The establishment of conscientious monopolies in rural communities

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Abstract: In the United States, healthcare providers have the federally protected right to conscientiously refuse to provide treatments or services that they feel violate their moral or religious values. This refusal of services is colloquially known as “conscientious objection,” which has become a polarizing topic in today’s medical and ethical landscape. Typically, physicians exercising their right to conscientious objection do not represent a barrier in access to care for most patient populations. This dynamic shifts, however, in rural America, where there are relatively few providers. In this commentary, we discuss some of the unique ramifications that are likely to occur when rural providers invoke conscientious objection in their medical practice and how this can in turn establish conscientious monopolies for the members of their communities.

Keywords: access to care; conscientious monopoly; conscientious objection; conscientious refusal of services; rural healthcare

Since the passage of the Church Amendments in 1973, healthcare providers in the United States have enjoyed the federally protected right to conscientiously refuse to provide treatments or services that they feel violate their moral or religious values [1]. Such refusal is more colloquially known as “conscientious objection” (CO). CO is commonly cited in the refusal of controversial services such as physician aid-in-dying, abortion, and contraception. Although CO is implemented by providers nationwide, the use of CO in the rural context has unique potential ramifications that are not readily apparent. In this commentary, we first introduce the idea of a “conscientious monopoly” (CM). We then discuss the unique position that osteopathic physicians practicing within the rural context may find themselves in with the establishment of such monopolies and the effects that this may have on their patient population.

Additionally, in recent decades, CO has become a politically charged and often polarizing issue that may seem to favor one political ideology over another. Before further discussing the merits and consequences of CO within medicine, we would encourage readers to approach this topic from an apolitical standpoint built upon the principles of CO, setting aside any political consequences that may occur from its use. As the authors of this commentary, we affirm a provider’s right to CO and merely wish to outline some of the unique potential ramifications that may occur within rural communities for providers who invoke CO.

CM is the phenomenon in which the CO of a particular medical service leads to the prohibition of such service for the community at large. CMs can be established when all providers of a particular medical service in a community collectively agree to morally object to and refuse to provide said service on the grounds of CO. Additionally, their establishment represents an underrecognized barrier in access to care for many patient populations.

A notable example of a successfully established CM was in 2013 when a group of urologists specializing in male sexual dysfunction at the Boston Medical Group decided to collectively object to the treatment of known male sex offenders seeking healthcare related to their sexual dysfunction. They reasoned that the delivery of care to enable sexual function to a group known to commit violent sexual acts could in turn perpetuate and enable this behavior [2]. As a result, this group of physicians was able to effectively create a CM in Boston barring the treatment of sexual dysfunction of sex offenders because there were few other providers in the area capable of providing these medical services.

Generally speaking, individual physicians exercising CO are unable to create a CM through their actions alone because there are often other providers in that area willing to provide that service. Establishing a CM within a community usually requires a concerted, coordinated effort by a group of physicians who share concordant moral values. While this paradigm may be true in most of America, the dynamics and effects of CO shift in rural communities.

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https://doi.org/10.1515/jom-2024-0012
Received January 16, 2024; accepted March 13, 2024; published online March 26, 2024

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Although the United States is facing a looming physician shortage, there is already a disturbing lack of both primary care and specialist physicians in rural areas. Approximately 20% of the United States population resides in a rural location, yet only 11% of all physicians practice in these areas [3]. The lack of physicians within these communities represents a critical barrier in access to care for a marginalized population. Due to this shortage of providers, it is not uncommon for a single physician to be the only provider in that community offering select health services.

In the case of the urologists at the Boston Medical Group, the establishment of a CM required a collective agreement among providers to refuse care [2]. This relative degree of difficulty in the establishment of CM is lessened in rural settings. The lack of providers in these communities even allows for single-provider CM in which the CO of one provider to a medical service can lead to a CM. This can then exacerbate issues in access to care for members in rural communities in which providers are able to readily establish monopolies.

These issues are further compounded given that the right to CO extends beyond the individual provider, because entire institutions are allowed to implement CO and refuse treatments and services regardless of the beliefs of individual providers employed by such institution [4]. An example of this phenomenon can be seen within the Catholic hospitals that are regulated by the Ethical and Religious Directives created by the U.S. Conference of Catholic Bishops [5]. These directives restrict a variety of legal treatments and procedures that can be performed by the providers at their institution. Catholic-run healthcare has long served an invaluable role in rural communities by increasing access to care for these patient populations. In over 50 communities, Catholic hospitals are the only providers of short-term acute hospital care, yet within these communities, Catholic hospitals can implement a CM with relative ease [6].

In order to address the issues related to CMs, additional providers or institutions willing to provide these contested services are needed within these communities. Although there is a high need for physicians in rural areas, the relatively low population density in rural communities is less supportive of multiple providers practicing in close proximity to one another. This can prohibit the viability of additional providers or institutions from operating in these areas, further maintaining the pre-established CM within these communities. On average, osteopathic physicians practice within rural communities more often than their allopathic counterparts [7]. Given that they are likely to encounter these issues in their rural practices, providers should be keenly aware of the ideas discussed in this commentary and should consider the unique ramifications that are likely to occur when they conscientiously refuse services to their patient population. This should not encourage them to offer services that violate their moral principles but rather consider solutions that may help mitigate some of the issues patients living under a CM may experience, such as offering advanced notification of services refused or assistance in the referral process to willing providers.

**References**