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Action Steps and Solutions for Physicians' Exercise of Conscience

Eliza Blanchard and Lynn Stoller

ABSTRACT

Conscience can influence physicians' interactions with patients in myriad ways and, by extension, can influence the interactions and internal dynamics of a health care team. The AMA's opinion around physicians' exercise of conscience appropriately balance the obligations physicians have to their patients and profession, and the rights of physicians as moral agents to exercise their conscience.[1] While the opinion is an effective starting point, further guidance is necessary to clarify the process by which physicians should identify, manage, and, if necessary, report their conscientious refusals to patients, supervisors, or colleagues. In addition to laying out a proposed process for identifying and managing issues of conscience, this article will use relevant and timely examples to help clarify how a physician could apply this process in an instance of conscientious refusal.

INTRODUCTION

Conscience can influence physicians' interactions with patients in myriad ways and, by extension, can influence the interactions and internal dynamics of a healthcare team. The AMA's opinion around physicians' exercise of conscience appropriately balances the obligations physicians have to their patients and profession, and the rights of physicians as moral agents to exercise their conscience. The opinion emphasizes many important nuances, including the difference between refusing to participate in a certain procedure, such as abortion or providing death-hastening drugs, and refusing to treat a certain patient because of that patient's race, gender, sexual orientation, gender identity, religion, or other protected class or identifier. The first is allowable under the dictates of physician conscience; the second constitutes discrimination, which is usually illegal and always unethical.[2]

Another important nuance recognized by the AMA's opinion is whether patients can access the care they wish to receive elsewhere, in a non-burdensome way that does not require them to travel a significant distance, spend a significant amount of money, or delay or compromise the quality of their care. Physicians are more likely to have the right to refuse to provide care when patients can access that care elsewhere than if patients cannot access the care elsewhere, or if doing so would be significantly burdensome. In this way, patients' right to the care they wish to receive can often be balanced with the physician's right to conscience, without leading to precedent in which patients can lose their ability or right to access necessary medical care.

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In spite of the strengths of the AMA opinion, further guidance is necessary to clarify the process by which physicians should identify, manage, and, if necessary, report their conscientious refusals[3] to patients, supervisors, or colleagues. In addition to laying out a proposed process for identifying and managing issues of conscience, this article will use relevant and timely examples to help clarify how a physician could apply this process in an instance of conscientious refusal.

RECOGNIZING IDENTITY

The AMA accurately points out that "physicians are not defined[4] solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs."[5] This point may seem self-evident, but in our work training physicians and physicians-in-training in religio-cultural competence,[6] physicians often express the perspective that they are defined—at least in their interactions with patients—solely by their professional role. Too many times physicians don't take into account the extent to which they are formed by their social identities such as race, gender, sexual orientation, socioeconomic status, veteran status, immigrant status, or religion. They often think of themselves as value- and culture-neutral, responding to a patient's values and culture without their own coming into play. In reality, the goal of religio-cultural competence is that patients receive competent care that takes into account their religious and cultural beliefs and practices, and are not negatively impacted by their physician's religious and cultural beliefs and practices. In other words, the values and perspective of the physician should not prevent patients from making healthcare decisions that are in line with their own values and perspective on what is right for them, and from having those decisions honored as long as it is legal to do so.

The first step to managing conscience in the care of patients, then, is to recognize that physicians are in fact themselves "informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs," and that these social identities may impact what care a physician is or is not comfortable delivering to patients. Once these social identities have been recognized and acknowledged in an encounter with the patient, physicians can begin the process of managing these identities to ensure the provision of culturally competent patient care.

