5.3.1 Conscientious Objection to Medical Assistance in Dying (MAiD)
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Educational Objectives
• Describe the Canadian laws and professional guidelines regarding refusals to participate in the provision of medical assistance in dying (MAiD)
• Describe the rights and obligations of physicians who conscientiously object to MAiD
• Describe the nature of conscience and of a refusal grounded on conscience
• Consider personal, professional, and social values that may inform beliefs surrounding MAiD

Case
Sam, a 62-year-old man, was diagnosed with Amyotrophic Lateral Sclerosis (ALS) three and half years ago. He is wheelchair bound and receives four hours of homecare support. He recently relinquished his driver’s license after he began having difficulties breathing and performing some of the basic activities of daily living, including dressing, toileting, and showering. He was prescribed medication for pain management. Sam lives in a rural community and has no family and few friends. He has asked his neurologist, Dr. H. (who has been the only physician involved in his care since his family doctor retired) about whether he can access MAiD. Sam knows that as his illness progresses he will eventually lose the ability to speak and communicate. The thought of this terrifies Sam. He tells Dr. H. that he is ready to die. Dr. H. tells Sam that he does not believe that he has reached the stage where MAiD is a reasonable option and that in addition, he cannot participate in a process leading to ‘premature death’ as a matter of personal conscience. He claims that causing a patient’s ‘premature death’ is morally wrong. Further, Dr. H. tells Sam that he also works at a hospital that objects to MAiD on religious grounds and will not provide this service to patients. He tells Sam that he will continue to provide him with more pain medication, additional home care, or other supportive care options. Dr. H. tells Sam that he is willing to send him to a different physician if he wants to be assessed for MAiD, but Sam declines because he feels ashamed for having asked Dr. H. about MAiD. Sam worries that this conversation may have damaged his relationship with his neurologist and Sam is unsure if he will continue to receive good medical care. Sam does not speak to any other healthcare professionals about his wish to die, although his desire to access MAiD persists. Four months after speaking with Dr. H., Sam lost the ability to speak, his breathing became much more difficult, and he experienced frequent aspiration. He no longer has the ability to communicate. He was recently admitted to a palliative care unit, where he continues to reside.

Questions
1. How might we understand Dr. H.’s refusal to participate in MAiD?
2. What are the ethical considerations that support conscientious objection in healthcare?
3. What are the ethical concerns about conscientious objection in healthcare?
4. Which Canadian laws and guidelines are relevant to conscientious objection to medical assistance in dying?
5. Did Dr. H. fulfil his legal or professional obligations towards Sam?
6. How should Dr. H. have managed his conscientious objection to medical assistance in dying?
Discussion

Q1. How might we understand Dr. H.’s refusal to participate in MAiD?

According to Dr. H., he refused to provide MAiD to Sam because of his moral opposition to physicians participating in a process that directly leads to the patient’s death. He also suggested that MAiD was not an appropriate treatment for Sam and that his employment within an objecting institution prohibited him from providing MAiD. In healthcare, refusals to act or refrain from action on the basis of moral convictions are described as conscientious objections (Pellegrino 2002; Wicclair 2014, p. 268). Although the nature of conscience is widely debated, most generally, it is understood as a personal inner voice that expresses moral judgments and commitments that can compel an individual to act or refrain from acting (Durland 2011, p. 1670). Acting in accordance with one’s deeply held moral convictions supports one’s moral integrity and can contribute to self-identity (Childress 1979; Wicclair 2011). Conscience can be retrospective in nature, when we judge the moral status of a past action. Or, as with Dr. H., it can be prospective insofar as we judge the moral permissibility of things that we anticipate doing or not doing in the future (Sulmasy 2008, p. 135). Conscience can also be secular or religious in nature (Lawrence and Curlin 2007). Furthermore, the content of one’s conscience can be derived from or shaped within social contexts and relationships. Fitzgerald (2014) argues that a “well-functioning conscience” requires a certain level of self-awareness of one’s attitudes and beliefs, which in turn requires social feedback. As such, healthcare professionals may require specific training to help develop and maintain a well-functioning conscience. Refusals to provide treatment on the basis of conscientious are different from refusal to provide treatment on the basis of clinical judgement or ability, however, both types of refusals can compromise a patient’s ability to access healthcare services if they are not given sufficient information or a referral to be able to access services form another provider.

Conscience is an inherently human capacity, yet some people affirm that hospitals and other healthcare institutions can conscientiously object to providing certain healthcare services, on the grounds that they have institutional moral commitments (Sulmasy 2008). Others maintain that institutions cannot have a conscience or make a conscientious objection (Durland 2011; Dickens and Cook 2000). In the context of MAiD, some faith-based organizations are refusing to provide MAiD on the basis of an institutional conscientious objection. Yet, in Canadian jurisprudence, freedom of conscience only holds for individuals, not for institutions. If there were support for institutional conscience, it could undermine the affirmative aspect of individual conscience, such that institutional conscience could require physicians and other employees to act in accordance with the institutional guidelines, physicians would be unable to exercise their own conscience if it disagrees with the institutional practices. In the context of MAiD, a physician willing to provide this service could have some difficulties doing so within an institution that refuses to offer MAiD. If Dr. H. had been willing to provide this service, his participation in MAiD would have constituted a conscientious refusal of hospital policies against the provision of MAiD.

