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ETHICS
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**National Ethics Teleconference
The Ethics of Rights of Conscience in Health Care Settings**

June 25, 2012

INTRODUCTION

Dr. Berkowitz:

Good day everyone. This is Ken Berkowitz. I am the Chief of Ethics Consultation at the National Center for Ethics in Health Care and a physician at the VA NY Harbor Healthcare System. I am very pleased to welcome you all to today's National Ethics Teleconference. By sponsoring this call, the National Center for Ethics in Health Care is providing an opportunity for education and open discussion of ethical concerns relevant to VHA. This call will feature an educational presentation on the ethics of rights of conscience in health care settings. That will be followed by an open, moderated discussion of the topic. After the discussion, we will reserve the last few minutes of the call for general discussion. This will be your opportunity to speak up and let us know what is on your mind regarding ethics related topics other than the focus of today's call.

ANNOUNCEMENTS

Ground Rules: Before we proceed, I have one announcement

The National Center for Ethics in Health Care (NCEHC) announces that effective July 1, 2012 staff from the NCEHC's Ethics Consultation Service will be available 24 hours a day, 7 days per week to perform ethics consultation in emergent situations that require action by the NCEHC. Emergencies that can be managed by your local ethics consultation service should be managed locally. All non emergent requests for ethics consultation from NCEHC should follow the routine practices of sending an email message to VHAethics@va.gov or by calling our Washington, DC office at 202 501-0364 or Dr. Kenneth Berkowitz, Chief, Ethics Consultation at 212 951-3385 or via the Outlook system.

This 24/7 on call service was developed primarily to meet requirements outlined in VHA Handbook 1004.02, Advance Care Planning and Management of Advance Directives. The Handbook sets forth procedures to follow for attempting to resolve conflicts between a surrogate and the treatment team about their interpretation of the patient's preferences as stated in the living will, when the local ethics consultation service is unable to resolve the conflict. Specifically, the Handbook requires that the local ethics consultation service must contact the National Center for Ethics in Health Care when, when, despite the intervention of the local ethics consultation resources there is unresolved conflict between the team and the surrogate about what should be done. While this is rarely an emergency situation we felt responsible to provide ethics consultation staff at the facilities with 24/7 access to experts from our consultation service.

To contact the National Center for Ethics in Health Care's Ethics Consultation Service outside of normal business hours Eastern Time a beeper number will be distributed through our normal communications channels and will be posted on our Intranet web site. You may expect that your page will be returned within 20 minutes.

One last thing, I need to briefly review the overall ground rules for this call:

We ask that when you speak, you begin by telling us your name, location and title so that we can continue to get to know each other better.

During the call, please minimize background noise and PLEASE do not put the call on hold.

Due to the interactive nature of this call, and the fact that this call involves sensitive issues, we think it is important to make two final points:

- First, it is not the specific role of the National Center for Ethics in Health Care to report policy violations. However, please remember that there are many participants on the line. You are speaking in an open forum and ultimately you are responsible for your own words.
- Second, please remember that this call is not an appropriate place to discuss specific cases or confidential information. If, during the discussions we hear people providing such information we may interrupt and ask them to make their comments more general.

PRESENTATION

Dr. Berkowitz:

We chose the topic of rights of conscience in health care settings for today's call because 1) concerns about rights of conscience in health care settings can be reasons for ethics consultations, 2) because VA staff members have contacted us requesting knowledge building in this area. We have been contacted several times by ethics

consultation services after a local provider has declined to participate in a clinical activity based on a right of conscience and ethics concerns were raised.

We expect that by the end of this session participants will be able to:

1. Define rights of conscience
2. Name values that are important when considering rights of conscience in health care
3. List criteria that have been used to describe legitimate rights of conscience
4. Describe the ethically acceptable limits of an individual's right of conscience to decline to participate in an aspect of a patient's care
5. Understand how to approach ethical concerns that arise when an individual wishes to decline to participate in a clinical activity based on a right of conscience

Let me introduce the faculty for today's call. From the National Center for Ethics in Health Care we have David Alfandre. Dr. Alfandre is a primary care physician and a member of our Consultation Service as well as the Integrated Ethics Manager for Ethics Consultation. We also have with us today Barbara Chanko. Ms. Chanko is a nurse and a health care ethicist here at the National Center for Ethics in Health Care. Thanks for joining us today David and Barbara. Let's get started.

