

Freedom of conscience: its critical role and its limits in medical practice

Jeff Blackmer
MD, MHSc, FRCPC
Vice-President, Medical Professionalism
February 2016



Conflict of Interest Declaration: Nothing to Disclose

I have no financial or personal relationships to disclose

Objectives

- 1) Provide an overview of the concept of conscientious objection
- 2) Note some current controversies in this area with a specific focus on assisted dying
- 3) Define the limits of conscience rights in medicine today

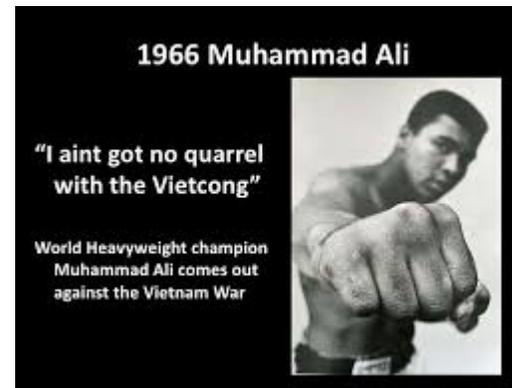
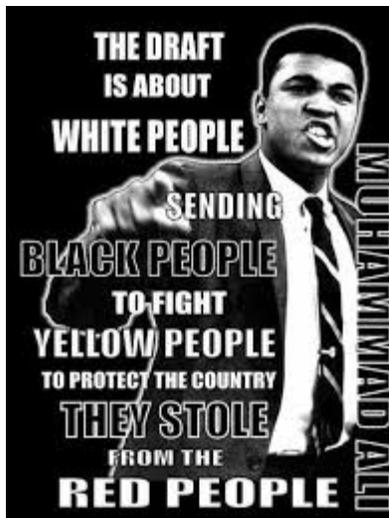


What is conscientious objection?

- Historically:
- A **conscientious objector** refused to engage in military service or go to war because doing so would conflict with deeply held personal beliefs. These can be based on religious conviction, or moral and ethical considerations.



Muhammad Ali



In Canada

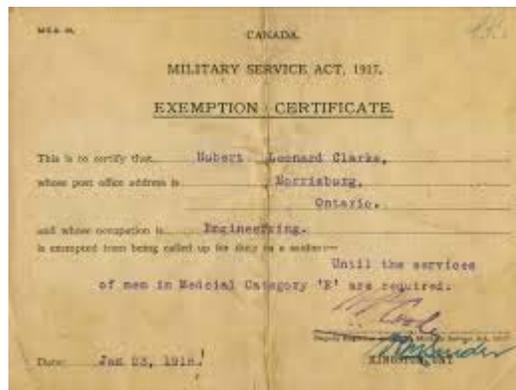
- Canada has recognized conscientious objector status since the late eighteenth century
- People claiming it during the First World War sometimes had difficulty convincing military tribunals that their grounds for exemption were genuine

- **Defining Exemptions**

- The Military Service Act (MSA) that introduced compulsory service to Canada in 1917 contained vaguely worded language on the subject of conscientious objectors.
- It appeared to exempt several religious denominations on grounds of conscience, but did not call the churches by name and failed to confirm whether religious objectors could be called to non-combatant service



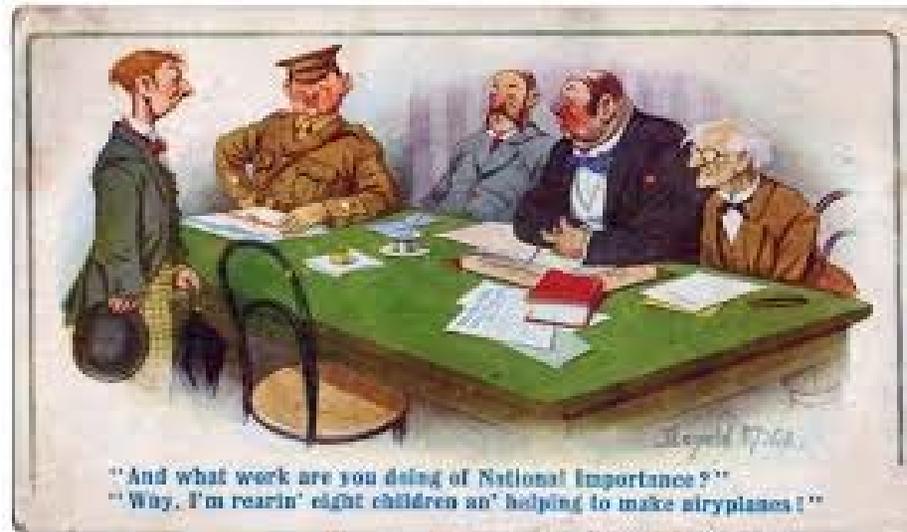
- Given the uncertainty, many religious pacifists found it easier to claim exemption as **farmers** rather than as pacifists because farmers could be excused from all forms of military service.