Q2. What are the ethical considerations that support conscientious objection in healthcare?

Conscientious objections might be justified on individual, institutional, or social grounds. For individuals, allowing conscientious objections in healthcare can promote physician autonomy (Meyers and Woods 2007). It can also promote a physician’s moral integrity and help to avoid the internal psychological suffering (guilt, self-criticism, and negative self-conception) that can result from acting in opposition to one’s conscience (Huxtable and Mullock 2015, 246). Individuals who object on religious grounds might also experience psychological suffering if they act against their conscience. For example, they may be judged or punished,
through suffering actual or perceived harm or stigmatization from other members of their religious community. Thus, Dr. H.’s conscientious objection may have a strong moral basis, but this right to object does not give him the right to abandon his patient.

At the institutional level, some argue that respecting conscience and allowing for objection can respect and foster physician’s professional or clinical judgment. For example, fostering the development of physicians’ conscience can be useful in clinical contexts that have serious time constraints in which physicians must make a quick decision and where there is insufficient time for critical reflection. The “pang of conscience” might help physicians to make better decisions and even defy the authority of superiors or institutions (Birchley 2011). The nature and scope of physician conscience is bound up with questions about the goals of medicine (Hardt 2008) and some worry that failing to respect physician conscience could significantly jeopardize physical or psychological health of patients (Sulmasy 2008; Wicclair 2011). Respect for conscience can also demonstrate tolerance for a diversity of moral beliefs and perspectives among healthcare providers.

At the social level, respect for individual conscience represents a level of ethical humility (Sorabji 2014: 139). That is, we cannot be certain that we know or can adequately discern moral truth. This humility may serve as a “true basis of tolerance” in healthcare (Sulmasy 2008: 144). Personal conscience may be intrinsically valuable within a free society. Physicians who are opposed to MAiD should, nevertheless, act in a manner that is respectful of their patients and should ensure that their patients receive appropriate care. In Sam’s case, Dr. H. could have handled the request for MAiD differently by ensuring that he exercised his conscientious objection in a manner did not compromise Sam’s request / need to discuss his wishes surrounding suffering and death.

Q3. What are the ethical considerations that challenge conscientious objection in healthcare?

Those who are critical of conscience cite concerns with the private nature of conscience, emphasize professional obligations to patients, and raise concerns about justice and access to healthcare services. First, conscience is private, so biases, prejudices, and other inappropriate beliefs can be masked under the veil of conscience. Insofar as objections can have a type of veto power, a refusal based on conscience can be viewed as a way to immobilize discussion and debate. In some contexts, conscientious objectors may be required to provide justifications for their beliefs as either a test of authenticity or as a way to allow for discussion and debate (Kantimer and McLeod 2014). There may be less of a need to do so within the context of MAiD because professional duties to provide patients with information or referrals can alleviate concerns related to the potential for such veto powers.

Nevertheless, a perceived veto power can exacerbate the power imbalance between physicians and patients and fail to respect patients’ values (Schuklenk and Smailling 2016). Dr. H.’s refusal to provide MAiD may have contributed to Sam’s fear of approaching another physician for information about MAiD. In patient-centred health care, medical decisions should reflect patient values, not physician values. Some argue that one’s professional obligations to patients ought to trump any value that conscience might have (Savulescu 2006; Giubilini 2014; Kolers 2014; Schuklenk and Smailling 2016). Further, some suggest that insofar as becoming a physician is voluntary, conscientious objectors should choose different professional activities if they are unwilling to fulfil their obligations to patients (Schuklenk and Smailling 2016). It may be the case that physicians who choose to practice in rural or remote areas have a particularly strong professional obligation to provide patients with the services that they are legally entitled to receive. This is because these physicians
have chosen to practice in areas with few or no colleagues to support them in cases where they may object to participate based on conscience.

Some argue that allowing for conscientious objection can risk patients’ abilities to access services (Minerva 2015) and suggest that patients may have to engage in a type of “doctor shopping” in order to find a willing physician (Mullock, 2015). Conscientious objections can result in inequitable workloads for physicians who are willing to provide a particular service and cause unfair healthcare service delivery (Schuklenk and Smalling 2016, p 4-5). If too many physicians object, it can make it nearly impossible for some patients, especially those who live in rural or remote areas to find another physician who is willing to provide the desired service. This can be seen as medical abandonment and cause some patients to experience unnecessary or prolonged suffering.

**Q4. What are the legal grounds of a physician’s right to conscientious objection to medical assistance in dying?**

According to the Universal Declaration of Human Rights, everyone has the “right to freedom of thought, conscience and religion” (Article 18, 1948). This basic human right is reaffirmed in section 2(a) of the Canadian Charter of Rights of Freedoms. The Supreme Court of Canada decision in *Carter v. Canada (Attorney General)* and Canada’s Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), both affirm that physicians, like any other citizen, have a right to freedom of conscience. The Court noted that any legislative and regulatory response to its decision in *Carter* must reconcile the Charter rights of both patients and physicians. Thus, balancing the rights of medical providers and those of patients is generally a matter of provincial and territorial responsibility.

