An Institutional Solution to Conflicts of Conscience in Medicine

by Carolyn McLeod

One of the most intriguing questions in medical ethics is whether individual physicians ought to be able to refuse conscientiously to provide services that patients seek. The issue requires us to delve into difficult problems, such as the extent to which physicians must subordinate their interests to those of their current or prospective patients, and how essential the services physicians object to are as new medical technologies develop. Despite the difficulty that surrounds this issue, many bioethicists—like Dan Brock and Mark Wicclair—have tried to address it in a single journal article. But Holly Fernandez Lynch is an exception. She gives conscientious objection in medicine (hereafter, "conscientious objection") the book-length treatment that it deserves.

Lynch opposes a blanket prohibition on conscientious objection. Among her reasons are that patients are not well served by physicians who have serious moral qualms about services that the patients need, and that medical professionalism does not require physicians to take all comers or to accede to all requests—even legitimate ones. She further explains that some refusals—such as a refusal to assist a sixty-year-old woman in conceiving a child—may be appropriate. We should not prevent physicians from making good objections, and we can probably think of some regardless of what our moral commitments are.

Lynch concludes that we need to allow some conscientious objection; however, some readers will find that she exaggerates this need. For example, some will object to what she says is the "strongest argument for retaining room for moral refusers": the inability to know the answers to many of the moral questions that create controversy in medicine, such as whether a fetus is a person. Some readers will have more faith than Lynch does in the resources of moral philosophy to provide proofs for such claims.

Some may also feel that she overstates the importance of allowing conscientious objection by defining the term too broadly. For her, conscientious objection includes "refusals grounded in values that are widely held within the profession and have been accepted as clinical standards" (p. 34). An example would be a refusal to allow a sick child to decide on his own what his treatment will be. This unusually broad conception allows Lynch to say that taking a strong stand against conscientious objection commits one to the unhappy view that physicians are mere technicians who have no personal autonomy or morality of their own. If the professional standard is no conscientious objection, then physicians can never object to patient requests on grounds of conscience, even when their conscience aligns with what their profession requires of them. But is such absurdity a consequence of refusing to condone conscientious objection? Not if the category refers, as Dan Brock believes it does, only to objections to what is legal and professionally accepted.

Even those of us who feel she exaggerates, however, could agree with Lynch that a strict prohibition on conscientious objection is inappropriate. The question then becomes: How are we to make room for conscientious objection without eliminating patients' access to important medical care? Lynch develops an "institutional solution" to this problem, the details of which take up much of her book.

The book has three main parts. In part one, Lynch describes the legal situation and the debate about conscientious objection in the United States. She argues in favor of resolving the debate by determining whether physicians have professional obligations that preclude them from exercising freedom of conscience in their capacity as physicians. She favors a model of medical professionalism that she calls the "gatekeeping paradigm." It does not confer such obligations on physicians, but rather gives them significant latitude in which services they offer their patients. This model places the responsibility for ensuring that patients get the care they deserve on the profession, which is the true gatekeeper to medical services and is entrusted with a "legal monopoly" over medical care.

Part one and part two both lay the foundation for Lynch's solution to the problem of conscientious objection. In part two, she argues that an institutional solution is better than an individual one, in part because it permits "morals matching": that is, matching physicians with patients based on whether they have similar moral values. In addition, she claims the institution that ought to fulfill the profession's responsibility of ensuring that patients can match themselves with the proper physician is the medical licensing board.

Part three—the largest section—describes the details of the institutional solution and defends it against possible criticisms. The details are laid out in a model statute and are roughly as

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follows. Physicians must register their conscientious objections with their licensing board, which must verify the sincerity of these objections and reject those that are discriminatory. Patients have access to the registries, which facilitates morals matching. If they cannot find a physician to satisfy their needs, they can complain to the board, which will have to compensate them (monetarily, if necessary) unless the board decides that their expectations are unreasonable. Lynch argues that patient requests must be legal and "scientifically proven effective for the patient's desired purpose" for a licensing board to take them seriously (p. 250). A board can develop other restrictions on reasonable demands, but only through a fair process of deliberation that involves "a wide variety of stakeholders" (p. 137).

The goal here is to strike a compromise between individual physicians who have reasonable (or not *un*reasonable) conscientious objections and patients who have reasonable demands for services that some physicians object to. Since a compromise—in Martin Benjamin's words—"splits the difference," each party to a compromise sacrifices something, rather than getting precisely what each wants. Lynch does not always appear to accept this fact about compromises, even though she comes up with what amounts to a compromise. With her institutional solution, patients sacrifice the ability to acquire services from any physician who ought to be qualified to provide them. They also are not guaranteed to get the service they want because the licensing board might fail in remedying shortages of "willing physicians" in their area. (These are among the "hard cases" for her theory that get discussed in chapter eight.) Physicians, regardless of the conscientious objections they may have, are obligated to inform patients of all of their treatment options, to provide care in emergencies, and possibly, though not necessarily, to give patients who make objectionable demands some kind of referral.

The idea of this institutional compromise is promising in many respects. By acting on it, we could, for example, substantially improve access to controversial services and enhance trust in physicians by allowing individuals to choose physicians with whom they share basic moral commitments. But Lynch's proposal is also worrisome in many respects. While discussing morals matching, she writes that patients "have a valid claim to avoid providing their support to medical services they find morally objectionable, even if that support involves no more than patronizing a physician who provides those services to others" (p. 91). Will licensing boards have to ensure matches for these patients if matches do not exist? In other words, if in a certain geographical area, there were no unwilling physicians—those who, for moral reasons, will not offer services such as abortions—will the relevant board have to recruit these physicians? Surely that would be a troubling result, for it would conflict with the profession's commitment to certain services being essential.

As well, the hard cases in which boards cannot find enough physicians, willing or unwilling, to perform an essential service could become so numerous that the whole system falls apart. Clearly, Lynch's proposal is not designed for places in which there is already a serious shortage of physicians, as is the case with family physicians in many parts of Canada, for example.

A further criticism is that licensing boards could engage in moral corruption while doing what the institutional solution requires, in part because there are no objective claims about patient rights that accompany this solution. For example, the outcome of the fair process of deliberation that decides which medical services are essential might be to exclude abortion services. Lynch does add that a board cannot remove "from its responsibility a medical service that has attained the status of standard of care" (p. 251). But this move seems entirely ad hoc—that is, designed to ensure that abortions are among the services that licensing boards must guarantee for patients.

Whether Lynch's framework is sound also depends on whether conflicts of conscience in medicine warrant some kind of compromise, which itself depends on how comparable the interests of the relevant parties (physicians and patients) are with one another. But Lynch does not delve deeply into what these interests are. For instance, she says little about what harm physicians would suffer if their appeals to conscience were denied or what harms they ought to be willing to suffer for the sake of their conscience. Moreover, she assumes without sufficient argument that a physician who denies care to a patient who could get it close by from another physician merely inconveniences the patient rather than harms her. I have argued that this last claim is false when directed at cases involving female patients who seek emergency contraception. Lynch does not do enough to counter views like mine on this subject.

Obviously, I have concerns about Lynch's institutional compromise, but they do not prevent me from recommending this book, which, as I suggested at the outset, deals more thoroughly with the topic of conscientious objection than any other treatment of it I have seen. Kudos to Lynch for taking on such a complex problem and for responding to it with useful and insightful discussion about why an institutional solution could be both appropriate and viable.