

# Rights vs. Responsibilities: Professional Standards and Provider Refusals

By Adam Sonfield

The U.S. media and state and federal policymakers have devoted a great deal of attention this year to the issue of pharmacists refusing to dispense emergency contraception and other prescription contraceptives. Little about this issue is, in fact, new; policymakers have engaged for decades in an ever-broadening debate over whether and in what circumstances individuals or institutions involved in the provision of health care or related services can refuse to provide services or information on moral or religious grounds (“New Refusal Clauses Shatter Balance Between Provider ‘Conscience,’ Patient Needs,” *TGR*, August 2004, page 1).

What has often been absent from this debate over providers’ rights has been any serious discussion about providers’ responsibilities—to their patients, colleagues, employers and the public. Some of these obligations are encoded in law; perhaps more importantly, they are enshrined in professional codes of ethics that define what it means to be a health care professional and supplemented by individual professional associations’ policy statements on various issues.

## The Values at Stake

Although different associations and professions frame the issues differently, core values that are generally agreed upon across health care professions and in the field of bioethics underlie the rights and the responsibilities of all health care providers:

- *Beneficence* requires the provider to act in the best interest of the

patient and her welfare and is closely related to *nonmaleficence*, the basic obligation to do no harm.

- *Justice* underlies the principle of nondiscrimination and the obligation of health care providers to work for the public good.
- *Respect for autonomy* leads to such principles as informed consent and confidentiality, as well as respect for the decisions of colleagues.

These core values have been translated into more specific ethical principles by numerous professional associations. Such guidelines are necessary in part because these values can at times conflict or appear to point in different directions. In the absence of respect for autonomy, for instance, beneficence can easily turn into paternalism in the hands of a highly trained health care provider caring for patients with inferior knowledge. And, while the International Code of Medical Ethics of the World Medical Association (WMA) asserts that “a physician shall always bear in mind the obligation of preserving human life,” in a separate declaration on abortion, the WMA discusses how the “diversity of attitudes towards the life of the unborn child” can lead to differences in how to interpret this obligation. Professional standards help to mediate these differences.

Despite the complexities of balancing these values, the professional medical associations have been remarkably consistent when it comes to the concept of refusal. In essence, professional standards typically endorse a provider’s right to

step away, or “withdraw,” from providing a health care service that violates his or her moral or religious beliefs. At the same time, these standards make clear that there must be limits to this right in order to ensure that patients receive the information, services and dignity to which they are entitled (see box, page 8).

Although not always spelled out in one place or in every association’s guidelines, this balancing leads to several clear obligations, including that:

- providers must impart full, accurate and unbiased information so patients can make informed decisions about their health care;
- patients must always have access to services in emergency circumstances;
- providers must not abandon patients but instead must refer them to another provider willing and ready to take over care; and
- providers seeking to “step away” must give adequate and timely notice to patients, employers and others who will be affected by their doing so.

It should come as no surprise that many of the most detailed standards and policy statements about refusal focus on abortion, contraception and other forms of reproductive health care, along with end-of-life care. These services have often generated controversy among policymakers and the general public. The professional associations have made their position clear, however: A health care provider’s moral or religious beliefs cannot justify attempts to override a patient’s autonomy. The right to withdraw from services cannot be used as a pretext for blocking or denying patients’ own rights to care.

## Responsibility and Reality

Public policy, however, has not always matched up with the principles endorsed by professional med-

ical associations, and the situation appears to be getting worse. Within weeks of the U.S. Supreme Court's decision in *Roe v. Wade* that legalized abortion nationwide in 1973, Congress passed legislation proposed by then-senator Frank Church (R-ID) to ensure providers' ability to withdraw ("Refusing to Participate in Health Care: A Continuing Debate," *TGR*, February 2000, page 8). The Church Amendment prevents the

government (as a condition of a federal grant) from requiring health care providers or institutions to perform or assist in abortion or sterilization procedures against their moral or religious convictions. It also prevents institutions receiving certain federal funds from taking action against personnel because of their participation, nonparticipation or beliefs about abortion or sterilization. The question is not specifically

addressed, but nothing in this policy suggests that anyone has the right to withhold information from a patient or refuse to refer a patient to another provider.

Almost every state in the country also has decades-old policies allowing individual health care providers to refuse to participate in abortion; many of these laws also apply to sterilization, and in 10 states, to contraception more broadly. These laws often depart more explicitly than the Church Amendment from the professional standards discussed above: Only a handful of these laws specifically provide an exception to refusal rights in emergency circumstances; most do not require health care providers to notify their employers if they intend to opt-out of certain services, and only three require any notice to patients; and about a dozen go so far as to allow providers to refuse to provide information, despite the broadly recognized obligations around obtaining patients' informed consent.

The architects of more recent legislation in many cases appear to have purposefully blurred or actually crossed the line between a right to withdraw and a right to obstruct. One subtle example of this was a provision included in 1997 legislation that created national standards for Medicaid managed care, including the standard that plans could not "gag" providers from telling Medicaid patients about treatment options not covered by the plan. Yet, Congress also allowed plans to refuse to cover counseling and referral activities to which they object on religious or moral grounds, creating a financial barrier to obtaining informed consent and ensuring access to care.