So to begin, Dr. Alfandre can you define what a right of conscience is?

Dr. Alfandre:

Sure, I'd be happy to. From the Encyclopedia of Bioethics, a right of conscience is the "right to protect [one's] moral integrity – to uphold the soundness, reliability, wholeness and integration of one's moral character,"---stated another way, to object to performing an act based on moral grounds. A prominent bioethicist and philosopher, James Childress who has written widely on this topic, has described a right of conscience (ROC) as "a person's consciousness of and reflection on his own acts in relation to his standards of judgment." In other words, as he describes, "In appealing to conscience I indicate that I am trying to preserve a sense of myself, my wholeness or integrity...and that I cannot preserve those qualities if I submit to certain requirements of the state or society."

Dr. Berkowitz:

So what you are saying is that a right of conscience protects an individual's choice to decline to participate in an activity because doing so would threaten the values that are central to who that person is, his or her identity, and how they've chosen to live.

Dr. Alfandre:

Right, it's not simply that doing the act is unpleasant or something they would prefer not to do. It's really a serious threat to an individual and their personhood.

Dr. Berkowitz:

Yes, I can see that. Because ethical concerns are conflicts or uncertainty over values, an ethical concern about a right of conscience might involve the values of a provider attempting to protect his or her conscience conflicting with some aspect of his or her duty to provide health care. A right of conscience claim means that the provider will experience guilt, shame, or loss of self respect by performing the act in question (ACOG 2007). Not all ROC claims are considered legitimate. For example, claims to conscience should not be based on self-interested motives such as fear of professional liability or loss of reputation or on convenience. Health care providers' objections that rely on undefined personal feelings or concerns like, "It just doesn't feel right," or, "I can't put my finger on it but I don't feel comfortable with it," should engender empathy for the discomfort that sometimes comes with being a health care provider, but these feelings and concerns alone do not legitimate the claim of ROC.

Barbara, can you tell us about some of the historical background in this area?

Ms. Chanko:

Sure. In societies that respect personal autonomy, the right of citizens to not participate in activities that violate their conscience has been regularly recognized and permitted. In the US, during the Vietnam War, the Supreme Court ruled that a person may be exempt from participating in the war if their opposition was founded on "moral, ethical, or religious beliefs about what is right and wrong, and that these beliefs be held with strength of traditional religious convictions."

It is worth considering the background of federal laws and guidance relating to health care conscience protection in general. The "federal health care conscience protection statutes" include the Church Amendments, Section 245 of the Public Health Service Act, and the Weldon Amendment.

Dr. Berkowitz:

Please tell us a little about each of these.

Ms. Chanko:

The conscience provisions contained in the Church Amendments were enacted at various times during the 1970s and provide protection from discrimination to health care providers and other individuals by organizations that receive Health and Human Services (HHS) funds. The protection is on the basis, among other things, of health care providers' refusal, due to religious belief or moral conviction, to perform or participate in any lawful health service or research activity. Specifically, the amendments prohibited institutions receiving federal funds to require an individual to "perform or assist in the performance of any sterilization procedure or abortion [against] his religious or moral convictions." These statutes allowed for affected practitioners to continue in clinical practice without compromising their own deeply held moral convictions.

Signed into law by President Clinton in 1996, Section 245 of the Public Health Service Act prohibits federal, state or local governments from discriminating against individual

and institutional health care providers (including participants in medical training programs) who refused to, among other things, receive training in abortions; require or provide such training; perform abortions; or provide referrals for, or make arrangements for, such training or abortions.

The Weldon Amendment, passed in 2005, has been readopted (or incorporated by reference) in each subsequent HHS appropriations act. Through this law, Congress has expanded provider conscience protections by prohibiting the provision of HHS funds to any state or local government or federal agency or program that discriminates against institutional or individual health care entities on the basis that the entity does not provide, pay for, provide coverage of, or refer for abortion.

Dr. Berkowitz:

So what you're saying is that these health care provider conscience protection statutes have been around for decades, and that they are strong protections of certain rights of conscience in health care.

Ms. Chanko:

Precisely. But these health care provider conscience protection statutes are specific and do not extend to other potential clinical procedures and treatments. However, the thinking that led to the creation of these laws can be relevant to other circumstances and can inform our ethical analysis.

