Limiting Conscience Rights in Obstetrics and Gynecology

American Association of Pro-Life Obstetricians and Gynecologists*

ABSTRACT: The American College of Obstetricians and Gynecologists (ACOG) released a Committee Opinion in November 2007 titled "The Limits of Conscientious Refusal in Reproductive Medicine." This document, claiming to speak on behalf of the entire profession of Obstetrics and Gynecology, proposed that conscience rights of healthcare professionals have limits with regard to certain aspects of patient care. Despite calls for revision from many within the profession, this document was reaffirmed in 2016, unchanged. This document provides a detailed analysis of the ethical flaws in ACOG Committee Opinion 385.

Key Words: ACOG, conscience, opinion, objection

Background

Flawed Assumptions

Committee Opinion 385 of the American College of Obstetricians and Gynecologists (ACOG) outlines the concept of conscience and that it may sometimes conflict with patients' desires regarding particular medical interventions. It then goes on to list four criteria to determine appropriate limits to conscience and concludes with several recommendations: potential for imposition, effect on patient health, scientific integrity, and potential for discrimination.

This detailed opinion on the right of conscience contains several flawed assumptions. First, the document assumes that patient autonomy

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is the final arbiter of treatment decisions. However, physician beneficence has traditionally been accepted as the first and final arbiter of treatment decisions. Physicians are trained to pursue only what is good for their patients, and this orientation towards the patient's best interest was essential to maintain trust in the healing profession and provide the best care. However, this led to paternalism, wherein the physician unilaterally made medical decisions without accounting for patients' perspectives about treatment.

In Western medicine, this imbalance began to change in the 1960's and 1970's such that patient autonomy, i.e., the right to self-determination, was appropriately accorded much greater weight. Patient autonomy gradually came to be seen as highest on the hierarchy of ethical principles, even outweighing the physician's concept of beneficence in many instances. But patient autonomy is not absolute. Patients cannot demand treatment interventions that are contrary to evidence-based medicine or standards of care. They cannot insist on unnecessary or harmful diagnostics or interventions. Conversely, there are times when the physician's exercise of beneficent care is supported and even lauded, e.g., treatment and prevention of suicide.

This flawed assumption that patient autonomy supersedes physician conscience is exemplified when ACOG states "although respect for conscience is important, conscientious refusals should be limited" based on four criteria, which are overly broad and biased. While physician autonomy is also not absolute, this tipping of the balance so strongly in favor of the patient based on assertions is ethically troubling.

A second flawed assumption Opinion 385 makes is that negative patient autonomy (the right to refuse) and positive patient autonomy (the right to demand) are morally equivalent.

Negative patient autonomy is nearly inviolable; it is rarely justified to impose unwanted treatment on a patient who has capacity and makes an informed decision. However, positive patient autonomy carries much less moral obligation. Patient demands are routinely denied by conscientious physicians for such things as unnecessary surgery, unwarranted antibiotics, inappropriate medical tests, etc., even in those situations where the requested treatment is within the bounds of accepted practice or in instances when other physicians might accede to the request for patient satisfaction or monetary gain.

Such physician refusals are generally based on patient beneficence, that such interventions are not in the patient's best interest. For decades, a physician has also been permitted to decline a patient's request based on his or her conscience. To not do so implies that the patient's right to access to specific treatment options outweighs the physician's right to avoid moral complicity in an action that he or she believes to be immoral.

This ACOG opinion supports this incorrect implication, as noted by its repeated referral to physicians as "providers." There is a major conceptual dif-

ference between a professional who professes allegiance to standards (those shared by the profession, as well as personal ethical standards) and a "provider," a technician who merely provides whatever is requested of him or her.

A third flawed assumption that Opinion 385 makes is that matters of conscience for the professional are matters of personal opinion. The (limited) concept of conscience as "self-knowledge" is expressed by ACOG when they define it as the "private, constant, ethically attuned part of the human character." This is a truncated and incomplete view of conscience. A person's conscience is inseparable from his or her worldview or religious beliefs.

