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Conscientious Objection: Widening the Temporal and Organizational Horizons

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ABSTRACT

The American Medical Association opinion "Physician Exercise of Conscience" is generally sound; its recommendations regarding notice, nondiscrimination, informed consent, referral, and non-abandonment are reasonable.[1] Within its focus on individual physicians' duties to particular patients, it could also emphasize that physicians should only share the reasons for their objections if patients express an interest and that they should only share the reasons in a respectful manner. The opinion, however, neglects wider time frames and higher levels of organization. It could comment on physicians' duty to form their consciences appropriately and to select specialities and practice settings that do not engender excessive conflicts. Given the number of physicians who are not self-employed and the role of law in establishing rights and responsibilities, the opinion could also address employers', legislatures', and courts' obligations to balance protecting physicians' integrity and assuring patients' access to medical treatment. Addressing these wider perspectives would greatly strengthen the opinion.

The American Medical Association (AMA) opinion "Physician Exercise of Conscience" has a very discrete focus: individual physicians' duties to particular patients. It articulates a variety of physicians' obligations including notice, informed consent, referral, and non-abandonment. In circumscribing its focus in this way, the AMA neglects wider time frames and higher institutional levels. For example, physicians have obligations in forming their consciences, choosing their specialties and practice settings, and accepting the consequences of their actions. While the central problem is the potential conflict between protecting healthcare providers' consciences and assuring patients' access, solutions may need to be implemented at higher levels of organization within the healthcare system. While the AMA opinion is generally sound, the AMA should also address these broader issues.

The AMA opinion states that, at times, physicians' deeply held personal beliefs that are based on diverse cultural, religious, and philosophical traditions may conflict with their professional obligations, that include protecting patients' interests and respecting their self-determination. Note that this characterization locates the conflict within the physician instead of between physicians and patients. The AMA opinion argues that patients and society rely on physicians' and the profession's integrity, and physicians should have considerable discretion in resolving these conflicts. The AMA concedes that this latitude should not be unfettered and articulates a variety of constraints. These constraints generally focus on individual treatment decisions and

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include nondiscrimination, informed consent, referral, and nonmaleficence.

Within this frame, the AMA opinion neglects the issue of physicians explaining the basis of their objections to patients. While discussing the basis of an objection to treat may facilitate the mutual sharing of perspectives, some patients have objected to their physicians raising such issues or the way they presented it. One patient, for example, described her physician as launching into a lecture about her need to rethink things after having asked him to prescribe birth control pills.[2] Minimally, physicians should not berate or demean their patients. Being attentive to the power differential within their relationship, physicians should assess patients' interest in this information and should not force it on patients who are not interested.

WIDER TIME FRAMES

In their report on the AMA opinion published in this issue of *The Journal of Clinical Ethics,* some members of the AMA Council on Ethical and Judicial Affairs (CEJA), note that their primary focus in writing the opinion was on individual physicians making decisions about their interactions with particular patients.[3] For example, they state that in situations in which physicians' personal integrity and professional obligations conflict, "physicians must decide whether and how personal conscience should guide their professional conduct." They distinguish between decisions based on intuition or emotion and those based on deliberation.

The AMA opinion does address some broader temporal issues. It argues that careproviders have an obligation to notify prospective patients in advance of interventions or services they are unwilling to provide. It also, interestingly, contends that obligations to patients increase with the duration of the relationship. (While establishing a physician-patient relationship is a clear threshold, it is not clear in what way the duration of the relationship is ethically relevant.) Finally, the opinion emphasizes that, when physicians terminate a relationship, they should make the patient's records available and provide needed treatment until the transfer is complete.

The AMA opinion could more forcefully address physicians' obligations in forming their consciences and selecting their specialties and practice settings. While one is morally obligated to act with integrity, one's action can be immoral if one's fundamental beliefs are wrong. An individual with racist beliefs may, for example, act with integrity, but nonetheless immorally, in discriminating against a member of a minority group. This is one of the bases for prohibiting discrimination. It is essential that individuals develop sound, fundamental moral beliefs, and that protections of conscience should exclude unethical beliefs.

Physicians have substantial discretion in selecting a specialty and practice setting. These choices may influence the likelihood and severity of conflicts between maintaining integrity and assuring access. For example, physicians who are morally opposed to abortion, sterilization, and contraception are more likely to encounter conflicts as obstetricians/gynecologists than as orthopedists. If such individuals become obstetricians/gynecologists, they are more likely to encounter conflicts in rural, small group practices than in urban, Roman Catholic institutions. Physicians have some affirmative obligation to reduce the likelihood of conflicts. Specifying and enforcing this obligation is, however, difficult.