- **Appeals from Churches and Peace Groups**
- Churches petitioned Ottawa to clarify the rules
- In July 1918, a judge decided that Mennonites, Seventh-Day Adventists, Quakers, and several other groups qualified as pacifist sects eligible for exemptions

- Approximately 93 percent of those called to register under the Military Service Act had appealed for exemptions, and the government was in no mood for continuing blanket exceptions
- Religious pacifists could still claim exemption with reasonable prospects for success, but their legal status under the MSA remained confused until the end of the war

- **The Exemption Process**
- Individuals claiming exemption from military service as conscientious objectors were required to have their status confirmed by official tribunals
- Often comprised of local patriots, the tribunals exercised wide latitude in the review and determination of cases



- Tribunals were especially unsympathetic to exemption requests based on reasons of **personal conscience** alone
- Rejected applicants for conscientious observer status who refused to serve faced possible prison terms

- A claimant's success often depended on his or her ability to prove membership in a pacifist denomination deemed acceptable under the MSA
- Members of tribunals were often unaware of the nature of religious pacifism, and many dismissed exemption claimants as “shirkers”

- Most religious exemptions were granted in Ontario and Western Canada, both sites of substantial immigration by Mennonites, Quakers, and other peace churches



- There is no confirmed total of those granted conscientious objector status, but the number was probably in the low thousands

Conscientious objection in medicine

- **Hippocratic Oath:**
- *I will follow that regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel.*

- Conscientious objection in medicine is the notion that a health care provider can abstain from offering certain types of medical care with which he/she does not personally agree
- This includes care that would otherwise be considered medically appropriate
- An example would be an obstetrician who refuses to perform abortions or sterilizations

- On the one hand, there is the argument that physicians have a duty to uphold the wishes of their patients, as long as those wishes are reasonable and the service requested meets clinical standards
- On the other is the thought that physicians themselves are moral beings and that their morality should not be infringed upon by dictates from the legislatures, medical community or patient interests

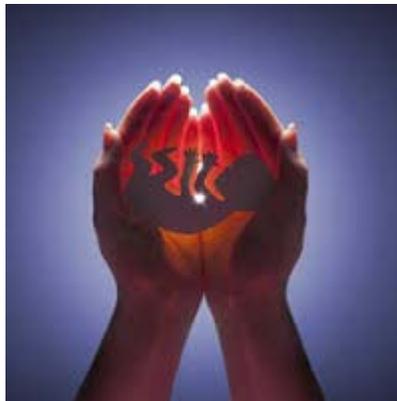
Liberty of Conscience in Medicine

Declaration: (<http://www.conscienceinmedicine.net.au>)

- The exercise of conscience is foundational to good medicine. It underlies every aspect of good medical practice, to make good patient care our first concern and to practice medicine safely and effectively.
- Liberty of conscience is critical for individual doctors as it lies at the very heart of our integrity and self-identity

- It is conscience that must compel doctors to refuse to participate in treatments they believe to be unethical or that they consider not to be in the best interests of patients
- It is not enough for doctors to simply be providers of medical services on demand from consumers or third parties, providing all that is legal whether or not it is consistent with their ethical base

- To sacrifice conscience and be concerned only with service provision is to destroy the heart and soul of medicine



- Governments may legislate to permit certain practices or procedures but governments must never force doctors to violate their conscience by compulsory engagement in such practices or procedures
- Infringement of conscience is a serious challenge facing modern medicine. Medical codes of conduct must never be subject to degradation by government.



