Emerging assault on freedom of conscience

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No provision in our Constitution ought to be dearer to man than that which protects the rights of conscience against the enterprises of the civil authority.

Thomas Jefferson

Discussion on physician autonomy at the 2014 and 2015 Canadian Medical Association (CMA) annual meetings highlighted an emerging issue of enormous importance: the contentious matter of freedom of conscience (FOC) within clinical practice. In 2014, a motion was passed by delegates to CMA's General Council, and affirmed by the Board of Directors, supporting the right of all physicians, within the bounds of existing legislation, to follow their conscience with regard to providing medical aid in dying. The overwhelming sentiment among those in attendance was that physicians should retain the right to choose when it comes to matters of conscience related to end-of-life intervention. Support for doctors refusing to engage in care that clashes with their beliefs was reaffirmed in 2015. However, a registrar from a provincial college of physicians and surgeons is reported to have a differing perspective, stating "Patient rights trump our rights. Patient needs trump our needs."[1] So, do the personal wishes of doctors hold much sway in Canadian society, where physicians are increasingly perceived as publicly funded service providers? Should the colleges of physicians and surgeons have the power to remove competent physicians who refuse to violate their own conscience? And what about FOC in a range of other thorny medical situations unrelated to physician-assisted dying?

The FOC issue is gathering attention in bioethical domains, but many busy clinicians are not apprised of the challenges and debates taking place. The FOC dispute is of utmost importance to medical practitioners, as some medical regulators, professional ethicists, and legal personnel, often far removed from the practice of clinical medicine, are rapidly attempting to restrict FOC for doctors under the umbrella of patient autonomy and human rights. Here I provide some fodder for consideration about the implications of conscience infringement in clinical medicine.

Regulatory imperialism in medicine

There are many challenging and unforeseen situations within the broad spectrum of clinical practice and medical specialties (**Table 1**).[2-8] Physicians from diverse backgrounds are increasingly beset with perplexing clinical scenarios that sometimes require difficult ethical decision making. If a physician does not agree with the request of the patient or the dictates of regulators, ethical collision might arise—a situation that can be rather stressful for doctors. As a medical community, are we committed to maintaining FOC for physicians, or are we prepared for others to predetermine how we should behave?

Most doctors agree that physicians should never do what they believe is morally wrong, no matter what alleged experts say.[9] Yet, some governments, human rights commissions (HRCs), and medical regulators have begun to question whether refusal to participate in legal medical interventions might be unacceptable. Some ethicists feel that "doctors who conscientiously refuse to perform legal procedures are offering partial medical services and are not fulfilling their obligation to care for their patients."[10] The Ontario Human Rights Commission posits that doctors should "check their personal views at the door" when providing medical care, even if those views are sincerely held moral convictions.[11] In addition, some legal professionals contend that "physicians who feel entitled to subordinate their patient's desire for well-being to the service of their own personal morality or conscience should not practice clinical medicine."[12] Going "against the flow" owing to conscientious or ethical conviction is often portrayed as "unprofessional" and disparagingly depicted as serving personal interests rather than providing optimal care.

How should health providers respond in polarizing clinical situations?[13] Some suggest it is the responsibility of doctors to maintain the standard of care (SOC)—that ethereal algorithm that defines what the community of clinicians allegedly deems appropriate and the grid by which to judge a physician's performance. Pronouncements about SOC have become increasingly ubiquitous and seem to dictate what is expected from physicians in clinical situations. This approach has considerable drawbacks.

- The SOC is often derived from clinical practice guidelines (CPGs). Sadly, by far most CPGs are influenced by commercial interests.[14-19] This finding has challenged the credibility of current CPG and SOC processes, as numerous egregious conflict-of-interest violations have been highlighted in the literature.[15,19-21]
- Standard-of-care dictates are often out of date owing to the slow process of knowledge translation[22-25] and long intervals between CPG reviews.[26] Knowledge can quickly change, and dogma can rapidly become dogmatically wrong. Consequently, physicians who follow emerging research literature, attend conferences, and adopt practices in line with up-to-date studies might be

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Table 1. Examples of clinical situations that might result in ethical tension or conscientious refusal

