Freedom of Conscience Revisited: 2010 and 2015

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The debate over freedom of conscience continues in the public square. The dilemma appears to be in deciding how far the right of conscience is to be tolerated; should individuals who object on the basis of moral belief be allowed to refuse to participate in actions which these individuals understand would violate their moral belief. Conflict arises when others claim the exercise of these moral acts limit their rights.

The medical community is very involved in the debate. Professional organizations have emitted opinions and published policy statements. The American Medical Association (AMA) *Principles of Medical Ethics* (2001), in principle 6, states a physician shall be free to choose whom to serve and whom to associate with, excepting emergencies. In 2007, the Council on Ethical and Judicial Affairs of the AMA published a revision of principle 6, addressing physician refusal to enter into relationship with a patient or refusing to provide a treatment on the basis of conflict with the physician's religious or moral beliefs. It acknowledged the right to refuse stated in principle 6, but added that this conscientious objection must be tempered by the statements of principle 8; which states when caring for a patient, physicians must regard the interests of the patient as "paramount;" and principle 9 which states that physicians shall support access to medical care for all peoples. The Council concludes that the physician's conscientious objection must be counterbalanced with obligations that will respect the patients' autonomy.

The American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics published a position paper in November 2007: *The Limits of Conscientious Refusal in Reproductive Medicine.* The Committee claimed a respect for conscience and recognized its value to the ethical practice of reproductive medicine. The committee opinion addressed specifically those physicians engaged in the practice of reproductive medicine, but admitted that the conflict of conscience could occur in other medical specialties as well. The document concludes with the following seven recommendations: (1) In the provision of reproductive services, the patient's well-being must be paramount. 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, (2) Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care, (3) 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, (4) 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 standard reproductive services that their patients request, (5) 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 providers moral objections, (6) In resource-poor areas, 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, (7) Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

The American Academy of Pediatrics (AAP) Committee on Bioethics (COB) published in 2009 a policy statement: *Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience.* The COB states there are positive individual and social benefits to a physician's ability to act according to his/her conscience, that the healthcare system should make "reasonable accommodations" for physicians with conscientious objections, but that this freedom of conscience must be restrained at times. The driver of the ethical decision is the respect for the patient's autonomy; physicians who object to procedures and treatments that are routine in a specialty should not enter that specialty. The statement concludes that since conscientious objections are not made on a medical basis but on a moral or religious basis, the ability to refuse to provide a service or a treatment on these bases is "not part of being a physician." The AAP COB concludes the policy statement with the following 7 recommendations: (1) The AAP supports a balance

between the individual physician's moral integrity and his/her fiduciary obligation to patients, (2) Physicians should work to ensure that healthcare delivery systems enable physicians to act according to their consciences and patients to obtain desired healthcare, (3) Physicians have a duty to patients to disclose standard treatments and procedures that they refuse to provide but are normally provided by others, (4) Physicians have a moral obligation to inform their patients of relevant alternatives as part of the informed consent process, (5) Physicians who consider certain treatments immoral have a duty to refer patients who desire these treatments when failing to do so would harm the patient, (6) Physicians should work to ensure that employers make reasonable accommodations for employees' conscientiously held views, (7) In emergencies, when referral would significantly increase the probability of mortality or serious morbidity, physicians have a moral obligation to provide treatment.

The response to the ethical dilemma and the recommendations by the ACOG and the AAP are similar: they appear to be guided by the AMA Code of Ethics. I will comment on the different issues as the organizations coincide and indicate where they differ.

In their recommendation 1, the ACOG states a conscientious refusal that conflicts with the patient's well being is allowed only if the patient's request is satisfied. The ACOG refers to the patient's well-being rather than health. Well-being is defined as a good and satisfactory condition of existence; this allows for very wide latitude. ACOG considers a refusal to provide a requested service an imposition on the patient of the physician's views. The AAP, in their recommendation 1, recognizes there ought to be a balance between the physician's moral integrity and the fiduciary responsibility to the patient. The ACOG claims the balance is between the conflict of conscience and the patient's request.

In their recommendation 2, the ACOG calls for complete information to be given to the patient for an informed decision to be made. The AAP in their recommendation 4 adds that physicians have a moral obligation to inform their patients of relevant alternatives as part of the informed consent process. Of course, complete and unbiased information is required for informed consent.

In their recommendation 3, the ACOG enjoins physicians with moral objections to some practices to inform their patients of their moral commitments and admonishes not to "use their professional authority to argue or advocate these positions." The AAP in their recommendation 3 agrees with clear and complete disclosure on the part of the physician. Complete and clear information is key for the preservation of the covenant of trust that is essential for a successful doctor patient encounter.

Recommendation 4 in the ACOG document calls for physician referral of patients who request services that they cannot in conscience provide to practitioners who would provide the service. The AAP in their recommendation 5 agrees that physicians have a duty to refer the patient to another physician, when failure to refer would result in harm to the patient. A physician who believes a practice to be morally objectionable would feel that being coerced to send the patient to another provider in order to satisfy the patient's request is being forced to participate in the practice that he/she considers morally objectionable and not in the best interest of the patient. In good conscience, a physician who objects to a practice on moral grounds ought not be forced into the position of being an agent in the procurement of the morally objectionable act for the patient.

