

MEDICAL ETHICS

MEDICAL PROFESSIONALISM AND CONSCIENTIOUS OBJECTION: ARE THE TWO COMPATIBLE?

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ABSTRACT

A growing concern exists about the tensions that may be found between medical professionalism and the concept of conscientious objection, on the part of physicians and other healthcare professionals, regarding healthcare decisions made by patients or their surrogates. This tension reflects the concept of what it means to be a healthcare professional in contrast to one's strongly held personal or religious ethical convictions. The major concerns revolve around issues at the beginning or at the end of life. These issues must be addressed to avoid serious conflicts with those for whom healthcare professionals have a duty to serve.

CASE STUDY

The family wants the feeding tube removed. They have watched their father deteriorating gradually for almost a year. Initially they hoped for significant improvement after he was transferred from the acute care hospital that treated him for the third, and most serious, in a series of strokes. They now realise that there will be no improvement. As a devoted loving family, they feel they have done him a grave disservice in their decision. The son, a physician, said, 'I know my father would not want to be kept alive like this, from everything that I know of him. We believed we were doing the right thing because we hoped he would improve as he had done after the previous less devastating strokes.' His sister, the youngest of the three siblings, concurred with her brother. The third brother lived out of town and indicated through them that he felt the same way.

The discussions included some members of the unit staff, but none directly involved with his daytime care. The meeting concluded with an agreement that the feeding tube would be inactivated, and that the patient would be made comfortable and allowed to die peacefully. Little did anyone attending the meeting realise the extent, degree and nature of the reaction of some staff members actively involved in the patient's care.

The following morning, the Chair of the Ethics Committee met with key members of the healthcare staff. The attending physician could not attend this meeting. The staff was stunned by the request to remove the tube. They felt that they had looked after the patient in an exemplary fashion and could not understand why the family should want to remove the tube. Even after it was explained to them and they 'understood' the concept of the right of refusal to put in the tube in the

first place, which would have deprived the patient of the last nine months of life, they felt emotionally troubled by the decision. Even though they could intellectually understand the legal right to withdraw the tube, they felt that intrinsically it was morally 'wrong'.

Over the next few days, some key nurses became more adamant about not wanting to participate in the decision, but most importantly, the attending physician expressed reluctance to take part, stating that in his opinion by implementing such an order, it would be the equivalent of his 'killing the patient'. This was despite his understanding that the law in Ontario and the rest of Canada allows for the withdrawal or refusal of treatment, even if the result is death, if a competent patient or a designated surrogate makes the decision. Despite that intellectual understanding, the physician concurred with the nurses about how difficult this would be because of his 'personal values', which were known to have a religious basis. Moreover, even when the actual order to terminate tube feeding was made by another physician, the attending doctor expressed reluctance to be involved in after care as that would be implying 'complicity' in the decision and act.

The resolution of this clinical conundrum was one that avoided dealing directly with the real ethical issue: what does it mean to be a professional? Can one deny patients the care they or their surrogates have requested because it conflicts with the professional's personal or religious beliefs? With some administrative reluctance and disquiet, the patient was transferred to another unit that was willing to provide suitable supportive palliative care. But the environment and care providers were different from those with whom the family had been familiar for almost a year. Although end-stage clinical care was provided, there was a sense among some of the staff and members of the Ethics Committee that something went ethically awry in the resolution of the problem.

CONFLICTS ABOUT MEDICAL CARE DECISION-MAKING

Many scenarios such as this can be cited, which play out in many hospitals and long-term care facilities.^{1, 2} Examples that may appear more dramatic, or appear to have greater degrees of conflict, relate to physicians and other healthcare professionals who oppose abortion, the removal of ventilators, the withholding of CPR in older frail patients, or the refusal of potentially life-saving surgery in those patients for whom families or healthcare

staff feel the risks and suffering are not worthwhile. In these and other similar situations the values of physicians and other healthcare professionals may conflict with those of patients or their decision-makers.

Several ethical questions arise related to the issue of whether the physician or other healthcare professional can be removed from the obligation to care for the patient for personal, presumably deep-seated or strongly felt reasons. Is this concept of 'Conscientious Objector' (CO) compatible with the concept of the fiduciary duties and professional obligations of physicians and other healthcare professionals to provide patient care whether or not they agree with the treatment? And is it ethically acceptable to request another healthcare provider to take on the clinical responsibility when this is logistically possible, or does this compromise the ethical fabric of the professional role or potentially enhance it? Lastly, in the face of what is often called 'moral distress', of physicians and other healthcare professionals, should organisations participate in programs or processes to assist healthcare providers to deal creatively with these profound feelings? How might professionalism be maintained in the face of 'moral distress'?

