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## RESEARCH ARTICLE

### The Practitioner's Paradox: Conscientious but ...Without Conscience

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#### ABSTRACT:

Over the last decade a group of moral philosophers concerned with medicine have argued, some stridently, that conscience has no place in the conscientious practice of medicine. And yet, it is hard to separate conscience from conscientiousness. This paper reviews and critiques the argument against conscience and the assumptions underlying it. It argues that it is often difficult to separate conscience, a moral perspective on appropriate practice, from the clinical knowledge and experience that practitioners possess and patients do not. The result is not paternalistic although it challenges the assumption that the patient in distress often knows best. The focus in this paper shifts from simple autonomy as a reflexive rule to the social and broadly clinical context in which decisions about procedures like abortion and medically assisted death are made.

**Keywords:** ethics, conscience, medicine, moral philosophy, practitioner

## Introduction

At least since 2012 an expanding phalanx of ethicists and moral philosophers interested in medicine have argued practitioners—doctors, nurses, midwives and pharmacists—should be prohibited from making clinical decisions based on or influenced by personal ethics or morals. As used in this paper, ethics are the rules by which a primary set of moral values—cultural, professional, or religious—are enacted. In denying conscience-based decisions, critics seek to create a unique class of citizens for whom moral perspectives are disallowed in the otherwise conscientious performance of professional duties. Savulescu, for example, acknowledges that refusing a physician's conscience-based judgment in the care of a patient "harms the doctor and constrains liberty."<sup>1</sup> Still, he insists, as a self-evident given, that "A doctors' conscience has little place in the delivery of modern medical care." This clarion call for the presumably conscientious but conscienceless practitioner is the more surprising because it is typically advanced by ethicists and philosophers who otherwise assert autonomy as a primary moral good in society-at-large and medicine specifically.

## The Paradox

The result is paradoxical because by most definitions to be "conscientious" implies, explicitly or implicitly, the engagement of conscience, "wishing to do what is right, esp. to do one's work or duty well and thoroughly."<sup>2</sup> "To do what is right" means, as *Merriam-Webster's Dictionary* makes clear, to act "governed by or conforming to the dictates of conscience," which, with sensitivity to issues of fairness and justice, requires "conformity to what one considers to be correct, right, or morally good."<sup>3</sup> Thus to be conscientious requires the inaction of a practitioner's conscience and perception of what is "correct, right, or morally good." That, however, is precisely what is denied when ethics and morals are ordered set aside. In that case "conscientious" is merely doing whatever one is asked or ordered to do.

"Conscientiousness" and "conscience" share the Latin root word *scientia*, meaning applicable knowledge and skill.<sup>4</sup> Making a conscientious decision thus assumes application of the practitioner's knowledge base: clinical, ethical, experiential, and practical. Problems arise when a patient's request seems clinically or morally problematic to the practitioner. To deny an ethical objection based on a moral perspective is to deny,

in essence, a critical aspect of the *scientia* a practitioner brings to a case.

Those who argue medical practitioners should ignore issues of conscience do so by imposing a paradigm of simple autonomy asserting the ethical primacy of an individual's wishes without regard to context or an understanding of treatment options. This ignores what in practice is a complex, relational engagement in which a patient's preferences and a practitioner's recommendations, and the reasons for each, must be considered together. Certainly, one has the right to request the service of another but that request can, by the other, be denied for any number of cogent reasons: ethical, clinical, or practical. To assume nothing is relevant except the individual patient's desire at a moment is to deny not only the autonomy of those others but also the reasons—clinical, ethical or moral—for their demur.