In recommendation 5 the ACOG affirms in an emergency, when referral and transport might affect negatively the physical or mental health of the patient, the physician has the obligation to provide the service requested by the patient regardless of the physician's moral objections. A properly and professionally conducted transport will not deteriorate the patient's physical condition. It is questionable that the patient's mental health would be affected by transport to another facility. In recommendation 7, the AAP agrees that in the case of an emergency, the physician has the moral obligation to treat the patient. When a physician is presented with a true emergent situation to treat is not a choice but an obligation.

ACOG's recommendation 6 has no comparative statement from the AAP. In this recommendation the ACOG demands, on the basis of access, that in poor resource areas, the providers with moral objections should practice in proximity to individuals who do not share their views. Controlling the location of a physician's practice is a violation of the physician's rights and his or her freedom. This demand is abusive and contrary to law.

In recommendation 7, the ACOG calls for legislation to advance policies that balance protection of conscience rights and ensure that reproductive services are accessible to all patients. Legislation to enforce ACOG's recommendations would render the dissenting physician unable to exercise his right to disagree. If these recommendations were enacted into law, a physician would have to disregard his moral convictions and comply to maintain his license and hospital privileges. The AAP, in recommendation 2, calls on physicians to work to ensure the healthcare system provides the opportunity for physician freedom of conscience and for the patient's requests to be granted.

Both professional organizations claim respect for the concept of freedom of conscience. However, in practice, they quickly downplay the importance of the concept of a free conscience on the basis of patient autonomy. In their zeal to champion their viewpoint, extreme demands are made on the dissenting physician.

The ACOG Committee on Ethics sets limitations on those that differ from their views on abortion, sterilization and contraception even to the extreme of recommending that dissenters practice in proximity to non-dissenters to ensure that patients have smooth unimpeded access to the services in question.

The AAP Committee on Bioethics affirms that freedom to disagree and refuse to comply with a patient's request based on religious or moral grounds is "not part of being a physician," adding that physicians who object to procedures and treatments that are routine in a specialty should not enter that specialty. The AAP chooses to ignore that all persons are moral agents and that a pediatrician makes moral decisions on a daily basis in his/her practice. The conflict arises when the moral decision made by the pediatrician who disagrees is in conflict with the organization's moral beliefs.

The dissenting physician is forbidden to speak his or her opinion, and his or her practice is kept under surveillance and control. It is disturbing that both the ACOG and the AAP candidly state there is no room for the dissenting physician in today's healthcare system. Exchange of ideas and untrammeled discussion are essential for an open society to thrive. Is one to understand the physician's moral convictions ought not be part of his/her moral deliberations in ethical medical decision making? Are the ACOG and the AAP policy statements recommendations free of their authors' moral beliefs? Do our patients want physicians with moral integrity? Closing debate tends to close minds.

The physician's right to object on the basis of his/her moral beliefs and refuse to comply with the patient's request is the focus of the debate and the apparent disaccord with the patient's autonomy. Does the physician's respect of the patient's autonomy supersede the physician's own self-determination? Should patient autonomy be balanced with physician beneficence? Is there a conflict between the two? Is the physician merely a provider of service without thoughtful consideration of the patient's best interest? Should the physician refuse requests that he/she knows are not in the best interest of the patient? What of the fiduciary responsibility the physician owes his/her patient?

Comment

The notorious *Tuskegee Study of Untreated Syphilis in the Negro Male* conducted by the United States Public Health Service, raised concern for patient safety in clinical research and influenced the Belmont Report of 1979. The Report set ethical principles for the protection of human subjects of research; the Report established 3 principles: respect for persons (autonomy), beneficence, and justice. The Belmont Report gave birth to "principlism," the principle approach to medical ethical decision making. A simple

method, based on a few principles, it is the code most frequently applied in clinical medical ethics today. The four principles are meant to be a framework for decision making. The four principles are: respect for autonomy, beneficence, non-maleficence, and justice. Respect for the patient's autonomy has become the principal moral obligation of the physician. This predominance of individual autonomy has resulted in significant influence on the doctor patient relationship.

The "autonomy movement" elicited an apparent conflict between the principles of beneficence and self-determination, making beneficence synonymous with paternalism, contrary to respect for self-determination. Paternalism presumes that the patient does not have the knowledge to make intelligent medical decisions, so the physician makes the choice for the patient. The paternalistic doctor believes he is the best judge of what is best for the patient. Beneficence seeks the good of the patient; what is medically good, what is good in terms of the patient's perceptions of his own good, what is good for humans as members of the community, and what is good for humans as spiritual beings. The principle of beneficence promotes and supports the patient's self-governance. An action that violates the patient's autonomy undermines the patient's humanity and disrespects the patient's capacity for reason and self-determination. The human being cannot flourish without the freedom and the capacity to make choices and develop a life plan. Beneficence and respect for a person's autonomy are in accord; there need not be a conflict between the two. The paramount ethical principle is beneficence, the duty of assisting others in need and avoiding harm. This principle is expressed by the Hippocratic maxim: Be of benefit and do no harm. The physician's fiduciary responsibility to his/her patient is grounded on this obligation.

