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Accommodating Conscientious Objection in Medicine—Private Ideological Convictions Must Not Trump Professional Obligations

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ABSTRACT

The opinion of the American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) on the accommodation of conscientious objectors among medical doctors[1] aims to balance fairly patients' rights of access to care and accommodating doctors' deeply held personal beliefs. Like similar documents, it fails. Patients will not find it persuasive, and neither should they. The lines drawn aim at a reasonable compromise between positions that are not amenable to compromise. They are also largely arbitrary. This article explains why that is the case. The view that conscientious objection accommodation has no place in modern medicine is defended.

INTRODUCTION

The thorny issue of conscientious objection accommodation in medicine is back on the agenda, and not just in the United States. Just slightly north, in Canada, religious doctors' groups are taking provincial regulatory bodies to court in order to establish that their members are well entitled to the accommodation of their conscience-based objections to participation in Canada's medical aid-in-dying regime.[2] Guaranteed patients' access to this service takes a back seat to concerns about doctors' individual feelings on the subject. This is so, despite the fact that the Canadian Medical Association, as well as existing legislation in Quebec, define medical aid in dying uncontroversially as a medical procedure.[3] Why are we typically going out of our way to ensure that the accommodation of conscientious objectors is guaranteed, regardless of the impact this has on patients' access to care? The long and short of it is that we are traditionally so accustomed to taking conscience claims made by doctors sufficiently seriously that there is little debate about the normative justifiability of conscience accommodation policies. This shows both in the AMA's "Opinion 1.1.7, Physician Exercise of Conscience"[4] itself, as well as in the helpful backgrounder prepared by BJ Crigger and colleagues.[5] (The full text of the AMA opinion is included as figure 1 in that article). Both lack a plausible ethical or professional justification for why society ought to accommodate conscientious objectors in medicine. That being said, the AMA opinion is in line with the AMA's historical embrace of what Robert Baker called "a laissez-faire conception of ethics, according to which physicians should be free to follow the dictates of their personal moral responsibilities."[6] Not coincidentally, Baker, the preeminent historian of medical ethics in the U.S., described the AMA as an organization that "abdicated its role as moral conscience of the profession."[7]

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CONSCIENTIOUS OBJECTION ACCOMMODATION AND THE "INTEGRITY OF MEDICINE"

The AMA opinion claims that the protection of individual conscience accommodation is "important for preserving the integrity of the medical profession." While it is not unusual for such policy statements not to provide reason or evidence and to rely solely on the authority of the issuing organization or institution,[8] it is nonetheless surprising that this claim is followed by "thus physicians have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities," as if that followed logically from the initial unsubstantiated claim. If anything, we have reason to suspect that conscientious objection accommodation would have the opposite effect, namely to subvert the integrity of the profession. It would subject eligible patients seeking help from a medical professional, *qua* professional, to the vagaries of this professional's idiosyncratic views of the universe. It is worth noting that this claim is not repeated in the article by BJ Crigger and colleagues. They focus their attention on the alleged need to accommodate conscientious objectors in order to protect their individual integrity. That clearly is not the same as claiming that the profession's integrity would be at risk if individual conscientious objectors were not accommodated.

"CONSCIENCE" CLAIMS—MUST THEY BE REASON BASED?

Remarkably, the AMA opinion assumes that it is self-evident what "conscience" is, because no attempt is made to define the central concept of the document. Crigger and colleagues offer us a reasonable attempt at conceptualizing "conscience," but we cannot be sure that that is actually an interpretation shared by the AMA. Crigger and colleagues mistakenly think that there is a need for conscientious objectors to show that their beliefs are deeply held, and that these beliefs do not "rest on intuition or emotion," a view mirrored by the AMA opinion. They also expect that "the physician be able to articulate how the values and principles that constitute the physician's identity-conferring beliefs justify acting one way or another." Crigger and colleagues are not alone in believing that objectors ought to have a reasonable case when they demand accommodation. That conscientious objectors would have to be able to provide reasons for their accommodation request seems obvious to most people. Many authors have arrived at a similar point of view, and they have tried to develop reasonableness criteria that objectors ought to meet.[9] However, and here reality meets theory, when it comes to, for instance, religious beliefs, it is practically impossible for any doctor to demonstrate that her or his professed beliefs are based on anything other than intuition and emotion.[10] Worse, we would have reason to be skeptical about the conviction claims made by religious conscience objectors, because the odds are not negligible that literally they do not believe what they claim to believe.[11] That matters quite a bit, given that the overwhelming majority of conscience-based objections are of a religious nature in the United States, but also in Europe, and I suspect elsewhere.[12] Unlike what Crigger and colleagues seem to think, today's conscientious objection protections are designed in such a way that objectors do not have to show that their convictions are based on something more reasonable than "intuition or emotion." The reason for this is that the courts, and legislators, rightly, refuse to take a stance on the typically religious convictions that purportedly motivate these objections.

