

Article 23

The “Convictions of Conscience” Clause: Clinicians and Consumers Beware

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A “convictions of conscience” clause, as called by proponents, or a “refusal of services” or “denial of care” clause, as called by opponents, is a statute or practice regulation designed to shield health care providers from discrimination by their employers when they refuse to perform procedures that violate firmly held religious or moral beliefs (Roshelli, 2009). Some states have proposed legislative or practice regulations that prohibit sanctions against licensed mental health practitioners who refuse services and/or referrals for clients about whose issues they have moral objections, such as sexual orientation, abortion, and religion. This article provides a review of the historical context for and current issues in mental health practice related to “convictions of conscience” clauses, as well as explores the ethical implications of these clauses for professional counselors and counselors in training.

Historical Context

A “convictions of conscience” clause, as called by proponents, or a “refusal of services” or “denial of care” clause, as called by opponents, is a statute or practice regulation designed to shield health care providers from discrimination by their employers when they refuse to perform medical procedures that violate firmly held religious or moral beliefs (Roshelli, 2009). Conscience clauses were first enacted at the

state and federal levels following the 1973 *Roe v. Wade* United States Supreme Court verdict holding that a woman's decision to undergo an abortion is constitutionally protected by the right to privacy (Roshelli, 2009; Sonfield, 2004). According to the Guttmacher Institute (Sonfield, 2008) the conscience clause laws were popularly accepted and promoted, with 46 states passing some version to protect physicians or hospitals that refuse to provide or participate in abortion. Thirteen states allow health care providers to refuse services related to contraception while 18 states allow refusal to provide sterilization services.

With the passage of these laws, opponents of refusal clauses have become concerned about the discrimination against certain patient groups inherent in permitting providers or institutions to opt-out of meeting accepted medical standards of care because of moral convictions. They call for providers to evaluate the real health consequences to patients of exercising personal "conscience rights" (Sonfield, 2004). They suggest health care decisions should be guided by evidence based practice not religious or personal beliefs (Roshelli, 2009). For example, the American College of Obstetricians and Gynecologists drafted an opinion in November 2007 regarding limits of conscientious refusal in reproductive medicine that states, "Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral belief on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities" (Sonfield, 2008, p. 2). Furthermore, the opinion asserts, "that regardless of their religious or moral objections, health care professionals must provide all patients with accurate and unbiased information, prior notice of professionals' objections and timely referral in cases of refusal, and medically indicated care in an emergency" (Sonfield, 2008, p. 2). Moreover, the opinion states that "the patient's well-being must be paramount" and recommended that professionals with objections to specific services ". . . maintain a referral process that ensures patients' access to care" (Sonfield, 2008, p. 2).

Additionally, 'Required to Fill' laws were enacted to prohibit health care professionals (i.e., pharmacists) from refusing to dispense medication solely for philosophical, moral, or religious reasons. Health care professionals were required to dispense prescription drugs and devices in a timely way or provide appropriate referrals for patients to obtain the necessary prescription drugs and devices, despite objections based on ethical, moral, or religious reasons.

This debate between ethical care and moral belief has also been waging in the field of mental health practice. In January of 2009, Julea Ward enrolled in a practicum class in a counselor education training program at Eastern Michigan University (EMU). In this class, Ms. Ward was assigned a client who had earlier been counseled regarding a homosexual relationship. She requested that this client be assigned to another counselor because working with a homosexual client was against her moral convictions. The position of EMU was that Ms. Ward was unable to provide counseling services that aligned with the ethical codes of the counseling profession that require that counselors not discriminate based on sexual orientation (American Counseling Association [ACA], 2005). Ms. Ward was expelled from the counselor education program whereupon she filed a lawsuit with support from the Alliance Defense Fund, a conservative Christian non-profit organization. The outcome of the lawsuit and further appeals upheld that the university followed due process and had a right to ensure that ethical codes were

followed. The case continues, with the Sixth Court of Appeals having recently heard an appeal in October, 2011 (Dixon, 2011). In a second case in 2010, Jennifer Keeton, an Augusta State University (ASU) student in Alabama filed a similar lawsuit with support from the Alliance Defense Fund. Ms. Keeton argued that ASU had violated her constitutional rights by demanding that she work to change her views opposing homosexuality (Schmidt, 2010). Both cases are similar in that they pit counselor education programs adhering to professional anti-discrimination ethical standards against students who refuse counseling services based on their moral beliefs.

