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Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

Policy Statement—Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience

COMMITTEE ON BIOETHICS

KEY WORDS

conscience, conscientious objection, cooperation

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abstract

Health care professionals may have moral objections to particular medical interventions. They may refuse to provide or cooperate in the provision of these interventions. Such objections are referred to as conscientious objections. Although it may be difficult to characterize or validate claims of conscience, respecting the individual physician's moral integrity is important. Conflicts arise when claims of conscience impede a patient's access to medical information or care. A physician's conscientious objection to certain interventions or treatments may be constrained in some situations. Physicians have a duty to disclose to prospective patients treatments they refuse to perform. As part of informed consent, physicians also have a duty to inform their patients of all relevant and legally available treatment options, including options to which they object. They have a moral obligation to refer patients to other health care professionals who are willing to provide those services when failing to do so would cause harm to the patient, and they have a duty to treat patients in emergencies when referral would significantly increase the probability of mortality or serious morbidity. Conversely, the health care system should make reasonable accommodations for physicians with conscientious objections. *Pediatrics* 2009;124:1689–1693

INTRODUCTION

Health care professionals may morally object to particular treatments and refuse to provide them. This practice is referred to as "conscientious objection."[1–3] This statement will not address claims of conscience on behalf of institutions. Possible examples of conscientious objection in pediatric practice include refusals to prescribe contraception, specifically emergency contraception[4]; perform routine neonatal male circumcision[5]; or administer vaccines developed with virus strains or cell lines derived from voluntarily aborted human fetuses.[6] Such objections may limit patients' access to information or treatment. Given this ethical dilemma, the legitimacy of such objections has become an important issue. Legislation has been proposed both to protect health care providers' ability to conscientiously object and to ensure patients' access to health care.[7]

Conscience

There are morally important reasons to protect the individual's exercise of conscience even if one disagrees with the content of the consci-

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entious belief. Conscience is closely related to integrity. Performing an action that violates one's conscience undermines one's sense of integrity and self-respect and produces guilt, remorse, or shame.[8,9] Integrity is valuable, and harms associated with the loss of self-respect should be avoided. This view of conscience provides a justification for respecting conscience independent of particular religious beliefs about conscience or morality. Claims of conscience are generally negative (the right to not perform an action) rather than positive (the right to perform an action).[10]

There are potential social benefits to protecting individuals' ability to act according to their consciences. These benefits include empowering individuals to think and act morally, encouraging the use of reason rather than force, exemplifying and encouraging tolerance, and encouraging moral action. For example, people are more likely to act morally if they are permitted to act on their own decisions.[11]

What constitutes a violation of conscience may be difficult to identify or validate. In some situations, claims of conscientious objection may hide self-serving motives.[12] For example, a potential military recruit may illegitimately assert conscientious objection not because of moral objections to killing but because of a concern for his or her personal safety. Personal affiliation with an organization that publicly proscribes certain actions makes it easier to identify true claims of conscience. Confirmation may also be difficult regarding actions that are not intrinsically immoral but only immoral under certain conditions. Whereas some traditions view war as intrinsically immoral, others view the use of lethal force as morally appropriate if certain criteria are fulfilled. Whether the criteria are fulfilled may depend on empirical claims about which there is controversy. Objectors have an obligation to explain and defend their position and may be required to demonstrate the sincerity and importance of their belief.[11]

There are, however, a number of difficulties in characterizing and validating claims of conscience. The boundary between legitimate conscientious objection and unjust discrimination is particularly problematic. For example, the medical profession would not tolerate a physician's refusal to treat patients of a particular racial group because the physician considered members of this group inferior. Discrimination is an affront to the dignity of the individual discriminated against and may impose significant practical burdens on the individual. Alternatively, clinicians might claim that an action is not intrinsically immoral but only immoral when performed by certain categories of persons. For example, a clinician might object to prescribing contraception to unmarried people because the clinician believes it facilitates immoral sexual activity. In such situations, clinicians should be careful not to violate patients' privacy by asking personal questions only to satisfy their own interests.[13] Legally, when claims of conscience conflict with claims of nondiscrimination in public accommodations, such as hotels and restaurants, nondiscrimination claims take precedence. Whether private physician practices should be considered public accommodations, and which groups of individuals should be protected against discrimination, are subjects of continuing societal debate.[14] The American Academy of Pediatrics opposes discrimination in the care of any patient or against any physician.[15]

Evaluating claims of conscience is also difficult, because some individuals object not only to performing an action themselves but also to assisting someone else to perform the action. Physicians who object to emergency contraception do not use it themselves and also refuse to prescribe it to others. They argue that assisting others to do something they themselves consider immoral makes them morally culpable. For example, a physician whose patient makes a credible threat against a third party would be morally culpable if he or she refused to warn the third party or to notify the police and the patient harmed the other individual.