PATIENT, GUARDIAN, OR REGULATORY REQUEST	SITUATION OF ETHICAL COLLISION
Parents of a young woman in Quebec request a virginity certificate	Based on personal moral beliefs, the clinician refuses to examine the hymen of the young woman, despite explicit consent from the young woman herself
Physician pressured to perform cardiopulmonary resuscitation	In a case consistently deemed medically futile, a conscientious clinician refuses to prolong dying, squander resources, and extend patient suffering by repeatedly commencing cardiopulmonary resuscitation[2]
Government pressures a physician to perform a punitive amputation	Orthopedic surgeon told by Afghani government officials to amputate a healthy man's leg as punishment for theft[3]
Parents request female genital mutilation for their child as a required part of their belief system	Volunteer physician working in a village abroad as part of an international medical team is asked to perform female circumcision, a procedure that violates his moral beliefs
Patient in Canada demands respect for autonomy in choice of physician	A pregnant woman refuses emergency obstetric care based on the clinician's sex and race. She demands referral to a female physician of a different ethnic origin
Physician asked to determine fetal sex	Request that the physician determine fetal sex at 12 weeks' gestation with the expressed aim of choosing feticide if the fetus is not male.[4] Based on moral beliefs denouncing discrimination against women, he refuses
Patient request for assisted suicide in jurisdiction where this has been legalized	A young patient with mental illness adamantly requests that a physician prescribe a lethal dose of sedation. Physician refuses
Administrative pressure to increase hospital efficiency at the expense of patient care	A physician is disturbed by his inability to provide optimal care for seniors with dementia owing to explicit institutional economic constraints[5]
Patient asks family physician to be dishonest	An immigrant woman implores her physician to lie to her husband regarding the nature of a previous surreptitious medical visit. Physician refuses to lie, based on moral beliefs
Patient in emergency demands narcotic analgesia	Physician is suspicious of narcotic abuse[6] and refuses to prescribe it
Parents of child refuse consent for life-saving blood transfusion	Based on moral stance to protect life, the physician considers legal measures to save the life of the child through blood replacement[7]
Patient with personal sexual obsession requests surgery to fulfil ongoing erotic fantasies	Some patients with various morbidities, such as those who are transabled, might request procedures that would inflict self-harm. Physician refuses to knowingly inflict harm[8]

considered "outside the box" and not in line with outmoded SOC perspectives that lag behind new findings.

- Unlike scientific questions, most ethical issues involve subjective judgment and cannot be answered by empirical research. Accordingly, if it is impossible to objectively determine that either of 2 ethical poles is right, both sides of the argument must concede that there is at least some possibility that opponents could be right.[27] In a pluralistic society with no common vision of what is right or good, assigning a dogmatic SOC on subjective matters of ethics can be arbitrary, biased, and a tool to enforce regulatory dictates of those in power. As such, SOC guidelines might not be suitable for credibly judging actions relating to ethical questions in clinical medicine.

So the question arises as to whether competent physicians should have the freedom to do what they believe is right and act in what they believe to be the best interests of patients, or whether they must be confined to what regulators with authority deem appropriate.

Considerations at the crossroads

The emerging move to restrict physicians' right to choose in clinical situations raises many issues that deserve consideration.

- Throughout medical history, celebrated advancements in medicine have generally occurred because conscientious practitioners courageously diverged from the status quo. Will the new professionalism crush iconoclasm, demand conformity, and mandate a preparedness to do what one believes to be morally wrong or unethical as a professional requirement to join and remain within the medical community?
- A policy to coerce health professionals to act against their own judgment will convert doctors into skilled technological servants, not professionals who assess and manage each patient according to their own wisdom and judgment. Is this transition in line with our mandate as health providers?
- It is alleged that maintaining a distinctive "professional conscience" that supplants "personal conscience" in professional situations will enable contrarian practitioners to fully participate in professional practice while adhering to personal beliefs. This professional conscience would allow physicians to abide by the SOC, while retaining their personal moral code in their private life. While some accept the notion of "moral flexibility" and divorcing personal values from professional behaviour, others contend that shifting morals translate into moral ineptitude and that maintaining modifiable contradictory

values depending on circumstances defies the definition of *conscience*. Can one legitimately "do no harm" while doing what one sincerely believes is harmful?

