Conscientious Refusal and a Doctors’s Right to Quit

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ABSTRACT

Patients sometimes request procedures their doctors find morally objectionable. Do doctors have a right of conscientious refusal? I argue that conscientious refusal is justified only if the doctor’s refusal does not make the patient worse off than she would have been had she gone to another doctor in the first place. From this approach I derive conclusions about the duty to refer and facilitate transfer, whether doctors may provide ‘moral counseling,’ whether doctors are obligated to provide objectionable procedures when no other doctor is available, why the moral consensus among doctors seems relevant even though it does not determine whether something is morally acceptable, and whether doctors should stay out of fields whose standard procedures they find morally unacceptable.

Keywords: conscience, doctor-patient, integrity, objection, refuse

I. INTRODUCTION

When a patient requests a procedure the doctor considers immoral, why can’t the doctor simply quit? The usual approaches to conscientious refusal ask whether a doctor’s professional duties require fulfilling such requests, and if so, whether those duties are outweighed by other moral considerations. Those are legitimate approaches. However, if a doctor simply quits the doctor-patient relationship, wouldn’t that dodge the problem by cancelling the doctor’s professional duties towards that patient, thereby eliminating any conflict between those duties and other moral considerations?

At the risk of sounding flippant, this is essentially what I argue. There is such a thing as an ethics of quitting – the moral constraints on terminating or

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curtailing a doctor-patient relationship. With qualifications, a doctor may refuse a patient’s request provided the refusal leaves the patient no worse off than the patient would have been had the patient never met that doctor in the first place. Sometimes refusal is not enough to put the patient in that position, and the doctor must take extra steps to ensure that the patient is no worse off; I call those extra steps “restitution.”

The ‘restitution approach’ is important also because it provides a framework for answering a number of questions concerning the ethics of quitting, such as whether a refusing doctor must refer the patient, whether a doctor may provide ‘moral counseling’ to a patient, and the significance of an ethical consensus in the medical profession.

Despite these virtues, the restitution approach has been overlooked in the conscientious refusal literature.

II. THE RESTITUTION APPROACH

Sometimes doctors have moral objections to fulfilling patient requests for certain procedures – ‘conscience cases,’ I’ll call them. The best-known examples concern prolife doctors who object to counseling and referring patients to abortionists, or providing abortifacient drugs (Brushwood, 1993, p. 205), or performing antenatal diagnoses of nonremediable fetal defects that might be managed with elective abortion (Blustein & Fleischman, 1995; Thorp & Bowes, 1992). Even a pro-choice doctor might object to the selective abortion of female fetuses, perhaps because the doctor believes sex selection is demeaning to women, or bad social policy.

Of course, the range of possible moral conflicts between physicians and patients extends well beyond abortion. A doctor may have moral objections to fulfilling a patient’s request for physician-assisted suicide, or providing reproductive assistance to a 60 year-old single woman who wants help conceiving and gestating a child, or providing futile life support at the request of a surrogate decisionmaker (Blustein, 1993, p. 291), or to terminating life support when the doctor believes the patient’s competent request for it is premature (Wicclair, 2000, p. 208).

Conscience cases can also involve disagreements between doctors and those with whom they have a contract for employment or reimbursement. For example, a resident must follow the orders of an attending physician, but may believe that will not serve the patient’s best interest. This can also happen in a group practice and in managed care settings.
One way for a doctor to resolve conscience cases is to terminate or curtail the doctor-patient relationship, so that the doctor is no longer that patient’s doctor (either entirely, or at least for the procedure in question). To ‘terminate’ a doctor-patient relationship is to end it completely.\textsuperscript{1} To ‘curtail’ it is to limit it so that a particular procedure is not available within that relationship. To say the relationship is ‘repealed’ is to say it is terminated and/or curtailed.\textsuperscript{2}

To motivate this way of thinking about conscientious refusal, consider a couple who came to a maternal-fetal specialist and requested an ultrasound so they can abort the fetus if it is female. The doctor is morally opposed to abortion for sex selection, and thinks, ‘Why did they have to come to me?’ Well, they didn’t, and had matters gone differently, they might not have. If this couple had never come to this doctor, this doctor would have no moral obligation to them.\textsuperscript{3} Moreover, if they had gone to some other doctor, this doctor would have no business interfering with their plans. This suggests two premises:

1. If you’re not this patient’s doctor, you need not do anything for this patient.\textsuperscript{4}
2. If this patient is the patient of some other doctor, you have no right to interfere with what they do.