CONSCIENTIOUS OBJECTOR ARGUMENTS

The concept of the CO historically and traditionally comes from those for whom strong religious beliefs propelled them to refuse to be involved in military service.³⁻⁵ There are biblical references to COs,^{6,7} and throughout history there appears to be a framework by which certain individuals might be excused from military service based on deep-seated beliefs, usually religious in nature. Often, an alternative mode of military service was substituted in its place, which would not entail killing or wounding. With the elimination of the military draft in the US, the issue is less pressing in that country, but during the period of compulsory service, there were clearly defined mechanisms to claim CO status.^{3,5}

The translation of CO status, which draws on the military experience, to the healthcare domain, is a recent development. It is a reflection of the many technological advances in medical science. However, certain practices, such as the provision of abortion or the refusal of life-saving treatments, do not require highly technical interventions yet may provoke strong responses from physicians and other healthcare professionals. These may trigger a refusal to participate in care on the basis of CO status within a defined and expressed personal belief system.

THE ABORTION ISSUE

It is in the realm of maternal choice and abortion that there seems to be the greatest controversy in delineating the limits of professional responsibility and one's personal deeply held beliefs.⁹⁻¹³ In response to strong feelings against participating in abortion procedures that

exist among many physicians and nurses, many organisations and professional groups have defined the parameters by which such healthcare professionals may be exempt. The assumption is that the 'moral distress' that would be experienced by a healthcare provider involved in a clinical process, which they find personally or morally repugnant, should allow exemption from these specific professional work activities.¹⁴ Various professional codes of ethics have defined the process and requirements by which a member of that profession can be excused from such clinical participation.

THE CONCEPT OF 'DUTY'

Where do one's primary responsibilities lie? Is it consistent with healthcare professionalism for one's duties, obligations and fiduciary responsibilities toward patients to depend on the personal moral comfort of the professional?^{15,16} The concept of self-regulation of healthcare professionals, which is the common practice in most Western countries, assumes that the duties to the public and its individuals can be guaranteed by being entrusted to the professional body.^{17,18} The concept of trust is one that challenges the contention that a healthcare professional can cease to provide patient-chosen care because he or she finds the course of treatment personally offensive.¹⁹ The equation becomes one of weighing the 'moral' distress of the healthcare professional against the personal, psychological or physical distress of the patient knowing that their treatment might be compromised or potentially withheld by the provider.

WHAT MIGHT BE THE BASIS OF CONSCIENTIOUS OBJECTION?

Another vexing question arises from the concept of a healthcare provider choosing to and/or being allowed to withdraw from treating a patient. What constitutes acceptable belief systems, religion or deep-seated principles to merit such extreme actions? The assumption must be that such a set of personal beliefs would be sufficient to justify the refusal to participate in a legally sanctioned healthcare decision by a patient or surrogate. The concern is that the care providers' 'moral distress' would seem to take precedence over the needs, decisions, beliefs and actions of the patient involved.

What constitutes a professional's embedded belief system, and who would objectively determine its validity or depth? In a healthcare facility or at an administrative level, would there be a list of acceptable religions, or formal belief systems that could form the basis of the care provider being relieved of potential duties that might cause 'moral distress'? If it were a religious conviction, would the person have to provide evidence that they belong to that religion and are devout believers, for example, by nature of the number of attendances at religious services?

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For the purpose of being excused from American military duty, the criteria for CO status were very rigorous in terms of determining the breadth, depth, consistency and duration of the religion that formed the basis of the CO.³⁻⁵ For those whose beliefs are not from a structured religious formulation, the problem is even greater – how can an external person or body determine the consistency and depth of the belief when it can only be enunciated at the subjective level? Within the framework of military CO, the service duty of the applicant was often directed to far more dangerous duties (such as being an ambulance attendant or driver in a war zone). This fulfilled the requirement of not being forced to kill, but these COs cared for those that were injured in battle – even though by doing so there was indirect support for the military action of killing. This raises an important inconsistency that one often witnesses in the framework of requests for CO status, where healthcare providers refuse to participate in any aspect of care, including aftercare, even when they have been excused from undertaking the specific objectionable act.

