Trevor Stammers argues for the importance of conscientious objection in good medical practice

CONSCIENCE WARS

key points

- Freedom of conscience has been under increasing assault by academic bioethicists and by recent assisted suicide legislation in Canada and New Zealand.
- However, far from hindering patient care, freedom of conscience has positive benefits for patients, healthcare institutions and the individual professional.
- It also ensures the beneficence of medical care – protecting against abuses by individual professionals and institutions.

There have been increasingly strident calls to see conscientious objection done away with in medicine for well over a decade now.[1] In a famous 2006 polemic published in the *BMJ*, an Oxford bioethicist asserted:

'A doctor's conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's good and the patient's informed desires. If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.'[2]

In his view, conscientious objection results in both inefficiency and inequity. However, whilst he is careful not to depict conscientious objection as an exclusively 'religious' problem, the reader is left in little doubt that he considers it to be primarily so.

> A world without conscientious objectors is like 'salt that has lost its saltiness'

The article's subheading begins 'Deeply held religious beliefs may conflict with some aspects of medical practice',[3] and at several points 'religious values' are unfavourably contrasted, explicitly and implicitly, with 'secular liberal values'. Even more explicitly, religious values 'corrupt' the delivery of healthcare and to allow conscientious objection on the basis of them is clearly discriminatory when 'other values can be as closely held and are as central to conceptions of the good life as religious values'.[4]

Doctors may have private religious convictions but as public servants they must conform to a shared set of secular values and practices, defined and regulated by law and governmental policy.

Those unable or unwilling to do this, thereby forfeit their ability to do their job: 'Doctors who compromise the delivery of medical services to patients on conscience grounds must be punished through removal of their licence to practise and other legal mechanisms'.[5]

Legal constraints on conscientious objection

More recently conscientious objection (hereafter for brevity CO) has also come under fire from lawyers as well as bioethicists. Munthe and Neilsen, two lawyers from Sweden in a recent paper claimed:

'that the notion of a legal right to conscientious refusal for any profession is either fundamentally incompatible with elementary legal ethical requirements, or implausible because it undermines the functioning of a related professional sector (healthcare) or even of society as a whole.'[6]

They explain their reasons for this claim by suggesting that advocates of CO 'might confuse *legal* rights to conscientious refusal for healthcare professionals with moral ones.'

They seek to substantiate this arguably rather patronising position by insisting that for any legal rule to be truly just, it must:

1. Apply uniformly and equally to all legal subjects of the jurisdiction.
2. The official reasons for the rule must not support another rule that applies more widely
3. Qualifications and clauses within the rule do not in any other way violate basic tenets of impartiality or non-discrimination

Therefore, a rule, for example, permitting CO only for healthcare professionals and only in the case of refusing assisted-suicide related activities, would fail to be just as its restricted applicability would violate all three of Munthe and Neilsen's requirements. It would cover only healthcare professionals, only apply to assisted suicide and only the particular content of a conscience related to opposing assisted suicide.

With reasoning such as this advocated by legal professionals, it is perhaps not so surprising that the New Zealand Parliament is currently considering a euthanasia bill[7] which, if passed unaltered, threatens to punish with up to three months imprisonment any doctors who refuse to refer for euthanasia. In Canada, which only legalised euthanasia in 2015, the Ontario Superior Court of Justice ruled earlier this year against the Canadian Christian Medical and Dental Society (CMDS),[8] stating that Canadian doctors *must* refer for Medical Aid in Dying (MAiD), thus affirming the CO restrictions imposed by the province's medical regulator. Justice Herman Wilton-Siegel in his ruling stated the Court considered that if CO were allowed, equitable access would be 'compromised or sacrificed in a variety of circumstances more often than not involving vulnerable members of society'.[9] I am not likely to be the only one who finds more than a hint of irony in the judge's inference that vulnerable members of society would be safer in a state that compels all doctors to refer them for euthanasia than in one that allows doctors to object.

The importance of conscientious objection

There are in my view, several powerful arguments in favour of not just grudgingly permitting CO but for embracing it as a generally positive good within healthcare.