Dr. Berkowitz:

Let's look to the literature and professional societies for guidance on rights of conscience in health care. Such ethical standards can assist ethics consultants in deciding how to balance patient and professional rights when considering provider requests to opt out of patient care. In particular, The American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) have provided guidelines that address these practicalities. While these guidelines were developed for obstetrician/gynecologists and pediatricians, we believe they can be appropriately extrapolated to other medical specialties, settings and situations. Dr. Alfandre, can you describe some of the main elements of the guidelines pertaining to the professional obligations of health care providers?

Dr. Alfandre:

I'd be happy to. There are 7 central points from those 2 documents. I'll summarize them one by one.

First. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.

Second. Health care providers must impart complete, accurate and unbiased information so that patients can make informed decisions about their health care.

Third. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.

Fourth. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the... services that their patients request.

Fifth. In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.

Sixth. In resource-poor areas, access to safe health care services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.

And finally, Seventh... [The] duty to perform a procedure... increases as the availability of alternative providers decreases and the risk to the patient increases.

Dr. Berkowitz:

Thank you. You've outlined an important list of professional obligations to provide care in situations where a provider has made a claim of a right of conscience. We'll make sure that the source documents are available for reference in the summary of this call that we post on the internet.

David, are there any other features of a ROC claim?

Dr. Alfandre:

Yes. Health care professionals also need to be consistent in how they are applying their claims. For example, if a pharmacist wants to opt out of a specific treatment on the grounds that it might harm a pre-implanted embryo, they would have to object to providing any treatment that might harm a pre-implanted embryo.

Dr. Berkowitz:

So what are the limits to a health care provider's rights of conscience?

Dr. Alfandre:

In their 2007 paper in *The American Journal of Bioethics*, Claudia Emerson and Abdallah Daar from the University of Toronto, (*Defining Conscience and Acting Conscientiously*, *AJOB* December, Volume 7 (12), 2007) suggest that it is not

productive to focus on potentially subjective definitions of legitimate ROC. However, they recognize limits to accommodating a claim to ROC that take into account health care provider's obligations. Other sources in the literature, including the ACOG document, have concluded similarly and discuss when a claim to ROC should not be accommodated. Examples include:

1. If the claim is based on incorrect science
2. If honoring the claim would lead to discrimination
3. If honoring the claim would negatively affect the patient's health
4. If honoring the claim would impose on the patient or,
5. If honoring the claim would prevent the health care provider from discharging the fundamental duties of his/her profession.

Dr. Berkowitz:

So for example, claims to not participate in the care of any patients with HIV, or any patients who have a criminal history, should not be accommodated because they lead to discrimination.

These examples also point out that if the objection is to the patient, rather than to the treatment, discrimination should be carefully examined when considering the ROC request.

Similarly, a ROC to not provide a clinical treatment in an emergency might not be accommodated because it could negatively affect the patient's health and would prevent the provider from discharging the fundamental duties of his/her profession.

Dr. Alfandre:

Yes. I wanted to emphasize a final point about understanding claims to a ROC. Specifically, it is not a ROC when a provider refuses to offer a clinical service because he or she believes it isn't clinically indicated, or because providing that service would be inconsistent with clinical standards. These objections are based on clinical grounds, not moral grounds.

Dr. Berkowitz:

I'd like to return to the discussion of values and obligations we were having earlier. For a ROC, how can ethics consultation services balance the conflicting values? To review those situations when a provider is attempting to protect his or her conscience but also has a conflict with his or her duty to provide health care.

Dr. Alfandre:

Accepted ethical standards dictate that within a health care relationship the patient's well-being must be considered paramount relative to the professional's interests. Opting out of patient care based on a ROC, then, is not a health care provider's *absolute* right, but rather is subject to ethically appropriate limits based on professional responsibilities. Health care providers have a responsibility to assure that the patients they are responsible for have information about all treatments that are relevant to their

care. Additionally, simply referring a patient elsewhere may not be sufficient to manage the ethics tension over values. Attention should be paid to assuring that patient care is not negatively affected because of a provider's ROC.

Dr. Berkowitz:

In other words, you are saying that health care providers have the right to exempt themselves from certain aspects of care as a matter of conscience, but this right is not unlimited. A health care provider's request to opt out of care based on a ROC must be weighed against their primary professional obligation to care for patients. If a health care provider is requesting to opt out of aspects of a patient's care because of an objection based on a ROC, VHA must make reasonable attempts to accommodate the provider's request without negatively affecting patients' health.

Dr. Alfandre:

Well said!

