Conscientious objection and physician-assisted suicide: a viable option in the UK?

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ABSTRACT

Conscience objection is a proposed way of ensuring that medical practitioners who object to physician-assisted suicide may avoid having to be involved in such a procedure if this is legalised. This right on the part of healthcare professionals already exists in certain circumstances. This paper examines the ethical and legal grounds for conscientious objection for medical professionals and shows how it is heavily criticised in circumstances where it is already used. The paper comes to the conclusion that as the grounds and application of conscience objection are no longer as widely accepted, its future application in any legislation can be called into question.

INTRODUCTION

This article is not concerned with defending or arguing against the legalisation of physician-assisted suicide (PAS), that is, a suicide that involves the medical profession in its process, neither does it seek to defend or destroy the concept and practice of conscientious objection per se. We are concerned with the matter of a medical practitioner's freedom to refuse to take part in particular, controversial medical procedures or interventions that she/he believes for moral reasons to be wrong. We will interrogate both the ethical and societal arguments and premises that underpin an entitlement to conscientious objection. We will also examine current UK case law and proposed statute as empirical evidence for how conscientious objection is interpreted. This will help us define and identify current application in clinical practice to see whether it remains, or ever was, fit for purpose as a meaningful clause in any PAS legislation. It is important to note that this discussion relates to PAS solely as euthanasia is not part of any current proposed change in law or practice.

WHY CONSCIENTIOUS OBJECTION AND PALLIATIVE CARE?

Circumstances considered to justify conscientious objection are when the required practice violates a practitioner's personal morality or belief. However, it also must not result in direct or invidious discrimination against the patient. Those invoking conscience to withhold withdrawing their service of conscience are duty-bound to refer on to another clinician without such sensibilities.[1] Currently medical examples concerning life and death are termination of pregnancy and withdrawal of life-sustaining treatment on Intensive Therapy Unit. Generally, these areas do not involve palliative care directly; however, debate and any legislation of PAS, in the public mind at least, are cast as having palliative care at its heart and a direct involvement in its future. In contrast, if surveys of specialist doctors in the field are to be believed, resistance to the legalisation of assisted suicide among palliative care specialists is overwhelming. As Lord Falconer, in the Bill that was rejected,[2] and other supporters of PAS state quite clearly, because conscientious objection is valid for equivalent situations involving life and death in healthcare (termination of pregnancy[3]), PAS should be no exception. Therefore, it is argued that space for objection and conscience would still be permitted.

At first sight this may seem a sensible and pragmatic compromise to allow PAS while protecting the freedoms and integrity of concerned practitioners with a personal moral objection. Indeed, the assisted suicide lobby can claim it is a fundamental right for physicians to be granted this option. This is why examination of conscientious objection, and the firmness of its foundation in healthcare, is both relevant and pressing. There are two interconnected, and in our view

fatal, weaknesses to its application: the change in society's view of professions and their autonomy and the recasting of the clinician–patient relationship—with case law and proposed statute providing evidence for this stance.

THE GROUNDWORK FOR CONSCIENTIOUS OBJECTION

The foundations for conscientious objection in a given practice lie in the definition of what we understand by a 'profession', yet profession as a concept is difficult to define. Friedson (in Etizioni, 1969),[4] a sociologist, surveyed all jobs claiming to be a profession to find similarities in structure or method of practice. Cardinal features were a level of autonomy both to administer the profession internally and to define its role in society. A profession is therefore responsible for selection, training, discipline and exclusion of its members. This autonomy and its authority were mandated by that profession's social contract with society and turned on a society's recognition and agreement that the relevant profession's practice was both too complex for the public to understand and the profession could be trusted under this social contract to police and administer itself. In medicine, this is encapsulated most clearly in what is known as the Bolam test—in which a potentially negligent practitioner is measured against the actions of 'a responsible body of medical opinion'. The plumbline of an individual's practice is what other suitably competent practitioners would do.[5] Even though this has had legal challenge previously, the standard by which practitioners are measured is still at heart the Bolam test.

