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Professional Ethics, Personal Conscience, and Public Expectations

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ABSTRACT

Examining to what extent physicians are, or ought to be, defined by the profession when giving advice to patients, this commentary seeks to offer a better understanding of the potential conflicts that the American Medical Association's (AMA's) "Opinion 1.1.7, Physician Exercise of Conscience," addresses.[1] This commentary conceptualizes the professions as knowledge communities, and situates the physician-patient relationship within this larger conceptual framework. So doing, it sheds light on how and when specialized knowledge is operationalized in professional advice-giving. Physicians communicate the knowledge community's insights to the patient. Thus, departures from professional knowledge as a matter of the professional's personal conscience are appropriately circumscribed by the knowledge community.

The AMA's "Opinion 1.1.7, Physician Exercise of Conscience" declares: "Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession." The aim of this commentary is to probe to what extent physicians are, or ought to be, defined by their profession when they give advice to patients. Examining that question leads to a better understanding of the interests affected when, as the opinion describes it, "at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life." Three sets of interests intersect in such situations: those of the profession, those of the individual professional, and those of the patient. Sometimes, the tension among them must be resolved in a way that requires the individual professional to put the patient's interests and the profession's expectations first. But sometimes, when value judgments or moral questions are at issue, no amount of specialized training makes the professional more competent to offer professional insights. It is therefore important to understand how and when specialized knowledge is operationalized in professional advice-giving.

PROFESSIONALS AS MEMBERS OF KNOWLEDGE COMMUNITIES

As a starting point, it is helpful to clarify the role of the individual professional within the profession. The professions are best understood as knowledge communities, that is, communities whose main reason for existence is the generation and dissemination of knowledge.[2] The most important feature of the professions—although the concept of "profession" itself is contested—is their

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knowledge-based character. As Daniel Halberstam noted, while individual professionals "may differ in their individual judgments about particular issues, their role as professionals traditionally implies their subscription to a body of knowledge that is shared among their peers."[3]

As a result of training and practice, professionals acquire common knowledge and experience, and they draw on a shared body of knowledge in order to solve similar problems.[4] Their common understandings allow for the generation and exchange of insights within the knowledge community. Given the shared knowledge and understandings of this knowledge, members of knowledge communities have shared notions of validity and a common way of knowing and reasoning. Within the profession, the acceptance of professional insights will depend on the rules established by the profession.[5] The current state of the art within the profession provides the foundation for the individual professional's advice, and current debates within the profession influence what counts as a defensible professional position. The knowledge community, moreover, shares certain norms and values that constitute their professional norms.[6] The relationship between the knowledge community and the individual professional, thus, is defined by their common knowledge. The normative corollary can be found in the law of professional malpractice, in which the standard of care against which the professional's advice is measured is determined by the profession itself: exercise of the profession according to the degree and skill of a well-qualified professional. The knowledge community thus determines the benchmark against which the individual professional's liability is assessed. In this way, the individual members of the profession are bound together by the knowledge community.[7]

Professional Expectations

This relationship between the individual professional and the profession leads to certain expectations. The knowledge community's and the professional's interests are reciprocal when it comes to dispensing professional advice. The knowledge community's interest lies in having the individual professional render accurate, comprehensive advice. Correspondingly, the individual professional has an interest in communicating the message according to the standards of the profession.[8] Because of these reciprocal interests, the proper site for conscience formation and negotiation of accommodations is located within the profession. The AMA's opinion on physicians' exercise of conscience is one such effort. Health law scholar Elizabeth Sepper notes that "physicians' conscientious judgments must be rooted in shared professional norms." The result is that arising "conflicts manifest themselves between a patient's values and the values of the profession as a whole, rather than one doctor's values."[9]

While there is no claim to superior competence regarding value judgments *per se,* the knowledge community is able to assess value judgments in light of its shared knowledge. Within its internal discourse, it can assess the effect of value judgments on professional knowledge and advice-giving by the individual professional. This tracks Sepper's observation that "each physician must seek to maintain professional integrity, not only personal beliefs. One's fellow physicians serve as a—or perhaps the—referent moral community."[10] As a result, justifications for departure from professional consensus should originate within professional norms and ethics.

Multiple links tie the individual professional back to the knowledge community. Halberstam notes that the professional "is understood to be acting under a commitment to the ethical and intellectual principles governing the profession and is not thought of as free to challenge the mode of discourse or the norms of the profession while remaining within the parameters of the professional discussion."[11] The malpractice liability regime, as already mentioned, likewise assumes this connection in imposing the profession's standard of care on the individual professional. Professionals may be held liable for "unprofessional" advice, that is, advice that fails accurately to communicate the knowledge community's insights.[12] Professional malpractice liability holds the individual professional to follow the standards of the profession. It ensures that the professional's advice accurately communicates the knowledge community's insights within the professional-client, or physician-patient, relationship. On the flip side, "unprofessional" advice is unprotected. Thus, Alex Stein writes, "[a] doctor commits malpractice when he treats a patient in a way that deviates from the norms established by the medical profession."[13] It is thus the knowledge community that determines the standard of care.

