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Conscientious objection and the duty to refer

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Abstract

Medical associations and leading courts reinforce the duty of physicians who conscientiously object to participating in treatment indicated for their patients to refer them to non-objecting practitioners. Ethical and legal duties require continuity of care when physicians withdraw from patients' treatment on grounds of conscience. The duty to refer might affect gynecologists when their patients request for example, contraceptive means, sterilization, abortion, medically assisted reproductive procedures, or gender reassignment. Legislation and leading law courts, notably the UK Supreme Court and Constitutional Court of Colombia, and professional associations such as the College of Physicians and Surgeons of Ontario, have clarified the duty to refer. Physicians are expected to cater their individual conscience to their professional ethical and legal duties, favoring their patients' choices over their personal objections. Physicians can object to "hands-on" conduct of procedures they find objectionable, but cannot deny referral on grounds of complicity in what other care providers do.

KEYWORDS
conscientious objection, duty to refer, freedom of conscience, professionalism, referral, religious objection, therapeutic continuity

1 | INTRODUCTION

In 1991, a leading figure in the development of modern bioethics, Robert Veatch, described the responsibilities of physicians who conscientiously object to participation in procedures appropriate for and requested by their patients to refer them to non-objecting practitioners as "absolutely intractable".[1] Physicians' claims to freedom of conscience, often religious, require maximum practical compliance, but equally do dependent patients' claims to freedom of access to lawful healthcare. The debate has advanced in more recent years through medical professional policies on human rights, and judgments of leading courts that have confronted health service providers' insistence that they not be participants nor complicit in moral wrongdoing that conflicts with patients' insistence on timely access to continuity of lawful, appropriate health services.

2 | THERAPEUTIC CONTINUITY

When medically qualified people hold professional licenses to practice medicine and they accept responsibility for individual patients' health, meaning the patients' "physical, mental and social well-being",[2] they preserve their human right of conscientious objection to participation in (non-emergency) procedures to which they conscientiously object. The UN International Covenant on Civil and Political Rights includes "freedom of thought, conscience and religion" as a "right" (Art. 18(1)). However, it is more accurate to regard the practice of medicine as a privilege, held under terms of a license awarded to practitioners. They possess and maintain this privilege on grounds not only of their medical qualification but also of their fitness to practice, including their moral fitness and ethical compliance.

Patients seeking therapy who come to practitioners, or who are allocated to them within hospital, clinic, or comparable healthcare systems, have entitlements to reasonable continuity of care until their treatment is concluded or their care providers refer them to suitable other care providers. This is self-evident when patients' care requires services that their physicians lack the specialized knowledge, training, skill, or experience to provide. This duty to patients also applies regarding indicated procedures—such as medical and surgical interventions and use or prescription of pharmaceutical products—that practitioners are equipped to undertake, but which they object to participating in on grounds of conscience. The duty to refer governs care that practitioners cannot, or will not, provide. Conscientiously objecting practitioners bear ethical and legal duties not summarily or arbitrarily to terminate their responsibilities for their patients' therapy or appropriate care, under sanctions for abandonment. On voluntary withdrawal from rendering indicated care to their patients, practitioners must refer them to other practitioners who are suitable, available, and willing to undertake the patients' continuing treatment.

The duty to ensure patients' continuity of appropriate care might present a challenge to practitioners in severely under-resourced settings, which exist not only in impoverished, low-income environments. Inhabitants of relatively wealthy countries might live in remote, sparsely populated areas served by a narrow range of health service providers working at long distance from each other. Long-standing concerns about the inadequate quality of health services available to rural populations come into sharper focus with improvements in data gathering and refined techniques of demographic analysis and contrast. Regarding conscientious objection to participation in delivery of healthcare services, however, in both urban and rural settings, the European Court of Human Rights has ruled that "states are obliged to organize the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled".[3]

There is no professional duty to undertake non-therapeutic treatments, nor to refer applicants to others, although practitioners must appropriately conclude any initiated treatments. Cosmetic treatments not clearly related to a mental pathology, such as genital surgery, might raise a spectrum of ethical concerns.[4] The same almost invariably applies to punitive interventions and treatments requested by third parties or approved by courts, to which proposed recipients do not provide voluntary or adequately informed consent, such as parents' requests for their children's ritual genital cutting, and contraceptive sterilization approved by courts as a condition of women retaining custody of their young children. Practitioners may inform patients and others of services within their technical capacity that they would conscientiously refuse to undertake because those services serve no therapeutic or health-related goal. In such cases, practitioners bear no duty of referral.