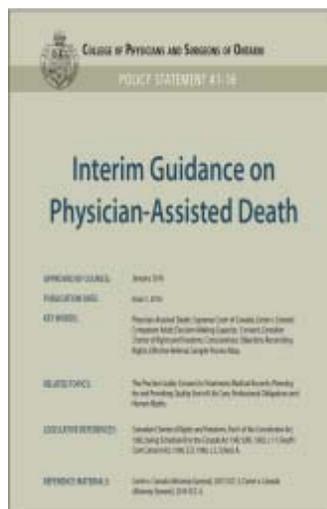
Evolution of legal approaches – US example

- Several states in the last few years have passed laws that protect health care providers from retribution if those providers, who invoke their conscience, refuse to provide medical care
- One example is the Michigan Conscientious Objector Policy Act of 2004 which allows providers to decline offering care if that care compromises the provider's beliefs, except in the event of an emergency
- Furthermore, a state law in Georgia extends conscientious objection to pharmacists by allowing them to refuse to fill a prescription for emergency contraception, even to a victim of sexual assault

- This issue was reignited in December 2008 by the passage of the Medical Conscience Rule by the Department of Health and Human Services in the closing weeks of the Bush administration
- It expanded the scope of several laws previously passed by Congress
- Those previous laws were designed to protect health care entities – including individual providers - who received any form of federal funding from reprisal if they chose not to provide certain medical services that violated their conscience, most notably abortion services

- The goal of the new law was to “prohibit recipients of certain federal funds from coercing individuals in the health care field into participating in actions they find religiously or morally objectionable” and to “prohibit discrimination on the basis of one’s objection to, participation in, or refusal to participate in, specific medical procedures, including abortion and sterilization.”
- DHHS website: “Health care providers should not be forced to choose between good professional standing and violating their conscience.”

- In Canada we lack this sort of legal specificity
- In general, legislators have left things up to the profession and to the regulatory bodies
- Recent CPSO policy change on conscientious objection and mandatory effective referral



Why should we permit conscientious objection?

- The question remains: Is there a place for conscientious objection in medicine?
- Is it acceptable for a health care provider to deny appropriate and legal medical care to a patient when asked to do so?
- Critics cite the supremacy of patient autonomy and the professional duty of a physician as reasons to oppose conscientious objection.
- The personal beliefs and morality of the physician should not enter into medical decision-making; the only thing that matters is what is “best” for the patient as both the patient and the law see fit

- This means that one has to accept several fundamental premises:
 - That patients can make reasonable decisions when presented with all the data.
 - That the duty of a physician is to honor a patient's wishes, if those wishes are within reason.
 - That patient autonomy and the right to guide one's own medical care are universal truths.
 - Conscientious objection inherently takes the decision-making power away from the patient and places it in the hands of the physician.

- On the other side, those in favor of the right to conscientious objection stress that the morality of the physician is an integral part in the doctor-patient relationship and should not be ignored
- The individual health care provider can decide what he or she will or will not offer to a patient
- The patient's requests are only one part of the decision-making process, the other part being the moral views and willingness to participate of the health care provider

- Health care providers should not be expected to “check their morals at the examination room door”
- While upholding the principle of respect for patient autonomy, conscientious objection allows physicians and HCP’s to also remain loyal to their own deeply held moral and religious convictions
- The question often remains: If we agree that some degree of objection is allowable, what do we then do in those situations?

Examples of issues in medicine today

- Abortion – classic example and still not fully resolved
- Artificial Reproduction
- Assisted Dying – most topical
- Birth Control
- Execution



Assisted dying

- SCC Carter decision:
- Found the laws prohibiting assisted suicide and euthanasia to be unconstitutional “*as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition*”
- One of the remaining points of contention from a legislative and regulatory perspective is the physician’s right to conscientious objection and whether mandatory effective referral is a reasonable approach

From the SCC decision:

- *A number of the interveners asked the Court to account for physicians' freedom of conscience and religion when crafting the remedy in this case*
- *The Catholic Civil Rights League, the Faith and Freedom Alliance, the Protection of Conscience Project, and the Catholic Health Alliance of Canada all expressed concern that physicians who object to medical assistance in dying on moral grounds may be obligated, based on a duty to act in their patients' best interests, to participate in physician-assisted dying*

- *They ask us to confirm that physicians and other health-care workers cannot be compelled to provide medical aid in dying*
- *They would have the Court direct the legislature to provide robust protection for those who decline to support or participate in physician-assisted dying for reasons of conscience or religion*