> In the history of ethics, the conscience has been looked upon as the will of a divine power expressing itself in man's judgments, an innate sense of right and wrong resulting from man's unity with the universe, an inherited intuitive sense evolved in the long history of the human race, and a set of values derived from the experience of the individual.[1]

> Recognizing this divine origin of an individual's conscience, a conscience clause is defined as "a clause in a general law exempting persons whose religious scruples forbid compliance therewith...[2]

ACOG reiterates its incomplete view of conscience when they claim "...not to act in accordance with one's conscience is to betray oneself." This is a small, private view of conscience. ACOG admits to no betrayal outside the self, such as to the community or to a higher power that sets such standards. In reality, to betray one's conscience is to have effects on the community: examples of failures in research conduct or in abuses of vulnerable patients in gynecology are examples of individual moral failures propagating harms to the community.

A fourth flawed assumption made by Opinion 385 is that *prima facie* values can and should be overridden in the interest of other moral obligations that outweigh them. ACOG admits that respect for conscience is a value, but they go on to say it is only a prima facie value. This is not so much a flawed assumption as one that is distorted. A *prima facie* value is one that is accepted on its own merit, without need for proof, though it may be contested and shown to be invalid in a particular circumstance. By emphasizing the possibility of override, and claiming conscience is only a prima facie value, they imply that this is of little consequence.

Criteria to Determine Appropriate Conscience Limits

In its section on "Potential for Imposition," the Opinion conflates refusal to provide a requested service by the professional with imposition of the professional's beliefs. It is instead an instance of negative professional autono-

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[1] Conscience. In Gale Group (Ed.), The Columbia Electronic Encyclopedia (2000 ed.).

[2] Conscience clause (n.d.). In Webster's Revised Unabridged (11th ed).

my. The professional's refusal does not preclude the patient from seeking or obtaining the requested service elsewhere. Geographic or sociologic constraints are separate and distinct.

The section on "Effect on Patient Health" could make a strong case for bodily harm to the patient (pain, disability or death), but ACOG expands the definition of "health" to include "a patient's conception of well-being."[3] Thus, the document asserts incorrectly that the patient's wishes, whatever they may be, trump professional autonomy.

In addition, they define the physician's fiduciary duties to include an obligation "to protect patients' health." Again, they could make this point vis-à-vis an obligation to protect from bodily harm, but they distort it by implying the patient's autonomy takes precedent over the physician's conscience. The example they use here is a conscientious refusal to do a tubal sterilization at the time of Cesarean section, claiming that the "attendant and additional risks" of a second surgical procedure should override the physician's conscience.

ACOG also minimizes the physician's obligation to promote fetal well-being. Though initially couched in terms of "protecting the safety of women," the implication is that this protection includes the "patient's conception of well-being" invoked earlier. But protecting women to the point of entertaining abortion due to the patient's personal concept of well-being is to violate the obstetrician's obligation to promote fetal well-being. The obstetrician has two patients—the woman and the preborn human person, the fetus. ACOG correctly prioritizes protecting the health of the woman, as this is the primary modality of caring for the fetal patient. Without caring for the mother, we cannot care for the fetus—but some acts on the mother (acts done in the name of her concept of well-being) do not advance her health and can even attack the fetus. The physician of conscience abides by the principle to "first, do no harm," and not cause pain, disability, or death to either patient, while still maintaining the duty to care for the woman as one of two patients.

In its section on "Scientific Integrity," ACOG correctly speaks against support for conscientious refusal based on invalid consequential reasoning. Some claims of conscientious objection are not genuine: a physician with a conscientious objection to personal involvement in an act might try to hide behind a potential adverse outcome as an excuse for his or her concern. He or she should speak openly about their objection being based on their moral convictions, not a potential adverse outcome. But in the same paragraph, ACOG incorrectly concludes from this that there is no room for discussing evidence of adverse

[3] American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 385 November 2007: the limits of conscientious refusal in reproductive medicine. Obstet Gynecol. 2007 Nov;110(5):1203-8. doi: 10.1097/01.AOG.0000291561.48203.27. PMID: 17978145.

effects and the uncertainty about such evidence. Claims of concern about adverse effects of certain morally-fraught acts still deserve conversation, even if they cannot completely justify a conscience refusal.