TYPES OF OBJECTIONS AND ASSOCIATED ACTIONS

It is also important for physicians to identify when they conscientiously object to providing certain care and when they object to providing care for reasons other than conscience. Objections to providing care can be divided into the following categories:

- *Personal preference:* Personal religious, spiritual, moral, and/or cultural preferences. An example might be a physician who objects to a family who wishes to perform an exorcism on the grounds that the physician personally believes it is silly or inconvenient. She/he does not have safety concerns and does not conscientiously object to the practice, in that she/he does not find it to be morally or ethically wrong. Instead, the physician's cultural norms may cause her/him to think the exorcism will not have an impact; it makes the physician uncomfortable; and the physician would prefer not to be involved.
- *Professional integrity:* Core professional and legal roles, responsibilities, and obligations. An example might be a physician who objects to a Jehovah's Witness couple who refuse to let their child with sickle-cell anemia receive a blood transfusion. The physician might object to treating this patient in accordance with the family's preferred treatment plan on the grounds that doing so would violate the physician's ethical and professional obligations to the patient.
- *Personal conscience:* Core moral and/or religious beliefs regarding what is right or what it wrong. An example might be a physician who objects to a patient's request to terminate a pregnancy. The physician would be experiencing a conscientious objection if she/he thinks that participating in the procedure would be a violation of her/his personal and religious beliefs regarding the sanctity of life, and that the physician would be unable to live with her- or himself if she/he participated in this procedure.[7]

Understanding what type of objection they are experiencing can help physicians to identify which action steps to take next. If the physicians' objection is based on personal preference, they can likely accommodate a patient's request in spite of their discomfort, or suggest a compromise that helps to mitigate any inconvenience caused by the request, while still fundamentally honoring it.[8] If the physicians' objection is based on professional integrity, they can consult hospital resources such as a lawyer, patient

advocate, and ethics committee to receive guidance as to whether following the patient's request actually would constitute a legal or ethical violation. They can also find out more about the patient's request and respectfully share more about why they object, with the goal of either reaching a compromise or, if all else fails and the action the patient is requesting is not legal, refuse to continue care.[9] Finally, they can suggest alternative methods when possible—for example, the possibility of a bloodless transfusion for a Jehovah's Witness patient. It is important to keep in mind that while alternatives should be explored, not all alternatives will be acceptable to all patients, even those who share a religious affiliation—for example, Jehovah's Witness patients may differ in which blood products they are and are not willing to accept.

Another example of this might be female genital cutting. This practice is not legal in the United States, so physicians who are asked to perform such a procedure could neither do so, nor transfer the patient to another physician. The best option in this type of situation is to educate the individual requesting the procedure on the potential harms resulting from this procedure and the fact that it is illegal, but in a respectful way so that the patient or family do not stop seeking healthcare.[10]

Physicians who object to providing care based on their personal conscience should follow a different type of action plan. They should inform their supervisor of any conscientious objections to providing care that they have, as soon as possible.[11] This might mean telling a supervisor when an objection arises in the course of caring for a specific patient; but it might also mean pro-actively telling a supervisor about any conscientious objections to providing types of care. For example, Jewish physicians who do not believe that brain stem death constitutes death, and know that they would conscientiously refuse to remove artificial nutrition or hydration from a patient who has been declared brain stem dead, should notify a supervisor of this objection before an emergency situation develops in which this objection may pose problems for a patient or family. This type of notification might happen at different stages, depending on the specific objection and how well the physicians are able to anticipate the objection ahead of time, based on the type of care they provide. Some physicians may have a deeply held objection to a procedure that they anticipate being asked to perform in the course of their work, and can pro-actively notify a supervisor as soon as they begin their job. Other physicians may not be fully able to anticipate which situations or procedures they object to until the situation arises or the procedure is requested. Since religiosity is fluid and flexible, the procedures that physicians object to may not be static throughout their time in practice. Again, physicians should notify supervisors if a procedure they used to object to is now acceptable to them, or *vice versa.*

Even when a conscientious objection is invoked, physicians should ensure that they inform patients of all available medical options, without trying to sway the patient in the direction that they prefer. If necessary, physicians should refer or transfer care to another physician, if there is a physician who is available to care for that patient and if transferring care is not onerous to the patient (that is, if the patient does not have to travel to a faraway healthcare facility or spend more money to receive care from the non-objecting physician).

