Laws, regulations, and ethical codes often address conflicts between personal beliefs and workplace demands. Such conflicts are common in the health setting, where work is intimately connected to matters of life and death, privacy, and dignity.

In the latest conflict attracting attention, pharmacists have expressed moral beliefs that interfere with women’s reproductive health needs. Journalists and others have reported cases of individual pharmacists refusing to fill prescriptions for emergency contraceptives. Because emergency contraception can act to block implantation of a fertilized egg, people who believe in protection of human life after conception find it morally objectionable.

State officials have responded in two ways. Some have endorsed legal requirements that protect women’s access to the drugs; others have sought to protect pharmacists’ conscientious objection rights. The American Pharmacists Association “recognizes the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure patients’ access to legally prescribed therapy without compromising the pharmacist’s right of refusal.”

In this and other contexts, we see disagreement over when to protect the professional’s freedom to reject on moral grounds a practice that is ordinarily required of the professional. The dispute over pharmacist refusals and workplace demands offers an opportunity to examine this broader question.

The Varieties of Conscience Claims

Health care workers may seek to be excused from several medical services on grounds of conscience. Many laws protect health professionals from employment penalties if they refuse to assist with abortion or sterilization procedures. A few laws allow doctors to avoid carrying out what they see as a morally objectionable decision to forgo life-sustaining treatment. Some laws excuse professionals from administering “futile” treatment that they see as morally inappropriate. And Oregon’s law allowing physician-assisted suicide permits clinicians to refuse to supply patients with life-ending medication.

Many other types of conscientious objection may be asserted in health settings. Clinicians may cite disability rights as the basis for an objection to performing tasks associated with prenatal diagnosis, or gender equality as the basis for a refusal to assist with sex-selection procedures. They may claim religious or moral beliefs as the basis for denying a single person’s request for infertility treatment. They may cite religious or cultural objections to retrieving organs from patients declared dead according to whole-brain criteria. Students may express moral opposition to using animals in training exercises.

In some circumstances, conscientious objection claims may mask self-interested or discriminatory motives. For example, professionals worried about disease transmission may refuse to care for an HIV-positive patient, claiming religious opposition to homosexuality or a duty to remain healthy for the sake of their families. An angry clinician may deny care to a disruptive patient, citing an ethical responsibility to protect other patients. Residents interested in lightening their work load may claim moral objections to avoid training sessions in abortion techniques.

Conflict Management Models

Because conscientious objection occurs in such varied circumstances, the acceptable resolution will be different in different situations. Nevertheless, there are several general models for handling such objections.

One is the contract model. At the outset of the encounter, the professional should disclose to patients any treatment limits. People in need of an excluded service may then seek that service from another professional. This model works in some contexts, but not when patients need care quickly or when no one else can take over the task of the objecting professional.

A second model imposes on the objecting professional a duty to refer or transfer patients to another professional willing to provide the contested service. The model shares some of the contract model’s problems—namely, it fails to meet patients’ interests when no one else is available. And this model may be unacceptable to professionals who see any assistance in securing the service as complicity in immoral behavior. One pharmacist expressed this view of referral: “That’s like saying, ‘I don’t kill people myself but let me tell you about the guy down the street who does.’”

A third model rules out the possibility of conscientious objection. According to this model, people who enter a profession agree to conform to its basic standards. By deciding to become a particular kind of professional, the individual gives up the freedom to avoid certain core duties. But this model has its own weaknesses. In many cases, the core duties of a profession are never explicitly disclosed, and people in the profession may reasonably protest that they neither

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by Rebecca Dresser
understood nor agreed to such a constraint on their freedom.

A fourth model draws on the military’s approach to handling conscientious objection. The “draft board” approach requires objectors to explain and defend their opposition to performing a particular medical procedure. The approach seeks to separate sincere beliefs from the other motivations that can underlie conscience claims. Among the problems with this model are that it can be damaging to morale, it cannot detect skilled liars, and the review process may be incompetent or corrupt.

A fifth model urges professionals to seek a compromise between personal beliefs and the patient’s interests in obtaining the disputed service. Different writers offer different ideas about the process for achieving compromise, but they all suggest that in some cases, closer examination of the problem will produce options that allow professionals to maintain their ethical integrity while meeting patients’ needs. Jeffrey Blustein suggests that the physician opposed to a legally and professionally permitted procedure could accept a duty to refer on grounds that it would be wrong to impose on patients a restriction that is not supported by many professionals and members of the public. Noam Zohar proposes that referral can be accepted if the professional distinguishes between personally violating one’s moral views and “facilitating the deeds of one’s co-citizens . . . that they legitimately regard as appropriate.” Although these approaches will be effective in some cases, they will probably not work for those who agree with the pharmacist quoted above.

The Institutional Framework for Conscientious Objection

The American Pharmacists Association endorses systems that both enable patients to obtain prescribed medications and allow pharmacists to exercise a right of conscientious objection. But commitment to this approach requires more than a simple policy statement. To meet their ethical obligations, professional organizations and individual professionals should act affirmatively to protect patients from unexpected and disruptive denials of services.

This affirmative effort should occur at several levels. At the organizational level, there should be an effort to clarify which activities are integral to the practice of a profession and which may be avoided by practitioners who have religious or other moral objections to them. As professionals, pharmacists owe basic service obligations to patients, including an obligation to fill medically appropriate prescriptions for approved drugs. Organizations representing the pharmacy profession should spell out the conditions under which pharmacists may be excused from this obligation for reasons of conscience.

Individual pharmacists planning to claim conscientious objection should take certain preparatory steps to reduce the harm their refusals impose on patients. Pharmacists opposed to dispensing emergency contraceptives should notify their employers so that another pharmacist can be enlisted to perform that task. If pharmacy operators cannot manage to have someone available to fill the prescriptions, or if they choose not to stock emergency contraceptives at all, then a prominent sign should alert customers to these restrictions. Pharmacy personnel should also notify area physicians and hospitals that the drugs are unavailable at specific locations. In states where emergency contraception is available without a prescription, pharmacies unwilling to offer the product should publicize this refusal as well.

Disclosure responsibilities should be assigned to individual objecting pharmacists, too. Although they should not be forced to deliver a medication for a morally opposed use, patients’ interests, together with society’s expectations of the profession, support imposing an obligation on pharmacists to inform patients about alternative medication sources. Objectors may claim that delivering this information is contrary to their ethical beliefs, but the obligation to convey accurate information about an approved drug is so fundamental to the profession that every pharmacist should be held to it. Accordingly, laws protecting conscientious objection rights should not excuse pharmacists from the duty to tell patients where prescriptions can be filled. Pharmacists failing to disclose alternative sources should be subject to professional disciplinary action. Pharmacists unwilling to conform to basic standards for information disclosure should seek employment situations that do not involve service to the general public.

People planning to take up pharmacy should address conscientious objection before they become professionals. Students should learn about the professional activities that could conflict with their personal views and should be prepared to discuss their views with potential employers and to seek positions that can accommodate their beliefs. Professional school applicants should be informed of educational requirements that they might find objectionable.

As nations become more ethnically and religiously diverse, and science and medicine develop new health interventions, new forms of conscientious objection are likely to emerge. Conscientious objection is not simply a matter for individuals, it is a matter for the professions and the broader society. Institutional responses are needed to prevent patients from bearing the burdens of excusing professionals from performing their customary services.

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