

Nadia N. Sawicki, "Who Judges Harm?" *The Journal of Clinical Ethics* 27, no. 3 (Fall 2016): 238-42.

Who Judges Harm?

Nadia N. Sawicki

ABSTRACT

The American Medical Association's (AMA's) "Opinion 1.1.7, Physician Exercise of Conscience" attempts to help physicians strike a reasonable balance between their own conscientious beliefs and their patients' medical interests in an effort to minimize harms to both.¹ However, some ambiguity still remains as to whether the severity of harms experienced by physicians and patients is to be assessed externally (by policy makers or by a professional body like the AMA), or internally by the subjects of those harms. Conflicts between conscientious physicians' self-assessments of the moral harm associated with various actions and the AMA's external assessments of such harms are likely to lead to challenges in the implementation of some provisions of its opinion. This commentary argues, however, that provisions (b) and (e) of the opinion, which describe the information physicians should provide about their own scope of practice and about the existence of controversial procedures, are less likely to conflict with physicians' subjective assessments of moral harm, and therefore will face fewer challenges in implementation.

The AMA's "Opinion 1.1.7, Physician Exercise of Conscience" is grounded in the principle that physicians have a responsibility to engage in sincere and nuanced moral analysis when balancing their

own conscientious convictions against their patients' interests. In a climate of increasingly polarized public debate, this modest foundational principle deserves emphasis, lest the sound bites of commentators with absolutist agendas crowd out individual actors' critical assessments of their own moral responsibility.

The AMA opinion and the commentary on the opinion by members of the AMA Council on Judicial and Ethical Affairs (CEJA),² who wrote the opinion, reference the professional, personal, and social harms that can arise if healthcare providers are denied the opportunity to live and practice in accordance with their deeply held beliefs, as well as the harms that patients can suffer if their access to healthcare services is limited as a result of a careprovider's conscientious objection. But one ambiguity that still remains is who, in such situations, is entitled to make judgments about the relative severity of these harms.

Consider the types of conflicts that may arise as a result of this ambiguity. When a physician who opposes abortion maintains that transferring the medical records of a patient seeking abortion is morally impermissible because it constitutes complicity with an immoral act, must we defer to the physician's determination? Or can professional bodies, employers, policy makers, or patients deem the transfer of the patient's records too "morally distant" from the act of abortion to constitute a harm to the

Nadia N. Sawicki, JD, is Professor of Law at Loyola University Chicago School of Law, and Academic Director of the Beazley Institute for Health Law and Policy. nsawicki@luc.edu
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physician? Likewise, when a patient claims that she is burdened by having to travel overnight and miss work for an elective abortion because her local providers refuse to perform the procedure, must we defer to her assessment of the severity of the harm she will suffer? Or can policy makers, professional societies, or physicians make their own determinations of what constitutes a burden of access? Could they potentially even conclude that limiting access to elective medical procedures can never constitute a harm to patients?

If we demand that physicians take potential harms into account when they engage in moral deliberation about how they choose to practice medicine, any ambiguity about how these harms are to be measured will lead to dramatic (and likely self-serving) variability in the outcome of the moral calculus. Therefore, the AMA opinion and the CEJA commentary ought to at least engage with the question of how harms to physicians and patients should be assessed, and ideally establish consistent and ethically sound guiding principles for the assessment of such harms. However, the commentary appears to give significant deference to patients' self-assessments of harm, while instead making external judgments about "moral distance" in evaluating harms to physicians—a contrasting set of positions for which the CEJA gives no principled defense.

In discussing the connection between conscientious refusal and harm to patients, the CEJA commentary refers to physicians' duty to "promot[e] the welfare of patients," to "provide care in keeping with a patient's medical needs and in light of the patient's values, preferences, and goals for care," and to consider whether a treatment refusal will "unduly compromise a patient's well-being or cause a patient to experience financial, medical, psychological, or other harm." The commentary notes that "harms to patients can come in a variety of forms," and that physicians should "be sensitive to the fact that what may initially seem to be a minor harm or burden would constitute a significant barrier to care for a patient, depending on the patient's individual situation." Taken together, these statements indicate that harms to a given patient are identified by reference to that patient's values and preferences, and that physicians ought to give some degree of deference to a patient's self-assessment of harm.

