

A Christian Medical Association *Policy Analysis*

The Limits of Conscientious Refusal in Reproductive Medicine

A Critique of ACOG Committee Opinion # 385, November 2007

By Robert D. Orr, MD, CM

A. This detailed opinion on the right of conscience contains several flawed assumptions:

1. **Patient autonomy is the final arbiter of treatment decisions**

- For several hundred years, physician beneficence was believed by all to be the final arbiter of treatment decisions. This was meant to reflect the generally accepted belief that whatever the physician felt was in the patient's best interest was what should be done.
- In western medicine, this imbalance began to change in the 1960's and 1970's such that patient autonomy, i.e., the right to self-determination, was appropriately accorded much greater weight.
- Currently, patient autonomy is felt to outweigh the physician's concept of patient beneficence in most instances. But patient autonomy is not absolute. There are times when the physician's exercise of beneficent care is supported and even lauded, e.g.,
 - treatment and prevention of suicide
 - imposition of life-saving treatment when a patient has made an irrational refusal
 - imposed isolation of a contagious patient who endangers society
 - imposed immunizations.
- This flawed assumption is exemplified when ACOG states "[a]lthough respect for conscience is important, conscientious refusals should be limited if...[4 broad criteria offered]." The criteria offered are overly broad and biased. (see critique below) While equally, physician autonomy is not absolute, this tipping of the balance so strongly in favor of the patient based on assertions is ethically troubling.

2. **Negative patient autonomy (the right to refuse) and positive patient autonomy (the right to demand) are morally equivalent**

- Negative patient autonomy is nearly inviolable; it is rarely justified to impose unwanted treatment (see above for examples).
- However, positive patient autonomy carries much less moral weight. Patient demands are routinely denied by conscientious physicians for such things as unnecessary surgery, unwarranted antibiotics, assisted suicide, etc., even in those situations where the requested treatment is within the bounds of

accepted practice or in instances when other (ignorant, sloppy, or unscrupulous) physicians might accede to the request.

- Such physician refusals are generally based on patient beneficence. However, for decades, a physician has also been permitted to decline a patient's request based on his or her conscience. To not do so implies that the patient's right to access to specific treatment options outweighs the physician's right to avoid moral complicity in an action that he or she believes to be immoral.
- This ACOG opinion supports this incorrect implication, as noted by its repeated referral to physicians as "providers." There is a major conceptual difference between a professional who professes allegiance to standards (those shared by the profession, as well as personal standards) and a "provider," a technician who merely provides whatever is requested of him or her.

3. **Matters of conscience for the professional are matters of personal opinion**

- The (limited) concept of conscience as "self-knowledge" is expressed by ACOG when they define it as the "private, constant, ethically attuned part of the human character." This is a truncated and incomplete view of conscience. A person's conscience is inseparable from his or her worldview or religious beliefs.
- "In the history of ethics, the conscience has been looked upon as the will of a divine power expressing itself in man's judgments, an innate sense of right and wrong resulting from man's unity with the universe, an inherited intuitive sense evolved in the long history of the human race, and a set of values derived from the experience of the individual." (Columbia Encyclopedia, 6th ed.)
- Recognizing this divine origin of an individual's conscience, a conscience clause is defined as "a clause in a general law exempting persons whose religious scruples forbid compliance therewith..." (Webster's Revised Unabridged)
- ACOG reiterates its incomplete view of conscience when they claim "...not to act in accordance with one's conscience is to betray oneself." They admit to no betrayal outside the self.

4. ***Prima facie* values can and should be overridden in the interest of other moral obligations that outweigh it**

- ACOG admits that respect for conscience is a value, but they go on to say it is only a *prima facie* value. This is not so much a flawed assumption as one that is distorted.
- A *prima facie* value is one that is accepted on its own merit, without need for proof, though it may be contested and shown to be invalid in a particular circumstance.
- By emphasizing the possibility of override, and claiming conscience is only a *prima facie* value, they imply that this is of little consequence.