Dr. Berkowitz:

What about providers who decline to provide information about medically indicated treatments, because doing so would violate their conscience? I'm aware of a prominent study in the New England Journal of Medicine from 2007 (*Curlin F.A., Lawrence R.E., Chin M.H., Lantos J.D. N Engl J Med 2007; 356:593-600*) that found that many physicians do not consider themselves obligated to disclose information about or refer patients for legal but morally controversial medical indicated procedures. In their study sample of over 1,100 physicians, Curlin et al found that 63% of physicians believed that it is ethically permissible for doctors to explain their moral objections to patients. 14% believed that physicians are not obligated to present all options and 29% believed they were not obligated to refer the patient to another clinician who does not object to the requested procedure.

Dr. Alfandre:

In VA, health care providers have a responsibility to assure that the patients they are responsible for have information about all treatments that are relevant to their care. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, gives patients the right to accept or refuse any medical treatment or procedure recommended by their VA provider. To inform the patient's decision, practitioners must supply information that other patients in similar circumstances would reasonably want to know, including information about the proposed treatment and all reasonable alternatives to that treatment, along with the known risks and expected benefits of each. Omitting discussion of therapeutic options that fall within the range of broadly accepted professional standards for medical care is not ethically justifiable – how can a patient make an informed choice if they are not aware of their options? Hence, a health care provider's claim to a ROC against discussing a treatment or procedure cannot supersede the patient's right to information about the treatment and its alternatives.

Dr. Berkowitz:

So how should an ethics consultation service approach a conflict of values when an individual wishes to decline to participate in a clinical activity based on a right of conscience?

Dr. Alfandre:

In the case of a health care provider who does not wish to participate in a treatment or procedure based on a claim of ROC, the following steps should be taken.

First, as we already mentioned, for it to be a claim of ROC, it must reflect the individual's belief that performing the requested activity would undermine values he or she perceives to be central to their identity. Claims to a ROC are objections based on moral grounds, and are not ROC claims if they are based self-interested motives (e.g., fear of professional liability or loss of reputation), incorrect science or convenience.

Second, if a health care provider is requesting to opt out of aspects of a patient's care because of an objection based on a ROC, VHA must make reasonable attempts to accommodate the provider's request. During the time that VHA is attempting to accommodate the provider's request, the provider must ensure that information about and access to the treatment is made available to all of their patients for whom it is clinically indicated.

If a health care provider's request to opt out of care based on a ROC cannot reasonably be accommodated without affecting the patient's health, imposing on the patient, leading to discrimination, or preventing the provider from discharging the fundamental duties of his/her profession, VHA should deny the request. In such cases, the health care provider must continue to provide information about and access to the treatment or procedure for whom it is clinically indicated. Health care provider's who continue to refuse to provide information and/or care after their request for a claim of conscience is denied should be managed according to HR policies for employees who are not performing their duties.

Dr. Berkowitz:

Can you provide us with an example of how to think about accommodating a request to decline to participate in a clinical activity due to a ROC?

Dr. Alfandre:

Sure. Let's talk about the example of emergency contraception. Requests to opt out of providing levonorgestrel EC (also known as Plan B™ emergency contraception) based on a ROC has been examined before in health care. A legitimate ROC to providing levonorgestrel might be a morally based objection to contraception. Because professional roles vary from discipline to discipline and from setting to setting, so too does the appropriate response to a request to opt out of care based on a legitimate ROC. It might be possible to accommodate a pharmacist's request to opt out of providing Levonorgestrel EC based on a legitimate ROC against contraception if there is another on-site pharmacist to step in on an as-needed basis, or if Levonorgestrel EC

can be provided in some other manner that would not be expected to negatively affect the patient. In contrast, it might not be possible to accommodate a primary care provider's request to opt of providing information about Levonorgestrel EC based on a similarly legitimate ROC. According to the American College of Obstetrics and Gynecology, women of childbearing age who are sexually active but do not wish to get pregnant should be counseled routinely about available contraceptive options, including available options for emergency contraception in the event of unprotected intercourse or contraceptive failure. For such patients, arranging for another primary care provider to step in to discuss contraception would arguably interfere with the patient's ongoing therapeutic relationship with the original provider. Therefore it might be reasonable in this circumstance to accommodate the request by limiting the provider's practice to exclude female patients with reproductive potential, or if this is not practical, to deny the provider's request on the basis that it cannot be reasonably accommodated without negatively affecting patients' mental or physical health.