Whether assisting someone else to perform an act that you consider immoral is wrong depends on a number of factors including intention. It would be wrong if you intend for the wrong to be committed and share the intention of the person you are helping. In other cases you might cooperate in the act but not share the other person's intention, and your assistance might be appropriate. Using a bank robbery as a nonmedical example, the getaway driver shares the robber's intention, but the bank manager who is forced to open the vault does not. The getaway driver's actions are wrong, whereas those of the manager may be excusable. The moral evaluation of assisting another without sharing his or her intention depends on a variety of practical considerations including the seriousness of the wrong, the causal relationship between the assistance and the act, the necessity of the assistance for completing the act, and the reason for providing the assistance. There is also the concern that cooperation may be misinterpreted as approval and might cause another to act wrongly.[16] Often, these relative determinations do not permit clear lines to be drawn between morally acceptable and immoral assistance. Questions regarding cooperation can become issues of conscience.

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Conscientious Objection in Health Care

Claims regarding conscientious objection in medicine should be evaluated on the health care system rather than the individual level, because neither the clinicians' nor the patients' claims clearly trump the others' in all situations. Conflicts are often framed in terms of an individual provider and a single patient. Both of these individuals have morally significant interests.[17] Consider a pediatrician who refuses to prescribe emergency contraception for a patient whose partner's condom broke during intercourse. A health care professional might choose to leave medicine rather than violate his or her conscience. This decision could have secondary effects not only for the professional and his or her family but also for patients. It might limit their access to other services. Alternatively, the health care professional might violate his or her conscience and experience significant guilt and shame and their secondary effects. Constrained access to health care may also have significant effects for patients, such as an unintended but possibly preventable pregnancy. Benefits and harms to patients should be evaluated from the patients' points of view. The frequency of particular outcomes is difficult to predict, and the type and magnitude of these outcomes do not lend themselves to weighing and balancing. Therefore, it is not possible to state in the abstract that either the health care professional's claim to conscientious objection or the patient's claim to access should always prevail.

Some refusals constitute an imposition of the physician's moral beliefs on the patient. Refusing to transfer a patient's medical records, for example, unfairly constrains a patient's subsequent action and is morally unacceptable.[9] More egregious actions, such as berating or humiliating patients, violate the respect that objectors themselves are seeking and are clearly morally wrong. It is not clear, however, that refusing to cooperate is morally equivalent to imposing one's views. Physicians, except in emergencies, have significant latitude in selecting patients, and pharmacies may not stock dedicated emergency contraceptives for reasons unrelated to conscience. Those who refuse on the basis of conscience should not be held to higher standards than those who refuse treatment on the basis of other accepted grounds.

Constraints on claims of conscience can, nonetheless, be justified on the basis of health care professionals' role responsibilities and the power differential created by licensure. Health care professionals fulfill a particular societal role with associated expectations and responsibilities. For example, physicians' primary focus should be on their patients' rather than their own benefit. These role expectations are based in part on the power differential between physicians and patients, which is the result of physicians' knowledge and patients' conditions.

Role obligations are generally voluntarily accepted; therefore, health care professionals' claims of conscientious objection may justifiably be limited. It is unreasonable for an individual to enter a profession or specialty with primary activities that conflict with his or her central values.[18] Individuals, however, may change their moral points of view after having accepted a role, or the role may be redefined during the course of their professional practice. The debate over physician-assisted suicide, for example, has evolved during many practicing physicians' careers.[8] The boundaries of medical practice, both in terms of what constitutes disease and the scope of available treatments, may also evolve over time. Although individuals should not knowingly enter a specialty with core activities that they are unwilling to perform, changes in medical practice over time should also be acknowledged.

Some have argued that the exercise of conscience is integral to being a professional, but this claim confuses professional and nonprofessional commitments. Physicians generally can refuse to perform actions that they consider medically inappropriate. A pediatrician may, for example, refuse to prescribe antibiotics for a viral respiratory infection or perform a surgery that has an unacceptable mortality rate. In contrast, conscientious objections are typically based not on medical knowledge but on moral, religious, or political beliefs.[9,11] The ability to refuse to provide a service or treatment on these other bases is not part of being a physician.

