraception" to rape victims—notwithstanding the fact that such medication may act as abortifacients when used by women during the post-ovulation periods of their menstrual cycles. In all of these cases, the patients or their representatives have claimed that their "rights" to particular procedures are paramount and trump all other considerations, including consideration of any moral or conscientious objections expressed by health care providers. The purpose of this article is to explore the legitimacy of this claim.

The Rights of Patients and Health Care Providers

Under existing principles of American law, patients receiving medical care ultimately retain the right to choose what is to be done to their bodies. This ability to choose has limits, however.

continued on page 5

- 1 Protecting the Health Care Provider's Right of Conscience
- 2 Biotechnology and the Connection Between Our Physical and Spiritual Natures
- 4 Movie Review: *Big Fish*
News from the Field
- 6 Book Review:
The Blank Slate
- 7 Center Resources
- 8 Conference Information!
Center News

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For example, in the vast majority of states, patients may not choose to have physicians assist with their suicide. In so far as the treatment or therapy the patient seeks is outside the established norms of medicine, a health care provider who declines to provide the treatment or therapy will be protected and in fact may be required to decline the requested care. The disputed question is, when the treatment or therapy is well *within* the established norms of medicine, to what extent can a patient demand that a physician or hospital provide a particular treatment or therapy over the health care provider’s objection?

At the beginning of the physician-patient relationship, a physician typically may limit the extent and scope of his obligation to treat a patient. Similarly, in most circumstances, a private hospital may limit the procedures it offers to the patients it serves. This power to prospectively define the limits of medical procedures and therapies a physician or hospital is willing to provide, combined with the historical ability of private hospitals and doctors to define their areas of specialty or to reject patients altogether, traditionally created substantial protection against claims

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by patients or would-be patients to services that offended the consciences of the health care providers.

This is still true to a large extent today. By informing prospective patients prior to entering into the patient-health care provider relationship that certain procedures or therapies will not be provided, doctors and hospitals often are protected against subsequent claims that they either are wrongfully denying patients appropriate therapies or abandoning the patients. By setting such limits at the outset of the relationship, both the patient and the health care provider have the option of declining to enter into the relationship upon the terms offered. Any attempts to establish limits on procedures or therapies after the patient-provider relationship has been established may be subject to the provider’s fiduciary obligations to the

patient that arose upon the establishment of the patient-provider relationship. Such delay also risks the possibility that the patient’s condition may become such that seeking or obtaining other medical assistance is unrealistic. Failure to set any desired limits on procedures or therapies prior to establishing the relationship may therefore expose providers to judicial orders requiring that they comply with patient demands.

Challenges to Health Care Providers’ Right of Conscience

The general consensus recognizing the right of physicians and hospitals to limit the treatments and procedures they provide is, however, under attack. Often thought of as a contemporary problem, this conflict between a patient’s demands and the physician’s concept of ethical medical care is as old as the medical profession itself. The Hippocratic Oath speaks directly to two issues likely to invoke sharp disagreement today—the role of the physician in bringing about the death of the patient, and abortion: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy.” The inclusion of such statements evidences the moral debate regarding such practices 2500 years ago.

Today it is often argued that the right to abortion, artificial means of contraception, assisted reproductive technology, physician-assisted suicide, or other legally permissible procedures or medications becomes meaningless without physicians who are willing to provide such services. That is, a patient’s very ability to choose these procedures or medications is dependent upon the existence of a doctor who is willing to facilitate whatever choice the patient makes. Consequently, a doctor’s unwillingness to act in a particular way due to her conscience becomes a barrier to a patient’s self-realization.

When understood in this manner, the question becomes that of whose freedom should trump. Should the doctor remain free to act in accordance with her conscience, or should the patient be free to obtain a legally permissible service from every doctor? Either way, someone’s liberty will be restricted. If the law compels physicians to provide treatments in conflict with their conscience, the freedom of a physician to practice medicine in accordance with his conscience is diminished. If the law leaves the matter to the private agreement of each individual patient and physician, the patient’s freedom to obtain certain procedures or medications

is diminished by the possibility that her treating physician will not offer the full array of legally permissible options. Which ruling is more just?

In order to answer this question, the two freedoms at stake must be examined. The patient’s claim is often presented in one of two ways; either in terms of personal autonomy or relief of suffering. The autonomy claims, while perhaps compelling when articulating a reason to be free from coerced medical care, are less persuasive when articulated as a reason to compel another to act. “My right to be free requires you to do X” seems easily balanced by the doctor’s claim “I have a right not to do X,” absent some promise or prior undertaking.

Alternatively, patients claim, “I am suffering due to my condition, and by doing X, my condition will be relieved, so you (doctor, nurse, pharmacist, hospital) must do X, as a part of your commitment to the relief of suffering.” This was the patients’ claim in *Washington v. Glucksberg*, in which the patients claimed a constitutional right to physician-assisted suicide.¹ While the Court acknowledged the reality of the suffering endured by the patients, the Court recognized that the legitimacy of other societal values precluded doctors from being forced to relieve the suffering of their patients in this manner.

The doctor or health care provider’s freedom to act in accordance with his conscience is often defended in contemporary discussions by the claim that forcing people to violate their consciences forces them to deny their uniquely constructed self-identities and is unjust. The more traditional justification for freedom of conscience is the right of all humans to serve God before people, and the ultimate futility of government demands to the contrary.

Now is the time for health care providers to search their consciences and consider their commitments. Because there are interventions within medicine that are legally—but not morally—permissible, health care providers must “choose this day whom [they] will serve.”² ■

¹521 U.S. 702 (1997).

²Joshua 24:15.

Editor’s Note: For a fully referenced version, please access www.cbhd.org.