- An issue that has gathered much controversy is the proposed mandatory patient referral for procedures primary physicians consider abhorrent. Ethical physicians refer to consultants they believe will undertake interventions to improve the well-being of the patient. To knowingly refer to someone they anticipate will proceed in a way they feel is destructive or unethical is to disregard the fundamental objective of a consultation, and to be complicit in harm. For example, as more than 80% of palliative care physicians object to and want no part of physician-assisted death,[28] a policy of mandatory referral will force these end-of-life care specialists to refer their patients to another who will execute the patient's request and the patient. What might such a policy do to the morale and the already short supply of palliative care physicians?
- What about doctors who have taken the Hippocratic oath—the bedrock of medical ethics throughout the history of Western medicine? These physicians swore to never do harm and to protect life from the moment of conception to the point of natural death. In the oath, they also swore "I will not give a drug that is deadly to anyone if asked, nor will I suggest the way to such a counsel."[29] Are some regulatory bodies explicitly coercing physicians to break a sworn oath? As such, are regulatory bodies compelling professionals to engage in a breach of trust? What is the value of an oath if regulators coerce members to violate it? Further, does counseling patients to attend another doctor not "suggest the way" and thus also violate this fundamental oath?
- The potential intrusion by nonmedical bodies such as HRCs into clinical practice decisions is confusing. Such commissions are allegedly in the business of protecting diversity, securing human rights, and combating discrimination. The policy of coercing ethical doctors to do what they feel is wrong or unethical displays supreme intolerance of diverse views and choice precisely at a time in Canada when HRCs are demanding more tolerance, heralding choice, and proclaiming respect for diversity. Is such intolerance of conscientious doctors by HRCs not discrimination on the basis of ethical orientation?
- Do HRCs claim to have the clinical perspicacity and familiarity with medical science and research to authoritatively arbitrate in complex matters relating to the intricacies and nuances within physician-patient interactions and relationships? Will physicians be entitled to express their sincere opinions to patients only as long as they say the "right" things according to the HRC grid, and enjoy freedom of providing care only as long as they choose the HRC-approved clinical course of action?
- According to the College of Physicians and Surgeons of Ontario, *discrimination* is "an act, decision or communication that results in the unfair treatment of a person or group by either imposing a burden on them, or denying them a right, privilege, benefit or opportunity enjoyed by others."[30] The Canadian Charter of Rights and Freedoms explicitly states that all Canadian citizens enjoy fundamental FOC.[31] Is a blanket policy of FOC denial for physicians not an affront to the Charter and flagrant discrimination (based on the College of Physicians and Surgeons of Ontario's definition) against a large group of physicians? Is a policy that coerces sincere, caring professionals to engage in actions they feel are wrong, unprofessional, or harmful not imposing a profound burden?
- In 2013, the Collège des médecins du Québec issued a warning for doctors to stop performing virginity testing,[32] despite patient requests. The President of the college referred to virginity testing as "outrageous, repugnant, irrelevant and unacceptable."[32] Further, conscientious physicians who steadfastly refused to fulfil such legal patient requests were hailed as courageous and honourable. So, is conscience "good" when the colleges agree and "bad" when the colleges see differently? Does such inconsistency suggest that the crux of this issue is not really "patient rights" or "conscience" at all?
- Some suggest that conscientious refusal based on science is honourable, but refusal based on morality or conscience is unacceptable. Webster and Bayliss describe *moral residue* as "that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised."[33] *Moral injury* has been defined as the consequences of "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs or expectations."[34] Consideration of personal trauma that might be done to individuals compelled to act against their moral conscience is an important part of this discussion. Do we wish to practise our profession in a milieu that will inflict moral trauma on physicians?
- The move to denial of conscience rights to physicians has been primarily instigated by groups such as ethicists and lawyers far removed from clinical medicine. Such anti-choice intrusion displays a lack of respect for the competence, ability, and integrity of health professionals and has the potential to adversely affect physician morale and the physician-patient relationship. Is the medical community prepared for such uninvited imposition of values?
- Denial of conscience rights demands the oxymoronic juxtaposition of physicians using their best clinical judgment and disposing of that judgment if patients or regulators disagree. What will this kind of inconsistency do to clinical care and the morale of the profession?
- As patients maintain the freedom to choose their physicians, they will likely prefer and select doctors they believe will do their very best for them at all times, no

matter what regulators deem suitable. What will happen to patient trust and physician-patient relationships if patients realize doctors must succumb to regulatory demands? How will patient care be affected if authoritarian dogma euthanizes the conscience of ethical physicians, forcing them to act against their own conscience?

- Finally, ethics are not black and white and there always remains a degree of uncertainty.[27] Views evolve in response to new research, new thinking, new attitudes, and new experiences—some things considered vile a few years ago are now celebrated; some things acceptable a few years ago are now considered vile. The work of ethics is dynamic and ongoing. With the degree of uncertainty involved in nuanced ethical situations, do regulators, HRCs, legal experts, or politicians have absolute transcendent acumen to determine and judge what is ultimately right in difficult clinical situations?

Concluding thoughts

Regulation of the medical profession is said to be done in the public interest. It is essential that physicians submit to capable regulation in order to secure medical competence and to preclude and address violations of professional and ethical behaviour—this is a hallmark of credible health care delivery. A policy of regulators coercing medical professionals to jettison their moral compass, to defy their own conscience, to enact what they believe is unethical or harmful, and to abandon their lifelong values and standards to participate in care they deem destructive or unconscionable is another matter altogether.

As Hippocrates—author of the Hippocratic oath and father of Western scientific medicine—recognized long ago, the personal character and virtue of individual physicians is central to high-quality health care.[35] It is crucial to avoid injury to the ethical integrity of principled physicians. Compelling doctors to do what they believe is morally wrong or reprehensible is a formula for the breakdown of character and has enormous individual and societal consequences.[36] As the steamroller to subordinate individual liberty and autonomy in the medical community has arrived,[30] physicians should seriously consider the implications of surrendering the sacrosanct physician-patient relationship to the purview of political and regulatory masters.

With the neglected and expanding pandemic of chronic disease,[37,38] the disgraceful shortage of palliative care for those suffering,[39] and the ongoing lack of access to basic primary care for many,[40] medical regulatory bodies should perhaps devote energies to fulfilling their mandate of "protecting the public," rather than spending time and resources intimidating credible physicians who are acting in good conscience as they seek to serve patients.

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Competing interests
None declared

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