- *The Canadian Medical Association reports that its membership is divided on the issue of assisted suicide*
- *The Association's current policy states that it supports the right of all physicians, within the bounds of the law, to follow their conscience in deciding whether or not to provide aid in dying*
- *It seeks to see that policy reflected in any legislative scheme that may be put forward*

- *While acknowledging that the Court cannot itself set out a comprehensive regime, the Association asks us to indicate that any legislative scheme must legally protect both those physicians who choose to provide this new intervention to their patients, along with those who do not*
- *In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying*

- *The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures.*
- *However, we note that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief*

- *In making this observation, we do not wish to preempt the legislative and regulatory response to this judgment*
- *Rather, we underline that the Charter rights of patients and physicians will need to be reconciled*

CMA Principles Based Recommendations

- *Physicians are not obligated to fulfill requests for assisted dying*
- *This means that physicians who choose not to provide or participate in assisted dying are not required to provide it or to participate in it or to refer the patient to a physician or a medical administrator who will provide assisted dying to the patient*

- *There should be no discrimination against a physician who chooses not to provide or participate in assisted dying*
- *Physicians are obligated to respond to a patient's request for assistance in dying*
- *There are two equally legitimate considerations: the protection of physicians' freedom of conscience (or moral integrity) in a way that respects differences of conscience and the assurance of effective patient access to a medical service*

- *In order to reconcile a physician's conscientious objection with a patient's request for access to assisted dying, physicians are expected to provide the patient with complete information on all options available, including assisted dying, and advise the patient on how to access any separate central information, counselling and referral service*

- *Physicians are expected to make available relevant medical records (i.e., diagnosis, pathology, treatment and consults) to the attending physician when authorized by the patient to do so; or, if the patient requests a transfer of care to another physician, physicians are expected to transfer the patient's chart to the new physician when authorized by the patient to do so*

- *Physicians are expected to act in good faith, not discriminate against a patient requesting assistance in dying, and not impede or block access to a request for assistance in dying*

Regulatory Colleges' Response

- To date, seven P/T Colleges of Physicians and Surgeons have published draft or final guidelines on the issue of assisted dying
- They all note that physicians cannot be forced to participate in assisted dying
- The CPSO is the only one to require mandatory effective referral

CPSO policy

- *Where a physician declines to provide physician-assisted death for reasons of conscience or religion, the physician must do so in a manner that respects patient dignity*
- *Physicians must not impede access to physician-assisted death, even if it conflicts with their conscience or religious beliefs*

- *The physician must communicate his/her objection to physician-assisted death to the patient directly and with sensitivity*
- *The physician must inform the patient that the objection is due to personal and not clinical reasons*
- *In the course of communicating an objection, physicians must not express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient*

- *In order to uphold patient autonomy and facilitate the decision-making process, physicians must provide the patient with information about all options for care that may be available or appropriate to meet the patient's clinical needs, concerns and/or wishes*
- *Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs*

- *Where a physician declines to provide physician-assisted death for reasons of conscience or religion, the physician must not abandon the patient*
- *An **effective referral** must be provided*
- *An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or agency*

- *The referral must be made in a timely manner to allow the patient to access physician-assisted death*
- *Patients must not be exposed to adverse clinical outcomes due to delayed referrals*

CMA response to the CPSO policy

- *The CMA has significant concerns with the requirement that physicians must provide an effective referral*
- *It is the CMA's view that both organizations ultimately share the same objective : to both protect physician conscience rights and patient rights and, in doing so, achieve an appropriate balance between physicians' freedom of conscience and the assurance of effective and timely patient access to a medical service*

- *The one substantive difference between the CMA's position and the approach proposed by the CPSO lies in the understanding of what it means to respect conscience*
- *For the majority of physicians who will choose not to provide assistance in dying, referral is entirely morally acceptable; it is not a violation of their conscience*

- *For others, referral is categorically morally unacceptable; it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act*
- *In other words, referral respects the conscience of some, but not others*

- *From the CMA's significant consultation with our membership, it is clear that physicians who are comfortable providing referrals strongly believe it is necessary to ensure the system protects the conscience rights of physicians who are not*

- *It is the CMA's strongly held position that there is no legitimate justification to respect one notion of conscience (i.e. the right not to participate in assisted dying), while wholly discounting another because one may not agree with it*
- *As such, in seeking an approach that achieves an appropriate balance, the CMA sought to articulate a duty that achieves an ethical balance between conscientious objection and patient access in a way that respects differences of conscience*

