

Conscientious Objection and Compromising the Patient: Response to Hughes

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Abstract

Hughes' offers a consequentialist response to our rejection of accommodation of conscientious objection in medicine. We argue here that his compromise proposition has been tried in many jurisdictions and has failed to deliver unimpeded access to care for eligible patients. The compromise position, entailing an accommodation of conscientious objection provided there is unimpeded access, fails to grasp that the objectors are both determined not to provide services they object to as well as to subvert patient access to the objected to services. Unpredictable future developments in drug R&D and resulting treatment and prevention options in medicine make the compromise position unrealistic.

Introduction

There are many points where we agree with Hughes in his excellent article, "Conscientious Objection, Professional Duty and Compromise."¹ Hughes agrees that conscientious objection is a problem in practice. We offered three solutions, based on philosophical argument, that secular ethics, professionalism and law, not doctors' personal consciences, should dictate the limits and extent of medical practice. Those solutions were:

1. Restrict entry in medical school or specialty training to those willing to offer relevant services.
2. De-monopolise medical services and allow other service providers to offer relevant services.
3. Remove the legal right to object to certain duties and deal with objection under labour law.²

Hughes advocates the 'compromise approach', which holds that a conscientious refusal to provide a legal good or service within the scope of the practitioner's competence is compatible with her professional duty "only if it does not present an excessive impediment to a patient's timely or convenient access to the good

¹ Hughes, J.A. (2017). Conscientious objection, professional duty and compromise: A response to Savulescu and Schuklenk. *Bioethics* 00:1–6. <https://doi.org/10.1111/bioe.12410>.

² Savulescu, J. and Udo Schuklenk, U. (2017) Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception. *Bioethics* 31: 162-170.

or service."³ For much of the rest of the paper he talks about “no impediment”, which isn’t quite the same proposition.

The compromise position is unworkable in practice

We are both consequentialists. If the compromise position worked in practice, we would have no objection. But it doesn't.

Variations of the compromise position have been the stated principle of existing practice and legislation in many jurisdictions as well as the stated policies of organisations such as the International Federation of Gynecology and Obstetrics⁴. Let us take Victoria in Australia as a case in point, it is as good an example as any. According to Section 8 of the Abortion Law Reform Act 2008, medical professionals with a conscientious objection must:

Inform the woman that they have a conscientious objection;
Refer the woman to another health practitioner, in the same profession, who the practitioner knows does not have a conscientious objection to abortion.
In emergency situations where the woman’s life is in danger there is no right to object

The rationale for conscientious objection in Victoria is that a woman’s right to make decisions about her body must be balanced against the religious beliefs or conscientious objection of a health practitioner. A health practitioner with a conscientious objection to abortion should not be discriminated against, but nor should their beliefs affect the ability of their patients to access healthcare.

However, in practice women are disadvantaged. Research by the Murdoch Childrens Research Institute⁵ shows that women whose fetuses are diagnosed with abnormalities can wait up to two weeks to be booked in for a termination in public hospitals. Interviews conducted with over 100 patients also found that some did not receive adequate assistance from health professionals to arrange a termination, forcing them to resort to Google or the Yellow Pages to find a private abortion service. Many faced a termination review panel at varying

³ *Op. Cit.*, p. 1.

⁴ FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. (2006) Ethical guidelines on conscientious objection. *Int J Gynecol Obstet*, 92 (3): 333-334. (Reaffirmed 2016)
<https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine> [accessed January 4, 2018]

⁵ Hodgson, J et al. (2017). Submission S073. Inquiry into Perinatal Services. Family and Community Development Committee. Available at https://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/58th/Perinatal/Submissions/S073_Hodgson_et_al.pdf (accessed 4 January 2018).

gestations, despite the law allowing terminations up to 24 weeks for *any* reason. According to Dr Jan Hodgson, "Many felt inadequately supported by their doctors if they decided to have a termination, often perceiving this as being negatively judged for choosing to end their pregnancy."⁶

Family Planning Victoria CEO Lynne Jordan reportedly said, "some women requesting abortions for reasons other than fetal abnormalities had also reported being told by their GPs that they could not provide access to the service."⁷ This is despite the law saying that doctors with a conscientious objection must refer patients to a doctor who does not object. About one-third of pregnant women are being cared for in Catholic hospitals in Victoria that will not perform terminations. No co-ordinated system exists to ensure equitable access to abortion across the state of Victoria. The department of health only publishes a list of two public hospitals that offer abortion services.

