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Professional Responsibility and Individual Conscience: Protecting the Informed Consent Process from Impermissible Bias

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In their article "Of More than One Mind: Obstetrician-Gynecologists' Approaches to Morally Controversial Decisions in Sexual and Reproductive Healthcare," Farr Curlin, Shira Dinner, and Stacy Tessler Lindau report the results of a qualitative study of self-reported attitudes of obstetrician-gynecologists toward decision making in the ethically controversial clinical area of reproductive healthcare. Qualitative research is useful for the generation of significant hypothesis. Curlin, Dinner, and Lindau generate such a hypothesis: "within the one profession of obstetrics and gynecology, there are different and dissonant ideas about how a caring physician should approach medical decision making in areas of moral ambiguity." Curlin, Dinner, and Lindau are entirely correct to state: "These differences have implications for ob/gyns and their patients."[1]

In our judgment, the main ethical implication concerns the distinction between professional responsibility to patients and individual conscience.[2] The failure to identify this distinction can and does land physicians, not just obstetrician-gynecologists, in a world of preventable ethical trouble in the informed consent process.

The professional responsibilities of physicians originate in the physician's fiduciary role. The ethical concept of the physician as fiduciary of the patient, and therefore of the physician as a professional, was introduced by two British physician-ethicists in the eighteenth century, John Gregory (1724-1773) of Scotland and Thomas Percival (1740-1804) of England. Gregory wrote the first modern medical ethics in the English language, and Percival the first text entitled "Medical Ethics" in any language. Their work was enormously influential on nineteenth-century medical ethics in Britain, Europe, and North America.[3] The framers of the 1847 *Code of Medical Ethics of the American Medical Association*,[4] the first modern national code of medical ethics, explicitly acknowledge their considerable debt to Gregory and Percival.

Gregory and Percival forged a three-component concept of fiduciary or professional responsibility.

1. The physician should become and remain intellectually and clinically competent by routinely basing clinical judgment, decision making, and behavior on the best available evidence.
2. The physician should use his or her knowledge and skills primarily to protect and promote the health-related interests of patients and keep self-interest systematically secondary.

3. Physicians should maintain and pass on medicine to future physicians and patients as a public trust that exists primarily to benefit present and future patients (making research a major component of professional responsibility), not as a private guild concerned primarily to protect the economic and other self-interests of its members.[5]

The first component secures the intellectual integrity of the physician as a professional, the second the moral integrity of the physician as a professional and the third the warrant for public confidence in physicians as a group living out the first two commitments.

Intellectual and moral integrity should guide the physician's role in the informed consent process. From among the technically possible and available alternatives for managing the patient's clinical condition, the physician should identify those for which there is a reliable evidence base of expected clinical benefit. Put more precisely, the physician initiates the informed consent process by identifying the medically reasonable alternatives for the clinical management of the patient's condition. Sources of bias originating in the physician's self-interests, economic and non-economic alike, should be identified and eliminated from this rigorous process of clinical judgment. The result is an expert, not a lay, judgment.

Self-consciously permitting moral values, concerns, or judgments of an individual physician that originate from sources other than expert clinical judgment about what will protect and protect the patient's health-related interests to shape the physician's clinical judgment about medical reasonableness involves impermissible bias in the formation of this crucial clinical judgment. This provides an ethical justification for the well-understood and long-standing ethical consensus about non-directive counseling. It is well understood that a physician's economic self-interest (for example, in self-referral for the performance of obstetric ultrasound examination or a cesarean delivery) counts as impermissible bias. An individual physician's *moral* commitments that originate in sources outside of expert clinical judgment fall into the same category. This judgment is unaltered by the sincerity or intensity of the moral commitments at stake, no matter their origin in a physician's individual moral life.

It is one thing for physicians to restrict their practice on the basis of individual conscience, provided that patients are clearly informed. It is something altogether different for physicians to express individual, conscience-based views about the moral status of the fetus and the morality of abortion in an attempt to influence a pregnant woman's informed decision making.

Medicine is not alone in being a profession that poses challenges to individual conscience. Consider military commanders electing precision aerial bombing of targets where civilians are known to be located, or a religious adviser counseling a penitent about the admitted sexual abuse of a child. Like the professions of arms and the ministry (as well as the law), medicine can become a morally perilous way of life. Failure to manage that peril responsibly, by disciplining individual conscience to the requirements of professional responsibility, will willfully undermine the profession of medicine from within. Not all of the respondents in the study by Curlin, Dinner, and Lindau appreciated this, which is very worrisome indeed.

NOTES

1. F.A. Curlin, S. Dinner, and S. Tessler Lindau, "Of more than One Mind: Obstetrician-Gynecologists' Approaches to Morally Controversial Decisions in Sexual and Reproductive Healthcare," in this issue of *JCE.*

2. L.B. McCullough and F.A. Chervenak, *Ethics in Obstetrics and Gynecology* (New York: Oxford University Press, 1994).

3. L.B. McCullough, **"**The Ethical Concept of Medicine as a Profession: Its Origins in Modern Medical Ethics and Implications for Physicians," in *Lost Virtue: Professional Character Development in Medical Education,* ed. N. Kenny and W. Shelton (New York: Elsevier, 2006): 17-27.

4. *Code of Medical Ethics of the American Medical Association* (Chicago: AMA, 1847).

5. McCullugh, "The Ethical Concept of Medicine as a Profession," see note 3 above.