The second premise has a qualification that is very important for conscientious refusal. There are degrees of immorality. In general we do not have a right to stop other people from doing something merely on the grounds that what they do is immoral. To justify interference with their actions, those actions have to be sufficiently immoral.\textsuperscript{5} Otherwise, the immorality means merely that you cannot do the act, not that you can actively prevent someone else from doing it. For example, if your neighbors are committing mild psychological abuse of their child, you probably would judge that the wrong did not rise to the level where it would be appropriate to take actions to stop them. (Assume they would not listen to reason.)

Degrees of immorality are possible in the refusal cases mentioned earlier. For example, on a gradualist view, abortion is less wrong early in gestation, and more wrong as the fetus develops. On this view, it is possible to believe that, although it is wrong for people to abort early in a pregnancy, it is not wrong enough that anyone should stop them at that stage. To take another example, the wrongness of a 60 year-old woman getting reproductive assistance to conceive and gestate a child may be a function of her qualifications as a mother. It may never be morally right, but its degree of wrongness may depend on her qualities and situation. Depending on which
moral positions are correct, similar points can be made about life support for
dying patients and physician-assisted suicide.

These examples show that we should qualify the second premise: ‘Unless what
the patient wants is sufficiently wrong.’ This qualification to the second
premise means that there are some cases where you are morally justified in
interfering with another person’s wrongful act, and other cases where, even
though the act is wrongful, you are not morally justified in interfering with it.
A lot will hang on this distinction.

These two premises support an argument for a qualified right of
conscientious refusal:

1. If you’re not this patient’s doctor, you need not do anything for this patient.
2. If this patient is the patient of some other doctor, you have no right to
interfere with what they do, unless what they do is sufficiently wrong.
3. Therefore, in any case where premises 1 and 2 are met (and their
exceptions are not met), you do not have to provide the requested
procedure, but you may not stop the patient from getting that procedure
elsewhere.
4. Therefore, if you can transform your existing relationship with a patient
into a sufficiently close approximation of what would have happened had
that patient gone to some other doctor, then you do not have to provide the
procedure, but you may not stop the patient from getting the procedure
done elsewhere.

The fourth step in this argument says, in effect, that a doctor can refuse to
provide a procedure on moral grounds, provided the doctor does not thereby
make the patient worse off than she would have been had she never gone to
him in the first place. In effect, the doctor resolves the conflict by repealing his
relationship with that patient, thereby canceling his or her duty to that patient.6
(The restitution approach assumes that refusing a patient request is a form of
curtailing a doctor-patient relationship, and that curtailing a relationship is
morally equivalent to partially – or in some cases completely – terminating
that relationship.7)

Now things get complicated, and the complications flow from two
possibilities. First, it is possible that the qualification to premise 2 is met:
what the patient wants is so immoral that the doctor is morally justified in
interfering with the patient’s efforts to get it from another doctor. If this is true,
then the third and fourth steps of the argument are different – the doctor does
not have to transform her existing relationship with a patient into a sufficiently
close approximation of what would have happened had that patient gone to some other doctor. For example, if the patient wants help enacting Munchausen's syndrome by proxy on her child, the fact that some doctor will do it (for a price) does not obligate her current doctor to refer her to the willing doctor.

The second complication concerns this condition in the fourth step of the argument: "if you can transform your existing relationship with a patient into a sufficiently close approximation of what would have happened had that patient gone to some other doctor." The complication is the possibility that this condition cannot be met. For example, the patient's situation may have changed since he first came to that doctor, and simple refusal might not leave him where he would have been had he not come to that doctor in the first place, either because his condition has progressed, or because time is running out, or both. If this happens, then, in order to transform the relationship into what would otherwise have been the case, the doctor must do more than simply refuse.