Farr et al⁸ in their landmark study of conscientious objection in medicine in the US, found that 8% of doctors stated there was no obligation on doctors to inform patients of all legally available medical options. The point out that the survey results are "not trivial":

"If physicians' ideas translate into their practices, then 14% of patients — more than 40 million Americans — may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29% of patients — or nearly 100 million Americans — may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments. The proportion of physicians who object to certain treatments is substantial. For example, 52% of the physicians in this study reported objections to abortion for failed contraception, and 42% reported objections to contraception for adolescents without parental consent."⁹

A survey of about 600 emergency rooms in Catholic hospitals in the United States reveals that more than half refuse to provide emergency contraception, less than half provide referrals to willing providers.¹⁰ Since Canada has legalized medical aid in dying not a day goes by without news reports of service refusals to eligible patients, often in religiously affiliated hospitals, but also in secular

⁶ Medew, J. (2015). Barriers to Abortion Remain in Victoria Seven Years After Decriminalisation. The Age. Available at <http://www.theage.com.au/victoria/barriers-to-abortion-remain-in-victoria-seven-years-after-decriminalisation-20151009-gk5dnz.html> (accessed 4 January 2018)

⁷ Ibid.

⁸ Farr, A. et al. (2007). Religion, Conscience, and Controversial Clinical Practices. *N Engl J Med* 2007; 356:593-600 DOI: 10.1056/NEJMsa065316

⁹ Ibid. p. 597

¹⁰ Nunn, A, Miller, K, Alpert, H, Ellertson, C. (2003) Contraceptive emergency. Catholic hospitals overwhelmingly refuse to provide EC. *Conscience* 26(2):38-41.

institutions.¹¹ Ultimately, what is attempted here is to subvert patients' legal entitlement, entitlements that were hard fought over in the courts and the political arena. The subversion effort is led by the same religious organisations whose arguments have been rejected by the courts, and, indeed, by the public. They now use their, typically publicly funded, health care infrastructure to have their way regardless. Delston describes how doctors in the United States who refuse to provide contraceptives resort to ever more sophisticated means to prevent equal citizens from the enjoyments of their rights, because they disapprove of their choices.¹² Artificial hurdles are mounted, for instance in front of women seeking access to birth control, such as reportedly asking women who never had sex to undergo Pap smears before the prescription of birth control.¹³

We have reason to believe from this data that there may be a more widespread problem than we imagine. It is a problem that may go unreported: the patient may not know, for example, that terminal sedation exists at all, or what the laws in their state regarding terminal sedation are, or if they do, if their own condition meets the criteria. Therefore, they would not necessarily know anything about their doctor's objection and its impact on their care.

The compromise position is clearly not working. This is not surprising. The compromise position is bound not to work, because the grounds of objection are typically not amenable to compromise.¹⁴ It is not the case that there are two reasonable sides trying to make the health care system work. It is the vulnerable and disempowered patient who is compromised.

Politicians and compatibility approach

Hughes argues that the compatibility approach is likely to have more traction with politicians and legislators. He is right - that is precisely the kind of policy they have opted for, and it hasn't worked.

"It is not clear that in a liberal society something's being legal implies that it is judged to be a social good. Given the presumption of liberty, it could merely be that there is insufficient reason to prohibit it."¹⁵

¹¹ Gerster, J. 2018. Faith-based health facilities obstructing access to assisted death: advocates. *Winnipeg Free Press* January 01. <https://www.winnipegfreepress.com/local/faith-based-health-facilities-obstructing-access-to-assisted-death-advocates-467571273.html> [accessed January 4, 2018]

¹² Delston, JB. (2017) When doctors deny drugs: Sexism and contraception access in the medical field. *Bioethics* 31: 703-710.

¹³ Saraiya, M, Martinez, G, Glaser, K, Kulasingam, S. (2009) Pap testing and sexual activity among young women in the United States. *Obstet Gynecol* 114: 1213–1219.

¹⁴ Schuklenk, U, Smalling R. (2017) Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of medical ethics* 43: 234-240.

¹⁵ Hughes *op cit*, note 1, p. 3

Yes, this is perfectly reasonable point. But when it becomes a part of public medicine it should plausibly be good. Or else we should say that respecting autonomy is a significant value of medicine.

Hughes closes by correctly pointing out that the medical profession holds significant power, especially with legislators. Conscience clauses may be necessary to get bills legalizing medical aid in dying passed. This is certainly true. But it should not stop us from arguing in public fora that such compromises are unnecessary, unprofessional and in practice significantly disadvantage the very people they are meant to serve. If anything, professionals' associations like medical associations that support conscientious objection accommodation should be asked why they are supporting unprofessional conduct.¹⁶ We have attempted to show that the heavens don't fall, morally, legally, practically or politically if a different, for instance Scandinavian approach is adopted.