The basis of a conscientious objection must also lie in a particular profession's definition and agreement that something particular within its scope of practice may present legitimate moral difficulty for some of its members when society wants and expects medicine to offer the service. While at this level of individual autonomy for the practitioner allows the healthcare professional to refuse to conduct a particular service, it still remains the clinician's duty to refer on to another practitioner who will. Therefore, conscientious objection rests on what the profession defines as its scope of practice and certain activities where members are free to decline their involvement. Using the language of ethics, autonomy in clinical practice is not the exclusive domain of any one group in a transaction; three autonomies are in play: the patient's autonomy, the profession's autonomy and the individual practitioner's autonomy.

CONSCIENTIOUS OBJECTION IN CURRENT PRACTICE IN THE UK

The problem with some forms of contract theories is that they are based on a presumption of consent at the time they are made and as such are presumed to be valid from the time they are formed. In other words no one has conducted a survey or referendum of the public at the time the contract is drawn up nor any late date—it is just presumed that the public consents (cf Thomas Hobbes). It can be argued that there are conflicting definitions of what contract theories are—and how explicit and informed they need to. Despite this at the heart of any type of contract theory is societal consent and this must be continued consent—no matter what form this contract may have.

The Western society is now arguably predominantly rights-based and can be seen as viewing all things as commodities. Medicine is no exception and this in turn removes the foundation on which conscientious objection relies. It redefines the notion and weightings of multiple autonomies irrespective of what was in the original social contract between medicine and society. Conscientious objection therefore is necessarily open to challenge. Some see it to have no role as the rights of the patient trump the practitioner's rights and by respecting conscientious objection the rights of the patient are being impaired.[6] Some argue that the profession has no autonomy but should follow what the public require of it. The judgement in Montgomery,[7] where the standards for the adequacy of consent were clarified, is an example. The court makes clear that this does not rest with the standard practitioner but with the standard patient. UK law specifically has also, by extension, narrowed the remit of conscientious objection only to the act itself—meaning that some feel that the right to refuse has been impaired further.[8] The authors would not necessarily agree that the patient does have such a right, but there is no denying that the ground for practitioners to be able to exercise autonomy is shrinking within the UK as healthcare is being seen as a commodity to which a patient has an unlimited right. Healthcare practitioners' role as gatekeepers is therefore being challenged.

So where does this leave autonomy generally, given that any interaction faces potential conflict in competing autonomies, their relative weighting and inevitable negotiation and compromise? In particular where does this leave conscientious objection, which appears now no longer to be under the administration or authority of a profession? May an individual be granted the right to withdraw, while remaining in the profession or does objection mean they are no fit for it? In short, would a pacifist be able to serve in an army's active fighting unit yet be able to refrain from combat, or would it be reasonable to say that their views and beliefs automatically bar them from the job. Clearly so, why on earth then should someone be able to practise in a branch of medicine in which their morality prevents them from fulfilling their specific and preknown duties of care? Through this lens, a gynaecologist who refuses to terminate pregnancies should not entertain being in that specialty[6] because the procedure is a key element of the service. While we can soften this position by arguing that work colleagues without such qualms

could take the work, they may object justifiably to having their clinical practice determined as much by the sensibilities of colleagues as by their own clinical judgement. One could imagine that one could therefore have a department where no gynaecologist is willing to conduct abortions—and a hospital which is unable to offer the procedure, which would be untenable. One could also imagine that gynaecologists could be interviewed and granted jobs depending on their moral stance on termination—which is clearly discriminatory. It is therefore argued that the obvious solution for all must be to get out of that specialty or indeed not to train in that specialty in the first place.

WHERE DO RIGHTS COME IN?

Instead of Friedson's[4] traditional view of a profession and its contract with society, there is a more accessible and contemporary starting point to consider the respective entitlements of the doctor and the patient: the purpose of the relationship itself and for who the interaction is there. This sees through the eye of the recipient (patient) and not the professional. Here conscientious objection looks wrong.

This current social perspective on joint decision-making emphasises the equivalence in relationship of the patient and the doctor and is a much more persuasive justification to see the patient's autonomy as sovereign[8] and a doctor's entitlement to trigger conscientious objection as an unjustifiable impediment to the fundamental rights of a patient in the relationship.