## Conscience: Legal and Professional

### *Conscripts or volunteers*

Stahl and Emanuel<sup>5</sup> argue that because the history of conscientious objection in the US is largely focused on military conscripts that in most cases it should be withheld from medical practitioners who are not conscripts but have freely chosen their profession. Schüklenk and Smalling similarly advance the general thesis that "it is implausible that professionals who voluntarily join a profession should be endowed with a legal claim not to provide services".<sup>6</sup> Health care practitioners knew what they were getting into when they chose to take on their professional roles, the argument goes; they therefore should do whatever is legally permissible upon request.<sup>7</sup> If they object to a patient's request then, unlike military conscripts, they can quit.<sup>8</sup>

But there is no distinction in covenant or law that sets military care, or the relevance of conscience, as distinct from civilian practice. The *United Nations Principle of Medical Ethics Relevant to the Role of Medical Personnel* states that military medical personnel, "particularly physicians," have a "duty to provide care and protection of the same quality and standard as is afforded to those who are not imprisoned or detained"<sup>9</sup> Similarly, World Medical Association's (WMA) 1956 *Declaration of Havana*,<sup>10</sup> and later, its 2012 *Regulations in Times of Armed Conflict*, stated that "medical ethics in time of armed conflict are identical to medical ethics in time of peace".<sup>11</sup> Medical ethics does not change, in other words, whether one is a conscript or a volunteer. Like civilians, military conscripts and volunteers have the right and in some cases the duty to object to procedures ordered by superiors.<sup>12</sup> "Doing the job" is not simply the provision of

services but the judgment—clinical, ethical and moral—to a conscientious judgment of best practices in the care of the patient.<sup>13</sup>

The right to conscientious objection by military personnel—conscripts and volunteers alike—is a subset of the general rights of *all* citizens to conscience. In proclaiming a “Final Rule” titled, “Protecting Statutory Conscience Rights in Health Care,” U.S. Department of Health and Human Services secretary Alex Azar in 1996 reviewed the long history of US legal protections of conscience rights. They were buttressed by a series of international covenants, professional guidelines and legal protections assuring U.S. practitioners the moral space to make ethical decisions regarding clinical procedures they may be asked to perform. These include, for example, the 1996 Coats Amendment; and the Department of Health and Human Services’

#### *Conscience Regulations.*<sup>14</sup>

In Canada “freedom of conscience and religion” is guaranteed to all citizens in the *Charter of Rights and Freedoms* (Section 15) as well as through a range of international covenants and agreements to which Canada (and in some cases the United States) is a signatory. These include article 18 of the *International Covenant on Civil and Political Rights*, article 14 of the *Convention on the Rights of the Child*, and article 3 of the *American Declaration of the Rights and Duties of Man*.<sup>15</sup>

In the same vein, the American Medical Association’s (AMA) *Code of Ethics* grants practitioners the right of conscience, and conscientious refusal in the performance of specific procedures “incompatible with the physician’s deeply held personal, religious, or moral beliefs.”<sup>16</sup> Finally, at issue is not the refusal of practitioners to provide “service” to the individual patient. A midwife, nurse or physician may willingly offer all possible care to a patient *excepting* performance of a procedure they find either ethically objectionable or clinically inappropriate. The right to make that decision about how best to care for the person is clearly not “implausible” but instead guaranteed by the cited plethora of agreements, covenants, and statutes.

#### **Abortion and MAiD**

In recent years, academic and legal debates over practitioner conscience have focused primarily on two different clinical procedures: Abortion and medical termination called, in Canada, Medical Assistance in Dying (MAiD). In the United States abortion is again a hotly contested subject after the

Supreme Court decision *Dobbs v. Jackson Women’s Health Organization*<sup>17</sup> overturned the 1973 *Roe v Wade*, which recognized a woman’s right to seek an abortion.<sup>18</sup> With *Roe* there was no consequent obligation for physicians to perform abortions, however, with the exception of when the life of the mother was at risk. Under *Dobbs*, the legal question of abortion is left to state legislatures. The result is that clinicians sometimes must choose either to defer to the restrictions of certain state laws or abandon their conscientious obligation for the well-being of the patient.<sup>19</sup> Ethically, the problem is especially acute in the case of problematic pregnancies where the life of the mother is at risk.

