Conscientious Objection Gone Awry — Restoring Selfless Professionalism in Medicine

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A new rule from the Department of Health and Human Services (DHHS) has emerged as the latest battleground in the health care conscience wars. Promulgated during the waning months of the Bush administration, the rule became effective in January. Heralded as a "provider conscience regulation" by its supporters and derided as a "midnight regulation" by its detractors, the rule could alter the landscape of federal conscience law.

The regulation, as explained in its text (see the Supplementary Appendix, available with the full text of this article at NEJM.org), aims to raise awareness of and ensure compliance with federal health care conscience protection statutes. Existing laws, which are tied to the receipt of federal funds, address moral or religious objections to sterilization and abortion. They protect physicians, other health care personnel, hospitals, and insurance plans from discrimination for failing to provide, offer training for, fund, participate in, or refer patients for abortions. Among other things, the laws ensure that these persons cannot be required to participate in sterilizations or abortions and that entities cannot be required to make facilities or personnel available for them. And they note that decisions on admissions and accreditation must be divorced from beliefs and behaviors related to abortion. On their face, these laws are quite broad.

But the Bush administration's rule is broader still. It restates existing laws and exploits ambiguities in them. For example, one statute says, "No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded" by DHHS if it "would be contrary to his religious beliefs or moral convictions."[1] Here the rule sidesteps courts, which interpret statutory ambiguities and discern congressional intent, and offers sweeping definitions. It defines "individual" as physicians, other health care providers, hospitals, laboratories, and insurance companies, as well as "employees, volunteers, trainees, contractors, and other persons" who work for an entity that receives DHHS funds. It defines "assist in the performance" as "any activity with a reasonable connection" to a procedure or health service, including counseling and making "other arrangements" for the activity. Although the rule states that patients' ability to obtain health care services is unchanged, its expansive definitions suggest otherwise. Now everyone connected to health care may opt out of a wide range of activities, from discussions about birth control to referrals for vaccinations. As the rule explains, "an employee whose task it is to clean the instruments used in a particular procedure would also be considered to assist in the performance of the particular procedure" and would therefore be protected. Taken to its logical extreme, the rule could cause health care to grind to a halt.

It also raises other concerns. In terms of employment law, Title VII of the Civil Rights Act, which applies to organizations with 15 or more employees, requires balancing reasonable accommodations for employees who have religious, ethical, or moral objections to certain aspects of their jobs with undue hardship for employers. But the new rule suggests that if an employee objects, for example, to being a scrub nurse during operative treatment for an ectopic pregnancy, subsequently reassigning that employee to a different department may constitute unlawful discrimination — a characterization that may be at odds with Title VII jurisprudence.[2] As officials of the Equal Employment Opportunity Commission remarked when it was proposed, the rule could "throw this entire body of law into question."[3]

Furthermore, although the rule purports to address intolerance toward "individual objections to abortion or other individual religious beliefs or moral convictions," it cites no evidence of such intolerance — nor would it directly address such intolerance if it existed. Constitutional concerns about the rule, including violations of state autonomy and rights to contraception, also lurk. And the stated goals of the rule — to foster a "more inclusive, tolerant environment" and promote DHHS's "mission of expanding patient access to necessary health services" — conflict with the reality of extensive objection rights. Protection for the silence of providers who object to care is at odds with the rule's call for "open communication" between patients and physicians. Moreover, there is no emergency exception for patient care. In states that require health care workers to provide rape victims with information about emergency contraception, the rule may allow them to refuse to do so.

Recently, the DHHS, now answering to President Barack Obama, took steps to rescind the rule (see the Supplementary Ap-

pendix). March 10 marked the beginning of a 30-day period for public comment on the need for the rule and its potential effects. Analysis of the comments (www.regulations.gov) and subsequent action could take some months. If remnants of the rule remain, litigation will follow. Lawsuits have already been filed in federal court, and Connecticut Attorney General Richard Blumenthal, who led one of the cases, has vowed to continue the fight until the regulation is "finally and safely stopped."[4]

This state of flux presents an opportunity to reconsider the scope of conscience in health care. When broadly defined, conscience is a poor touchstone; it can result in a rule that knows no bounds. Indeed, it seems that our problem is not insufficient tolerance, but too much. We have created a state of "conscience creep" in which all behavior becomes acceptable — like that of judges who, despite having promised to uphold all laws, recuse themselves from cases in which minors seek a judicial bypass for an abortion in states requiring parental consent.[5]

The debate is not really about moral or religious freedom writ large. If it were, then the medical profession would allow a broad range of beliefs to hinder patient care. Would we tolerate a surgeon who holds moral objections to transfusions and refuses to order them? An internist who refuses to discuss treatment for diabetes in overweight patients because of moral opposition to gluttony? If the overriding consideration were individual conscience, then these objections should be valid. They are not (although they might well be permitted under the new rule). We allow the current conscience-based exceptions because abortion remains controversial in the United States. As is often the case with laws touching on reproductive freedom, the debate is polarized and shrill. But there comes a point at which tolerance breaches the standard of care.

Medicine needs to embrace a brand of professionalism that demands less self-interest, not more. Conscientious objection makes sense with conscription, but it is worrisome when professionals who freely chose their field parse care and withhold information that patients need. As the gatekeepers to medicine, physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them. Qualms about abortion, sterilization, and birth control? Do not practice women's health. Believe that the human body should be buried intact? Do not become a transplant surgeon. Morally opposed to pain medication because your religious beliefs demand suffering at the end of life? Do not train to be an intensivist. Conscience is a burden that belongs to the individual professional; patients should not have to shoulder it.

Patients need information, referrals, and treatment. They need all legal choices presented to them in a way that is true to the evidence, not the randomness of individual morality. They need predictability. Conscientious objections may vary from person to person, place to place, and procedure to procedure. Patients need assurance that the standard of care is unwavering. They need to know that the decision to consent to care is theirs and that they will not be presented with half-truths and shades of gray when life and health are in the balance.

Patients rely on health care professionals for their expertise; they should be able expect those professionals to be neutral arbiters of medical care. Although some scholars advocate discussing conflicting values before problems arise, realistically, the power dynamics between patients and providers are so skewed, and the time pressure often so great, that there is little opportunity to negotiate. And there is little recourse when care is obstructed — patients have no notice, no process, and no advocate to whom they can turn.

Health care providers already enjoy broad rights — perhaps too broad — to follow their guiding moral or religious tenets when it comes to sterilization and abortion. An expansion of those rights is unwarranted. Instead, patients deserve a law that limits objections and puts their interests first. Physicians should support an ethic that allows for all legal options, even those they would not choose. Federal laws may make room for the rights of conscience, but health care providers — and all those whose jobs affect patient care — should cast off the cloak of conscience when patients' needs demand it. Because the Bush administration's rule moves us in the opposite direction, it should be rescinded.

Dr. Cantor reports representing an affiliate of Planned Parenthood in a legal matter unrelated to conscientious objection. No other potential conflict of interest relevant to this article was reported.

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5. Liptak A. On moral grounds, some judges are opting out of abortion cases. New York Times. September 4, 2005.