Some physicians may object to referring a patient to another institution or careprovider when the patient can access care that the physician finds immoral, on the grounds that even making the referral makes the physician morally complicit. While we are sensitive to this type of objection, we believe that physicians must communicate with their patients about their healthcare options and make referrals, if necessary, in order to help patients access the care that they choose. Issues of physicians' conscientious refusal involve a balance between the rights of physicians and the rights of patients, and we believe that refusing to tell patients about their healthcare options or refusing to allow patients to access those options goes too far in infringing on patients' rights. While physicians do have the right to conscientiously refuse to provide certain care, they do not have the right to stand between patients and the care they wish to receive, either by failing to provide patients with information about what type of care is available to them, or by refusing to transfer care to another physician who will provide that care. Physicians, as professionals, have obligations to their patients as well as to their own moral and religious beliefs. We believe that transferring care enables physicians to uphold both sets of responsibilities, whereas failing to inform patients about their options or to transfer care accordingly does not uphold physicians' responsibilities to their patients.

CONSCIENTIOUS REFUSALS IN PRACTICE

Conscientious refusals are often discussed in cases related to abortion; contraception; caring for lesbian, gay, bisexual, or transgender patients; or aid in dying and other end-of-life contexts. In our work,

however, we have seen another example in which conscientious refusals can come into play: in cases when a woman does not want to know her medical diagnosis and wants her husband, father, or son to receive her medical information and make healthcare decisions on her behalf. Cases of this type came up with particular frequency when we conducted an in-depth assessment of cultural competence in Israeli healthcare. Given the United States' increasing rates of immigration, and racial, ethnic, and religious diversity, many physicians in the U.S. likely have seen, or will see, similar cases themselves. This case helps to illustrate how a physician can experience a conscientious objection based on values such as gender equality, self-determination, or a professional commitment to a patient's autonomy and informed consent.

The first step a physician should take if asked by a female patient to follow this treatment plan would be to assess what social identities are coming into play. The patient could be informed by social identities such as religion and national origin, since many religions and cultures may have the practice of having the eldest man in the family make medical decisions. For the physician, social identities coming into play might include gender (that is, a female physician who worries the patient and family don't think a female doctor can be competent) or national origin (that is, self-determination and individuality tend to be considered core American or Western values, so having a patient who prefers communal decision making may be less familiar or accessible).

Once physicians think through which social identities are coming into play, they should determine which type of objection they are experiencing. Physicians could be experiencing an objection based on personal preference, on the grounds that they personally would never choose to have their healthcare decisions be made by someone else, and that communicating through the patient's husband instead of the patient will be inconvenient in that the healthcare team cannot ask the patient basic questions related to her care and comfort without going through the patient's family member. Should this be the case, physicians should treat the patient in spite of their personal disagreement with the patient's preference and establish which decisions, if any, the patient is willing to make to help minimize inconvenience (for example, the patient may not want to make larger decisions about her treatment, but may be comfortable making day-to-day decisions regarding whether she needs another aspirin).

Physicians might be experiencing an objection based on professional integrity, because informed consent is generally considered a core legal and ethical component of patients' autonomy in the U.S., and physicians may therefore be unsure whether they are legally or ethically allowed to follow the patient's husband's treatment decisions rather than the patient's. In this instance, the physician should consult with the hospital's legal team and ethics committee to establish whether the patient's request is both legal and ethical. The ultimate answer to this question would depend on the exact request being made, but we generally find that choosing not to make further healthcare decisions is also a form of exercising autonomy, and that honoring such requests is generally legal, ethical, and an important part of providing culturally competent care. Often we find that, in the U.S., autonomy is collapsed with informed consent, such that patients are only acting autonomously if they have been fully informed as to all of their treatment options and then make a decision accordingly. However, as Daniel Fu-Chang Tsai notes, respect for autonomy can be defined more broadly as "patients' . . . right to voice their medical treatment preferences, and physicians'. . . concomitant duty to respect those preferences."[12] Using this definition of autonomy indicates that a patient who wishes to have her family make decisions on her behalf has, in fact, voiced a preference for her medical treatment, and that physicians should respect her preference.

