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Philosophy and Theology: Notes on “The Limits of Conscientious Refusal in Reproductive Medicine”

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In November 2007, the Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) issued committee opinion 385, titled “The Limits of Conscientious Refusal in Reproductive Medicine.” The committee enumerated a series of recommendations that “maximize accommodation of an individual’s religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.” These recommendations include the following seven provisions:

1. In the provision of reproductive services, the patient’s well-being must be paramount. Any conscientious refusal that conflicts with a patient’s well-being should be accommodated only if the primary duty to the patient can be fulfilled.

2. 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.

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3. 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.

4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.

5. In an emergency in which referral is not possible or might negatively affect a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider’s personal moral objections.

6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. 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. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients’ rights to health care services.

7. Lawmakers should advance policies that balance protection of providers’ consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.\(^3\)

In order to justify these recommendations, the opinion of the committee appeals to a definition of conscience as “the private, constant, ethically attuned part of the human character. … An appeal to conscience would express a sentiment such as, “If I were to do ‘x,’ I could not live with myself/I would hate myself/I wouldn’t be able to sleep at night.”\(^4\)

Certain elements of the definition of conscience proposed by the ACOG committee are unobjectionable, such as the desire to avoid inner discord and the “ethically attuned” aspect of conscience which hints at a response to something objective. A concern for patient well-being is certainly laudable. However, on the whole, the foundation of the seven ACOG recommendations as well as many of the recommendations themselves are at odds with a sound understanding of ethics and conscience and furthermore fail to appreciate, or respect, the genuine pluralism that exists about the nature and claims of conscience.

The committee’s understanding of conscience reflects a particular philosophical view, one that can hardly be taken as self-evident. It is not made clear in the document that

\(^3\)Ibid., 5.

\(^4\)Ibid., 2.
why this peculiar account of conscience (perhaps originating with Thomas Hobbes) was adopted, nor why this one philosophical view of ethics and conscience should be imposed on the entire membership of the ACOG. With Hobbes, the ACOG guidelines presuppose that ethics is ultimately a matter of the private emotions and sentiments rather than a matter of common rationality and practical wisdom, as Plato, Aristotle, Cicero, Thomas Aquinas, Immanuel Kant, John Henry Newman, and Simon Soloveychik held. The difference between a properly formed conscience and a malformed conscience consists in part in that a properly formed conscience reflects an ethical soundness which is not an idiosyncratic private taste, but rather may be a communally, publicly shared judgment precisely because it is based on shared rationality.

In the ACOG opinion, conscience reflects not one’s best judgment at the conclusion of a process of moral deliberation from fundamental moral principles about what is right and wrong all things considered (ultima facie), but a feeling that is merely a matter of a provider’s personal experience of loss of self-respect. “Although respect for conscience is a value, it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance.” The committee opinion thus construes claims of conscience as prima facie values that can and should be “overridden” by the agent in light of other moral considerations. When this idiosyncratic desire not to feel shame is set against the well-being of a patient, naturally the patient’s well-being trumps the private, sentimental desire to keep one’s hands clean. The ACOG conception of conscience as a prima facie guide contradicts, for example, the proximate supremacy of conscience as an unconditional command (Kant), a magisterial dictate (Newman), and the famous dictum of conscience, “were its might equal to its right, it would rule the world” (Butler). Sophocles in Antigone, Socrates in the Crito, and Aquinas in the Summa theologiae (I-II, Q 19.5) all testify that an agent’s best ethical judgment—the judgment of conscience—simply cannot be overridden.

Not only is the ACOG’s definition of conscience only one among many understandings of conscience and hardly representative, but also its peculiar definition is problematic in two additional respects. First, there is no reason why conscience must be constant, for people can and should change their consciences to accord with the truth as best as they can determine it. Second, the violation of conscience does not necessarily lead to emotional turmoil or subjective feelings of guilt (“If I were to do ‘x,’ I could not live with myself/I would hate myself/I wouldn’t be able to sleep at night”). A violation of conscience makes the agent objectively guilty for having knowingly and willingly done something against the agent’s best ethical judgment. Being guilty in this sense is fully compatible with a wide range of emotional reactions. The wicked sometimes sleep soundly.