The United States Supreme Court wrote on the subject,

> What principle of law or logic can be brought to bear to contradict a believer's assertion that a particular act is "central" to his personal faith? Judging the centrality of different religious practices is akin to the unacceptable "business of evaluating the relative merits of differing religious claims" . . . it is not within the judicial ken to question the centrality of particular beliefs or practices to a faith, or the validity of particular litigants' interpretation of those creeds . . . courts must not presume to determine the place of a particular belief in a religion or the plausibility of a religious claim.[13]

The courts have correctly noted that there is no way to test the reasonableness of these convictions, so, what matters, in law, is that someone says that she or he holds particular views, ideally Christian views, because we are familiar with those traditions in liberal Western democracies. For all practical intent and purposes, that is the state of intellectual affairs with regard to the accommodation of conscientious objectors in medicine. It seems an exercise in futility for U.S.-based proponents of reasonableness criteria, such as Robert F. Card[14] or Crigger and colleagues, to argue for particular standards an objector must meet when it is clear that your average religious objectors cannot meet those standards, and

when it is clear that the highest court in the U.S. has already rejected that approach.

WHY ACCOMMODATE CONSCIENTIOUS OBJECTORS?

This brings us to the crux of the matter. Some of the guidance pieces of the article by Crigger and colleagues fall into place once we accept their premise that conscientious objectors have a moral claim to be accommodated. It is then that we can engage in the activities they (and the AMA opinion) engage in, namely to draw up principles or policies that should govern conscientious objectors. However, it is far from clear that that is the appropriate response to accommodation claims. Incidentally, the conceptual problems mentioned earlier come back to haunt Crigger and colleagues throughout their article. I will return to this later in this commentary.

A fair number of authors have argued over the years that the starting point of both the article by Crigger and colleagues as well as the AMA opinion is mistaken, and that we should not accommodate conscientious objection claims.[15] I, too, have argued that we have no sound moral reason to do so.[16] This is not the space to present these arguments in great detail again, but in a nutshell, here they are: People join the medical profession (and particular specialties within it) voluntarily. In fact, they often compete vigorously for scarce medical school places. They know that their profession's scope of practice is ultimately determined by society, the very same society that provides these professions with a monopoly on the provisions of services that fall within that scope of practice. Medical practice is invariably changing over time and so is the societal understanding of what forms part and parcel of that monopoly practice. Doctors cannot credibly claim that the addition of a new professional service is irrelevant to their obligations, because they did not sign up for a deal that included that particular service. In fact, they decided knowingly to join a profession the scope of practice of which was beyond their individual control.

It could be argued that doctors had reason to assume that conscientious objection accommodation would be available to them in case of the addition of services with which they might disagree. This argument is also flawed, because conscientious objection accommodation itself is a policy issue that is bound to be subject to change. A number of European countries, for instance, including Sweden, Finland, and Iceland, have done away with conscientious objection accommodation in the context of abortion, with no negative consequences for the profession's service delivery. [17]

As I have put it elsewhere, the upshot of this argument is this:

> It remains unclear why untestable conscience claims from privileged professionals who voluntarily join a particular profession, and who have been endowed by society with a monopoly on the provision of particular procedures, should be accommodated, given that this toleration subverts the very objectives the profession is designed to achieve. This does not deny anyone the right to hold any number of private religious or moral beliefs, as they see fit and as they choose to hold. What we are denying is that professionals are entitled to subvert the objectives of the profession they voluntarily joined by prioritizing their private beliefs over the professional delivery of services to the public, especially when they are monopoly purveyors of those services.[18]