The safety of patients

The first argument concerns public safety. Earlier this year, it was revealed that over the course of a decade, 456 patients had their lives cut short by being administered high doses of opiate painkiller after being admitted for non-terminal conditions to the War Memorial Hospital in Gosport.[10] Concerns were first raised as early as 1991 about patients' lives being ended prematurely, but they were ignored. Over the twelve years up to 2000, the doctor in charge had signed 854 death certificates for patients, 94% of whom had been administered opiates. Is a repeat of this scandal really less likely to occur in a state which compels all doctors to participate in administering lethal injections, albeit at least ostensibly at the patient's request?

Those whistleblowers whose concerns were initially dismissed at the start of the Gosport killings, exercised great courage in speaking out. There is arguably a close relationship between whistleblowing and CO.[11] If, as in Ontario, healthcare personnel are not permitted to exercise CO about medical killing, how much more difficult is it going to be for anyone to whistleblow when the ending of lives ceases to be restricted to those patients who have requested it?

Benefits to healthcare institutions

This brings me to my second argument in favour of CO – that is of its benefit to institutions. Far from CO bringing society to its knees, as the Ontario judge implied, the moral integrity facilitated by accommodating it holds society to account. A world without conscientious objectors is like 'salt that has lost its saltiness' which as Jesus said is 'no longer good for anything but to be thrown out' (Matthew 5:13). Magellson comments that professions which are of central importance to society depend on their practitioners having moral integrity. Medicine, he suggests, is such a moral activity and therefore should permit CO.

Rights of conscientious refusal benefit healthcare institutions by fostering the moral agency of healthcare professionals necessary for such institutions to run properly, and institutions benefit from having moral agents capable of engaging in critical dialogue internally, as well as vis-à-vis other

If... healthcare personnel are not permitted to exercise [conscientious objection] about medical killing, how much more difficult is it going to be for anyone to whistleblow when the ending of lives ceases to be restricted to those patients who have requested it?

institutions and the public. CO enables healthcare professionals to dissent when external pressures lead to wrong policies or procedures. Some readers may have inwardly baulked at my linking the Gosport scandal with CO, but it is relevant. CO as I have said has many parallels with whistleblowing, including the fact that managements that care more about reputation and public image than about transparency and justice will attempt to crush both.

The attempt to drive all expressions of moral or religious belief, practice, or conviction out of healthcare will also lead to a sharp decline in patient well-being. Patients too, have different moral or religious convictions to which we need to be sensitive. We should not steamroll over them with secular liberal values which they may not share. This is rightly recognised in the sensible advice of the 2008 General Medical Council (UK) guidelines: *Personal Beliefs and Medical Practice: Guidance for Doctors* which states in para 21:

'Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs. You must respect patients' right to hold religious or other beliefs and should take those beliefs into account where they may be relevant to treatment options.' [12]

How can the profession be sensitive to the moral and religious conviction of our patients if we drive out of the profession those of our own who have conscientious objections to some legal practices?

Promoting moral integrity and preventing moral distress

The third argument concerns moral integrity. Acknowledging the right to conscientious objection is not merely giving way to a whim or selfishness. Magelssen, [13] in his defence of CO writes:

'We all have deeply held convictions that we consider important to us… Having moral integrity means being faithful towards these deeply held considerations… When you act against your deeply held convictions the link between your principles and actions is severed.'

Refusing to participate in what one considers as ending innocent life prematurely is not just being awkward. To take part or collude in any practice despite one's beliefs is morally objectionable, is a form of self-betrayal and entails a loss of self-respect and moral distress which can be highly damaging, leading to feelings of 'I could not live with myself if I did that.'

Moral integrity, though not referred to as such, is clearly seen throughout the Bible as an essential component of human flourishing. 'Give me an undivided heart' cries out a morally distressed King David (Psalm 86:11) and the Apostle Paul speaks of the 'insincerity of liars whose consciences are seared' (I Timothy 4:2). If we don't practise what we believe to be right, then we do damage to ourselves. However, if society compels us to participate in actions we consider to be morally wrong, then society damages us. It is a form of moral torture.