The idiosyncratic foundation of the ACOG document’s recommendations is not only philosophically (and theologically) problematic from a diverse variety of perspectives (such as those represented by Sophocles, Socrates, Aquinas, Kant, Butler, Newman, and Soloveychik), but the recommendations themselves are also

5Ibid., 3.
highly objectionable. “Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request.”6 A pro-life physician could follow the letter of this recommendation and refer a patient to another pro-life doctor. However, if construed (as seemingly intended by the committee) as a duty to refer to a doctor who has no conscientious objection to abortion, this recommendation proposes a duty to cooperate in the wrongdoing of another by not merely providing what is needed to commit wrongdoing, but by helping patients precisely in their wrongdoing. It would indeed be absurd to say, “I would have a guilty conscience if she did ‘x.’” However, it is not at all absurd to say, “I would have a guilty conscience if I helped her to do ‘x.’” Conscience may or may not demand that one rebuke or obstruct other providers, but it surely demands that one not formally assist in the wrongdoing. This becomes intuitively clear when we substitute for “x” something uncontroversially evil. Would it really “absolve” a physician from guilt if he did not personally prescribe a drug in order for a patient to commit date rapes, but rather helped the rapist achieve his goal by referring him to another doctor to fill the prescription? It is true that some patients would still do “x” even without a referral. However, formal cooperation in the wrongdoing of others is not eliminated simply because the wrongdoer is intent on doing wrong regardless of the cooperation given.

One would have strong reason to suspect that the ACOG has chosen its definition of conscience precisely to yield the specific recommendations that it wanted, given that the ACOG’s previous policy positions would imply a very different understanding of the nature, scope, and claims of conscience. Previously, the ACOG has championed the individual judgment of the physician about what counts as medically indicated for a patient in particular circumstances as a buttress against laws criminalizing abortion procedures. On this view, if a particular physician believes it is in the best interest of the health of the woman to have an abortion, then this judgment qualifies the procedure as legal under the guidelines set by Roe v. Wade and Doe v. Bolton. In the words of the ACOG statement of policy on abortion (reaffirmed in 2004), a partial-birth abortion “may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of the woman, and only the doctor, in consultation with the patient, based on the woman’s particular circumstances can make that decision. … The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.”8 It would seem then that the judgment of the individual physician about what is medically indicated trumps any sort of universalized ruling that abstracts for the particularities of the situation as understood by the physician chosen by the patient. However, some physicians in conscience refuse to provide contraceptives or perform abortions because, having

6Ibid., 5.
7Ibid., 2.
examined the empirical evidence,\(^9\) in their judgment these practices are contrary to the well-being of their patients. In these cases, when an affirmation of the autonomy of a physician in determining medically indicated care might result in an abortion not being performed, opinion 385 overrides the judgment of the treating physician in favor of “standard care” as determined by the ACOG, a kind of legislative body.

The ACOG opinion not only unfairly limits a doctor’s liberty in action but also infringes on a physician’s freedom of speech. In other contexts, the ACOG has argued against “gag rules” that inhibit a physician from communicating to the patient about what is, in the physician’s judgment, relevant for making sure the patient can give informed consent and proper treatment. “Serious ethical problems arise if organizational rules (so-called “gag rules”) preclude such disclosures.”\(^10\) However, in opinion 385, physicians may not even communicate their own views about treatment unless they parrot “professionally accepted characterizations of reproductive health services.” Freedom of speech is therefore sharply curtailed, since doctors are expressly forbidden “to argue or advocate” views that dissent from ACOG committee policy. Such physicians are also forced, even in contexts where such matters may not be at issue, to make their views known to patients, and yet at the same time the new ACOG gag rule forbids them to indicate why they hold these views.

The flawed understanding of conscience accepted by opinion 385 actually commits the ACOG, by extension and analogy, to positions that reasonable people would in other circumstances find repugnant. This may be seen by substituting other practices for abortion and contraception. The same rules, for example, adopted in a different cultural and legal milieu, would only allow a conscientious objector not to perform female genital mutilation (FGM) so long as the objector were forced to refer patients to those who do perform female genital mutilation, and as long as someone else were available. If the physician responds that female genital mutilation goes against his conception of good medicine, not only must the physician act in certain circumstances against what he believes is medically indicated, but the objector must also mouth to the patient or guardian “professionally accepted characterizations” of the practice, as understood in the predominant cultural and enforced legal milieu without “use of their professional authority to argue or advocate” against FGM.