Sonfield (2004) identified a social conservative campaign to enact laws to expand the scope of refusal policies. Arizona and Mississippi are prime examples at the state level. The Arizona legislature created and passed a law prohibiting an educational program from taking any action (e.g., remediation, suspension, dismissal) regarding students who refused to counsel a client based on religious or moral objections. Specifically it states:

A university or community college shall not discipline or discriminate against a student in a counseling, social work, or psychology program because the student refuses to counsel a client about goals that conflict with the student's sincerely held religious belief or moral conviction. (H. Bill 2565, 2011, p. 1)

The American Counseling Association (ACA) advocated that "...like all other health professionals, counselors are trained to put the needs of their clients ahead of their own. Multicultural competency--the ability to work with a client based on his or her particular beliefs, values, and spirituality--is a core skill required of all counselors" (Evans, 2011, pp. 2-3). Many believed that the passage of this legislation would hamper an educational programs ability to train counselors to put aside their personal values and concentrate on the needs of their client.

Mississippi Governor, Haley Barbour, campaigned on and celebrated what he claimed to be the most expansive conscience exception law in the nation. Indeed, the law covers a wide range of services including counseling, diagnosis, and research, as well as dispensing or administering any type of drug, device, surgery care, or treatment (Sonfield, 2004). Providers protected include hospital, clinic, or nursing home employees, pharmacy or medical school faculty, students, or counselors.

Approval of regulation changes related to mental health practice sought by three Nebraska mental health licensing boards have been "on hold" for more than 2 years after the Nebraska Catholic Conference objected to ethics clauses that would prohibit mental health professionals from discriminating against clients based on sexual orientation (Hicks, 2010). The Nebraska Catholic Conference wants a practice regulation change that would allow mental health providers to refuse to treat, and refuse to refer, clients because of religious or moral objections (Hicks, 2009a). In an interview, Dr. Joann Schaefer, Nebraska's Chief Medical Officer and Director of Public Health, stated that the Nebraska Legislature would not protect sexual orientation due to the fact that legislation that attempted to add this class to state anti-discrimination laws had been defeated (Hicks, 2009b).

In this controversy, the provider's right to religious or moral freedoms is at odds with the government's duty to protect the citizen from discrimination. In 2009 testimony to the Nebraska Board of Mental Health Practice, Dr. James Cole argued on behalf of the

Nebraska Psychological Association, that the highest duty of a behavioral health regulation and ethical code is “do no harm” by protecting the rights, safety, and welfare of the public, not the religious freedom or values of the credential holder. He further argued that the Catholic Conference’s language, if adopted, would allow any licensed mental health professional to refuse treatment and/or referral for vulnerable clients. In the event of a harmful consequence (e.g., suicide, self injury, or harm to others) the credential holder could claim no responsibility by invoking the superior moral value thereby rendering the entire anti-discrimination clause unenforceable (Cole, 2009). The potential harm to clients is especially a concern in rural areas such as Nebraska where consumers have limited choice of providers (Sonfield, 2004).

These lawsuits and laws spotlight what Sonfield (2004) referred to as a long-gathering movement to allow health care providers, institutions and payers to place their needs before the needs of those they serve and to refuse services or referral for services by claiming a moral or religious objection. On the national level, a strong warning has emerged that expanding and radical policies are intentionally designed to undermine the ability of governments at all levels to balance providers’ rights with patients rights (Roshelli, 2009, Sonfield, 2004; Sonfield, 2005; Sonfield, 2008; Stein, 2008, Yakush, 2008), and that the “convictions of conscience” clauses sanction discrimination and shield providers from civil or criminal liability and action by the regulatory board against the licensee if following their moral convictions places consumers at risk. The practice and ethical implications for counselors and the programs that train them are profound.

Ethical Concerns for Professional Counselors

The work of professional counselors is guided by the ethical code of the American Counseling Association (ACA, 2005), which outlines a course of action that best serves those utilizing counseling services and promotes the values of the counseling profession. Counselors and counselors-in-training “have a responsibility to understand and follow the *ACA Code of Ethics* and adhere to applicable laws, regulatory policies, and rules and policies governing professional staff behavior at the agency or placement setting. Students have the same obligation to clients as those required of professional counselors” (p. 15). Counselors are expected to abide by the code regardless of other affiliations. The ethical code speaks directly to issues of client welfare, non-discrimination, and mandatory referral.

Client Welfare

The *ACA Code of Ethics* clearly states that counselors encourage client growth and development in ways that foster the interest and welfare of clients, and that the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients (ACA, 2005, p. 4). In fact, it is a fundamental assumption of the *ACA Code of Ethics*, as well as other ethical codes within the mental health profession, to “avoid harm to clients . . . and to minimize or to remedy unavoidable or unanticipated harm” (p. 4). In other words, the needs of clients, not counselors, are the priority. Ethical codes and practice regulations exist to assure the welfare of clients, not accommodate the personal beliefs of providers. “Convictions of conscience” clauses imply that self-interest rather than devotion to client welfare can be the counselor’s priority.