Such a position seems to contradict, in the boldest and most serious terms, the concept of healthcare professionalism and non-abandonment of one's patients. Within Catholicism, which has a very strong and structured opposition to therapeutic abortion, it is expected of healthcare professionals to provide necessary aftercare in a woman that has had a therapeutic abortion if that is what is necessary for her well-being. This concept of 'legitimate cooperation' requires Catholic healthcare providers not to abandon their patients even when they have received a therapy that is religiously forbidden. From the Health Ethics Guide 'The principle of legitimate cooperation in the Catholic moral tradition acknowledges that, in some instances, the good that is sought can be achieved only through cooperation with what we find morally unacceptable.'²⁰

THE SPECIAL CASE OF ABORTION

The concepts of non-abandonment and professional obligation have been played out deleteriously in some jurisdictions in the US with respect to the permanently contentious issue of abortion. Over the past few years, California's legislative commitment to provide abortion services to its citizens has conflicted with another law, which allows physicians and other healthcare providers to remove themselves from participating in abortion services on the basis of CO status.¹² In many California jurisdictions, abortion services are lacking, despite the potential availability of trained physicians.^{12, 21} Of special interest is the relative ease with which the CO status can be invoked without any rigorous basis for determining the depth and relative importance of that designation. The issue of 'moral distress' is not an important issue to achieve the CO designation, and some studies suggest that the

reasons for choosing the CO status are far removed from the usual conceptual framework.

Within the context of abortion, for which the greatest ethical and legal controversy appears to exist, substantial accommodation to preferences of healthcare providers has been made. This is even at the expense of timely and effective access to abortion services (even in extreme cases of rape or incest), with all the acknowledged risk to women who must seek alternatives. The practice appears to have shifted away from the needs of the women who request abortion, to the sensitivities of the healthcare providers. This includes an acceptance of the provider's interpretation of the abortion process and the implications to the fetus, irrespective of the legal framework of defining 'life' in the particular jurisdiction in question. The belief system is sometimes so great that it extends to the provision of contraceptives and formulation of criteria for healthcare funding by the US for third world countries.²² It has also spread to the use of fetal tissue for research purposes (stem cell research); the medical use of tissue from the aborted fetus is interpreted by some as contravening the inviolability of the fetus irrespective of the process or clinical reasons for the abortion.

ISSUES IN CARING FOR OLDER PEOPLE

In the realm of care of older people, the main issues for which CO status has been sought have been related to chronic illness²³ and interventions, such as nutrition and hydration;²⁴ withdrawal of life-support systems, such as respirators and dialysis; and cardio-pulmonary resuscitation (CPR).²⁵ Some healthcare providers believe that nutrition and hydration are not medical treatments, but rather intrinsic human obligations to patients irrespective of the degree of technology required to provide the hydration and nutrition (tube feeding or total parenteral nutrition). To these people the refusal of nutritional efforts, although ethically and legally recognised as an acceptable manifestation of autonomy, is interpreted very differently from the actual withdrawal of these supports once put in place. This is despite a substantial literature supporting the principle that the refusal and the withdrawal of potentially life-saving treatments are ethically comparable. This position has been supported legally in all common-law jurisdictions.

Yet in healthcare settings, it is still common to have clinical scenarios in which healthcare providers balk at, or blatantly refuse to provide, required care for the withdrawal of feeding tubes.²⁴ Some also find it difficult to continue to care for a patient that refuses potentially life-saving surgery or chemotherapy. In the dialysis domain, it appears to be a standard in clinical practice to accept patients' decisions to refuse further dialysis, yet most would consider it unprofessional for members of the healthcare team to refuse to provide aftercare in such cases.²⁶ However, the same patients might

experience rejection by healthcare professionals should they wish to have a feeding tube withdrawn. Is the meaning of technologically based hydration and nutrition substantially different from the cleansing action of dialysis? From the perspective of care providers who experience 'moral distress' in one clinical situation compared to the other, this seems to be the case. It should not matter what the basis of the patient's refusal of treatment is in terms of validating whether or not the healthcare provider's 'moral distress' is justified.²⁷

IS THERE A RESOLUTION?