I call this the 'restitution approach' because we can think of the doctor's efforts to make the patient no worse off as a kind of restitution: if refusing makes the patient worse off than she would have been had she not gone to that doctor in the first place, then the refusing doctor must (subject to qualifications mentioned below) make restitution by making her situation roughly what it would have been had she not come to him at all.⁸ (More later about what this involves.) The restitution approach comprises the four-step argument presented above and the following statement of the right of conscientious refusal:

**Right of conscientious refusal:** To refuse a patient request on moral grounds, ask what the patient's situation would have been had she chosen another doctor, and put her there — unless you'd be morally justified in interfering with her getting that procedure even when another doctor provides it.

If you can't meet these conditions, then you must give her what she wants — unless she would not have found another doctor to do so.

(I will argue for the italicized clause later.)

Earlier I mentioned many kinds of conscience cases, including abortion, futile treatment requests, 60 year-old would-be mothers, assisting an AIDS patient's suicide, and many more. Can one approach handle such a diverse set of
problems? The answer is that refusal is justified by restitution (or the fact that restitution is not necessary to put the patient where she would have been had she never gone to the refusing doctor). On this approach, refusal is not justified by the nature, sufficiency, or weight of the doctor's reasons for refusing. Thus, the doctor's reasons for refusing — and their nature, weight, or sufficiency — are irrelevant to the justification. So long as either the doctor provides restitution, or restitution is unnecessary (because a simple refusal will leave the patient where she would have been had she not gone to that doctor in the first place), the refusal is justified even if 1) the refusal is sincere but the doctor's moral analysis is mistaken, or 2) the doctor's refusal is based on a nonmoral concern, such as a personality conflict.

This is not to say that refusal is justified only when the conditions of the restitution approach have been met. There may well be other ways to justify conscientious refusal; certainly other ways have been proposed, and nothing in this article is intended as an objection to other approaches. Some refusals might even be justified in more than one way. I claim simply that the restitution approach is in the toolbox along with everything else, that it has been overlooked, that it can justify refusals other approaches might not justify, that it has implications different from those of other approaches, and that it helps account for some widespread but seemingly unsupported moral intuitions about conscientious refusal (discussed in the next section).

Of course, sometimes restitution is necessary, but the doctor either will not or cannot provide it. In such cases, justifying a refusal does require a sufficient moral objection, for the restitution approach says that restitution need not be made when the doctor would be "morally justified in interfering with [the patient] getting that procedure even when another doctor provides it." To be morally justified in interfering with another doctor providing a procedure to that doctor's patient probably requires a moral objection to what they are doing; the objecting bystanders' own distress or convenience seems insufficient.9 (Whether that moral objection must be correct, or merely sincere, is a relevant question, but beyond the scope of this paper.) Even here, however, the nature of the moral objection is not relevant, only its weight: it must be weighty enough to justify interference.

Long-standing doctor-patient relationships characterized by considerable trust and commitment on both sides call for separate discussion, for those characteristics affect what it takes to make full restitution. Suppose a doctor in general practice has seen a patient for 30 years, the patient trusts her deeply, she feels highly responsible for him, and they feel some attachment to each
other. Had he seen another doctor 30 years ago, he might have an equally close relationship with a doctor willing to provide the procedure, but there is now no way to achieve that close a relationship with another doctor soon enough to get the procedure done. If so, then the patient loses something when his long-term doctor refuses, and the refusing doctor must compensate for that ‘something’ as part of the restitution.\textsuperscript{10}