In Canada, a 1988 decision by the Canadian Supreme Court (*R. v. Morgentaler*) ruled prohibitions to abortion in the Criminal Code violated a woman’s rights to security of person under Section 7 of the *Canadian Charter of Rights and Freedoms*.<sup>20</sup> As a result, the infrastructure to provide abortions became the responsibility of provincial Ministries of Health. That said, individual ministries were and remain under no legal obligation to ensure sufficient facilities for those seeking abortion. Canadian practitioners remained free to refuse on conscientious grounds to perform an abortion except where the life of the woman was endangered.

#### *Medical Termination (MAiD)*

In Canada the issue of medical termination rather than abortion has been the flash point for debate over conscientious objection in medicine. In 2015 the Supreme Court of Canada ruled the right to medical termination is protected under sections of the *Charter of Rights and Freedoms*.<sup>21</sup> That right was restricted at first to those suffering irremediable pain in an end stage illness. A series of subsequent judgments refined and expanded the original decision<sup>22</sup> to include an increasing range of chronic, non-terminal conditions.<sup>23,24</sup> While the right to request medical termination was guaranteed, Canadian courts have not mandated provincial health ministries ensure adequate provision of clinics providing MAiD. Nor under federal or provincial legislation are practitioners required as a matter of licensure to perform any single clinical procedure within their area of competency. Ethically and legally, judgment is reserved to the practitioner based on experience, clinical knowledge and an ethical conception of what is meant by best care.

#### **Misconceptions**

Some critics confuse the rights of practitioner conscience with a right of patient access to health care without undue burden.<sup>25</sup> Access is determined not by the individual practitioner, however, but by statutes defining first what is legally permissible and second, the extent to which adequate facilities are made available for those services. If abortion is illegal in a US State, then access is denied not by the practitioner but the State. The same can be said of medical termination (and abortion) in Canada where provision of specific resources, including hiring of medical professionals, is the responsibility of provincial health ministries and provincially supported hospitals. They may or may not assure local health districts have medical personnel and resources available for abortion or MAiD services.

A second misconception is that practitioners who refuse to perform abortions or medical termination only do so on the basis of religious affiliations: "Conscience clauses today are an unwarranted concession of special rights to Christian healthcare professionals, at least in secular Western Democracies."<sup>26</sup> Objections may arise from a range of perspectives including professional guidelines (for example, CHPCA/CSPCP 2019) and non-religious ethical perspectives.<sup>27</sup> To assume conscientious objections are limited to an individual's religious perspective is to misconstrue the broader class of those who may on ethical grounds object to performing a specific procedure. Thus, for example, Kim and Ferguson<sup>28</sup> advance as reasonable appeals to conscience when a practitioner's ethical values are grounded in what are understood to be one or more core values in traditional Hippocratic medical ethics.

Those who argue medical practitioners should be solely beholden to what is, first, legally permissible and second, requested by a patient, do so based two fundamental premises. First, they assume practitioners are primarily technicians without the background or training and thus the right to make complex moral choices. "All the knowledge in the world about the facts of medicine cannot give one special expertise in making evaluative choices base on those facts."<sup>29</sup> From this perspective the practitioner is no more than a means to an end, servicing without question or deliberation a patient's request or a superior's directive.

Conscience critics assume the *only* pertinent standard is the right of the individual to demand a legally permissible procedure. Insisting an individual's choice as the sole determinant in what is a collective procedure "short-changes solidarity, beneficence, and community; that endorses self-centred, even possessive individualism; that

overvalues independence and wrongly devalues forms of valued dependence that are ubiquitous in human life.<sup>30</sup> Valued dependences are interdependences nested in relations of reciprocity and trust based on shared histories of care and the value systems of the practitioner, as well as those of the patient. By appealing to principles, norms or rules, critics fail to realize the importance of the lived experience of health care professionals, as well as those of patients.