With respect to the evaluation of harms experienced by physicians, however, the CEJA takes a less deferential approach. It asserts that "physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identity;" and refers to moral

distress, compromised personal integrity, and loss of self-respect as consequences of an inability to practice in this way. But when discussing issues of moral complicity, the commentary concludes that "The degree to which an individual's action (or inaction) implicates him or her in a moral wrong depends on the individual's 'moral distance' from the wrongdoer and/or the act," and appears to give little deference to physicians' own perspectives on moral distance. In subsequent sections, the commentary seems to establish conclusive positions on what types of acts are more or less "morally distant," and therefore more or less likely to cause harms associated with moral complicity. "Providing information about treatment options" that the physician finds morally objectionable, according to the CEJA commentary, is "morally distant" enough from providing the treatment itself that "the risk to physician integrity is outweighed by the professional obligation to inform." Providing a referral for such care, in contrast, "is clearly less morally distant from the objectionable act[;]" while merely providing a phone number is more "morally distant." The definitive way in which these conclusions about moral distance are presented suggest that there is some objective way to assess degrees of moral complicity. But the CEJA, unfortunately, provides no justification for reaching its own conclusions about the severity of complicity-related harms.

The AMA opinion could have dictated that harms on both sides are to be assessed subjectively (or internally) by the subjects of those harms; alternatively, it could have established objective (or external standards) about the severity of harms suffered by patients and physicians in various contexts. Instead, without sufficient ethical analysis in the CEJA commentary, it seems to apply different approaches to different types of subjects—reaching its own conclusions about the severity of harm to physicians in cases of moral complicity, while at the same time suggesting deference to patients' perspectives on access-related harms. This position is particularly surprising given that the opinion was adopted by a professional medical body that is likely to have greater expertise in assessing the harms that result from limitations on access to medical care than in evaluating moral culpability within the context of individual belief systems.

Some physicians whose conscientious convictions limit the types of medical care they provide will surely dispute the AMA's assessment of the moral distance (and therefore moral harm) associated with various actions. Any potential disagreement between conscientious physicians and the pro-

fessional body that purports to represent them will thus lead to challenges in the implementation of AMA opinion.

The starkest example of the difficulty that may arise in implementing the AMA opinion when self-assessments and external assessments of moral harm conflict is in the context of physicians' referrals. Provision (f) provides that, in general, physicians should provide patients with referrals for treatments the physicians do not offer. However, it also explicitly recognizes that some physicians' deeply held beliefs might prohibit referral; thus, it offers an alternative option, suggesting that such physicians instead provide patients with "impartial guidance . . . about how to inform themselves regarding access to desired services." But because the opinion does not acknowledge that some physicians may find this alternative equally objectionable (or advise those physicians on how to proceed), the possibility of conflict remains.

Luckily, the AMA opinion also presents two recommendations that are less likely to conflict with physicians' self-assessments of moral harm, and are therefore likely to result in fewer challenges in implementation. These are provisions (b) and (e), relating to the information physicians provide to their patients about their own scope of practice and about relevant treatment options to which those providers object on grounds of conscience.

Provision (b) provides that before entering into a relationship with a patient, a physician with conscientious objections "make clear any specific interventions or services the physician cannot in good conscience provide . . . focusing on interventions or services a patient might otherwise reasonably expect the practice to offer." Even fully crediting conscientious physicians' subjective assessments of moral distance, complicity, and harm, this provision is unlikely to be problematic. In my extensive research of this issue, I have been able to find no principled argument in support of the claim that such a simple notification requirement would render physicians morally complicit in objectionable conduct and thereby cause them harm.³

Moreover, even in the most widely publicized modern example of conscientious objection to medical care (albeit in the corporate context), no such argument has been made. Since the 2010 passage of the Patient Protection and Affordable Care Act, religiously affiliated employers have steadfastly objected not only to the act's mandate that they provide contraceptive coverage under their insurance policies, but also to its notification provisions.⁴ Notably, however, their objections to the notification

provisions are grounded not in the requirement that they simply identify themselves as religious objectors, but in the fact that this self-identification necessarily triggers the government's use of the employers' own benefits infrastructure to facilitate objectionable contraceptive coverage.⁵ According to the petitioners in *Zubik v. Burwell*, "If all the government wanted from petitioners were to know that they want to opt out of the contraceptive mandate, then this litigation would have ended the day it began."⁶ Surely, if there were an argument to be made that mere notification of one's conscientious objections to specific types of medical treatment rendered one morally complicit in the objectionable care itself, that argument would have been aired before the Supreme Court rendered a hotly disputed opinion on this issue in the context of corporate objections.