In addition to issues that precede particular decisions, there are also issues that succeed them. Some careproviders may refuse to perform actions that violate their conscience even if the refusal results in harm to patients. In such circumstances, the AMA acknowledges that physicians have an obligation to accept the consequences. The AMA, however, does not state what these consequences may or should be. They might include malpractice litigation by the patient or disciplinary proceedings by the state medical board. Causing the death of or permanent injury to a patient could justify revoking a physician's license.

HIGHER LEVELS OF ORGANIZATION

In addition to a broader temporal horizon, the AMA should also address higher levels of organization within the U.S. healthcare system. A fundamental issue in this debate is how to protect both physicians' consciences and patients' access. This may best be accomplished at higher levels in the healthcare system. Holly Fernandez Lynch, for example, argues that state licensing boards should be responsible for compiling and publicizing lists of willing and refusing physicians and for assuring a sufficient number of willing physicians.[4] While the AMA mentions the institutional level, it does not discuss institutions' or the government's roles and responsibilities.

The article by CEJA members appears to focus on self-employed physicians who are in solo or small group practices. It, for example, makes reference to "structuring one's practice."[5] Within this framework,

the AMA opinion states physicians should "Be mindful of the burden their actions may place on fellow professionals."[6] It, however, does not address what obligation these fellow professionals have to allow colleagues to act in accordance with their consciences. For example, must careproviders be willing to work to allow their colleagues to participate in annual or weekly religious observances? It also does not address how physicians' employers should address their employees' claims of conscientious objection. How should the owner of a physician practice respond, for example, to a nurse or medical assistant who generally administers injections, but who objects to administering depot medroxyprogesterone acetate (DMPA, a long-acting contraceptive injection drug—Depo-Provera)? Addressing employers' obligations would have provided the AMA the opportunity to discuss claims made by members of other professions, such as nurses.

It should, however, be noted that a significant minority of physicians are not self-employed. The AMA's own 2014 study of physicians' practice arrangements found that 32.8 percent of physicians worked directly for a hospital or in a practice with at least some hospital ownership, and that 49.2 percent of physicians were not owners of a practice.[7] One of the questions is, to what degree are employers obligated to accommodate employed physicians' objections? The extremes, again, are unreasonable; employers should be willing to take *de minimums* actions, but should not be required to endure undue hardships. Defining what constitutes a reasonable accommodation is context-dependent.[8]

Physicians' ability to act according to their conscience may be conditioned by state or federal law. "Conscience clauses" vary in terms of what types of individuals and institutions are covered, beliefs are protected, treatments are addressed, and immunities are provided. Some legislation, for example, covers pharmacists and insurance plans in addition to physicians and hospitals, and some include physician-assisted suicide in addition to abortion and sterilization. Statues also do not consistently address situations in which patients are likely to suffer harm. Some recent proposals to expand protections are very broad and include counseling and referral within their definitions of healthcare.[9] Conscience clauses should appropriately balance the protection of physicians and patients.

Protection against discrimination is currently an important legislative and judicial issue. While the AMA opinion is clear that physicians have an obligation not to discriminate, it could be clearer that the dignitary harms caused by discrimination are sufficient to constrain physicians' freedom to refuse to provide particular treatments to only certain categories of patients, for example, in-vitro fertilization to gay, lesbian, bisexual, transgender, or unmarried couples, based on their core moral beliefs.

CONCLUSIONS

Within its restricted frame, the AMA opinion reiterates sound and generally accepted recommendations regarding conscientious refusal. Even within its focus on physicians, it should consider wider time frames and higher organizational levels. Physicians have duties in forming their consciences and have some obligations in selecting their specialties and practice settings. The resolution of the potential conflict between physician's integrity and patients' access generally requires developing institutional responses and will be shaped by regulation and legislation.

NOTES

1. "Opinion 1.1.7,. Physician Exercise of Conscience," *Code of Medical Ethics* (Chicago, Ill.: AMA, 2016). The opinion is reprinted as figure 1 in BJ Crigger, S.L. Brotherton, P.W. McCormick, and V. Blaha, "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).

2. "When Doctors Play Judge," Anderson Cooper 360° Blog, 12 November 2007, *http://www.cnn.com/CNN/Programs/anderson.cooper.360/blog/2007/11/when-i-go-to-doctor-i-expect-him-or-her.html.*

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

4. H.F. Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* (Cambridge, Mass.: MIT Press, 2008).

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

6. Ibid.

7. "New AMA Study Reveals Majority of America's Physicians Still Work in Small Practices," *AMA News Room,* 8 July 2015, *http://www.ama-assn.org/ama/pub/news/news/2015/2015-07-08-majority-americas-physicians-work-small-practices.page.*

8. M.R. Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge, U.K.: Cambridge University Press, 2011).

9. M.S. Swartz, "'Conscience Clauses' or 'Unconscionable Clauses': Personal Beliefs Versus Professional Responsibilities," *Yale Journal of Health Policy, Law, and Ethics* 6, no. 2 (2006): 269-350.