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Thinking about Conscience

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ABSTRACT

The path to consensus about physicians' exercise of conscience was not linear. It looped back on itself as new insights illuminated earlier deliberations and in turn led to further insights. In particular, coming to agreement about physicians' responsibility in regard to referral charted a route through many course corrections.

By now, Dear Reader, you're aware that the American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) recently developed guidance in the vexed matter of physicians' exercise of conscience. Should physicians ever be allowed to hold the dictates of personal conscience about the commitments they take on as members of the medical profession and the expectations both colleagues and patients hold of them? Is it important for the profession to acknowledge the standing of its members as moral agents in their own right and respect their need to preserve physicians' identify-conferring values? How should physicians balance responsibility to deeply held personal beliefs and responsibility to the values that inform their profession?

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Over the two years of CEJA's deliberations, these questions were of great moment among council members, who differed sharply in their individual views at the outset. Ultimately, however, members came together around a position all could endorse, albeit with greater or lesser degrees of individual disappointment in the result—to borrow from the philosopher Martin Benjamin, the council reached what members deemed an "integrity-preserving compromise."

Reaching "yes" in answer to the first two questions above was relatively straightforward. The greater part of the council's attention thus was devoted to thinking through that third question. CEJA began by seeking to identify "acts of conscience" that all could agree would be unacceptable on the part of a physician: for example, no physician who has the requisite skill should ever decline to provide care in an emergency, or impose care over the reasonably informed refusal of a patient who has decision-making capacity, on the grounds of individual conscience. From there it moved on to thinking about what would be ethically permissible in the realm of physicians' exercise of conscience.

If physicians, who are individual moral agents as well as members of an ethically freighted profession, should sometimes be able to follow personal conscience in the conduct of their professional lives, how are they to do so in a responsible, ethically acceptable way? For the council, the crux of the mat-

ter was whether physicians who invoke conscience have an ethical responsibility to refer the patient, and if so, the nature and scope of that responsibility.

Deliberation on referral opened in earnest at the council's June 2011 meeting, with members positing what they labelled the "perform~refer~inform" continuum. That is, they suggested, faced with a tension between professional expectations and personal belief, physicians have the opportunity to fulfill the professional expectation (perform), to refer the patient to another healthcare professional who will fulfill the expectation (refer), or make the patient aware of all relevant treatment alternatives (inform).

The council felt it had adequately considered the "perform" endpoint within its discussion of the boundary conditions that defined some acts of conscience that would be unacceptable for a member of the profession of medicine and so turned its attention to the "inform" endpoint of the continuum. CEJA disposed of this in relatively short order as well, concluding that the well-established professional duty of informed consent requires physicians always to inform patients about all medically relevant options, irrespective of whether specific treatment alternatives or clinical services conflict with the physician's deeply held personal beliefs.

In beginning to think about the "refer" point of the continuum during this meeting, CEJA broadly parsed the notion between two possibilities, transferring a patient to establish a new relationship with another healthcare professional for the purposes of all care to be delivered going forward, versus referring a patient to another professional for the limited purpose of receiving a specific intervention or service. And there the matter rested until CEJA reconvened.

When the council returned to the question of referral at its next meeting (in August 2011), the issue of complicity emerged as central concern. That is, the council asked, does a physician who refers a patient for a specific intervention that the physician finds personally morally objectionable become complicit in a moral wrong? If the answer to that question is "yes," can the profession (and patients) legitimately expect physicians to compromise their personal moral integrity?

A first attempt to address these questions led the council to draw further distinctions with respect to referral; namely, distinguishing what they identified as "formal" and "informal" referral. By "formal" referral, CEJA had in mind referring a patient to a specific healthcare professional who will provide the problematic service. By "informal" referral, the council meant to capture a more amorphous category of behavior, for which the index example was directing a patient to a healthcare institution at which the problematic service is available. The sensibility articulated in this distinction is that complicity could be considered a problem of degree.

Discussion of complicity continued into CEJA's subsequent meeting in October 2011 and beyond. As discussion progressed, the notion of harm to patients began to be layered over considerations of possible (moral) harm to physicians, morphing into a more encompassing focus on burdens to patients over CEJA's meetings in February and June 2012. Among the factors discussed in varying depth over time as relevant to forming an understanding of possible harms or burdens to patients were whether services that were morally problematic from the physician's perspective were medically necessary or elective, or were or were not time sensitive. In turn, discussion of burdens to patients led to questions about burdens to the physician, including the depth or severity of threat to deeply held beliefs, and on into questions about the impact of a physician's action in conscience on colleagues or the community.

Other considerations that emerged through this lens of "burdens," such as the availability of services otherwise in the community, whether the physician's action would have a discriminatory effect, or whether the physician had an existing relationship with the patient, also played back into conversations on previous topics, inviting additional reflection and refinement in these areas.

By the time CEJA began reviewing an actual draft of its report in August 2012, these deliberations had led to proposed recommendations that were extensive and highly specific. With proposed language in hand, however, several members argued that issues around referral had not yet been resolved satisfactorily. It would take ongoing conversation through another two meetings to achieve a formulation with which all members were sufficiently comfortable to allow CEJA to submit the report to the AMA's House of Delegates in June 2013.

Responses from the AMA's House of Delegates prompted further reflection on how the council could best frame guidance on referral (and in some instances other provisions) through a further three iterations before CEJA's report and recommendations were finally adopted in November 2014.

Thus CEJA's conversation on this topic evolved through several stages as council members identified and debated factors relevant to physicians' exercise of conscience, at times circling back to earlier provisional conclusions in the light of subse-

quent discussions. Throughout, multiple themes were woven into discussion of any given topic, and the council's sense of how to lexically order various considerations fluctuated over time as conversation highlighted different threads in the complex tapestry that was the overall report.

This may give the false impression that CEJA's deliberations were organic, free form, *ad hoc,* if not even undisciplined. To a certain extent conversations were indeed spontaneous, but always within a framework that had been roughly laid out at the inception of the work. Each council session was grounded in readings identified by staff and council members to help refine the provisional conclusions that were reached or to illuminate issues that were identified during the preceding session. The council's actual conversations were far richer than this brief description or the final report itself can do justice to, since both distill many hours of at times vigorous debate into a few meagre paragraphs.

The Council on Ethical and Judicial Affairs recognizes that its work is unlikely to satisfy every stakeholder fully. Some will take exception to its analysis; others will question the practicality of its recommendations. The council's goal is to take into account the interests and concerns of physicians, patients, and others in charting a navigable path through complex and potentially volatile issues in clinical practice.

DISCLAIMER

The views expressed here represent my personal reflections as a participant-observer and should not be attributed to members of the Council on Ethical and Judicial Affairs, individually or collectively, although I hope they would recognize their work process as I describe it here.