Finally, physicians could be experiencing an objection based on personal conscience if, for example, gender equality is of deep importance to them and if they think they would be upholding an immoral patriarchal structure if they do not inform the patient of her diagnosis or ask her about treatment decisions.[13] If physicians truly believe they could not conscientiously care for this patient, they should transfer care to another physician who is comfortable providing this care. They should not, however, tell the patient about her diagnosis against her will or otherwise prevent her from receiving care in the way she has chosen, in accordance with her beliefs and values.

CONCLUSION

The recommendations described in this article are meant to expand on the important opinion outlined by the AMA and to provide concrete action steps for physicians to help them recognize and manage the impact of their identities in the provision of culturally competent care for patients. We

hope that these recommendations and examples will showcase how to resolve conscientious objections in ways that recognize the moral agency of individual physicians while maintaining their professional obligations to provide care to patients in accordance with the patient's, rather than the physician's, beliefs, values, and preferences.

NOTES

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

2. There are federal laws protecting against discrimination in public accommodations on the basis of race, color, religion, national origin, and disability. There are no federal laws protecting against discrimination in public accommodations on the basis of sex. Some state and local governments have such laws, but what constitutes "sex" and "public accommodation" is not consistent. There are also no federal laws protecting against discrimination in public accommodations on the basis of sexual orientation or gender identity; 19 states and Washington, D.C., have such laws. B. Browning, "Sweeping LGBT Rights Bill to Be Introduced This Week," 21 July 2015, *http://www.advocate.com/politics/2015/07/21/sweeping-lgbt-rights-bill-be-introduced-week.*

In spite of the sometimes inconsistent legal status around discrimination in public accommodations, the AMA states that a physician can ethically decline to enter into a doctor-patient relationship with a patient if the "specific treatment" requested conflicts with the physician's religious, personal, or moral beliefs, but may not refuse to provide treatment to a patient "because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination." "Opinion 10.05. Potential Patients," *Code of Medical Ethics* (Chicago, Ill.: AMA, 2016).

3. This article will discuss issues of conscientious refusal, but applauds the AMA for recognizing that conscience can lead to physicians' desire to intervene in violation of law, hospital protocol, or other policies.

4. The word "defined" comes from the AMA, so this article cannot comment on the intended meaning of that word. For the purposes of this article, however, we understand "defined" to mean that physicians do not see encounters with patients solely through a professional lens, but also have personal perspectives that may be informed by religion, culture, or other factors, and that these perspectives, as well as their roles as physicians, inform their encounters with patients, and in some cases lead to conscientious objections to certain medical procedures.

5. "Opinion 1.1.7, Physician Exercise of Conscience," see note 1 above.

6. The Joint Commission defines cultural competence as "The ability of health care providers and organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter." The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (Oakbrook Terrace, Ill.; The Joint Commission, 2010). The Tanenbaum Center would therefore define religio-cultural competence as "the ability of healthcare providers and organizations to understand and respond effectively to the religious and/or cultural beliefs and practices brought by the patient to the healthcare encounter."

7. K. Culhane-Pera et al., *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers* (Nashville, Tenn.: Vanderbilt University Press, 2003).

8. Ibid.

9. Ibid.

10. American Academy of Pediatrics, "Policy Statement—Ritual Genital Cutting of Female Minors," *Pediatrics* 125, no. 5 (May 2010), *http://pediatrics.aappublications.org/content/pediatrics/early/2010/04/26/peds.2010-0187.full.pdf*

11. Culhane-Pera et al., *Healing by Heart,* see note 7 above.

12. D. Fu-Chang Tsai, "Personhood and Autonomy in Multicultural Health Care Settings," *AMA Virtual Mentor* 10, no. 3 (2008): 171-6.

13. It is important to note that conscientious objections do not have to be based in religious beliefs. In this instance, the objection is based on a sincerely and deeply held belief in gender equity. An objection to providing care should still be considered a conscientious objection if physicians could not live with themselves if they do not act in accordance with their beliefs, regardless of whether their beliefs are grounded in religion or in something else.