Provision (e) further provides that physicians should "Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects." The commentary by Crigger and colleagues justifies this requirement on the grounds that informing patients about such treatments is "morally distant" enough "that the risk to a physician's integrity is outweighed by the professional obligation to inform[.]" While there is likely a great deal of variation in physicians' perspectives on moral complicity, the conclusion by Crigger and colleagues—that the moral harms associated with informed consent are limited—is not likely to conflict significantly with conscientious physicians' self-assessments of moral harm.

In a 2007 study published in the *New England Journal of Medicine*, 8 percent of physicians surveyed responded that a doctor who objects to a procedure on religious or moral grounds is not obligated "to present all possible options to the patient, including information about obtaining the requested procedure" when discussing treatment options with a patient.⁷ However, these survey results may not be sufficient grounds to conclude that individual physicians balancing their own conscientious beliefs against their professional obligations to patients will in fact refuse to comply with the AMA's informed consent provisions now that they are in effect. First, the survey question asks physicians not just about informed consent, but also about providing patients with "information about obtaining the requested procedure," which is more closely akin to a referral conversation. Secondly, physicians' responses to a survey about general professional obligations do not predict how those physicians would respond to an actual case of conflict with their own patient—par-

ticularly if physicians take seriously the AMA's expectation that they engage in nuanced ethical self-analysis when faced with conflicts of conscience.

Finally, from a more substantive perspective, research suggests that even those with highly conservative religious perspectives may not actually oppose an informed consent requirement. For example, although the United States Conference on Catholic Bishops' (USCCB's) "Ethical and Religious Directives for Catholic Health Care Services" provides that physicians are not morally obligated to present information about treatment alternatives that are not "morally legitimate,"⁸ some ethicists operating in the Roman Catholic tradition interpret physicians' informed consent obligations under the USCCB's "Directives" to permit (or even require) disclosure of controversial medical treatments.⁹ Ronald Hamel, former senior director of ethics for the Catholic Health Association of the United States, has argued that the USCCB's "Directives" should be interpreted to require full disclosure of "all factually relevant information" to patients.¹⁰ "While some will disagree," Hamel writes, "the full disclosure of medically appropriate or indicated options, factually relevant information—including direct abortion—in difficult obstetrical situations can and should occur, within certain parameters."¹¹

Even though some conservative perspectives support full informed consent in such contexts, individual physicians may still oppose the AMA's conclusion that the provision of informed consent is not morally burdensome. For these physicians, there may be alternative means of satisfying the goals underlying provision (e). As I have written elsewhere, patients could be put on notice of the existence of treatment alternatives by way of a lesser disclosure duty.¹² Under such a limited disclosure model, physicians would be required to explain that while an objectionable intervention exists (by either referencing the intervention by name, or by speaking generally) it is not available due to their conscientious objection. Physicians would not, however, be required to provide any details about the intervention's medical benefits, risks, or mechanisms of action.¹³ Notably, I have been unable to identify any scholarship offering a principled defense of the position that physicians risk being complicit in immoral behavior if they merely inform patients of the existence of morally objectionable but medically relevant treatments.¹⁴ While such a limited disclosure would not fully satisfy provision (e) of the AMA opinion, it might be offered as an alternative (akin to the referral alternative) to help resolve any remaining tension between physicians and the AMA

regarding the moral harms associated with informed consent.

In conclusion, the AMA opinion and the CEJA commentary do not adequately discuss the question of how harm to patients and to physicians ought to be assessed. As a result of this omission, and the fact that the AMA appears to set an objective external standard about moral harms to physicians associated with different types of conduct, it is likely that there will be challenges to the implementation of the AMA opinion (particularly the referral provisions). That said, the AMA's objective approach to assessing moral harm to physicians is likely to be less problematic in the context of provisions (b) and (e), which require that physicians provide patients with information about the physicians' own limitations on practice, and about the existence of medically appropriate treatments. While objections may still arise, I expect that physicians who take to heart the AMA's expectation that they carefully consider the balance of harms when making ethical judgments about appropriate medical practice are unlikely to oppose these modest notification requirements.

NOTES

1. "Opinion 1.1.7, Physician Exercise of Conscience," *Code of Medical Ethics* (Chicago, Ill., American Medical Association, 2016).

2. 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 Physicians' Exercise of Conscience," in this issue of *JCE*, 27, no. 3 (Fall 2016). The AMA opinion is reprinted as figure 1 in this article.