3 | THE GYNECOLOGICAL FOCUS

In several countries, much current discussion and controversy on the duty of referral addresses recently introduced legal accommodation of medical aid in dying. However, since the mid-1960s, following liberalizing legal reforms, the dominant gynecological focus of conscientious objection was, and remains, on abortion. This built upon earlier Judaeo-Christian condemnation of artificial contraception for violation of the biblical directive to "Be fruitful and multiply".[5] Some general medical practitioners and others decline to prescribe contraceptive products, and pharmacists might decline to fill prescriptions. Gynecologists might similarly decline to fit contraceptive devices, and concerns now include emergency contraception when analogized to abortion. Contraceptive sterilization procedures such as tubal ligation might be refused for precluding human reproduction, but treatments intended to overcome infertility by facilitation of reproduction might also attract objection. Objectors might focus on artificiality of procedures and/or, for instance, the wastage of gametes and embryos often inherent in in vitro fertilization (IVF) procedures.

Practitioners who object to treating unmarried individuals or couples, for instance for contraception lest they promote promiscuity, or for infertility lest they promote out-of-wedlock birth, offend modern legal and ethical provisions against discrimination on grounds of marital status. Those who object to treating same-sex couples seeking children, such as through sperm donation for females or ovum donation and surrogate motherhood for males, similarly offend provisions against discrimination on grounds of sexual orientation. Objection to assisting surrogate motherhood might be acceptable, without referral, when practitioners perceive exploitation of any participant, although courts might find that properly regulated, paid surrogacy does not offend public policy.[6]

Gender reassignment surgery, such as hysterectomy and double radical mastectomy to achieve a masculine torso for a female-to-male transsexual patient, or creation of an artificial vagina for male-to-female transitions, has also become a focus of objection. In a Canadian case before the Court of Appeal of Ontario, a practitioner objecting to a professional requirement of referral explained that she told her patient seeking gender reassignment treatment "I believe that God has created us male and female, and that choosing to change your gender is working against how God has made you" [7, para. 141]. The Court upheld as constitutional the human rights policy of the College of Physicians and Surgeons of Ontario that practitioners who object to providing medical procedures or pharmaceuticals on the basis of their religion or conscience must provide the patient with an "effective referral". The College defined this as a referral made in good faith to "a non-objecting, available, and accessible physician, other health-care professional, or agency".[8] Referral must be made in good faith, since physicians raising conscientious objection cannot ethically or lawfully practice deception or evasion to compel their patients' involuntary compliance with the objectors' own religious or moral beliefs. The feasibility of referral not to another practitioner but to an agency, such as

a professional medical association, has been explored in the scholarly literature (see Section 6 below).[9]

4 | THE DUTY TO REFER

Legislation and judgments of highest courts express conscientious objectors' duty of appropriate, timely referral. For instance, New Zealand's Abortion Legislation Act 2020 takes abortion out of the criminal law and regulates pregnancies only of more than 20 weeks' duration as a health issue. The Act follows the 1977 legislation it replaces in providing that an objecting practitioner "at the earliest opportunity" must inform the patient "how to access the contact details of another person who is the closest provider of the service requested".[10] The UK Supreme Court saw such a provision in a wider context, unanimously observing that "it is a feature of conscience clauses generally within the healthcare profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional's duty of care toward the patient" [11, para. 40]. The Ontario College of Physicians and Surgeons was aware of this 2014 finding when in 2015 it issued its human rights policy that requires objectors to provide "effective referral" of patients.[8]

Legal recognition and enforcement of the professional duty to refer presents a dilemma for practitioners who object to participation in particular procedures for fear of complicity in wrongdoing. The objection to complicity by referral arises from the understanding that it is as wrong to be complicit in another's offense, or sin, as it would be to commit that offense oneself. Practitioners who refer their patients to others are clearly not participants in procedures that the others conduct. The UK Supreme Court took a narrow view of what constitutes "participation" in a medical act, limiting participation to "hands-on" involvement [11, para. 38]. The Court excluded managerial tasks from the protection of conscientious objection [11, para. 39], as did, for instance, the Constitutional Court of Colombia in 2008 when hospital managers declined to schedule a medically indicated abortion for a 13-year-old rape victim who, on diagnosis of pregnancy, had attempted suicide.[12] The Constitutional Court treated objecting physicians' duties of referral as comparable to, and as binding as, the duties of hospital managers required to schedule patients' procedures.[13]

Refusal of referral to non-objectors accordingly cannot be based on the claim that referral amounts to participation in procedures that non-objectors conduct. Objection to referral on grounds of complicity in such procedures would extend practitioners' exemption from the duty of care owed to patients to an extent that courts tend to find unacceptable. Law and ethics oppose discrimination on grounds of religious and conscientious beliefs, and require maximum practicable accommodation of such beliefs, but to grant practitioners an extended exemption from observance of legal duties of care owed to their patients by invoking complicity through referral, is usually judicially held unjustifiable.