Neither the practitioner nor the patient are isolates operating in splendid anonymity. Each becomes an individual only within a communal context. That includes as well the active participation of a range of medical personnel including doctors, mid-wives, nurses, pharmacists, and local health administrators. Equally engaged in medical decision making may be a patient's family members, and their history, in the request for or refusal of a specific procedure. All these different voices may influence a practitioner's decision making.

Clearly, the practitioner's responsibility to provide the best care of the patient is, on all these grounds, not a simple thing, "defined by the law and consideration of the just distribution of finite medical resources."<sup>31</sup> From that perspective both a patient's requests and a physician's recommendation may be set aside when administrators decide limited resources should be reserved for others deemed more deserving. This was the argument of Daniel Callahan who famously argued seniors should receive only palliative care to assure more expensive procedures would be first available for younger, more productive workers.<sup>32</sup> In that case, the ethics of care becomes a matter not of a physician's judgment or a patient's preferences but limits imposed by a healthcare system.<sup>33</sup> Ethics then becomes a simple matter of accountability in health systems with inadequate support.

Finally, denying the conscientious demur restricts the right of the practitioner to criticize systemic limits affecting care or morally questionable directives that may impede care.<sup>34</sup> As Mills wrote, society "needs protection also against the tyranny of the prevailing opinion and feeling; against the tendency of society to impose ... its own ideas and practices as rules of conduct on those who dissent from them." Because something is legally permissible or officially sanctioned does not mean it is morally acceptable or, in medicine, clinically appropriate. Examples of physician protests of immoral but sanctioned behavior stretch across the 19<sup>th</sup> and twentieth centuries.<sup>35, 36</sup> argue that protection. Conscientious objectors serve as a

mechanism by which professions (and societies) may “self-correct” when procedures are challenged on ethical or moral grounds.<sup>37</sup> Conscientious objection is thus a critical check on the both excesses and limits imposed by officialdom, civilian or military.

### The Duty to Care

What critics and defenders of conscience prerogatives agree upon is that “people have to take on certain commitments in order to become a doctor.”<sup>38</sup> These are presented by some, like Amir Attaran,<sup>39</sup> as a “fiduciary responsibility” “undertaken to act for and on behalf of another in a particular matter in circumstances which give rise to a relationship of trust and confidence”.<sup>40</sup> Typically employed in commercial and corporate law, its introduction to issues of medical ethics implies medicine is a commercial enterprise amenable to a corporate perspective. Even accepting its relevance to medicine imposing it into any discussion, as Mister Justice Frankfurter observed in *SEC v. Chenery Corporation*, “... only begins the analysis; it gives direction to further inquiry. To whom is he [or she] a fiduciary? What obligations does he owe as a fiduciary? In what respect has he failed to discharge these obligations? And what are the consequences of his deviation from his duty?”<sup>41</sup> In law the representation owed is contractual, based on the agreement of representation in a specific area of counsel, service or action. It does not require the lawyer accept any and all requests a client might present, only that on agreeing to representation the lawyer carry out in a lawful manner.

Its utility in medicine is often employed within the idea of an unwritten, un-negotiated metaphorical social contract governing the propriety and purpose of medical practitioners. This assumes the practitioner's allegiance and responsibilities are not first to the person in need but to the society that grants practitioners *en large* the exclusive right to clinical practice. A medical organization supervising individual pledges “to be trustworthy in its competence and use of its special knowledge, privileges and powers to help society and the individuals in it.”<sup>42</sup> That pledge becomes a promise binding each member.

