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Conflicts of Conscience in Health Care: An Institutional Compromise

Abstract

Conscience clauses protecting health care workers from consequences stemming from their refusal to perform a variety of medical services have been on the books in nearly every state since the landmark decision of Roe v. Wade. These statutes have become increasingly controversial as they have been expanded to cover services beyond abortion, particularly as a result of their failure to implement mechanisms to preserve patient access to desired medical interventions, seemingly protecting physician conscience at the expense and burden of patients. The existing commentary on this issue tends to be clustered around two poles: those arguing that physicians have a professional duty to put the interests of their patients first, even when that means subrogating their own moral beliefs, and those arguing that conscience is a non-negotiable "right" that is not sacrificed upon entry into a profession. This book recognizes serious deficiencies in each of these extreme approaches, and instead offers a compromise that could simultaneously protect both physician conscience and patient access.

The most desirable solution to the existing conscience clause debate is the facilitation of doctor-patient matching, pairing individuals on the basis of their deep moral values, eventually eliminating conflicts of conscience altogether, or at least minimizing them. In the meantime, however, the pharmacy and hospital contexts offer important lessons on the value of institutional compromise, allowing individual health care workers to exercise conscientious refusal while imposing an obligation on some overarching institution to accommodate patient requests. State licensing boards, responsible for implementing and regulating the professional monopoly held collectively by physicians, might serve a similar role. State legislatures should empower these boards to take measures to ensure that the supply of willing and competent physicians in a given geographic area is sufficient to meet patient demand, and these boards should accept strict liability for failure to maintain patient access at levels commensurate with those that would be present were conscientious refusal a non-issue. For their part, physicians should be protected from liability and many professional consequences when they refuse to provide services on moral grounds, so long as they provide patients with advance notice of the services they are unwilling to perform, provide care regardless of moral objections in cases of patient emergency, offer full informed consent, and facilitate access to other willing providers. The book recognizes that there are important social benefits to preserving moral diversity in the medical profession and maintaining a role for physician conscience is integral to that goal, so long as individual patients are not forced to bear the burden of moral beliefs that are not their own.