ABSTRACTS of the Papers to be Presented in the

Symposium on “THE FUTURE OF RIGHTS OF CONSCIENCE IN HEALTH CARE: LEGAL AND ETHICAL PERSPECTIVES”

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Conscientious Objection in Clinical Practice: Disclosure, Consent, Referral, and Emergency Treatment
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Discussion of conscientious objection in health care often occur at a high level of abstraction from the clinical practice of medicine. In my presentation, I will describe the processes of establishing a patient-physician relationship, obtaining informed consent, transferring care to another provider, and providing emergent treatment. I will consider the ways in which the knowledge and power differentials between physicians and patients shape each of these activities as the basis for making recommendations regarding the nature and scope of professional obligations and conscientious objection in health care.
Does Conscientious Objection Extend to Referral?
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In the debate concerning conscientious objection (CO), many who would grant individuals the right to CO require referral to a third party for the relevant medical intervention. Yet, those who seek conscientious objector status often regard referral as itself objectionable. A number of factors lead to disagreement over whether CO extends to referral, including: different understandings of professional obligation, diverse intuitions concerning complicity, varying degrees of concern over the patient’s ability to secure the requested intervention without referral, and, most importantly, contrasting accounts of the basis for CO. Considering this last source of disagreement, one finds two camps. On the one hand, we have those who establish CO upon an entirely religious, private, personal, or idiosyncratic view of things and, on the other, those who base it in reasons accessible to all, albeit controverted. Calling the first account personal and the second professional, this paper argues, first, for a professional understanding of CO. Second, based upon this understanding of CO, the paper argues that CO must extend to referral. That is, a professional who objects to some intervention need not refer the patient to a non-objecting colleague. For the objector does not claim that he may not do the relevant act; but, rather, that the relevant act is simply objectionable to a well-formed professional conscience. Therefore, to refer would be to violate professional conscience, not simply his conscience. If the basis for CO were entirely religious or personal, referral might not be objectionable. Indeed, some religions prohibit members from performing acts regarded as permissible for others – for example, orthodox Jews are not to turn on lights during the Sabbath while others may do so for them; similarly, Catholics are not to eat meat on certain religious holy days yet do not regard it as wrong for others to do so. Accordingly, we must distinguish the two competing grounds for CO in order to determine its relation to referral.
Avoiding the Conscientious Objection “Emergency”: An Institutional Approach to Conscientious Objection

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An institutional approach to conscientious objection can minimize the cases in which individual objections jeopardize patient care. Such an approach requires attention to three matters. First is the scope of permitted conscientious objection claims. Should the individual health professional be free to avoid participating in any practice he or she claims is morally objectionable? If not, what are appropriate limits on the scope of permissible conscientious objection? A second matter is the proper model for handling conscientious objection claims. What are the strengths and weaknesses of different models proposed in the literature? A third matter is effective prevention. By alerting students and professionals to potential problems ahead of time, educational and health care institutions can avoid both violations of individual conscience and inappropriate denials of health care to patients.
Title: The Scope of Freedom of Conscience

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Twenty years ago this year, the U.S. Supreme Court’s decision in *Employment Division v. Smith* articulated a rule that significantly reduced the scope of free exercise protection. Stressing the resilience of free exercise, the paper documents that half the jurisdictions in the United States have now expressly rejected the Supreme Court’s narrowing of protection of conscience, and relatively few jurisdictions have expressly followed the Supreme Court’s lead. The paper will also examine briefly comparative approaches to protection of freedom of conscience, both with respect to internal forum matters and broader manifestations of religion. Drawing on developments in contemporary virtue ethics, the paper concludes with an argument that it is vital to have protections of conscience that are sufficiently broad to protect cultivation of and respect for the forgotten virtue of reverence.
I. Why Protect Conscience

A. We protect conscience because of the understanding of the human person, and of human equality, in the natural rights tradition of the American Founding.
B. We protect conscience because of the protection of liberty in our common law and constitutional tradition.
C. We recognize that minority rights must be protected within majority rule.
D. Government by its nature is coercive and suppressive. Religious liberty was the first freedom that animated the American colonists and resulted in the structural protections of our constitution and the Bill of Rights.
E. We protect conscience because medicine, as a profession, is governed by a code of ethics.
F. We protect conscience because of the witness of the great souls in history who have awakened the conscience of prior generations in America and around the world to tyranny and oppression.
G. Conscience protection is widely recognized and accepted by Americans.

II. Conscience is not unlimited.

A. Defined by law and ethical standards.
B. Conscience cannot be a pretext for malpractice, negligence, or poor communication.
C. Patients protected by an open marketplace, by ethical standards, and by law.

III. How conscience plays out in practice

A. Both patients and doctors have rights and responsibilities.
B. Freedom of conscience is guided by objective standards.
C. Freedom of conscience protects human life and dignity.
D. Freedom of conscience improves healthcare and informed consent.
E. Freedom of conscience improves the patient/physician relationship.
F. Freedom of conscience makes it possible to attract and retain better doctors.
G. Freedom of conscience prevents discrimination.
Thinking about How, and How Far, to Extend a Right of Conscience

Kent Greenawalt

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My paper will be about various understandings of conscience and its close relatives, about how claims of conscience should be weighed against the interests of consumers and providers of health care, about the formulations that might strike an appropriate balance, about the desirability of legislating for specific areas and personnel, as contrasted with a general approach that would leave specific outcomes to be determined by discrete evaluations.
Refusals to Provide Health Care or Protected Exercise of Rights of Conscience

(Ascribed title)

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National Women’s Law Center

Abstract:

Religiously-based refusals to provide health care services, information and referrals continue to proliferate, yet there is little protection for patients and consumers. Because patients and customers are the more vulnerable and less knowledgeable party to the transaction, the system should contain greater safeguards for their protection. Health care providers’ expressions of conscience must not result in patients and customers being denied access to health care services, information and referrals.