It is not easy to resolve this apparent conflict between the intrinsic respect for the autonomy of patients and their substitute decision-makers and the personal values of healthcare professionals.²⁸ This has become a foundational ethical principle in North America and is gradually being accepted in most Western countries. This conflict may reflect inadequate exposure during the professional educational process of what it means to be such a professional. In view of the existence of the concept of CO in professional codes of ethics, this conflict may additionally reflect a loss of professional purpose by practitioners, a contemporary diminishment of the concept of professionalism, which has been replaced by the view of contractual relationships.¹⁵ The contrast between the 'covenantal' concept of professionalism (as reflected in the concepts of duty and obligation) and the contemporary 'contractual' relationship (which as been enhanced by the incursion of the existing formal healthcare systems landscape) may be at the root of the present growth of the CO status concept.¹⁵⁻¹⁹ Healthcare professionals whose main relationships with patients are part of 'systems' rather than uniquely professional relationships may no longer internalise the strong sense of historical, cultural and professional calling that has separated them as healthcare professionals from other members of society.²⁹

Is there any way to rekindle the sense of professional obligations and duties so that those who seek to avoid caring for patients in the guise of CO status will find a way to provide the necessary care? Can this be done while finding ways to productively deal with one's moral qualms? The basic concept of self-regulation as a healthcare profession implies an inherent duty to society that removes governments and legislation from interfering with what is deemed an important professional ethical principle. With such self-regulation comes an obligation to provide care, to meet the personal needs of the patient, when to do so might potentially compromise the interests of the provider.

If there is going to be a process by which CO can be recognised in unusual circumstances, there should also be a system that is understood and is consistent across the healthcare system so that all involved should be aware of the criteria for the exception to providing

services. One proposal includes the following criteria formulated by C Meyers and RD Woods:¹²

1. if the applicant has a sincere scruple-based objection,
2. if the scruple fits an otherwise coherent system of beliefs,
3. if the scruple is consistent with other beliefs and actions, and
4. if the scruple is a key component of the petitioner's moral or religious framework. If an exception is granted, all reasonable alternatives should be explored to ensure that physicians fulfil their obligation to provide service, including having the petitioner provide only follow-up.

The ideas expressed in this framework clearly include assuring that the professional service will be provided and that necessary follow-up care must be made available one way or the other. Very important is the concept that the basis of exclusion from providing care should be substantial, and not be of a superficial nature. Perhaps informing one's employer (if in a hospital service, for example) or one's potentially applicable patients of one's strong beliefs might also be an expectation to prevent the possibility of conflict or patient abandonment.

ENHANCED EDUCATION

Can a more robust and dedicated professional education system that addresses these issues meet the demands of healthcare professionalism?³⁰ Do physicians and other healthcare providers in their professional schools experience courses and mentors who inculcate the concepts of healthcare professionalism while they are mastering the technical aspects of their profession's role?³¹ From the development and growth of the CO movement within healthcare, this does not seem to be the case. Perhaps the process of healthcare professional education from the onset must focus on the concepts of the duties and obligations toward patients that come with the profession. The concepts of non-abandonment as a core value must be taught as part of the professional ethic. There should also be a process of personal exploration and growth that helps individuals deal with their professional responsibilities towards their patients, within the context of their individual values and beliefs. For those who find difficulty in dealing with any related dichotomies, counselling can take place to help re-direct the person into a place in the profession that will be safe from such moral conflicts, or a different life's work might be considered.

If we do not address the issue of professional duties and obligations as being the paramount consideration when undertaking patient care, the concept of patient autonomy as one of the key contemporary ethical principles will become meaningless.²⁸ To develop a culture where the patient is no longer the focus of

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commitment but rather just one in the fabric of decision-making is to ignore the whole concept of healthcare professionalism²⁸. Substantial progress has occurred since the days of so-called 'paternalism' where physicians alone made treatment decisions (but at least these decisions usually reflected the ethical principle of 'beneficence'). One should be careful not to shift to a state whereby the physician or other healthcare professional, once again, becomes the primary arbiter of decision-making. Such a development would undermine the very basis of healthcare professionalism, and the history and culture within which it has developed over centuries. As healthcare professionals we cannot sacrifice that special patient and societal trust because of our individual and personal needs or values. Patients must continue to be the centre of our efforts, and their needs must always be paramount in our decision-making processes and actions.

CONCLUSION

Being a physician or other healthcare professional is an honour and privilege. The public's faith in our dedication and motivations to attend to their needs is why the qualities of trust, integrity and duty are imbued with such professionalism. These qualities have a long historical tradition in Medicine, and have been adopted as key features within the more recently developed healthcare professions. They are based on our collective fiduciary responsibility to those that entrust their care and lives to us. One must be very careful not to sacrifice this trust for one's own personal value systems, even when they may cause some degree of personal or 'moral distress'. It is the responsibility and challenge of physicians, and all other healthcare professionals, to find ways to focus on the needs of those we care for, and to find ways to address our own needs so as to allow us to function within our profession. We must maintain integrity while we acknowledge our personal needs, but never at the expense of those we care for in our professional roles.

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