Dr. Berkowitz:

Is there anything that the facility ought to do when concerns about ROC arise?

Dr. Alfandre:

Yes. For health care providers who are likely to be involved in aspects of care that involve a ROC, service lines or facilities should design and establish systems to consider and accommodate ROC claims if and when they are brought up by a provider. This should also be done in a timeframe that would be least likely to burden patients or staff. During consideration of such requests, and attempts at systems redesign to possibly accommodate valid requests, all patient care and appropriate treatment must continue to be delivered by the health care providers involved.

Dr. Berkowitz:

Thank you. Dr. Alfandre, any summary thoughts before our open discussion?

Dr. Alfandre:

Yes, thanks. Employees have rights of conscience that are grounded in law and ethics. It is very important for staff to recognize that fact. Additionally, Veterans have legal entitlements to care for which VA is committed to providing. The desire to respect an employee's right of conscience must be balanced with, and may be limited by, other values in the provision of care, including the professional obligation to provide care. Because evaluating ethics concerns surrounding an employee's right of conscience is a complex decision, ethics consultants can play a vital role in managing these concerns at their facility.

MODERATED DISCUSSION

We've saved time for discussion. Please introduce yourself and let us know what is on your mind.

Caller from San Antonio: I'm pleasantly surprised to hear those last comments on birth control. I know in one of our small rural clinics, I was told by Primary Care that there were two providers who did not want to prescribe birth control and I was surprised by that. But I thought that was something we had to accommodate.

Dr. Berkowitz: When you said it was something to accommodate, what did you mean?

Caller: I thought we had to accommodate the provider's opt-out in the same way that providers can opt-out of abortion. What I was probably doing was extrapolating all the talk about pharmacy and it's good to hear that I wasn't exactly correct on that.

Dr. Berkowitz: Again what is important is the guidelines from the professional literature that Dr. Alfandre went through. The goal is to accommodate everyone's claims to ROC but we shouldn't accommodate them if the claim is based on something that's not factually correct or incorrect science; if honoring the claim would negatively affect the patient's health; if honoring the claim would impose on the patient; if honoring the claim would lead to discrimination or if honoring the claim would prevent the health care provider from discharging the fundamental duties of his/her profession...those are the questions you would have to ask for in those clinics.

Caller from Houston: I had an issue that came up here that may be relevant and this is a case of a sexual offender who wanted a penile implant. Do you have any thoughts about that?

Dr. Alfandre: Yes. It's not an uncommon problem we hear about in the field. Again, if you think about the guidance that we've talked about, obviously you need to get the provider into the room so you can have a discussion about what some of their concerns are. As we talked about before, there are clinical objections to providing treatment and moral objections. If it's about a moral objection, then your service would use some of the guidance we've talked about. In terms of the example you gave, you'd need to know more about what was on the provider's mind and what some of the concerns were. One of the important aspects of having a call like this is getting people talking about concerns that arise in their facility...and that's a great thing.

Dr. Berkowitz: And to add to that, I think a well founded right of conscience claim should relate to declining to participate in a clinical treatment or procedure but not to decline providing care to a particular group or class of patients. In the Encyclopedia of Bioethics, it quotes "*The conscience objection in question should not be based on who is to receive the treatment or procedure. Instead, conscientious refusal should be based on the type of treatment or procedure in question, rather than, for example, provision of this treatment or procedure to members of a particular racial or ethnic group*" Or in this case to a particular class of patient such as all patients who have any history of sex offense. As Dr. Alfandre was alluding to, there may be particularly high risk patients or patients where they think it would be clinically unadvisable based on the specifics of that patient, but to say that we're not going to give erectile dysfunction treatment specifically

to anyone with a history of sex offense without considering the content of that case, is not an ethically justifiable concept for the overall class of patients.

Caller: We have Veterans who may identify as a gender outside their physical makeup and for instance, if we have a male who self identifies as a female and wishes to be placed in a female room. We've recently had a case where the clinician was uncomfortable when we were doing bed assignments on what to do in this type of scenario. Fortunately we utilized a private room but were there not that availability, they were concerned about other female patients and that the patient is still male.

Dr. Berkowitz: I think we've strayed a little from ROC but I will say that VA's position on this is becoming increasingly clear. There are national policies related to transgender patients that incorporate our goal to be patient-centered; we really have to find a way to a way to respect each patient's own designation of their gender while respecting other patient's as much as we can. Again, I'm not sure how this fits in with right of conscience.