Beneficence and the goals of medicine

My final argument is that if conscientious objection is outlawed, the whole purpose of medicine becomes distorted. This is a very wide topic but put simply, if the doctor merely does as the state or patient dictates, what place is there for professional judgement, clinical experience and the objects of medicine to cure sometimes, relieve often, but comfort (and I would add) care always? Of course, CO is not unbounded – it must be reasonable, and it must be objecting to particular actions or procedures *not* particular groups of people, but neither should the patient's demands always prevail with no limits.

A recent article against CO in cosmetic surgery illustrates this point well. Its author held:

'It seems reasonable to argue that what the patients believe to be in their best interests should be considered their best interest. This poses a *prima facie* obligation on cosmetic surgeons to perform the treatment they the patients want even when they disagree with their patients. It should not be left to the doctor to decide whether to perform them or not'. [14]

In a rigorous critique of such casuistry, Saad [15] dubs this attitude as patient preference absolutism (PPA) and points to several problems with such an approach.

It overlooks an important distinction in patient autonomy between the positive and negative. Patients may well he argues, have the right to refuse to take medication for a gouty toe but they do not have the right instead to demand a surgeon remove a gouty toe to relieve the pain. He also points out that PPA risks undermining both beneficence and expert clinical judgement. 'If beneficence is reducible to acquiescence, it is hard to see how it can ever have any continuing significance in ethics'.

Conclusion

CO is necessary for patient safety, and benefits healthcare institutions by reducing the risk of institutionalising unethical practice and enabling diversity in the workforce which matches the range of moral and religious beliefs among patients. It is also a defence against moral distress in healthcare staff and against the rise of patient preference absolutism, which if unchecked will undermine clinical expertise, professional judgement and make beneficence irrelevant.

Trevor Stammers *is Reader in Bioethics and Director of the Centre for Bioethics and Emerging Technologies at St Mary's University College, Twickenham*

references

1. Wyatt J. *The doctor's conscience.* CMF File 39 (2009) *bit.ly/2QLoAUd*
2. Savulescu J. Conscientious objection in medicine. *BMJ* 2006; 332:294 *bit.ly/2IPJZsw*
3. Savulescu J. *Ibid*: 294
4. Savulescu J. *Ibid*:294
5. Savulescu J. *Ibid*:294
6. Munthe C, Nielsen M. The Legal Ethical Backbone of Conscientious Refusal. *Cambridge Quarterly of Healthcare Ethics* 2017; 26(1): 59-68 *bit.ly/2PuZWXG*
7. End of life choice bill – New Zealand Parliament *bit.ly/2CH5JU3*
8. Laurence L. Ontario court forces Christian pro-life doctors to refer patients for euthanasia. *Lifesite* 31 January 2018. *bit.ly/2CFPqdu*
9. Grant A. In Ontario, patients' rights trump physicians' rights when dealing with medical assistance in dying. *Constitutionally Canadian* 5 February 2018 *bit.ly/2PvYsfE*
10. Brown D, Calver T. Gosport hospital deaths: The numbers behind the scandal. *BBC News* 29 June 2018 *bbc.in/2yUtKcn*
11. See for example Haigh R, Bowal P. Whistleblowing and freedom of conscience: Towards a new legal analysis *Osgoode Hall Law School of York University bit.ly/2OlWQsj*
12. Personal beliefs and medical practice *General Medical Council bit.ly/2N8gCSO*
13. Magelssen M. When should conscientious objection be accepted? *J Med Ethics* 2012;38:18–21 *bit.ly/2EgovGl*
14. Minerva F. Cosmetic surgery and conscientious objection. *J Med Ethics* 2017;43:230–3 *bit.ly/2A6HpvH*
15. Saad TC. Mistakes and missed opportunities regarding cosmetic surgery and conscientious objection. *J Med Ethics* 2018;44:649–650 *bit.ly/2IQFCxv*