When presented with an irresolvable conflict between care and conscience, the providers’ duty of care to the patient must be paramount. Medical professionals are regulated and granted the privilege of a license from the state in order to advance the state’s interest in protecting public health and safety. A health care provider’s primary duty when practicing pursuant to the authority granted by that license is the well-being of the patient.

I will describe the extensive existing protections for individuals and institutions that refuse to provide certain health services, and how current laws provide little protection for patients. I will argue that there is a need for more robust legal, regulatory and administrative protections to ensure the timely delivery of health care services, information and referrals. To refute the common misconception that being refused health care services is merely a matter of inconvenience, I will describe the tangible harms of refusals, including possible violations of other laws, such as informed consent.

And finally, I will examine several cases decided under Title VII, which protects the expression of religion in the workplace. While Title VII has limited utility in resolving many of the conflicts that arise, it nonetheless presents a model that has been effective in protecting both employees’ religious expression and patients’ access to health care.
Is There a Right of Conscience in Health Care?
Richard S. Myers
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Ave Maria School of Law

The clashes between state mandates and the consciences of health care professionals are increasing. The recent debate about the scope of federal protection for conscience in the area of abortion is just one manifestation of a growing problem.

This paper explores the sources of legal protection for a right of conscience. The federal constitutional protections are quite narrow, as an examination of recent case law indicates. The paper explores the recent cases on this topic, which have rejected claims for conscience. Other sources of protection (in state law or federal statutes) are also quite limited in most contexts.

This paper explores the reasons for this state of affairs and offers suggestions for how the protections for conscience rights can be increased.
Individual Rights vs. Institutional Identity:
The Relational Dimension of Conscience in Health Care

Robert K. Vischer
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Abstract

Our society’s longstanding commitment to the liberty of conscience has become strained by our increasingly muddled understanding of what conscience is and why we value it. Too often we equate conscience with individual autonomy, and so we reflexively favor the individual in any contest against group authority, losing sight of the fact that a vibrant liberty of conscience requires a vibrant marketplace of morally distinct groups. Defending individual autonomy is not the same as defending the liberty of conscience because, although conscience is inescapably personal, it is also inescapably relational. Conscience is formed, articulated, and lived out through relationships, and its viability depends on the law’s willingness to protect the associations and venues through which individual consciences can flourish: these are the myriad institutions that make up the space between the person and the state. In our debate over the proper scope of liberty of conscience in health care, we need so step back and bring conscience's relational dimension into focus. In particular, in the effort to protect the conscience rights of individual providers, we need to avoid negating the institutional autonomy of the relational venues in which a more fulsome conception of conscience can flourish.
My paper will contain three parts. The first part will reveal the current status of protection of rights of conscience of health care providers in American (federal and state) law, as well as the status of protection of those rights in the professional and cultural sectors of society. It will focus in particular on the Rights of Conscience Regulations adopted by the Department of Health and Human Services in 2008. The second part will briefly review the historical conceptual foundation for protection of rights of health care providers in America, mentioning not only points of political theory and legal protection but cultural and professional protections including the Hippocratic Oath. Finally, the third part will briefly consider whether rights of conscience of health care providers will be protected in law, in the medical profession, and in the cultural environment in America in the future. It will suggest that providers rights of conscience have been and can be achieved protected while patient access to services can be accommodated, but only if there is full commitment to protecting, not sacrificing or giving nominal respect for, rights of conscience.
Empowering Private Protection of Conscience
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On May 24, 2009, Catherina Cenzon-DeCarlo, a New York nurse, filed suit against Mount Sinai Hospital, claiming she was illegally forced to assist with a second-term abortion despite her religious and moral objections. Catherina filed suit under the Church Amendment, 42 U.S.C. § 300a-7(c), which prohibits federally-funded organizations from discriminating against health care professionals who refuse to participate in abortion procedures because of their religious beliefs. Catherina’s case is the latest flashpoint in a raging debate about healthcare conscience protections that began with the so-called Bush Conscience Regulation, now under review by the Obama Administration. Supporters of the Bush Regulation have pilloried Obama for suggesting that his Administration might repeal it--as if the Bush Administration wrote on a blank slate that Obama could now wipe clean, if he so chooses. I have argued in the past that the political hysteria surrounding the possibility that the Obama Administration might rescind the Bush Regulation is greatly overblown.

Mt. Sinai’s response on August 10, 2009, exposed a gaping hole in the shield federal law has erected around individual conscience. Mt. Sinai asked that Catherina’s case be dismissed, arguing that Church Amendment may be enforced only by the federal government and does not confer a private right of action. This paper will examine the merits of this claim. It may ultimately conclude that to give meaningful protection, Congress should empower individuals to stand up for their own religious and moral beliefs.