Another obstructionist provision, named after its sponsor, Rep. Dave Weldon (R-FL), was passed in 2004 as part of an annual appropriations law. It forbids federal, state and local governments from requiring any

#### WHAT LEADING PROFESSIONAL ASSOCIATIONS SAY ABOUT PROVIDERS' REFUSAL

"The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care."—*World Medical Association, Declaration on the Rights of the Patient*

"The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice....The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."—*American Medical Association, position statement on informed consent*

"Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse...the nurse is justified in refusing to participate on moral grounds....The nurse is obliged to provide for the patient's safety, to avoid patient abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the patient."—*American Nurses Association, Code of Ethics*

"A [physician assistant] has an ethical duty to offer each patient the full range of information on relevant options for their health care. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer an established patient to another qualified provider. PAs are obligated to care for patients in emergency situations and to responsibly transfer established patients if they cannot care for them."—*American Academy of Physician Assistants, Guidelines for Ethical Conduct for the Physician Assistant Profession*

"[P]harmacists [should] be allowed to excuse themselves from dispensing situations which they find morally objectionable, but that removal from participation must be accompanied by responsibility to the patient and performance of certain professional duties which accompany the refusal....ensuring that the patient will be referred to another pharmacist or be channeled into another available health system....Pharmacists and their employers will need to develop processes that support the decision of the individual pharmacist while still providing the appropriate services the patient seeks."—*American Pharmacists Association, 1997-98 policy committee report on pharmacist conscience clause*

"Pediatricians should not impose their values on the decision-making process and should be prepared to support the adolescent in her decision or refer her to a physician who can....Should a pediatrician choose not to counsel the adolescent patient about sexual matters such as pregnancy and abortion, the patient should be referred to other experienced professionals."—*American Academy of Pediatrics, position statement on counseling the adolescent about pregnancy options*

"Nurses have the right, under responsible procedures, to refuse to assist in the performance of abortion and/or sterilization procedures....Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in emergency situations....to provide nonjudgmental nursing care to all patients, either directly or through appropriate and timely referral....[and] to inform their employers, at the time of employment, of any attitudes and beliefs that may interfere with essential job functions."—*Association of Women's Health, Obstetric and Neonatal Nurses, position statement on nurses' rights and responsibilities related to abortion and sterilization*

individual or institutional provider or payer to perform, provide, refer for, or pay for an abortion. This goes well beyond the Church Amendment and violates several of the principles endorsed by the AMA, ANA and others. The National Family Planning and Reproductive Health Association has filed a lawsuit, arguing that the Weldon Amendment conflicts with the requirement that clinics receiving federal Title X family planning funds provide abortion referrals when requested subsequent to nondirective counseling about patients' full range of pregnancy options. California's attorney general has also sued, asserting that the new law would force the state to either sacrifice billions of dollars of federal aid or else ignore several of the state's own laws, including those requiring the provision of abortion services in emergency circumstances; in June, a federal judge rejected the U.S. government's motion to dismiss that lawsuit.

A law passed in Mississippi in 2004 may be the best example of the expansive new breed of refusal clause. It allows almost anyone connected with the health care industry—from doctors, nurses and pharmacists to the clerical staff of hospitals, nursing homes and drug stores—to refuse to participate or assist in any type of health care service, including referral and counseling, without liability or consequence. In the process, it violates every one of the obligations to patients and employers listed above around information, referral, emergencies, notice and the like.

### Finding Balance

A CBS News/New York Times poll in November 2004 found that nearly eight in 10 Americans believe that pharmacists should be required to fill prescriptions for birth control, even when they have religious objections. A poll of U.S. doctors in June yielded similar findings. Yet notably,

much of the public debate around emergency contraception, and contraception more generally, has centered not simply on pharmacists' refusal to fill a prescription. Rather, many observers have focused on cases where pharmacists have refused to transfer a prescription or refer a client to another pharmacist and where they have made oftentimes hostile attempts to dissuade women from using the product.

Some advocates for expansive refusal rights have argued that such actions are justified and should be protected. They assert, for example, that a pharmacist who refers a woman to someone else to fill her prescription for contraception is just as guilty as if the pharmacist filled the prescription himself. As one anticontraception pharmacist put it in an interview with the *Washington Post*, "That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.'" These arguments have been made for decades, yet the fact remains that they are in direct conflict with the ethical guidelines that govern the health care professions and that make clear that abandoning a patient in this way is unacceptable.

Such extremist behavior appears to be fueling a backlash. Policies adopted this year in Illinois and Nevada and introduced in at least five other states and in Congress would ensure that patients have access to legally prescribed medications, often by requiring a pharmacy to meet this need even if an individual pharmacist it employs refuses (see related story, page 10). Several of the proposals specifically prohibit pharmacists from refusing to refer or transfer a prescription and forbid verbal abuse and threats to breach patients' confidentiality. The AMA responded to the pharmacist controversy in June by adopting a resolution supporting legislation to ensure that pharmacists and pharmacies either fill valid prescriptions or "pro-

vide immediate referral to an appropriate alternative dispensing pharmacy without interference."

Some reproductive rights advocates have raised practical questions about whether it is possible to accommodate pharmacist refusal and still guarantee women's access to the contraceptives to which they are entitled. It sounds reasonable that a pharmacy ensure that every prescription is filled, even if an individual pharmacist refuses, but this can be difficult in pharmacies where only one pharmacist is on duty at a time. Perhaps requiring referral to another pharmacy is an answer, but is that pharmacy close enough? Does it accept the customer's insurance? Does it have the drug in stock? Will the pharmacist there refuse as well? And what impact will that have on the original pharmacy in terms of customers lost?

Such concerns have led to even more creative proposals. The AMA, for example, has called for legislation allowing doctors to dispense medication when no pharmacist within 30 miles is "able and willing" to do the job. Lawmakers, likewise, have addressed some of these details in crafting their proposals. Ultimately, no policy may be able to address every contingency, however. In such cases, professional standards are there to provide guidance, and to remind everyone that responsibility to the patient must always be the top priority and that a right to withdraw must never be turned into a right to obstruct. ☹

*This article was supported in part by grants from the Prospect Hill Foundation and the Compton Foundation. The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute.*