CONCEPTUAL PROBLEMS IN THE AMA OPINION

The AMA opinion seems to conflate private beliefs and professional personas or roles when it states that doctors "are not defined solely by their profession," as if that mattered. The opinion then proceeds to making the already alluded to unsubstantiated claim about the integrity of the medical profession being at risk if doctors' private views are not accommodated. The opposite is likely the case. Patients do not visit their doctors as private individuals with private, deeply held beliefs, they visit doctors as professionals, and they have every reason to expect uniformly professional services across the profession and between professionals. Conscientious objection accommodation does away with all of that, and as a result, it does away with medical professionalism while prioritizing doctors' idiosyncratic private convictions (or, more precisely, these doctors' untestable claims about the substance and meaning of those convictions) both over their professional obligations, but also over the care of patients and health outcomes. Conscientious objection accommodation today, for all practical intents and purposes, prioritizes the protection of the religious conscience over the care of patients. To name just one example, in Italy today about 70 percent of gynecologists conscientiously object to performing abortion. This is arguably a major factor in the staggeringly high back street abortion rate in that Roman Catholic country.[19]

DOCTORS' MEDITATIVE EFFORTS TRUMP PROFESSIONAL OBLIGATIONS TO PATIENTS

The AMA opinion offers a laundry list of issues doctors should consider when they ask for conscientious objection accommodation, but none of that matters practically, and all of it is introspective. None of the criteria proposed are designed to be tested by the profession, regulatory bodies, or the courts. Part of the reason for this is, as mentioned earlier, that the courts will steer clear of asking for "reason" or "rationality" when it comes to the substance of conscientious objection. That, in turn, reduces these suggestions to a meditative activity as far as objecting doctors are concerned. Patients would be at the receiving end of this meditation lottery. It is disappointing that that is apparently the best a professional association such as the AMA can envisage on this subject.

The skeptical reader might wish to give the opinion's (a) to (g) list a critical trial run. With the exception of (a), "Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician or compromise the physician's ability to provide care for the individual or other patients,"[20] there is not a single guidance point that would force doctors to explain themselves. However, professionals are accountable for their actions to the societies that gave them monopoly provider status with regard to the provision of scope-of-practice services. The AMA opinion amounts to a "give it some thought" kind of bullet point list addressed at individuals who have already decided that their private ideological convictions are of greater significance than their professional obligations to patients. To ask a "professional" with such a mentality to "be mindful of the burdens their actions may place on fellow professionals,"[21] among other exhortations, seems, frankly, no more than a throwaway line.

Having already conceded the broader point, namely that medical professionals are entitled, *qua* professionals, to decline to provide professional services on untestable private conscience claims, the AMA opinion even concedes what is, in many jurisdictions, considered a compromise position. The compromise position accepts that objecting doctors do not have to provide professional services within their scope of practice, in non-emergency situations, on their conscience say-so, but they must transfer patients, without further ado, to a colleague who they know will provide the requested service. This compromise is not a compromise that objectors would consider a reasonable compromise. If you believe that abortion is akin to murder, it does not quite amount to a reasonable compromise that you should be obliged to pass a pregnant woman on to a colleague whom you know will commit what you consider to be a murderous act. Guidance point (f) of the opinion instead makes clear that doctors objecting to such transfers, too, would be well entitled to refuse even that giving of information.[22] All of this is deemed to be sound professional advice, against the backdrop of these doctors' unaccountable meditative efforts.

RANDOMNESS OF WHAT OBJECTIONS SHOULD BE ACCOMMODATED

The AMA opinion, having failed to establish why we ought to accommodate conscientious objectors in the medical profession, fails necessarily, too, when it tries to draw defensible policy lines with regard to the kinds of conduct that objectors should be able to get away with, versus behavior that would be unacceptable. The only concession to patients' interests in the opinion is that doctors must provide care in emergency circumstances, hence their conscience views apparently can be disregarded then. There appears to be some very limited concern by the authors of this document for patients' access to care after all. However, that is roughly where they think the inconveniencing of doctors' idiosyncratic private beliefs should end.

Crigger and colleagues argue that while doctors may decline to provide services to particular patients, doctors must not be motivated by a patient's "race, religion, sexual orientation, disease status, or other reason that would constitute discrimination against a class or category of patient." Presumably this is so because such a motive would be unreasonable. I wholeheartedly agree with their apparently existing AMA opinion, but none of this follows from their view on conscientious objection. On what ground would racist doctors, who belong to an Aryan Nation church, be denied the accommodation of their conscientious objection requests when it comes to patients of particular racial groups that their religion (or other ideology) tells them they must not touch? After all, what matters is that they strongly feel that that is what their religion (or other ideology) requires of them, and that they want to do the right thing by their religion (or other ideology). It is all a very deontological affair, like much of what drives the case for the accommodation of conscientious objectors in the first place. There is nothing by way of argument that can be deployed by conscien-

tious objection accommodationists that does not result in arbitrary policy.