It’s nearly impossible for the refusing doctor to make up for the loss of 30 years of trust and familiarity. However, she may not have to. Consider the interference clause again: restitution need not be provided when fulfilling the request would be sufficiently immoral that the refusing doctor would be justified in interfering with another doctor and patient who attempt to fulfill a similar request. If we construe refusal to provide the procedure, together with refusal to put a patient where he would have been, as a kind of interference, we should also construe refusal to provide the procedure, together with inability to put him there, as a kind of interference. In the case of the 30-year doctor-patient relationship, the doctor is unable to put her patient where he would have been – that would take years. Therefore, to justify a refusal to provide the procedure when the refusing doctor is unable to entirely replace the current relationship, the procedure must be immoral enough to justify a degree of interference equivalent to somehow taking the trust and familiarity out of the relationship between another doctor and another patient. In short, the more the patient loses by the refusal, the more restitution the doctor must make, and the more the doctor is unable to completely restitute, the more immoral the procedure must be to justify her failure to provide complete restitution.\textsuperscript{11} Thus, the degree of immorality matters not only to whether restitution must be paid, but also to how much restitution must be paid – sometimes partial restitution is enough. This means that, unless the procedure is sufficiently immoral, the doctor will not be justified in refusing her long-term patient his request, even though she would be justified in refusing that procedure to a relatively new patient.\textsuperscript{12}

III. FIVE QUESTIONS ABOUT REFUSAL

When conscientious refusal is justified is not the only question here. There are also several controversial questions about the right way to undertake a conscientious refusal, and the restitution approach provides a unified way to answer them.\textsuperscript{13} Some ethicists say the doctor has a duty to at least refer and
facilitate a transfer to another doctor, and probably to counsel the patient as well.\textsuperscript{14} Others argue that the doctor should \textit{not} refer the patient, or at least not when the treatment the patient wants is sufficiently immoral.\textsuperscript{15} It can also be argued that the doctor should perform the procedure anyway, if there is no other doctor available to do the procedure in time.\textsuperscript{16} Some say the doctor should reveal his moral views to the patient (Pellegrino, 2000, p. 80; Thorp et al., 1992), but it is not clear that doctors should provide uninvited moral advice. Some writers advise doctors to make their moral views known up front (Pellegrino, p. 80; Wear, Lagaipa, & Logue, p. 155), but that may require a degree of foresight it is not always reasonable to expect. Some go so far as to recommend that doctors stay out of a specialty altogether when their moral values preclude them from performing procedures considered standard in that specialty.\textsuperscript{17} Other writers deny this, arguing that medicine loses when moral dissenters are excluded (Pellegrino, p. 80; Thorp, Wells, Bowes, & Cefalo, 1995, pp. 27-28).

There are two additional issues lurking here. First, if there is a duty to refer, it seems to be inconsistent with conscientious refusal: it’s permissible for a doctor to refuse to do a procedure because the procedure is immoral, but if the procedure is immoral, then it seems immoral for any other doctor to do the procedure.\textsuperscript{18} If so, then the doctor should neither perform the procedure nor refer the patient to anyone else. Call this ‘referral inconsistency’ – the duty to refer appears to be inconsistent with the duty not to perform the procedure (See also: Bayles, 1979, p. 167).

The second additional issue concerns the significance of medical consensus on the morality of a procedure. Many writers approach conscientious refusal by asking whether the requested procedure is one that most other doctors consider morally acceptable. This ‘majority limitation’ has also been proposed for the duty to refer, for justifying conscientious refusal generally, and for ascertaining when a doctor should stay out of a field whose standard practices he finds immoral. The general idea is that refusal, referral, or going into a field despite misgivings, are okay if the majority of doctors agree that it is, and not okay otherwise.

For example, the majority limitation on the duty to refer has been suggested by Jeffrey Blustein, who says, “there is a duty to refer implicit in one’s freely choosing to become a physician” (and in the ethical duty not to abandon a patient), and notes the “prevailing view” within the medical profession that “referral is obligatory only when the requested intervention is generally regarded within the profession as itself permissible” (1993, pp. 312-313).
Mark Wicclair has suggested that the majority view within the medical profession is important (though not dispositive) in determining when a doctor may refuse to provide a procedure on grounds of conscience in the first place:

Ascribing more weight to conscience-based objections to assisted suicide and other practices which are contrary to current professional norms can be defended by claiming that recognizing such appeals to conscience promotes the moral integrity of the medical profession as well as the individual physician. (2000, pp. 222-223, emphasis added)