Claims to exemption on grounds of complicity can have different bases and implications.[14] Claims are more difficult to accommodate when allowing them imposes burdens or indignities upon others. The burden and disadvantage imposed on dependent patients by conscientious objectors' refusal of appropriate referral persuaded the Ontario Court of Appeal to uphold the policy of the College of Physicians and Surgeons, disregard of which policy could support a charge of professional misconduct. The trial court and the Court of Appeal recognized the sincerity of the appellants' religious convictions, and that the College policy impaired manifestation of their religious faith through the practice of medicine. The Court further recognized that "[t]he scope of freedom of conscience may be broader than freedom of religion, extending to the protection of strongly-held moral and ethical beliefs that are not necessarily founded in religion" [7, para. 82], although that case was brought, and decided, only regarding religious freedom.

Weighing against the burden of referral on practitioners is the burden on dependent, anxious patients in need of medical care. Regarding procedures in which the appellants refused to participate, such as abortion, contraception, sterilization, infertility treatment, and gender reassignment, the Court observed that:

> It is impossible to conceive of more private, emotional or challenging issues for any patient … these issues are difficult for patients to raise and to discuss, even with a trusted family physician … some of these decisions frequently confront already vulnerable patients; patients with financial, social, educational or emotional challenges; patients who are old, young, poor or addicted to drugs; patients with mental health challenges or physical or intellectual disabilities; patients facing economic, linguistic, cultural or geographic barriers; and patients who do not have the skills, abilities or resources to navigate their own way through a vast and complicated health care system. [7, para. 121]

The Court added that "decisions concerning many of these procedures are time-sensitive–obviously so in the case of abortion and emergency contraception. Delay in accessing these procedures can prevent access to them altogether" [7, para. 122].

For these reasons, patients turn to their family physicians for advice, care and treatment, including forms of treatment in which the physicians decline to participate personally on grounds of conscience. The Court found that "[g]iven the importance of family physicians as 'gatekeepers' and 'patient navigators' in the health care system, there is compelling evidence that patients will suffer harm in the absence of an effective referral" [7, para. 124]. Without professional guidance, however, family and other physicians can aggravate patients' distress. A counsellor at a non-profit abortion clinic testified that hundreds of women:

> came to us having suffered delays in finding us after first contacting their family physicians or others in the health care sector seeking information about,

> and possibly a referral for, abortion services. In many cases, women would tell me that not only would their doctors not refer them or help them find care, but their doctors would voice their own personal feelings and religious or moral objections … [The patients] felt traumatized and actively denigrated by their physicians' denial of assistance … They deeply felt their doctors' lack of respect for them and their choices. [7, para. 146]

5 | INDIVIDUALISM AND PROFESSIONALISM

We can understand that individuals who assess that an act, though lawful, is morally wrongful or sinful also find it wrong actively to facilitate that act through another. Members of the Christian Medical and Dental Society of Canada challenged the Ontario College of Physicians and Surgeons' referral policy based on their sincerely held beliefs. One explained to the trial court, "[m]y faith is the most important part of my life. It defines who I am, what I do and how I do it. I practice medicine first as a Christian" [7, para. 67]. Other practitioners might be more legalistic or pedantic, by explaining that they practice medicine as licensed professionals, drawing a distinction between acting in their individual personal capacity and in their professional capacity. Patients usually come to them, or are directed to them, for instance as members of their hospital or clinic staff, not because of their personal qualities, but because of their professional status, credentials and capacities. In private practice, they present themselves to the public, and attract patients to rely on them, not because of their religious or other convictions, but because of their membership in their profession.

On graduation and admission to medical professional practice, many physicians commit themselves to a modern variant of the ancient Hippocratic Oath. The version given by the World Medical Association, the Declaration of Geneva, was established in 1948 and is periodically updated, most recently in 2017, but it has always opened with the pledge that "The health and well-being of my patient will be my first consideration".[15] This professional commitment places consideration of the patient's well-being before commitment to the individual practitioner's religious faith, even when the practitioner was motivated to enter the calling of medicine by a religious sense of obligation to heal the sick. A practitioner who treats patients primarily to satisfy a perceived religious mission risks using patients instrumentally, violating the Kantian ethic of not using people only as a means to one's own ends. In professional ethics, often reinforced by law, practitioners who put advancing their own interests, whether material or spiritual, above serving their patients' interests, such as by refusing to refer patients for care in which the practitioners conscientiously refuse to participate or be complicit, place themselves in an unethical and possibly unlawful conflict of interest.