What does that mean? The Hippocratic tradition defines practice as the responsibility “to care, comfort, be present, help with coping, and to alleviate pain and suffering.”<sup>43</sup> The primary obligation is not first to the state but the patient. In a modern version of this argument the practitioner maintains fidelity with the patient in an association dependent on the practitioner's practical

experience and special knowledge.<sup>44</sup> Put another way, “By entering a health care profession, the person assumes a professional obligation to place the well-being and rights of patients at the center of professional practice”.<sup>45</sup> Patients choose practitioners whose clinical and ethical perspectives are, ideally, similar to their idea of the care they hope to receive. A patient seeking MAiD from a physician opposed to it is free to find another willing to fulfill their request. If others are not available, it is the responsibility of the governing health organization to assure availability of willing practitioners in its jurisdiction.

### The Care of the patient

Nowhere in any of these formulations is there an insistence that practitioners must be relieved of conscience in the conscientious performance of their duties. Both as practitioners and as members of professional organizations the sole ethical imperative is the best care of the patient. But to say “physicians are responsible for legally permitted, efficient, and beneficial care to a patient ...”<sup>46</sup> begs the question of what is beneficial. The *American Academy of Hospice and Palliative Medicine*, for example, states its fundamental goal is to “relieve patient suffering and to enhance quality of life.”<sup>47</sup> In the same vein, a joint statement by Canadian Hospice and Palliative Physician associations defined MAiD as contrary to the goals of both hospice and palliative practice.<sup>48</sup> Both endorse the practitioner's right to conscientious objection should they believe medical termination either inappropriate in a specific case or morally objectionable in all cases.

### Autonomy

Those seeking to deny practitioners the general right of conscience embrace, at least implicitly, a Kantian conception of morality as self-governance thus assuming all possess, “an equal ability to see what morality calls for and are in principle equally able to move themselves to act.”<sup>49</sup> There is, from this perspective, no other arbiter than the individual whose knowledge is assumed to be sufficient to make independent clinical decisions. As McCullough argued,<sup>50</sup> physicians have their knowledge base and patients have theirs. For the physician to advance his or her ethics and clinical perspective rather than simply accept the patient's demands is *a priori* paternalistic and therefore objectionable.

But as economist Kenneth Arrow pointed out long ago, physicians sometimes know what patients do not; “patient centered” medicine is not simply acquiescence to the demands of a moment but the



application of the practitioner's knowledge and experience to the patient's condition and needs.<sup>51</sup> With a rapidly expanding and ever more precise knowledge base, one where the science and the techniques based on them are rapidly changing, "the client is always right" might serve as a useful maxim in the clothing store or the automobile showroom but not necessarily in the clinic or the hospital. There is no "Consumers Report" to inform patients of optimal procedures in complex care crises. What for the person in care is a new, terrifying and discouraging reality is one the attending physician has seen many times in clinic. Practically, patients are necessarily guided by the practitioner's perspective.

We know, for example, that almost all persons suffering strokes or spinal injuries causing paraplegia or quadriplegia will go through periods of suicidal ideation. But we also know that with sufficient rehabilitation and support that within two years the majority will report a quality of life as good, if different, as that previously experienced.<sup>52, 53</sup> A physician who denies a request for MAiD during the early days of a patient's recovery on the basis of that knowledge is not being egregiously paternalistic. That physician is saying, "I know what you do not yet know; I can see a good future if you'll let me help you." And, too, that practitioner is saying the patient's life remains valuable and worth saving.

#### *MAiD and its limits*

An example of the different levels of knowledge and potentials for care was recently presented to me by a Canadian physician whose male patient in his 80's had been assessed and found eligible for MAiD before moving to a long term care facility. He was diagnosed with chronic, progressive and what would be eventually terminal illnesses. When asked during an initial intake interview if he knew what MAiD was the patient answered "a quick and painless death." When then asked if he wanted to die immediately he said no, he wanted to visit his girlfriend in Central America. When told that could be arranged—he could easily afford a clinical companion to assist him if he traveled—he withdrew his request.<sup>54</sup> Those who assessed him as qualified had not considered, or offered options that would enhance his life, only simplify his ending.