The majority limitation is also invoked in support of claims that doctors should avoid specialties with standard procedures they find morally objectionable. For example, Thorp and Bowes advise prolife doctors to stay out of perinatal medicine if their moral beliefs prevent them from at least discussing the prochoice point of view:

After careful consideration, some may conclude that their prolife convictions will preclude the practice of modern perinatal medicine. If a physician cannot discuss issues of antenatal diagnosis with patients and present both viewpoints, then it would be better for all concerned if he or she entered another field. (1992, p. 1219)

Similarly, Blustein and Fleischman suggest that, if a doctor cannot do procedures that are considered standard practice by most of their colleagues, then that doctor should stay out of specialties that require those procedures (1995, p. 26).

Now these are peculiar claims, for majority consensus determines very few ethical truths. Moreover, a moral consensus may change over time, and surely the morality of a procedure does not change just because it comes to be seen differently. Given that the problems with the majority limitation are so obvious, it is not enough to refute it; we must also account for its wide appeal. I will later argue that the consensus of the profession is an important factor in conscientious refusal – not because the majority is likely to be right, but for very different reasons.

The controversies above can be organized into these five questions:

A. Referral inconsistency: Can it be consistent to refuse to do a procedure on moral grounds, yet refer the patient so someone else will do it?

B. Majority limitation: What moral significance, if any, should we attribute to a majority consensus about what is morally acceptable medical practice?
C. **The only available doctor:** Can the absence of other available doctors mean that a doctor must perform an objectionable procedure?

D. **Moral counseling:** To what extent should a doctor discuss with a patient the doctor’s moral reasons for refusing?

E. **Avoiding the field:** When, if ever, do a doctor’s moral beliefs obligate the doctor to stay out of a specialty?

A. **Duty to refer and referral inconsistency.** There is a widely-held view that refusing doctors have a duty to refer patients who are leaving for one reason or another. This view reflects the fact that the patient’s situation may have changed since she first came to see her doctor, either because her condition has progressed, or time is running out, or both. This may create a duty to refer and perhaps otherwise facilitate a transfer, for if the patient’s condition has changed, she may need another doctor quickly and be unable to go out and look for one. If she had not come to that doctor in the first place, she might very well have another doctor who, right now, would be treating her condition the way she wants. Therefore, in order put her in the situation she would otherwise have found, her doctor must refer her to another doctor.

What about referral inconsistency? The inconsistency is that it’s permissible for the doctor to refuse to do the procedure only if the procedure is immoral, but if the procedure is immoral, then it’s immoral for any other doctor to do the procedure. Thus, it seems the doctor should neither perform the procedure nor refer the patient to anyone else. The solution to this inconsistency stems from the interference exception (italicized below) to the right of conscientious refusal:

Ask what the patient’s situation would have been had she chosen another doctor, and put her there — *unless you’d be morally justified in interfering with her getting that procedure even when another doctor provides it.*

If what the patient wants is *not* immoral enough to justify the refusing doctor in interfering with her efforts to get it from another doctor, and she would have found another doctor had she not come to that doctor, then given that the doctor must restore her to the situation that would have happened *had* she gone to another doctor, her doctor must see to it that she gets another doctor. Her doctor must refer her to a doctor willing to do the procedure. If referral is not enough, then her doctor must take further steps to facilitate her to another doctor. Thus there is no inconsistency: the duty to refer exists only if the procedure is too immoral to perform, but not immoral enough to justify
interfering with someone else’s performance of it. In cases where the procedure is immoral enough to justify interference, there is no duty to refer (refusal to refer being a kind of interference).

**B. The majority limitation.** Earlier I questioned the common view that what the majority of doctors in the relevant specialty consider appropriate is relevant to whether a referral should be provided, or conscientious refusal is justified, or a doctor should stay out of a field. I question this because what a majority believes is irrelevant to what is moral. Why, then, do so many people believe it is relevant here? The answer is that majority consensus is not irrelevant to a doctor’s duties in those cases where fulfilling the patient’s request is immoral but not immoral enough to justify interference. The consensus among doctors is relevant because, if the patient had sought out some other doctor in the first place, the odds are high that she would have encountered a doctor whose views are consistent with the majority.