Medicine is a moral activity. The physician and the patient must make a moral choice. The physician's moral beliefs are fundamental to his/her integrity and foundational to the obligations to the patient as a moral agent. The internal morality of the doctor patient encounter will enable the physician to make the right choice, with the good intention, and result in the act that produces the best consequence for the patient. The physician is a thinking person who applies moral discernment to his or her decision making.

Resources

1. American Medical Association Code of Medical Ethics; Principles of Medical Ethics 2001.

2. Physician Objection to Treatment and Individual Patient Discrimination, Report of the Council on Ethical and Judicial Affairs, American Medical Association, CEJA Report 6-A-07, 2007.

3. The Limits of Conscientious Refusal in Reproductive Medicine, American College of Obstetrics and Gynecology, Committee Opinion, Committee on Ethics, Number 385, November 2007.

4. Policy Statement- Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience, American Academy of Pediatrics, Committee on Bioethics, Pediatrics, volume 124, number 6, December 2009.

Addendum

This essay was written in 2012. All three professional organizations have made subsequent statements on the topic of physician right of conscience.

In June 2015, the AMA issued a set of seven recommendations on physician responsibilities in exercising conscience. These recommendations were outlined in opinion 10.6 *"Physician Exercise of Conscience,"* in the *Code of Medical Ethics.* The AMA reiterated that physician freedom of conscience is not unlimited. The first recommendation is a statement admonishing the physician to thoughtfully consider if an act or failure to act on behalf of a patient would result in significant moral distress or to compromise his/her ability to provide care. This is a significant difference from the 2007 statement; the recognition that the act against conscience could result in moral distress to the physician and even affect his/her practice. This concern for the well-being of the dissenting physician from the AMA is encouraging. Recommendations 2 through 4 advise to make clear when starting a new doctor patient relationship those interventions the physician is not

prepared to provide, to ensure these actions or failures to act do not discriminate against the patient or group of patients, and to be mindful of the burden that these acts could have on fellow professionals. Recommendation 5 advises to uphold the standard of informed consent and to inform the patient of all options for treatment including those the physician morally objects. Recommendation 6 states the physician should refer to another physician who would provide the intervention the physician declines. And adds, if the physician declines to refer, "the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services." The term "impartial guidance" is clearly vague, could serve to describe several approaches. Is this to mean information to guide the patient to a physician who will perform the morally objectionable act or an organization that would do the same? Or is it to advise the patient to go online for information? Recommendation 7 advises the physician to continue to provide other care to the patient or to terminate the relationship "in keeping with ethical guidelines." There is no mention of which ethical guidelines the recommendation refers. The 2015 AMA recommendations are very similar to those of 2007.

In the year 2010, the ACOG reviewed and reaffirmed the 2007 *The Limits of Conscientious Refusal in Reproductive Medicine* policy statement number 385. A reaffirmed policy statement is one that has been approved to stay as current policy in the topic. In 2011, The American Board of Obstetrics and Gynecology (ABOG) issued a *Bulletin for Basic Certification in Obstetrics and Gynecology.* Section III Part F of the Bulletin explains that a physician can have his/her certification revoked if he or she acts in "violation of ACOG or ABOG rules and/or ethical principles." The combination of the reaffirmed ACOG policy statement 385 and the ABOG 2011 Bulletin is a threat to physician conscience rights. The physician either complies with the rules or loses his certification. This is a clear example of coercion.

In the year 2014, The AAP reaffirmed the policy statement published in 2009: *Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience.* The 2009 statement stands as current policy of the AAP.

It appears that the ACOG and the AAP continue to hold the view that physicians in their respective specialties have to abide by the organization's moral views, even at the risk of losing accreditation. The AMA refrains from making this demand; the AMA is not a specialty organization.

In their excellent review article, Genuis and Lipp comment in the closing page,

> *"It will be a noteworthy and significant day for individual practitioners, for the medical profession, for individual patients, and for society as a whole when we demand preparedness to do what one believes to be unethical, wrong, or evil as a prerequisite professional responsibility in order to join the medical community. It will be a sobering moment, indeed, when a willingness to capitulate to regulatory demand becomes a more important and established value in the medical community than integrity of character and an unwavering resolve to do what is good. It will be a paradoxical state when we exhort doctors to "Do no harm" but simultaneously compel them to do what they believe is harmful—as long as a patient requests it or an authority demands it."*

(Genuis, SJ, Lipp, C, Ethical Diversity and the Role of Conscience in Clinical Medicine, *International Journal of Family Medicine,* Volume 2013, Article ID 587541, 18 pages.
http://dx.doi.org/10.1155/2013/587541)