One responsibility of the physician's role is providing medical information, including risks, benefits, and alternatives, during the informed-consent process. This role responsibility is supported by the value of autonomy and patients' need for information to make autonomous decisions.[12] Permitting physicians, on the basis of a claim of conscience, not to disclose a legally available treatment option of which the patient is unaware but might otherwise choose would significantly undermine the practice of medicine. For example, it would be unfair for a victim of sexual assault who was unfamiliar with emergency contraception not to be informed of its existence. Acknowledging that language is not value neutral, the information disclosed should be accurate, complete, easily understood, and focused on the patients' decision-making needs. Physicians should document the informed-consent process in the patient's medical record.

As previously mentioned, clinical information should be provided in a respectful manner.[19] Physicians can ex-

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plain the reasons why they do not provide certain treatments or services while respecting patients' autonomy. The power differential between physicians and patients may, however, create unintended coercion. Patients should be able to refuse to listen to physicians' reasons.

Similar considerations require clinicians to provide prospective disclosure and referral. Physicians who, on the basis of conscience, refuse to provide particular treatments or services within the usual scope of practice for their specialty have an obligation to disclose this to potential patients. This knowledge may be important to patients in selecting physicians. In some situations, it may be feasible to transfer care. Although some clinicians object that referring makes them morally complicit,[8] patients may be harmed by the lack of referral. Patients, particularly adolescents, may not know how to identify a willing health care professional. Patients may also face a significant delay in obtaining a new-patient appointment. The power differential in the physician-patient relationship is based not only on physicians' greater medical knowledge but also on their greater knowledge about the health care system. In situations of potential harm to patients, physicians have a duty to refer in a timely manner. This duty may be fulfilled by informing patients about referral services such as those provided by hospitals or insurance companies. Physicians should provide other, ongoing care while transferring patient care responsibilities. For example, a physician who decides not to see unimmunized patients should continue to treat an established, unimmunized patient's asthma until a new primary care provider can be established.

Special obligations on the part of health care professionals also result from the system of licensure.[17,20] Licensure requirements constrain others from providing similar services and limit patients' access. Physicians' relative monopoly on health care services and their fiduciary obligations to patients create an obligation to treat, irrespective of conscientious objection, in emergencies. Health care providers have a duty to perform procedures within the scope of their training when the patient's health is at significant risk and an alternative health care professional is unavailable.[11,13]

Protection of physicians' conscience and provision of legal health care services are both goods that the health care system should protect. A variety of accommodations are feasible. For example, alternative modes of providing emergency contraception include advance prescription, pharmacist provision, and over-the-counter sales.[21] Employers have important legal obligations and can provide an essential coordinating function within the health care system. They should provide reasonable accommodations, such as job restructuring or modified work schedules.[18] Referral services may also be created to provide resources for patients seeking care.[21] Accommodation efforts should recognize a wide variety of potential barriers for patients, including education level, income, and geography. Local variation in circumstance makes broad policy recommendations difficult.[17]

Conversely, physicians have obligations to their patients. These obligations include disclosure, provision of informed consent, referral, and emergency treatment.[22] Physicians have a moral obligation to disclose their beliefs to employers and to accept reasonable accommodations from them.[18] Physicians should avoid placing undue burdens on their colleagues. Self-employed physicians should avoid creating situations that inordinately constrain patients' access to legal treatments. For example, a physician with a conscientious objection to a particular procedure should avoid intentionally displacing the only willing provider of that procedure for a large geographic area.

RECOMMENDATIONS

1. The American Academy of Pediatrics supports a balance between the individual physician's moral integrity and his or her fiduciary obligations to patients. A physician's duty to perform a procedure within the scope of his or her training increases as the availability of alternative providers decreases and the risk to the patient increases.
2. Physicians should work to ensure that health care–delivery systems enable physicians to act according to their consciences and patients to obtain desired health care.
3. Physicians have a duty to prospective patients to disclose standard treatments and procedures that they refuse to provide but are normally provided by other health care professionals.
4. Physicians have a moral obligation to inform their patients of relevant alternatives as part of the informed-consent process. Physicians should convey information relevant to the patient's decision-making in a timely manner, using widely accepted and easily understood medical terminology, and should document this process in the patient's medical record.
5. Physicians who consider certain treatments immoral have a duty to refer patients who desire these treatments in a timely manner when failing to do so would harm the patients. Such physicians must also provide appropriate ongoing care in the interim.

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6. Physicians should work to ensure that employers make reasonable accommodations for employees' conscientiously held views and that responsibilities are equitably distributed among colleagues.
7. In emergencies, when referral would significantly increase the probability of mortality or serious morbidity, physicians have a moral obligation to provide treatment.

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