- *It is the CMA's position that the only way to authentically respect conscience is to respect differences of conscience*
- *Pitting conscience rights and patient rights against each other creates a false dichotomy and an unnecessary trade-off*

- *As many have argued, it is entirely possible not to compromise or limit patient access on any level without compromising the exercise of conscience*
- *The argument to the contrary is not empirically supported internationally, where no jurisdiction has a requirement for mandatory effective referral, and yet patient access does not seem to be a concern*

- *The focus ought to be on the obligation to ensure effective access to the service*
- *Enabling effective patient access by putting in place systems that facilitate access, as the Provincial-Territorial Expert Advisory Group has proposed and as we find in the Netherlands for example, emphasizes that it is a responsibility of the community to ensure access, rather than placing the burden of finding services solely on individual physicians*

- *The CMA's policy objective is to support those who will choose to provide or participate in assistance in dying and those who will not*
- *To that end, the CMA has clearly outlined an objecting physician's positive obligations that respect differences of conscience, while proposing the creation of resources that effectively facilitate patient access*

- *In doing so, the CMA's position articulates a duty that is widely morally acceptable and that allows physicians to act as moral agents without in any way impeding or delaying patient access to assisted dying*
- *It is in fact in a patient's best interests and in the public interest for physicians to act as moral agents, and not as technicians or service providers devoid of moral judgement*

- *At a time when some feel that we are seeing increasingly problematic behaviours, and what some view as a crisis in professionalism, medical regulators ought to be articulating obligations that encourage moral agency, instead of imposing a duty that is essentially punitive to those for whom it is intended and renders an impoverished understanding of conscience*

CMA's submission to the Federal Special Joint Committee on Physician Assisted Dying

- “The CMA strongly recommends that physician freedom of conscience be recognized as a key component of the federal legislative response to Carter, as a necessary measure to ensure pan-Canadian consistency”



Limitations to conscientious objection

- A fiduciary relationship is one in which “one party exercises power on behalf of another and pledges himself or herself to act in the best interests of the other.” (Norberg vs. Wynrib)
- The physician-patient relationship is understood as a fiduciary one because sick patients entrust physicians with significant discretionary power over their health and well-being
- Due to this entrustment, physicians owe their patients the classic duties associated with a fiduciary relationship, such as “loyalty, good faith, and avoidance of conflict of duty and self-interest”

- This fiduciary duty means there are some limits on the right to conscientious objection

- In today's society, some of these may be relatively self-evident:
 - Male physicians refusing to see female patients
 - Physicians refusing to treat a patient with HIV because they do not condone their lifestyle or sexual preferences
 - Physicians refusing to wash their hands for religious reasons

- Another limit is a requirement to provide **accurate medical information**
- Patients have a right to receive accurate information and counseling on all legal and medically safe options from their clinicians
- Core to medical communication is a fundamental asymmetry of knowledge between physician and patient; crucially, this is increased by a lack of knowledge on the patient's part about what she does not know
- Medical professionals do not have the right to curtail the patient's knowledge or exploit its limits based on their moral worldviews

- Most people also agree that protection of conscientious objection should be limited by **the urgency of an individual patient's situation**
- The more urgent the clinical scenario, the higher the expectation that the physician would have to intervene, even in a situation where they feel morally compromised
- The issue of assisted dying in rural and remote communities may challenge this concept



- Disclosure of conscientious objection requires a clinical encounter that is infused with **compassion and respect**
- Communication of conscientious objection should be a statement about the physician, not the patient or his or her circumstances
- Discussions should be compassionate, respectful, and in the first-person
- “Based on my own beliefs, I am not able to help you with that. What I can do is answer any medical questions you might have about the procedure, and give you information about its availability.”

Summary

- The concept of conscientious objection is complex and controversial
- Some believe that physicians have an absolute obligation to provide whatever medically-approved services the patient requests
- Others feel that physicians have a right to act on their deeply held moral beliefs and convictions

- Much of the current controversy is centered around assisted dying and mandatory effective referral
- In this situation, the CMA believes that a solution can be found that helps ensure patient access while also respecting differing views of conscience
- Exceptions to this right exist, and physicians should always avoid imposing their own views and moral beliefs on their patients



cma.ca | amc.ca