Consider refusal: if most other doctors would do the procedure, then the patient probably would have found a willing doctor had she not come to the refusing doctor first. In that case, the refusing doctor must refer her (provided the procedure is not sufficiently immoral to justify interference), for her position has changed since she came to him. If, however, most other doctors would not do the procedure (whether their reasons for refusing are moral or otherwise), then the refusing doctor has no duty to refer. After all, the patient will be no worse off than she would have been had she never come to that doctor in the first place.\(^{19}\) This reasoning explains the last clause to my specification of the right of conscientious refusal:

If you can’t meet [all the above] conditions, then you must give her what she wants – unless she would not have found another doctor to do so.

How large must the majority be before we can say that the patient would not have found another doctor to provide the procedure, and that her doctor may therefore refuse to refer? Suppose 90% of all available doctors would have refused to provide the procedure. The patient might still have kept looking until she found a doctor in the 10% minority who would provide the procedure. The majority of unwilling doctors must be very large, or to put it another way, the patient’s odds of finding a willing doctor must be very small, before her doctor may refuse to refer a patient whose request is not immoral enough to justify interference.

I used referral to explain this analysis. The majority limitation will come up again in the next subsection, concerning refusal when no other doctor is
available, and in the last subsection, concerning when doctors should stay out of a field.

C. When no other doctor is available to do a procedure, must the doctor who finds it morally objectionable do it anyway? Now suppose that the procedure is not immoral enough to justify interference (and hence refusal to refer). Suppose further that no other doctor will take this patient because her condition has progressed too far, but that one of them would have taken her earlier and given her the procedure she requests. Referral and transfer are no longer possible, interference is not justified, and the majority consensus is such that the patient had a reasonable chance of finding a willing doctor had she not come to the refusing doctor in the first place. From this combination of factors it follows that the refusing doctor must provide the requested procedure. If, however, the procedure is immoral enough to justify interference, then the refusing doctor does not have to provide the procedure whether or not another doctor is available.

D. Limited moral counseling is required. Our fourth question is whether doctors may – or should – reveal their moral reasons for refusing to provide a requested procedure. I answer that doctors have a duty to reveal their moral reasons for refusal because, if they do not, patients may mistakenly conclude that there are medical reasons for the refusal. In that event, the patient is worse off because she came to the refusing doctor: she now has a false belief that may limit her perceived options. In order to avoid making patients worse off in this way, doctors not only may but should reveal their moral objections to providing a given treatment.

There are limitations, of course. A doctor’s persuasive ability can overwhelm patients who tend to defer to doctors and other authority figures, or who cannot compete with the doctor in reasoning and verbal ability. The doctor should communicate his objection in a way that does not diminish the patient’s ability to exercise her own moral judgment. This does not mean that a doctor may not persuade a patient to revoke her request for the procedure, but if he does, he must do so by helping the patient to see another point of view, and not by overwhelming and effectively coercing the patient.

E. When doctors should stay out of a field. Some writers suggest that doctors who cannot bring themselves to provide treatments considered acceptable in a given specialty should stay out of that field. Once again, what the majority believes is irrelevant to whether a procedure is morally acceptable. And once again, a majority consensus is relevant here in another way.

Doctors should stay out of fields where they cannot provide procedures most other specialists deem acceptable – in those cases where the procedure
is so immoral that interference is justified. However, if interference is justified, then they can enter a field where they will routinely refuse to provide procedures other specialists consider routine – a form of interference.

Suppose a pro-life maternal-fetal doctor practices in a location where pro-choice maternal-fetal specialists are not hard to find, and where many patients hold pro-choice views. Under those conditions, if the nature and strength of her pro-life views are such that she is not justified in interfering, then she has a duty to refer patients to doctors who perform abortions. Why can’t she stay in the field and simply refer all patients who want abortions? She probably can, provided that her routine refusals and referrals do not interfere unduly with her patients or her community of specialists.