- B. Comments on the four criteria ACOG uses to determine appropriate limits to claims of conscience.
1. **Potential for Imposition**
 - This section of the Opinion conflates refusal to provide a requested service by the professional with imposition of the professional's beliefs. It is instead an instance of negative professional autonomy. The professional's refusal does not preclude the patient from seeking or obtaining the requested service elsewhere. Geographic or sociologic constraints are separate and distinct.
 2. **Effect on Patient Health**
 - While an important point could be made when considering significant bodily harm to the patient (pain, disability or death), ACOG expands the definition of "health" to include "a patient's conception of well-being." Thus they again assert, incorrectly, that the patient's wishes, whatever they may be, trump professional autonomy.
 - In addition, they define the physician's fiduciary duties to include an obligation "to protect patients' health." Again, they could make this point vis a vis an obligation to protect from bodily harm, but they distort it by implying the patient's autonomy takes precedent over the physician's conscience. The example they use here is a conscientious refusal to do a tubal sterilization at the time of Cesarean section, claiming that the "attendant and additional risks" of a second surgical procedure should override the physician's conscience. Thus their assumed threshold is exceedingly low.
 - ACOG minimizes the physician's obligation to promote fetal well-being. Though initially couched in terms of "protect[ing] the safety of women," the implication is that this protection includes the "patient's conception of well-being" invoked earlier.
 3. **Scientific Integrity**
 - ACOG correctly speaks against support for conscientious refusal based on invalid consequential reasoning. Some claims of conscientious objection are not genuine. If a physician has a conscientious objection for personal involvement, he or she should so state rather than trying to hide behind a potential adverse outcome. However, in regard to this consequential reasoning, ACOG goes on to incorrectly infer that uncertainty of evidence should be ignored.
 - Such consequential claims by physicians may, however, have a legitimate place in decisions about public policy.
 4. **Potential for Discrimination**
 - Again, ACOG begins with a valid argument --- like patients should be treated alike, without discrimination. Thus a physician who claims conscientious objection to doing a certain procedure is not justified in refusing the procedure for one patient while providing it for another

equivalent patient. However, the example they use is fallacious --- refusing to provide contraceptive assistance to an affluent patient who may be able to procure it elsewhere may be justified, they say, while doing so for a poor young mother without transportation is not because it is unjust.

- The Opinion goes on to claim as “oppressive” the denial of reproductive services for a homosexual couple while providing the same for a married heterosexual couple. The AMA clearly states in its Principles of Medical Ethics that “A physician shall...except in emergencies, be free to choose whom to serve...” Assisted Reproductive Technology is not an emergency service.

C. Critique of ACOG’s Recommendations

1. “In the provision of reproductive services, the patient’s well-being must be paramount. Any conscientious refusal that conflicts with a patient’s well-being should be accommodated only if the primary duty to the patient can be fulfilled.”
 - Reproductive services are rarely matters of life and death. This assertion, then, is that a physician’s “obligation” to provide elective reproductive services for a patient is greater than his or her conscience. This is patently false.
2. “Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.”
 - This is a reasonable recommendation. A duty to present accurate information does not, however, prevent him or her from expressing his or her moral beliefs on the matter.
3. “Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.”
 - This is not an unreasonable recommendation in situations of individual practitioners in an elective healthcare setting. It becomes problematic and probably unworkable in situations of cross coverage and in emergency settings.
4. “Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they

can in conscience provide the standard reproductive services that their patients request.”

- This recommendation totally ignores the issue of moral complicity. Some physicians may be willing to follow this, but others believe their involvement in the referral process involves moral wrongdoing --- without their involvement, the morally troublesome procedure would not have happened. [Orr RD. The role of moral complicity in issues of conscience. *American Journal of Bioethics*, November 2007, in press]
5. “In an emergency in which referral is not possible or might negatively affect a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider’s personal moral objections.”
- This recommendation is valid, though such emergency circumstances in reproductive health care would be very rare indeed. An example would be when a surgeon with moral qualms against ending the life of a living fetus is caring for a woman with a life-threatening ruptured ectopic pregnancy, and he finds at surgery that the fetus is still alive. He is obligated to save the woman’s life, even if it means violating his moral understanding of the sanctity of fetal life.
6. “In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients; rights to health care services.”
- This is a claim with no foundation. Patients in “resource-poor areas” may well be without access to a neurologist, vascular surgeon, dermatologist, or perhaps even a general surgeon. There is no professional requirement that all health care services must be available to everyone at all times. Certainly a physician in such an area must be willing to provide all emergency services in which he or she is adequately trained. However, there is no such obligation for elective procedures, even if he or she is capable.
7. “Lawmakers should advance policies that balance protection of providers’ consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.”
- The comments to Recommendation #6 apply equally here. There is equally no societal obligation to ensure convenient access to all elective health care services for everyone.