Caller: Well, I think the clinician didn't really know how to address it in terms of what the patient wanted and with respect to other patients.

Dr. Berkowitz: I think this reinforces the point made earlier in the call, sometimes people frame a feeling as a right of conscience and in fact it's really either moral distress or difficult feelings that they're faced with in response to certain aspects of care. Again, I'm very empathetic and I think that all the provider's concerns and all of the patients' concerns should be unpacked, understood and addressed. I'm just not sure that because a provider is uncomfortable, that makes it a ROC.

Dr. Alfandre: I would like to add to that. Ethics Consultation Services can be helpful when, providers may describe uncomfortable feelings or discomfort in caring for patients. But that alone doesn't describe a right of conscience. So then the conversation you can have with providers is finding out more about what these beliefs and ideas they have are about providing this particular treatment or procedure and see if the objection is based on moral grounds or clinical ones, or a general discomfort; does it rise to the level of, as James Childress says, "*In appealing to conscience I indicate that I am trying to preserve a sense of myself, my wholeness or integrity...and that I cannot preserve those qualities if I submit to certain requirements of the state or society.*" So there are some criteria to apply when someone says I'm uncomfortable with providing this and therefore I have I have a right to not provide it. Part of this call is to understand what a right of conscience is and then as Dr. Berkowitz said, what are the ethically acceptable limits on rights of conscience. So those are two useful steps ethics consultants use when working with all types of providers who describe discomfort and moral distress.

Caller, VISN 16: Thank you for that nice description. If a clinician completely informs the patient and proactively states up front what they feel is morally appropriate and then the provider is having a problem feeling complicit if he/she actually then refers that

patient on...is there a mechanism in VHA that still balances the rights of patients but yet uphold the clinicians' feeling of moral complicity and self-integrity if they then take that step and refer?

Dr. Alfandre: Yes, I recommend you look at one of the documents we stated in our talk, The Limits of Conscience Refusal in Reproductive Medicine. In that article, they talk about the concerns about complicity that providers may bring forward. There appears to be general consensus in the literature that the issue of complicity is not terribly relevant in issues like this. Let me quote from the American College of Obstetrics and Gynecology opinion. It says "*Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act. Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees.*" I would also add that rather than a compromise of one's own values, it is a referral is the professional obligation one accepts as a member of the profession.

Dr. Berkowitz: I think it will certainly make people feel uncomfortable and not feel good about it but it's really outweighed by the obligation that if you're not going to be able to provide a certain aspect of care then at least it should be in the hands of another provider who can. I think the general consensus is that you have to allow patients to have that option.

Caller, New York: Did any professional Codes of Ethics give you assistance in providing this information?

Dr. Alfandre: We tried to be broader in formulating this call, and go beyond professional codes of ethics; two of the best documents in the literature are the two we describe in this talk. We did find that there seemed to be a general consensus that the patient's well being was considered paramount relative to the professional's interests.

Dr. Berkowitz: I do think there's some relevant information in the American Nursing Association's Code of Ethics, The American Medical Association's Code of Ethics, and The American Pharmacist Association's Code of Ethics as well.

Caller, Salisbury: I run into ROC with Anesthesia in DNR situations and they say it's against their conscience to take people where they will not be able to resuscitate them. Any tips on how to work through that with them?

Dr. Berkowitz: I would be happy to work with you offline to work through those. If anyone has specific questions about this topic, please feel free to contact our Ethics Consultation Service for assistance. We would be more than happy to work with you.

FROM THE FIELD

We can use the remaining time for further discussion or to address any other ethics topic that is on your mind...

CONCLUSION

I want to take the last minute of the call to thank everyone who has really worked very hard on the development, planning, and implementation of this call. It's not a trivial task, and I really appreciate everyone's effort, including Ellen Fox, Sherrie Hans, Barbara Chanko, Bridgette Wiley and James McAllister. I also want to acknowledge the VANTS staff that support these calls.

Please note that our web sites, <http://vaww.ethics.va.gov> or <http://www.ethics.va.gov> contain all of the summaries of prior National Ethics Teleconferences. A summary of this call, and the references that we described, will be posted to our website. If you have suggestions about topics for future calls or any question about this or other ethics-related matters please let us know. If you send messages to us on Outlook, the address is vhaethics@va.gov.

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