3. See N.N. Sawicki, "Mandating Disclosure of Conscience-Based Limitations on Medical Practice," *American Journal of Law & Medicine* 42, no. 1 (1 January 2016): 121-4.

4. Current federal regulations require that employers seeking religious accommodation from the mandate either file a self-certification form with their third-party administrators, or notify the U.S. Department of Health and Human Services of their objection to the mandate. The notification provisions also require that employers identify their insurance issuers or third-party administrators in order for the government to facilitate contraceptive coverage by the employers' existing insurance companies. 26 *C.F.R.* § 54.9815-2713A(b)(2)(B). "Final Rules Regarding Coverage of Certain Preventative Services," 80 *Fed. Reg.* 41318 (July 14, 2015), finalized as 26 *C.F.R.* § 54.9815-2713A.

5. See generally, "Briefs for Petitioners" in *Zubik v. Burwell*, 2016 WL 93988 (U.S. Jan. 4, 2016); *East Texas Baptist University v. Burwell*, 2016 WL 93989 (U.S. Jan. 4, 2016).

6. "Briefs for Petitioners" in *East Texas Baptist Uni-*

versity v. Burwell, 2016 WL 93989 (U.S. Jan. 4, 2016), at *38-39. See also “The Little Sisters of the Poor’s Brief on the Interim Final Regulation,” *Little Sisters of the Poor v. Burwell* (No. 1:13-cv-02611-WJM-BNB), 2014 WL 4489994, at *2, FN2 (10th Cir. Sept. 8, 2014) (“The Little Sisters have never objected to merely identifying themselves so that the government can leave them alone.”).

7. F.A. Curlin, R.E. Lawrence, M.H. Chin, and J.D. Lantos, “Religion, Conscience, and Controversial Clinical Practices,” *New England Journal of Medicine* 356, (8 February 2007): 593-600, 593 and 597 (reporting “a cross-sectional survey of 2000 U.S. physicians from all specialties”). An additional 6 percent of respondents reported that they were undecided on this issue.

8. Directive 27 provides that “Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all” (emphasis added). U.S. Conference of Catholic Bishops, “Ethical and Religious Directives for Catholic Healthcare Services,” 5th ed., 17 November 2009, <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>, p. 20.

9. See R. Hamel, “Early Pregnancy Complications and the Ethical and Religious Directives,” *Health Progress* 48 (May-June 2014) (discussed below); M.R. Panicola and R.P. Hamel, “Conscience, Cooperation, and Full Disclosure: Can Catholic Healthcare Providers Disclose ‘Prohibited Options’ to Patients Following Genetic Testing?” *Health Progress* 52 (January-February 2006) (arguing that under Roman Catholic doctrine, “good moral reasons exist for providing patients with all factually relevant information, including that related to prohibited options”); P.A. Tully, “Morally Objectionable Options: Informed Consent and Physician Integrity,” *National Catholic Bioethics Quarterly* 8, no. 3 (Autumn 2008): 491-504, 491, 502 (arguing that physicians seeking to comply with the USCCB’s “Directives” ought to inform patients about the existence of objectionable options and explain their moral objections); A. Lustig, “Conscience, Professionalism, and Pluralism,” *Christian Bioethics* 18, no. 1 (2012): 72-92, 87-8 (arguing that public disclosures by pharmacists of their refusal to offer contraceptives “may be viewed as the necessary costs of conscientious action.”).

10. Hamel, “Early Pregnancy Complications,” see note 9 above, pp. 50-1.

11. *Ibid.*, 50.

12. Sawicki, “Mandating Disclosure,” see note 3 above.

13. From the perspective of patients’ access, this alternative is clearly suboptimal, because it would impose upon patients the burden of finding new providers who will provide information and treatment. However, this is a required burden even under provision (e) in its current form. Moreover, this burden is no greater than the burden patients currently experience in states with strong legislation protecting conscientious objection by medical pro-

viders. For further discussion of this issue, see Sawicki, “Mandating Disclosure,” see note 3 above, p. 87.

14. Indeed, even the text of USCCB’s Directive 27, which states that informed consent only *requires* disclosure of “morally legitimate” treatment alternatives, would not seem to *prohibit* this limited disclosure alternative. USCCB’s “Directives,” see note 8 above, p. 20. See also Tully, “Morally Objectionable Options,” see note 7 above, pp. 502-3 (explaining why complicity doctrine would not bar mere disclosure of morally impermissible options).