However, on what I will call the ‘aggregation principle,’ under certain conditions a doctor is obligated to stay out of a field. Although each referral may not inconvenience a given patient unduly, the cumulative volume of terminations and referrals might produce a large volume of patient inconvenience. If so, over time our maternal-fetal doctor will create a lot of interference (in the form of inconvenience), albeit distributed over many people and not very heavily on any one of them. One way to avoid all that inconvenience is for the doctor to routinely disclose her pro-life views at the outset, make sure the patient understands that other doctors are pro-choice, and advise the patient that she may later want a procedure which that doctor will not provide, but which the other doctors will. Depending on the nature of the doctor’s practice, that may be enough. However, if disclosures up front do not sufficiently reduce the total volume of inconvenience, that volume may constitute more total harm to others than the harm the doctor would suffer by staying out of that specialty.

It can be argued that harms distributed over many people, none of whom suffer unduly as individuals, can be aggregated for purposes of determining whether a pattern of behavior over time is morally permissible. If so, then the total volume of interference can be weighed against the harm the doctor suffers by staying out of her chosen field. On the ethical principle that harms can be aggregated in this way, the doctor should stay out of the field. If, however, we reject that principle, then even in the circumstances described above, the doctor is not obligated to stay out of the field. I do not know whether the aggregation principle is true, so I will leave this issue unresolved. Readers with stronger views about aggregation can draw the proper conclusions about when, if ever, doctors are obligated to stay out of fields.
IV. CONCLUSION

Doctors have a qualified right to conscientious refusal because they have a qualified right to quit, a right to repeal all or part of their relationship with a patient. The qualifications stem from the principle that a doctor’s refusal should not make the patient worse off than he would have been had he never gone to that doctor in the first place. A doctor’s refusal is justified provided (1) restitution is unnecessary to ensure the patient is no worse off, or (2) the doctor makes full restitution, or (3) what the patient wants is sufficiently immoral to justify interference. This restitution approach enables us to settle several controversies about conscientious refusal: when there is a duty to refer, why the moral consensus among doctors seems relevant even though it does not determine what is morally acceptable, whether doctors must provide objectionable procedures when no other doctor is available, whether ‘moral counseling’ is permissible, and whether doctors should stay out of fields whose standard procedures they find immoral.

NOTES

1. In most cases refusal does not require termination, but it might if the procedure in question is the only treatment that doctor can provide that patient, or if there is something about the patient that makes all treatments from that doctor immoral.

2. Although a bit awkward, I use “repeal” this way because statutes can be repealed “in whole or in part,” and I want a word that means something like “terminating in whole or in part” to cover both termination and curtailment.

3. Note that AMA ethics opinion 9.06 says doctors are free to decline new patients: “Although the concept of free choice assures that an individual can generally choose a physician, likewise a physician may decline to accept that individual as a patient.” (American Medical Association, 2000, p. 207).

4. This premise probably should be qualified by adding, ‘unless there is an emergency, and you are the only doctor available to do this procedure.’ However, that qualification does not affect my analysis of conscientious refusal, and would require independent argument, so I will leave it out.

5. How much immorality is sufficient depends on the nature of the interference. The more intrusive the interference, the more immoral the activity must be. However, this question will not concern us in most conscience cases, for the interference will be the same in most cases – refusing to refer the patient to another doctor.

6. As a practical matter, any doctor who refuses a patient request on moral grounds in a context where refusal effectively terminates the relationship may want to consult a lawyer first. In most jurisdictions a doctor is liable for the tort of “abandonment” if he or she unilaterally terminates a doctor-patient relationship either without adequate notice to the
patient, or during a critical stage, or both (61 Am. Jur. 2d., 2001; Katsetos, 1976; Miller, 1959). This should not be a problem in most conscience cases. If the requested procedure is medically necessary, then the doctor is not likely to consider it morally unacceptable. Moreover, in many cases the patient is not in a critical stage, and even if he is, referral and transfer may well be possible.

7. The consequences for the patient are probably greater if the relationship is terminated rather than restricted—hence the doctor usually should, if possible, curtail the relationship without terminating it—but the ethical constraints are much the same for both curtailment and termination.