Valuing Diversity and Non-Discrimination

The *ACA Code of Ethics* states that counselors “do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/ spirituality, gender, gender identity, sexual orientation, marital status/ partnership, language preference, socioeconomic status, or any basis proscribed by law” (ACA, 2005, p. 10). It continues to state that counselors do not discriminate against clients “. . . in a manner that has a negative impact on these persons” (p. 10). In other words, counselors do not treat one client differently from another because of the counselor's beliefs or values that may relate to the group memberships or values of the client, and counselors do not engage in actions that could result in harm to these clients. The code not only state that counselors should not discriminate against clients because of membership in any of the categories stated above, it directs counselor to “examine potential barriers and obstacles at individual, group, institutional, and societal levels that inhibit access and/or the growth and development of clients” (p. 5), and to “promote change at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered” (p. 9). Thus, if counselors recognize that their moral convictions are creating barriers in access to services or supporting societal conditions that create mental health issues for clients, then they should work to promote change in themselves and those institutional or societal barriers.

In Nebraska, the refusal clause involves the right to discriminate against all classes listed in the anti-discrimination policy (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status). Cole (2009) provided strong testimony that the “conscience clause” eviscerates the moral authority of the professional codes of ethics and the intent of the anti-discrimination clause and attempts to replace them with religious conviction. Should “convictions of conscience” clauses be enacted, discrimination against classes of clients is not limited to displaying prejudice against homosexual clients. In effect a credential holder could ignore the entire anti-discrimination clause and claim a moral or religious right to discriminate against any protected category or any client with whom they perceived a value difference that created discomfort for them.

Mandatory Referral

One of the primary aims of the “conviction of conscience” clause is to prohibit sanctions against counselors who deny services and in some cases deny referrals based on conflicts with personal values. Counselors do not need additional legislation or practice regulations to address issues related to their moral convictions. The *ACA Code of Ethics* does recognize that counselors may consider themselves unable to provide professional assistance based on their personal values and provides direction for counselors who find themselves in this situation. It states first that “clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor” (ACA, 2005, p. 4). The code specifically directs counselors to explain to clients their qualifications, credentials, and relevant experience or limitations and to determine if they are able to be of professional assistance to clients. In other words, before entering into a counseling relationship, counselors have the opportunity and the responsibility to disclose to clients if their moral

convictions could cause them to not be able to provide ethical services to the client. The code requires counselors to "respect the diversity of clients and . . . to avoid imposing values that are inconsistent with counseling goals" (p. 4). Disclosure of moral convictions that would make imposing values difficult should be done prior to working with a client as part of the informed consent process.

If, after initiating counseling, the situation arises where counselors believe that strong feelings about certain moral issues may make it difficult to maintain ethical behavior or appropriate boundaries with clients, they have two courses of action. In these situations, counselors are encouraged in the ethical code to consult and seek supervision from professional colleagues in order to ensure their practice is non-discriminatory toward the client if they continue services. The other choice provided is to discontinue services, but the code then continues to say that if counselors determine they are unable to provide or continue counseling relationships, they should be "knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives" (ACA, 2005, p. 6). Thus, they do not abandon or neglect clients but make arrangement for provision or continuation of treatment. Mandatory referral is a long-standing practice expectation. Refusal to refer because of moral convictions may subject clients to potential harm and is clearly discriminatory and unethical practice that is not in the client's best interest. Such action also directly contradicts counselors' ethical responsibility to actively work against the very limitation of access to services the "convictions of conscience" clauses promote.

Conclusion

In summary, "convictions of conscience" clauses clearly endorse practice regulations that are in violation of the nationally accepted ethical standards of practice for the counseling profession. Sonfield (2005) observed that absent from the debate about providers' rights was providers' responsibilities to their patients, colleagues, employers and the public. Ethical principles require providers to act in the best interest of the client and his or her welfare (beneficence), be nondiscriminatory and work for the public good (justice), and respect client autonomy. Client welfare and standard of care, valuing diversity and non-discrimination, and counselor competence and mandatory referral obligations are compromised when a "convictions of conscience" clause becomes public policy. Especially since professional ethical standards already endorse a counselor's right to step away or "withdraw" as long as they provide a referral to a qualified provider who can provide ethical care. Sonfield (2005) argues that the ethical standards are very clear that there are limits to this right in order to ensure that clients receive the information, services, and dignity to which they are entitled. Allowing special interest groups to foster change in the professional mental health practice regulations sets an inappropriate and dangerous precedent. Practice regulations should be informed by and in compliance with the nationally accepted and endorsed practice expectations outlined in the ethical code. If providers have a concern because of their religious beliefs, they need to resolve that issue—not by denying services and/or referral but rather in a manner unambiguously consistent with the *ACA Code of Ethics*, not in opposition to it.

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