It is simply too easy to say, "he (or she) asked for it." We know that at least three of the first 88 deaths attributed to Jack Kevorkian revealed, on autopsy, no clinical abnormalities despite diagnoses of chronic conditions like MS.<sup>55</sup> An ethical objection to MAiD may result in clinical investigations that will

identify and then resolve patient complaints. In 2017, for example, I was asked to review the case of a woman in her early 90's with chronic cardio-pulmonary deficits who had requested and was assessed as eligible for MAiD asked for it after being told she would need to move to a care facility because she could no longer dress herself. Attending with a palliative physician assigned to the case, an examination revealed her limiting physical deficiencies were the result of treatable bursitis in her shoulder. Cortisone injections reduced the symptoms and restored her ability to dress and care for herself. As a result, the request for medical termination was retracted and she died in her sleep at home several years later.

Reflexively accepting a MAiD without deeper investigation accepts the patient's autonomy without attention to the real, underlying clinical needs of the person. A deeper question is what we, as a society, believe is so hopeless we permit a patient to choose medical termination rather than a continued life. In 2018 the shared, medically induced deaths of George and Shirley Brickenden, both in their 90's, was lauded by local media.<sup>56</sup> After seventy-three years of marriage they wanted, they said, to die together before they became physically to continue the basically comfortable life they were living. Both had a series of chronic but not terminal conditions that were well supervised medically. To qualify for MAiD their deaths had to be "reasonably foreseeable." A physician's approving Mr. Brikenden's request wrote, "The patient has a serious and incurable illness, which is age-related frailty. It is end stage." His wife was presumably similarly afflicted.

But "Age-related frailty" is certainly not an "end stage" condition. The Brikendens might easily have lived comfortably another three, five or ten more years. A physician who refused their request would have argued neither was suffering from untreatable, painful conditions. Their real complaint was fear of a future that might or might not occur. If one believes medicine's goal is the enhancement and protection of life, fear and ennui are a reason for a psychiatric or social services referral rather than reflexive acquiescence to those fears. Denying their request would not be inappropriately 'paternalistic' but instead a clinically sound and ethically informed judgment.

#### **Conclusion**

There is a heavy burden on those who would deny a single class of citizens a right guaranteed to all. Those who argue against practitioner

conscience insist that an individual's request requires others honor that choice irrespective of ethical or clinical reservations. No wonder that "bioethics has been criticized for its limited moral vocabulary centered on the value complex of individual rights, self-determination and privacy ... Individualism has been called a 'myth' precisely because it separates personal lives from the social environment, and assumes that our self is not constituted by social processes."<sup>57</sup>

Abortion and MAiD are not individual acts but requests by one for the participation of others in procedures that while legal may, to some, seem clinically questionable and ethically problematic. The conscientious objector in medicine does not abandon the goal of the "best care" of the person but seeks to assure it within an ethic that sets medicine's goals as life's preservation and its maximization in the treatment of the individual. For their part, those who seek to deny the right to practitioner conscience assume a consumerist view in which the patient is a customer and "the customer is always right. The fiduciary responsibility of the physician is not simple acquiescence, however, but what he or she perceives as the best care possible with a treatment acceptable to the patient.

A narrow focus on conscience objection has left ethicists—and health bureaucracies—generally free to ignore broader issues of access and service, the means by which society assures personnel and resources are available to all in need. Attention to the context of care would sufficient palliative, psychiatric, rehabilitative and social resources maximizing life quality in even the most stressed circumstances. Persons of conscience stand, at any moment, as critics who may challenge the legality (or illegality) of the moment. In cases briefly included here, in refusing a patient's request for MAiD the practitioner's focus on clinical solutions provided alternative treatments that enhanced the life of the person in care.

The argument by those who insist conscientious practice without conscience should be the standard is thin. It assumes not only an equality of knowledge such that all requests by patients are fully informed but that the right of one should dominate the right of another irrespective of clinical, ethical, or moral reservations. That is not an argument for which, on reflection, there is no substantive basis.

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