In its section on "Potential for Discrimination," the document begins with a valid argument that patients should be treated alike and without discrimination. Thus, a physician who has a conscientious objection to doing a certain procedure is not justified in refusing the procedure for one patient while providing it for another equivalent patient. However, the example they use is fallacious: refusing to provide contraceptive assistance to an affluent patient who may be able to procure it elsewhere may be justified, they say, while doing so for a poor young mother without transportation is not because it is unjust. But this is not justified, a provider should not discriminate based on socioeconomic status, but should act according to a consistent moral standard that does not discriminate between patients but opposes procedures based on moral principles.

The Opinion goes on to claim as "oppressive" the denial of reproductive services for a homosexual couple while providing the same for a married heterosexual couple. The AMA clearly states in its Principles of Medical Ethics that "A physician shall...except in emergencies, be free to choose whom to serve..." Assisted Reproductive Technology is not an emergency service.

Critiques of Recommendations

The Opinion closes with recommendations including that "[a]ny conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled."

Reproductive services, as distinct from care of complications after a service, are rarely matters of life and death. The assertion that a physician's "obligation" to provide elective reproductive services outweighs the physician's autonomous conscience is contrary to medicolegal tradition, including Supreme Court case law in the U.S.

The Opinion then ignores the issue of moral complicity by recommending that "physicians and other health care professionals have the duty to refer patients...to other providers if they do not feel that they can in good conscience provide the standard reproductive services that their patients request." Some physicians may be willing to follow this, but others believe their involvement in the referral process involves moral wrongdoing, for without their involvement, the morally troublesome procedure would not have happened.[4] This makes the referral *itself* morally objectionable, an option not ever entertained in the Opinion.

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[4] Orr RD. The role of moral complicity in issues of conscience. American Journal of Bioethics, November 2007, in press.

Finally, the Opinion asserts an obligation for providers with conscientious objections to remain nearby providers with no objections in order to assure patients have options: "Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide." This recommendation ignores the context that patients in "resource-poor areas" may be without access to many services (neurology, dermatology, dental surgery), and no other professional society insists that all health care services must be available to everyone at all times. Certainly, a physician in such an area should be willing to provide emergency services in which he or she is adequately trained. However, there is no compunction to provide elective reproductive procedures.

There is equally no societal obligation to ensure convenient access to all elective health care services for everyone, even though the Opinion recommends that lawmakers advance policies that compromise conscience protection with access to procedures like induced abortion.

Clinical Questions and Answers

Q. Are there reasonable aspects to Committee Opinion 385?

Opinion 385 notes that "health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services."

This is a reasonable recommendation. A duty to present accurate information does not, however, prevent him or her from expressing his or her moral beliefs on the matter, so long as patients are treated with respect.

The Opinion goes on to explain that "where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions."

This is not an unreasonable recommendation in situations of individual practitioners in an elective healthcare setting. In rare circumstances, it could become problematic or unworkable in situations of cross coverage and in emergency settings. However, most services under consideration in the Opinion are not typical emergency services, such as delivery, miscarriage care, or care for complications from reproductive procedures; instead, services such as assisted reproductive techniques and abortion are outpatient and elective.

In the same vein, the Opinion concludes that "in an emergency in which referral is not possible...providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."

This recommendation is valid, though direct feticide is never medically indicated. The pro-life provider can provide emergent delivery or treatment of ectopic pregnancy in these situations, and this is not ethically equivalent to direct feticide or dismemberment.

Q. What was the response to Opinion 385 among pro-life physicians?

Since its original publication in 2007, the Opinion has generated significant pushback among organizations such as the U.S. Congress, the office of the secretary for Health and Human Services, the American Association of Pro-life Obstetricians and Gynecologists, the Christian Medical and Dental Association, and the Catholic Medical Association.[5] Although a revision of the Opinion was promised in 2008, the Opinion was reaffirmed in 2016 without changes.

[5] Committee Opinion 11: Non-Representation of Pro-Life OB/GYNs in the American College of Obstetricians and Gynecologists. Issues Law Med. 2022 Fall;37(2):221-230. PMID: 36629768