The Ontario Court of Appeal agreed with the trial court that:

> the appellants [i.e. the objecting physicians] have no common law, proprietary or constitutional right to practice medicine. As members of a regulated … profession, they are subject to requirements that focus on the public interest, rather than their interests. In fact, the fiduciary nature of the physician–patient relationship requires physicians to act at all times in their patients' best interests, and to avoid conflicts between their own interests and their patients' interests … The practice of a profession devoted to service to the public necessarily gives rise to moral and ethical choices. [7, para. 187]

Not all legal systems technically regard physician–patient relationships as fiduciary, meaning founded on trust, but all hold licensed physicians to professional standards of patient care. The Court summarized the physician–patient relationship by finding that "[o]rdinarily, where a conflict arises between a physician's interest and a patient's interest, the interest of the patient prevails" [7, para. 187].

Conscientiously objecting practitioners might be in a wider dilemma than having to resolve how their duties to particular patients can be reconciled with their religious or other convictions. The duty is to refer in good time and good faith to whichever practitioners are suitable and available to serve referred patients' healthcare needs. That is, the objecting practitioner faces complicity not just in particular patients' care, but in a healthcare system in which clinical services to which they conscientiously object are lawfully available, and have to be appropriately rendered, through their agency when necessary, to eligible patients. Practitioners with this dilemma must consider how, and indeed whether, they can discharge the duties of clinical practice in their profession, including the duty to refer, consistently with adherence to their faith. A contentious view of some scholars in bioethics is that physicians who will neither provide their patients with indicated lawful services to which the physicians conscientiously object, nor refer the patients to other suitable providers, should not be allowed to practice clinical medicine [9, pp. 58–65, 229–232].

6 | APPROPRIATE REFEREES

The first endnote to the Ontario College statement *Professional Obligations and Human Rights* explains that "[a]n effective referral does not necessarily, but may in certain circumstances, involve a 'referral' in the formal clinical sense, nor does it necessarily require that the physician conduct an assessment of the patient to determine whether they are a suitable candidate for the treatment to which they object".[8] This appears to mean that the required referral may be formal or informal, and that the objecting physician need not assess a patient's clinical eligibility to receive treatment the patient requests. The Court of Appeal accepted evidence of

"the pivotal role of family physicians, such as the appellants, as the key point of access to the services at issue for the majority of patients". [7, para. 118].

Accordingly, referral might not necessarily be to a specialist practitioner. It might be to another family physician or general practitioner known not to share the referring practitioner's conscientious objection to the patient's request, or for instance to an appropriate nurse practitioner, midwife, or non-physician counsellor who can help the patient to review options for care that include potential outcomes to which the referring physician objects. Depending on local professional practice, there might be a choice of suitable mid-level providers to whom referral would be appropriate. This might mean that general medical practitioners might suitably refer patients requesting abortion or IVF without determining beyond initial discussion whether, by clinical criteria, they are pregnant or infertile. However, objecting specialists might be required to be more precise in determining to whom they refer patients, satisfying the requirements to "provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns", and to "proactively maintain an effective referral plan for the frequently requested services they are unwilling to provide". [8, paras. 12, 16].

The Ontario College policy definition of "effective referral" includes connecting a patient to a "non-objecting … physician, other health-care professional, or agency".[8] An "agency" might include a governmental body or quasi-governmental body such as a professional medical, nursing or midwifery licensing and disciplinary authority, a voluntary professional association, a private sector community agency such as a family planning association or an association addressing infertility, or a community self-help society concerned with a relevant concern or healthcare need. Such agencies might both relieve objecting physicians of searching for suitable referees, and patients of the uncertainty of finding them. Professional medical associations in particular would serve well to equip themselves to be able to advise, at local levels, to whom their members could effectively refer their patients' for convenient access to services to which the referring members object.[9]

7 | APPLICANT PATIENTS

Traditional understanding is that physicians do not owe legal duties of professional care to those who are not their patients. There is no general legal duty on physicians to be Good Samaritans. If people who are not their patients ask to become their patients, for services the physicians cannot, or, on grounds of conscience, will not, provide, they can decline without incurring any duty to refer the applicants to others. However, legislation or professional policies might impose legal duties of care in emergency or other circumstances. For instance, the policy on human rights of the College of Physicians and Surgeons of Ontario provides that physicians must "take reasonable steps to accommodate the needs of existing patients, or those seeking to become patients, where a disability or other personal circumstance may impede or limit their access to care" [8, para. 3].

What resources, including of time, physicians can devote to treating or to referring those they have not accepted as patients is a legitimate concern in determining discharge of the professional duty of respect and confidentiality. The Ontario College policy on the duty to accommodate allows an exception when accommodation would "(a) subject the physician to undue hardship, i.e. where excessive cost, health or safety concerns would result, or (b) significantly interfere with the legal rights of others" [8, para. 4]. The legal rights of others include the rights of existing patients to receive an appropriate standard of care, which is a matter of professional practice under judicial oversight.[16] For everyone, however, it is widely if not universally accepted that "[p]hysicians must provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their conscience or religious beliefs" [8, para. 17].

CONFLICT OF INTEREST

The author has no conflict of interest.

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