8. "Restitution" is a legal concept that means, among other things, "[r]estoration of status quo and...amount which would put plaintiff in as good a position as he would have been if no contract had been made..." Black's Law Dictionary, 1180. Obviously I don't propose that doctors must make restitution in the form of paying money to their refused patients.

9. This is my considered moral judgment, but if I am wrong, then the restitution approach applies to an even wider range of cases than I believe it does, so my overall argument is none the worse off.

10. If the doctor and patient have a successful existing relationship in other respects, then it is unlikely that a moral conflict will require terminating the entire relationship. Termination of such a relationship might be necessary if, for example, the procedure is the only treatment that doctor has to offer that patient, and the patient's changed circumstances make that procedure immoral.

11. For simplicity, this example assumes that the refusal requires termination of the 30-year relationship. In most actual cases, refusal would probably not require termination of the entire relationship—just curtailment of what the doctor will provide. However, that refusal will probably inflict some damage on the relationship in the form of suspicion, feelings of betrayal, and so on. That damage requires restitution too, and if the doctor cannot achieve that part of the restitution, then the procedure must be immoral enough to justify the degree of interference equivalent to inflicting such damage on the relationship between another doctor and patient attempting to carry out that procedure.

12. The conscience cases discussed so far all concern requests from patients or their surrogates. However, some conscience cases involve requests from third parties, such as an employer, third-party payor, or colleague. A resident, for example, may believe the attending's order conflicts with the patient's best interest; a doctor may object to an MCO's practice guidelines for the same reason. I cannot in this paper adequately discuss how the restitution approach applies to third party requests like those from MCOs, insurers, senior physicians, and the like. First, what the third party requests conflicts with the patient's request or best interest (and this is likely), and that complicates the analysis. Second, the restitution approach works through the moral equivalent of terminating or curtailing a doctor's relationship with a patient, thereby terminating or curtailing the doctor's duties to that patient. However, relationships with employers and third party payors are usually characterized by formal contracts with specified duties and rights that cannot easily, by the terms of the contract, be modified. Even leaving the moral force of the law out of it, one has some moral obligation to keep one's promises and agreements. Third, restitution is different in third party request cases, for a doctor receives payment from those third parties; is a doctor obligated to make restitution by waiving her right to payment even when the third party is morally in the wrong? These complications, together with the fact that conscience cases abound in managed care, merit separate discussion in another paper.
13. I believe the restitution approach may also provide a new way to handle the well-worn topic of futility, but that is a larger project for another paper.

14. Wear et al. (1994) identify (but do not endorse) this as the “usual formula.” It is endorsed by The Hastings Center (1987), and Thorp and Bowes (1992) say that doctors have a duty to refer when their moral views preclude them from performing a procedure. The AMA Code of Medical Ethics does not require a referral per se, but ethics opinion 8.115 does require that the patient be notified of the termination of the doctor-patient relationship sufficiently far in advance for “another medical attendant to be secured” (2000, p. 173). In another context, Michael Bayles says the “standard view” on conscientious refusal generally (for all professionals, and not just doctors) is that refusing professionals have a duty to refer their clients to other professionals who will provide the requested service (1979, p. 166).

15. Edmund D. Pellegrino contends that there is no duty to refer when the doctor believes the procedure or treatment is “intrinsically and seriously wrong.” The doctor is not yet off the hook, however: “[T]he physician must continue to care for the patient until a substitute is found. The physician can help the patient to the extent of commenting on the professional reputation and skill of the substitute but not on the substitute’s willingness or unwillingness to perform an abortion or assist in suicide” (2000, p. 79).

16. Wicclair discusses (but does not endorse) a version of this position (2000, p. 220).

17. “[I]t may be best for all concerned if individuals with strong objections to abortion avoided the practice of modern perinatal medicine” (Blustein & Fleischman, 1995, p. 26). Thorp and Bowes take a similar position with regard to the limited issue of presenting and discussing both points of view on the acceptability of a given procedure (1992, p. 1219).


19. The issue is not whether she could have found another doctor, but whether she would have found another doctor; we are interested in what she probably would have gotten had she not gone to this doctor, not in what it was possible for her to get.

REFERENCES