Public Expectations

Patients seeking professional advice will reasonably expect that they will receive competent and comprehensive professional advice in accordance with the profession's insights. That is to say, patients expect that they will access the entire body of knowledge that constitutes the state of the art in the field.

The physician-patient relationship—like any professional-client relationship—is typically characterized by an asymmetry of knowledge; patients seek a physician's advice precisely because of this asymmetry. The very reason a physician's advice is valuable to patients is thus predicated on the knowledge the physician possesses and clients lack.[14] The nature of this relationship gives rise to fiduciary duties.[15] The client's interests are only served if the physician communicates professional knowledge that is accurate (under the knowledge community's current assessment), reliable, and personally tailored to the specific situation of the patient. To bridge the knowledge gap, and to ensure the protection of the patient's decisional autonomy interests, the physician has to communicate to the patient all information necessary to make an informed decision.[16]

THE BASIS OF PROFESSIONAL ADVICE

Given these expectations, what justifications underlie valid professional advice? As just mentioned, patients seek a physician's advice because they want to access a useful body of knowledge that physicians possess but patients lack. This asymmetry of knowledge is the very reason a professional's advice is useful to the patient. In order to solve the patient's problem, the patient depends on accurate and comprehensive professional advice. Yet sometimes the physician may depart from, or refuse to deploy, the full range of professional knowledge for various reasons. We might think of them as outliers from professional knowledge.[17] And these outliers' advice may be distinguished by looking at the justifications underlying the advice that departs from professional consensus.

Outliers within knowledge communities whose disagreement is based on alternative assessments within the range of the profession's shared ways of knowing and reasoning are part of the knowledge community. Their advice constitutes good professional advice so long as it reflects defensible findings based on the profession's agreed-upon standards for evaluating professional knowledge. Generally, we want to encourage this type of outlier, because new ways of thinking advance the field and may gain the status of core knowledge. Consider, for instance, the increased acceptance of the medical benefits of marijuana, once considered an outlier position. But outliers whose disagreement is premised on rejecting the shared ways of knowing and reasoning that tie the profession together due to external, including religious, beliefs place themselves outside the knowledge community.

Professional Knowledge

Professional knowledge is not monolithic, and there is a range of opinions that count as good professional advice.[18] The knowledge community's shared ways of knowing and reasoning limit the range of acceptable opinions found within them.[19] From a legal perspective, the law of professional malpractice and the law governing the admissibility to expert testimony traditionally take this into account.

As Robert Post has pointed out, "Malpractice law protects the vulnerability of clients by requiring professionals to maintain strict standards of expert knowledge."[20] In other words, malpractice liability ensures that the professional's advice accurately communicates the knowledge community's insights within the physician-patient relationship. The tort regime has developed the doctrine of "respectable minority" or "two schools of thought," available as defenses against claims of malpractice in many jurisdictions, to acknowledge the fact that there often is not one single correct answer.[21] The doctrine states that "Where two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority . . . who follow one of the accepted schools."[22] Ultimately, it is up to the knowledge community to determine what constitutes good advice.

The law of evidence bases the admissibility of expert knowledge on various factors, depending on the jurisdiction. In all jurisdictions, however, the common factor concerns methodology. Courts governed by *Frye v. United States* defer to the scientific community by asking whether there is "general acceptance in the particular field,"[23] while courts governed by *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[24] are asked "to judge science by the standards that scientists deploy in judging science."[25] This mirrors the knowledge community's shared notions of validity and common ways of knowing and reasoning upon which valid professional advice should be based.

Exogenous Bases

But sometimes, professional advice may not be grounded in these shared notions of validity and common ways of knowing and reasoning. Pharmacists who believe that abortion is a grave moral wrong and therefore refuse to advise on the availability of certain forms of birth control they consider abortifacients, for example, do so based on a personal religious belief that is not the result of a

reinterpretation of professional knowledge by means of a shared methodology. Physicians, likewise, may have a political, philosophical, or religious disagreement with the profession. Justifying departures from professional knowledge and limiting otherwise available advice based on such exogenous reasons places professionals outside of the knowledge community. Instead, religious or other exogenous justifications form the basis for the professionals' advice. If patients do not receive full information, they may not know what is being withheld, or even that any information is being withheld.[26]

Furthermore, patients do not know what is contested professional knowledge and what is not. They may encounter a professional who, for religious reasons, will not provide advice on certain treatment options or medications. But the justification for omitting this information will not be based on professional knowledge. Patients, however, in order to make an informed decision, must reasonably be able to expect that professional advice will be based upon reasons internal to the knowledge community rather than individual, exogenous justifications for departure.