While there are two sides to the rights dialectic, it is our Western communities' totem that a professional's duty is to provide what is requested unless an over-riding reason exists that is held by a body of the professional to refuse it, the most relevant example of which is Cardio Pulmonary Resuscitation (Tracey[9]). A medical professional is not duty-bound to provide a treatment that will not work or the burdens or harms of giving it are disproportionate. The problem is who defines the benefit or harm. The individual professional's ability to define this harm is shrinking, and harm as perceived by the patient is being given greater consideration.

In rights-based societies conscientious objection remains justifiable in itself as an individual freedom, but not by being expressed at the expense of someone else's entitlement within a professional relationship. If a doctor enters the profession, it is argued by some, they must follow its agreed and mandated duties in their sphere of practice, and a specific, relevant conscientious objection ceases to be an option in their professional life.

EMPIRICAL EVIDENCE: LEGAL POSITION WITHIN UK LAW

We have discussed the basis of conscience from its ethical foundation. We have argued that the autonomy given to professionals is being eroded and that patients' rights are seen to supersede professionals. These claims may seem difficult to substantiate—but we would argue that this stance is confirmed by the legislation that exists concerning termination of pregnancy within UK law as this has gradually changed too. As we have discussed, it is stated that the conscience clauses that exist in the circumstance of doctors refusing to participate in termination would be applied to the practice of PAS.

Conscience was incorporated in the 1967 Abortion Act.[3] In 1988, in a case brought by a medical secretary, the limit of conscience in medicine was demarcated clearly by the House of Lords to the actual act in question—in this case to the actual performing of an abortion.[10] The Lords interpreted the word 'participate' in its '*ordinary and natural meaning*', which meant that s4 (the conscience clause) only applied to those clinicians required to take active part in the abortion itself. Ms Janaway, who was a medical secretary, had refused to type a letter referring a person for a termination as she felt this 'set the ball in motion'. However, she was not covered, even though for her this was an active participation and was as close as she could come to it. She lost her job.

In 2014 the matter of what was meant by participation was nailed down in law by Lady Hale in a further case[11] that came to the Supreme Court. The presiding judges reversed a Scottish court's decision that the 'Conscience Clause' in the Abortion Act 1967 applied to midwives who have a conscientious objection to providing care for someone having a termination. The Supreme Court reiterated that 'participation' only constituted the direct performance of an abortion, there was no legal exemption from being required to give other material support, and that this included the process of care. Lady Hale clarified and tested what Parliament would have had in mind in allowing a practitioner's conscience to over-rule their participation. In a comprehensive analysis, she considers the scope and limits of participation for all manner of staff and the system as a whole. Her conclusion, which is difficult to argue against, is that it is clear that 'Participation in my view means taking part in a 'hands-on' capacity'.

The Conscientious Objection Bill[12] is discussing this further and there is discussion about widening the remit of conscience. It has passed through the committee stage and awaits a report. The debate at committee stage is broad-ranging, comprehensive and is worth reading to see the complexity and strength of views. The matter is by no means settled but shows clearly that to see conscience as a safe haven is unwise as it will take a lot to reverse the Supreme Court ruling on Doogan.

The general effect of Janaway and Doogan turns now on what is meant much more explicitly by 'hands-on' and would suggest where legalisation of PAS is concerned, that a doctor refusing to sign a prescription for lethal drugs in someone wanting them for their

suicide, or declining say admission under their care to a hospice because they wanted medically assisted suicide, may well not be protected by a conscience clause as it is insufficiently hands on. For a doctor, the signing of an Abortion Certificate, for example, is insufficiently close to participation in the termination to fall under s4 and this feels very much like the writing of a prescription for lethal drugs, where the decision to take them or not sits with the patient and is the hands on element—is making the bullet participation, or does it require one to pull the trigger?

CONCLUSION

The moral and practical arguments for and against PAS itself remain and fall outside this article. What we have sought to highlight is that there are significant changes in the ethical understanding and the legal standpoint of conscience since the 1967 Abortion Act. As we have discussed, conscience is not universally assented to and there has been a change in the emphasis given to the right of the individual. The law has reflected this—as what a practitioner can object to has become increasingly narrow. In short conscientious objection is a fig leaf that is withering.

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