Liberal Western democracies, depending on their constitutional arrangements and the power of institutionalized Christianity, have drawn policy lines in different areas, but none of those are a logical, foreseeable consequence of conscientious objection accommodation itself. Why should a female Muslim psychiatrist not insist that she only speak to her male patients through her *niqap*, and be accommodated? The only reason she would have trouble getting her accommodation request granted today, in liberal Western democracies, is that the statutory bodies or courts are unfamiliar with the ideology she has chosen. In the same way that society denies racist doctors the conscience accommodation that they might seek with regard to patients from certain "races," they could deny accommodation to doctors who ask for conscience accommodation with regard to abortion or the *niqap*. That this does not occur is likely a consequence of the continuing respect for particular religious convictions and not for others. That, however, is incompatible with a secular state's neutrality when it comes to conscience views.

WHAT IF FUTURE CONSCIENTIOUS OBJECTORS DID NOT JOIN THE PROFESSION?

Crigger and colleagues express concern that certain individuals might not join the medical profession if their conscience claims were not readily accommodated. They assume that that is a problem. However, a more plausible reply to this concern would be: "So what?" A lot of people choose not to join the medical profession for any number of reasons. I have a strong tremor in my hands that would prevent me from performing a whole range of professional medical services. It seemed obvious to me that I should not burden patients or fellow professionals with a limited scope of practice approach to professional services and instead leave that profession to those equipped to provide the full range of services that fall within that specialty's scope of practice. Strangely, when it comes to persons who, prior to joining a profession, make a considered choice to adopt beliefs that would prevent them from delivering the scope of services the profession was established to deliver, Crigger and colleagues decry the supposed loss to the profession, were such individuals unable to join the profession due to the lack of accommodation. I think we ought to celebrate an individual's decision not to burden future patients and professional colleagues with their idiosyncratic beliefs by not joining a profession that the scope of services one finds objectionable.

I have taught bioethics for a number of years in a large health sciences faculty. Invariably, among the dentistry students in any given year, there were a fair number of students who explained their choice of profession with their moral objections to abortion. However, many also did consider it unprofessional to burden future patients with their personal convictions on this subject. Hence their decision to study dentistry instead. *Contra* Crigger and colleagues, there is no evidence to suggest that the delivery of quality medical services would suffer if such budding medical doctors decided to pursue other career opportunities. If anything, we should be concerned about the facts from a survey of 2,000 doctors in the U.S.: the authors state that 54 percent of doctors surveyed believe that a supernatural being intervenes in patient care, and that "the religious beliefs and practices of physicians also strongly influence the ways physicians interpret their clinical observations and the empirical data."[23] Crigger and colleagues then go on to express concerns about "callous, disrespectful" doctors' unprofessional behaviors, a matter unrelated to the question of whether people with strongly held personal beliefs that affect their ability to perform their professional functions should join such a profession in the first place.

LAST BUT NOT LEAST—THE LAW

What is the relationship of the argument and analysis presented thus far and the law? As noted earlier, conscientious objection accommodation has been provided for in many a jurisdiction and court cases, so is it not reasonable for professional associations to provide guidance points to professionals wanting to make use of their legal rights? A professional who chooses not to provide professional services due to a judgment call that is not professional, but deeply personal, engages by definition in unprofessional conduct. That remains true even if that professional happens to be legally entitled to such conduct. Professional associations should provide no ideological backing for such unprofessional conduct. They arguably ought to admonish their members to behave professionally at all times, while on the job. Support for conscientious objection accommodation does the opposite.

CONCLUSION

The AMA opinion provides conscientious objectors with a convenient document to point to when

asking for the accommodation of any objection, bar the provision of professional care during emergency circumstances. I wonder how a group of authors working for a patient lobby organization, rather than the AMA, would have approached the very same issue. It is doubtful that their hypothetical "opinion" would look anywhere close to the AMA "Opinion 1.1.7, Physician Exercise of Conscience." What I find most puzzling, when reading this opinion and similar documents issued by doctors' lobby organizations such as the British Medical Association or the Canadian Medical Association, is that there is this pretense that the concerns expressed in these documents have to do with protecting medical professionalism, when they constitute the exact opposite. These documents go out of their way to protect a privileged group of monopoly provider professionals who do not wish to provide the services that they contracted to provide to the public. Professional associations, such as the AMA here, reduce themselves to nothing other than ordinary trade unions lobbying for their members' interests. That is not objectionable, but it would be helpful if they were at least more transparent about their objectives.