Could this information deficit be cured by disclosure? Advice-giving physicians could tell patients that the advice they dispense is limited. The state might even require that any professional whose advice departs from the knowledge community's insights, due to exogenous justifications, provide such a disclosure.[27] In principle, such disclosure will inform patients of the limited scope of professional advice. However, in practice, there is a significant filtering problem. Imagine doctors informing patients that, due to their religious faith, they will only dispense advice consistent with their faith. Even if patients are of the same faith, it is at least questionable whether it will be obvious to patients which advice is left out. Just as professional knowledge communities are not monolithic, faith communities are not monolithic. But even if disclosure puts patients on notice, professionals are still potentially not communicating the full range of professional knowledge. As the AMA's opinion notes, physicians must "make clear any specific interventions of services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer." In light of public expectations and the autonomy interests of patients, physicians nonetheless ought to provide comprehensive advice on the full range of available professional knowledge.

THE LIMITS OF PROFESSIONAL KNOWLEDGE

Knowledge communities have specialized expertise, based on shared understandings of their field's knowledge. The knowledge community has a superior understanding of issues directly related to its core knowledge. But only the knowledge community's specific insights matter. Deference is thus awarded to core knowledge, not to peripheral interests, such as purely economic interests of the profession not based on professional expertise.[28] Likewise, no amount of specialized training by itself makes a professional more competent to render general value judgments on moral issues unrelated or only tangentially related to professional insights. For example, professional determinations based on medical expertise can be made regarding the total and irreversible cessation of all brain functions ("brain death") and its diagnostic criteria. However, it is a value judgment whether this medical diagnosis constitutes the end of life of the individual. This is a matter of ethical, philosophical, and religious dimension beyond medical expertise.

CONCLUSION

Physicians' primary allegiance ought to be to their patients, on the one hand, and to their professional knowledge community on the other. They are the conduits through which the knowledge community's insights are transmitted to patients. A critic might object that this understanding places the membership in a profession above other constitutive aspects of a physician's identity. I do not mean to suggest that all other aspects of a professional's identity are secondary, and this is particularly true for the professional's religious beliefs. But the focus here is on the role of knowledge communities and the role of the advice-giving professional within the physician-patient relationship. In this position as conduit between the knowledge community and the patient, within the physician-patient relationship, the individual rendering professional advice is a professional first. And departures from professional consensus as a matter of personal conscience of the professional are appropriately circumscribed by the knowledge community, such as in the AMA's opinion on physicians' exercise of conscience.

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. C.E. Haupt, "Professional Speech," *Yale Law Journal* 125, no. 5 (March 2016): 1150-547.

3. D. Halberstam, "Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions," *University of Pennsylvania Law Review* 147, no. 4 (April 1999): 771-874.

4. Haupt, "Professional Speech," see note 2 above, p. 1250-1.

5. Ibid., 1251.

6. Ibid.

7. Ibid., 1242.

8. Ibid., 1251.

9. E. Sepper, "Doctoring Discrimination in the Same-Sex Marriage Debates," *Indiana Law Journal* 89, no. 2 (Spring 2014): 703-34.

10. Ibid., 735.

11. Halberstam, "Commercial Speech," see note 3 above, p. 834.

12. C.E. Haupt, "Unprofessional Advice," *University of Pennsylvania Journal of Constitutional Law* (forthcoming, 2017).

13. A. Stein, "Toward a Theory of Medical Malpractice," *Iowa Law Review* 97 (2012): 1209-12.

14. Haupt, "Professional Speech," see note 2 above, p. 1271.

15. Halberstam, "Commercial Speech," see note 3 above, p. 845.

16. Haupt, "Professional Speech," see note 2 above, p. 1271.

17. C.E. Haupt, "Religious Outliers: Professional Knowledge Communities, Individual Conscience Claims, and the Availability of Professional Services to the Public," in *Law, Religion, and Health in the United States* ed. I.G. Cohen, H.F. Lynch and E. Sepper (Cambridge, U.K.: Cambridge University Press, forthcoming, 2017).

18. Haupt, "Unprofessional Advice," see note 12 above.

19. Haupt, "Professional Speech," see note 2 above, p. 1251.

20. R.C. Post, *Democracy, Expertise, and Academic Freedom: A First Amendment Jurisprudence for the Modern State* (New Haven, Ct.: Yale University Press, 2012), 47.

21. Haupt, "Unprofessional Advice," see note 12 above.

22. *Chumbler v. McClure,* 505 F.2d 489, 492 (6th Cir. 1974).

23. *Frye v. United States,* 203 Fed. 1013, 1014 (App. D.C. 1923).

24. *Daubert v. Merrell Dow Pharmaceuticals, Inc.,* 509 U.S. (1993).

25. C.B. Mueller, "Daubert Asks the Right Questions: Now Appellate Courts Should Help Find the Right Answers," *Seton Hall Law Review* 987 (2003): 1007.

26. J. Morrison and M. Allekotte, "Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious or Ethical Reasons," *Ave Maria Law Review* 9, no.141 (2010); 148-9.

27. C.M. Corbin, "Compelled Disclosures," *Alabama Law Review* 65, no. 1277 (2014): 1340-51.

28. Stein, "Toward a Theory of Malpractice," see note