Would such rules, for the physician practicing in places where FGM is legally and culturally accepted, provide an adequate protection (let alone “maximize accommodation”) for the doctor conscientiously objecting to FGM?

Consider examples closer to home. A physician working in a correctional facility is asked to facilitate giving a lethal injection to a prisoner on death row. The physician firmly believes that capital punishment is immoral and further, having closely followed this prisoner’s case, is convinced the condemned is actually innocent. However, let us suppose that state law allows only employees of the correctional facility to be in the room during the execution, and since he is the only physician employed in the prison, according to the principles for conscience set by the ACOG, the physician has a duty to execute the prisoner. Likewise, in places where euthanasia or physician-assisted suicide is legal, similar conscience guidelines would require physicians opposed to these practices to kill or help kill their patients if no other physician is available.

Part of the argument made by the ACOG is that the obligations undertaken by the physician’s acceptance of his role as physician (and the privileges this entails) bind the doctor more firmly than the judgment of conscience. However, it in no way follows that undertaking certain obligations vacates the demands of conscience. Ironically, the committee report would undermine the autonomy of physicians to an even greater degree than a military oath to obey superior officers limits the autonomy of soldiers. A man volunteering for military service freely takes an oath to obey his superior and receives all the privileges and responsibilities that come with that oath. But let us suppose his lawful superior orders him to do something that the soldier considers to be immoral. In the understanding of conscience imposed by the ACOG committee, a soldier could disobey an order only if there were other soldiers available to carry it out. If not, then the soldier has a duty to carry out the order that he considers immoral. Surely, however, the demands of conscience must not be gerrymandered by the availability of less enlightened and conscientious people.

One of the concerns of the committee is that the exercise of conscientious objection not create or reinforce racial discrimination or socioeconomic inequalities in society. However, the ACOG opinion itself encourages unfair discrimination against anyone who refuses to take innocent human life, including many religious believers, particularly Catholics. Any Catholic who accepts the teaching of the Church will be unable to practice medicine in accordance with the recommendations of the committee. Like any intentional killing of innocent human beings, performing abortions violates Catholic teaching, and indeed when knowingly and willingly done, the agent who procures an abortion “incurs an automatic (latae sententiae) excommunication” (can. 1398). Circumstances—such as practicing medicine in a remote location—might lead to a situation in which a Catholic doctor is the only physician available to perform an abortion, and under the rules of the committee would therefore be required to do so. In a more typical case, the committee opinion seems to require a conscientious objector to refer a woman for abortion to a provider who will perform the abortion. In other words, it requires the conscientious objector to cooperate in the abortion. As Bishop Rene H. Gracida notes, “Accomplices are also subject to the penalty of excommunication if the abortion would not have been
committed without their efforts (canon 1329.2).” Thus, if the referral were really needed in order to perform the abortion, the one making the referral would seem to share in the penalty of automatic excommunication. And if the referral were not really needed in order to secure the abortion, it is difficult to see why the physician should be required to perform a superfluous act, other than to mislead a patient about the physician’s views on abortion.

Conscientious Catholic physicians cannot act in accordance with the committee’s regulations. The committee view creates a professional environment discouraging if not prohibitive to Catholics and certain other faithful Christians who oppose abortion. Thus, in effect, opinion 385 also reinforces prejudice and discrimination against ethnic minority groups who are disproportionately Catholic and Evangelical, such as Latinos and African-Americans.

The many difficulties occasioned by opinion 385 could be reasonably avoided, and the legitimate autonomy of both patients and doctors secured, by recognizing the proper scope of liberty on all sides. Physicians have the autonomy to determine what is in their view medically indicated for the patients they serve, and to determine whether they are willing to provide this service; patients have the autonomy to reject or accept any options offered by their physicians as well as the freedom to choose their physician. Either side may misuse their autonomy, but as a prima facie starting point this seems much preferable to the one-sided emphasis on patient autonomy found in the committee opinion. Physicians should not be cast into the role of medical automatons forced to perform actions contrary to their best ethical and medical judgments.

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