NOTES

1. "Opinion 1.1.7, Physician Exercise of Conscience," *Code of Medical Ethics* (Chicago, Ill.: American Medical Association, 2016), included as figure 1 in BJ Crigger, S.L. Brotherton, P.W. McCormick, and V. Blake, "Report by the American Medical Association's Council on Ethical and Judicial Affairs on Physician's Exercise of Conscience," in this issue of *JCE,* 27, no. 3 (Fall 2016).

2. U. Schuklenk and R. Smalling, "Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies," *Journal of Medical Ethics* (22 April 2016): doi:10.1136/medethics-2016-103560.

3. CBC, "Doctor-assisted suicide a 'therapeutic service', says Canadian Medical Association," 6 February 2015, *http://www.cbc.ca/news/health/doctor-assisted-suicide-a-therapeutic-service-says-canadian-medical-association-1.2947779*; O. Dwyer. "Quebec passes assisted dying law," *Canadian Medical Association Journal* 186 (2014): E368, *http://www.cmaj.ca/content/186/10/E368.full.pdf+html.*

4. "Opinion 1.1.7," see note 1 above.

5. Crigger, Brotherton, McCormick, and Blake, "Report by the American Medical Association's Council on Ethical and Judicial Affairs," see note 1 above.

6. R. Baker, *Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution* (New York: Oxford University Press, 2013), 316.

7. Ibid.

8. World Medical Association, "Declaration of Geneva," *http://www.wma.net/en/30publications/10policies/g1/.*

9. R.F. Card, "Conscientious Objection, Emergency Contraception, and Public Policy," *Journal of Medicine and Philosophy* 36 (2011): 53-68.

10. J. Marsh, "Conscientious refusal and reason giving," Bioethics 28 (2014): 313-9.

11. A. Mercier, "Religious belief and self-deception," in *50 Voices of Disbelief: Why We Are Atheists,* ed. R. Blackford and U. Schuklenk (Oxford, U.K.: Wiley, 2009), 41-7.

12. D. Laycock, "Regulatory exemptions of religious behavior and the original understanding of the establishment clause," *Notre Dame Law Review* 81 (2006): 1739-842; Strasbourg Consortium for European Court of Human Rights cases, *http://www.strasbourgconsortium.org/.* I owe these references to B. Leiter, *Why Tolerate Religion?* (Princeton, N.J.: Princeton University Press, 2013), n. 4.

13. *Employment Division, Department of Human Resources of Oregon v. Smith,* 494 U.S. 872 (1990).

14. R.F. Card, "Reasonability and Conscientious Objection in Medicine: A Reply to Marsh and an Elaboration of the Reason-Giving Requirement," *Bioethics* 28 (2014): 320-6.

15. E. LaFollette and H. LaFollette, "Private conscience, public acts," *Journal of Medical Ethics* 33 (2007): 249-54; J. Savulescu, "Conscientious objection in medicine," *BMJ* 332 (2006): 294-7; R.A. Charo, "The celestial fire of conscience—refusing to deliver medical care," *New England Journal of Medicine* 352 (2005): 2471-3; R. Rhodes, "The Priority of Professional Ethics Over Personal Morality. Rapid Response to Julian Savulescu, Conscientious Objection in Medicine," *BMJ* 332 (2006): 294-7.

16. U. Schuklenk, "Conscientious objection in medicine: Why private ideological convictions must not supercede public service obligations," *Bioethics* 29, no. 5 (2015): ii-iii; Schuklenk and Smalling, "Why medical professionals have no moral claim," see note 2 above.

17. C. Fiala et al., "Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care," *European Journal of Contraception and Reproductive Health Care* 21 (2016): 201-6.

18. Schuklenk and Smalling, "Why medical professionals have no moral claim," see note 2 above.

19. F. Minerva, "Conscientious objection in Italy," *Journal of Medical Ethics* 41 (2015): 170-3.

20. "Opinion 1.1.7," see note 1 above.

21. Ibid.

22. Ibid.

23. F.A. Curlin, S.A. Sellergren, J.D. Lantos, and M.H. Chin, "Physicians' Observations and Interpretations of the Influence of Religion and Spirituality on Health," *JAMA Internal Medicine* 167 (2007): 649-54.