Referrals

Hughes goes on to claim, "Savulescu and Schuklenk assume that the contract should require the controversial services to be provided by every doctor."¹⁷

There are good reasons not to force people to perform abortions and euthanasia - they may well do it in an inferior manner. For this reason, it is better to select people who will be willing to perform the service. A few conscientious objection accommodation requests, dealt with on a case by case basis, may be unavoidable, but they should not be based on a right to be accommodated. Perhaps we don't disagree in substance with Hughes. But the balance of power should certainly shift from doctors to patients.

Hughes claims conscientious objection and referral-on can be a stable psychological and moral compromise. Of course, there are a wide variety of reasons for conscientiously objecting to killing humans and some of these are perfectly consistent with still fulfilling a professional role of sympathetically referring a person on to a better service provider. However, our claim was directed to those who hold "hard line views" which claim abortion or euthanasia constitute the murder of an innocent person. Those kinds of views are morally difficult to reconcile with actions which facilitate the alleged evil, and in fact psychologically tend to represent major impediments, of the kind that Hughes objects to, to abortion and euthanasia.

Career choices

¹⁶ Schuklenk, U. (2016) Accommodating conscientious objection in medicine: Private ideological convictions must not trump professional obligations. *Journal of Clinical Ethics* 27(3): 227-232.

¹⁷ *Ibid.*

By adopting one of our strategies, those kinds of objectors would be discouraged from entering the relevant specialty or being able to obstruct medical practice. Prior to entering medicine or a specialty, people have no right to reconstruct its range of provisions.

It is puzzling why a person who held a strong objection to abortion would enter a specialty like obstetrics and gynaecology in which that is a part of the service, just as it would be puzzling why a Jehovah's witness would enter haematology. Of course, humans are very complex and values very diverse. There might be ways in which both could function well in their jobs but a good place to start is to make society's expectations clear: choose this job and you cannot expect your conscience, aka your idiosyncratic personal values, to dictate how the service will be delivered and to whom. At present, from the very moment training begins, would-be professionals can dictate what they will and will not do. This is untenable.

Future of medicine

Medicine will only become more and more controversial. There is great disagreement about what constitutes well-being, and to what extent medicine's role should be limited to fighting disease as opposed to aiming at improving the human condition. Health care professionals are already drawing arbitrary individual lines in terms of what services they provide, and this is likely to get worse. To give just one example: Pharmacists surveyed in 2008 in Nevada declared variously that they would not provide erectile dysfunction drugs (1.7%), emergency contraception (7.5%), infertility drugs (1.4%) and medical abortifacients (17.2%).¹⁸ Apparently, next to religious views, age was a predictor of (un)willingness to provide particular professional services to eligible patients. We have tried to provide a secular approach to resolving these difficult issues.¹⁹ Conscientious objection is the thin end of the wedge of value pluralism. Many, but arguably not all, conscience related claims are reflections and consequences of ongoing societal culture wars. NeJaime and colleagues point out that conscientious objection is a 'transnational phenomenon, and the organizations and activists encouraging these claims work across borders.'²⁰

¹⁸ Davidson, LA, Pettis, CT, Joiner, AJ, Cook, DM, Klugman, CM. (2010) Religion and conscientious objection: a survey of pharmacists' willingness to dispense medications. *Soc Sci Med* 71(1):161–5.

¹⁹ Savulescu, J. (2007). Autonomy, the Good Life, and Controversial Choices. In R. Rhodes, L.P. Francis, and A. Silvers (Eds.), *The Blackwell Guide to Medical Ethics*. Oxford: Blackwell Publishing, pp. 17 – 37.

²⁰ NeJaime D, Siegel R. (2018) Conscience Wars in Transnational Perspective: Religious Liberty, Third-Party Harm, and Pluralism. In: Mancini S, Rosenfeld M. (eds) *The Conscience Wars: Rethinking the Balance Between Religion, Identity, and Equality*. Cambridge: Cambridge University Press [in press].

Perhaps, in practice, there is no great distance between our views, and Hughes' no impediment view. We suspect that to achieve "no impediment" we need to adopt something like our proposals. But that is an empirical question. If patients got what they are entitled to, we would have no objection to the "no impediment" or other compromise position. At present, the compromise view only compromises patients. It is cost-neutral to the objector.