Neither the Court nor the federal legislation addresses whether physicians who refuse to assist a patient in dying on moral or religious grounds are required to provide the patient with an effective referral, that is, one that is made in good-faith to a non-objecting, available, and accessible healthcare provider or agency. Some physicians may worry that a referral can be seen as compromising their moral integrity in a way that is similar to personally providing medical assistance in dying.

Québec is currently the only province with legislation relating to medical assistance in dying. *Bill n°52: An Act Respecting End-of-life Care* was enacted in 2014. In Québec, a physician who refuses on the basis of conscience must report their objection to the director of her institution. The director is then obligated to find a physician who is willing to perform MAiD. Physicians must also fill out a form notifying an agency, **Le Groupe interdisciplinaire de soutien (GIS)**, each time they receive a request for MAiD. The GIS assists patients in the MAiD eligibility review process and facilitate the provision of MAiD, where applicable. The reporting structures for MAiD in Québec have helped to reduce concerns related to conscientious objection by implementing structural mechanisms for managing MAiD.

There are currently no other provincial or territorial MAiD legislation in Canada. Provincial medical regulatory Colleges outline provinces-specific guidelines for managing conscientious objections to MAiD (See Environment scan chart). To date, many of the guidelines require that physicians who object to assisting patients to die to provide patients with sufficient information and resources to enable informed choice and provide care options. More widely debated, however, is whether objecting physicians have an obligation to provide an effective referral or transfer of care to a willing provider. To address concerns about the availability of MAiD information and services, some provinces have set up referral of transfers of care hotlines and centralized bodies to provide MAiD information to patients.
Some provinces and territories have also allowed faith-based healthcare institutions to refuse to provide MAiD on the basis of ‘institutional conscience.’

**Q5. Did Dr. H. fulfil his legal or professional obligations towards Sam? How should Dr. H. have managed his conscientious objection to medical assistance in dying?**

In Sam’s case, Dr. H. exercised his constitutional right to conscientious objection. Yet, he failed to fulfil his legal and professional duties towards his patient. Dr. H.’s enjoyment of the right to conscientious objection also tasks him with an obligation to provide Sam with information about MAiD and to provide Sam with either an effective referral to another physician or agency or information about how to access such services. Although Dr. H. mentions that he can “send” Sam to another physician, the manner in which he provided Sam with information failed to demonstrate adequate respect for Sam’s right to explore MAiD. Moreover, as evident in the case above, Dr. H.’s response to Sam’s inquiry about MAiD resulted in Sam feeling shame for having broached the topic. It is likely that Sam’s conversation with Dr. H. unduly negatively influenced his ability to accept a referral or speak about MAiD with another healthcare provider.

Dr. H. could have managed his conscientious objection to MAiD differently. First, when Sam asked about MAiD, Dr. H. should have recognized this as an invitation to discuss Sam’s wishes, beliefs, and values surrounding his illness, suffering, life, and death. For example, Dr. H. could have asked Sam what he fears and wishes surrounding suffering and death and what is important to him at the end of life. Dr. H. could have also asked Sam if he would like to continue this conversation with a counsellor or receive additional social support. Second, Dr. H. should have ensured that the language used to express his conscientious objection was non-judgmental. For example, instead of questioning Sam’s belief that MAiD was a reasonable option, Dr. H. could have affirmed Sam’s belief and suggested that they discuss the full range of options, which could include MAiD. Furthermore, instead of asserting that he believes that MAiD is “morally wrong”, Dr. H. could have simply said that he is not able to provide MAiD for personal reasons but would be willing to provide Sam with a referral to another physician or agency. The assertion that a practice is ‘morally wrong’ can unduly influence patients’ confidence, self-conception, and decision-making.

Third, depending on the province or territory within which Dr. H. and Sam reside, there is a procedure for ensuring that the obligations to support patients’ informed choice and access to MAiD is fulfilled. Dr. H. had a professional obligation to ensure that Sam was either given an effective referral or transfer of care to another physician, or that an agency, such as the GIS (in Quebec), was notified of Sam’s request. Dr. H. should have made it clear to Sam that he had a right to discuss and access a process to assess if he met the requirements to access MAiD services.

In the end, Sam may not have chosen to access MAiD, but regardless, the opportunity to discuss his wishes surrounding suffering and death would have been beneficial for Sam. Dr. H. should have ensured that he exercised his conscientious objection in a manner that demonstrated respect for Sam’s values and beliefs and also promoted his autonomy and well-being.

As the provision of MAiD continues it will be increasingly important for provinces and territories to devise effective measures and procedures for respecting the Charter right of individuals who choose to practice medicine, while also providing patients with timely and comprehensive information and access to MAiD.
References

1. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) (formerly Bill C-14), 1st Sess, 42nd Leg, Canada, 2016 (assented to June 17, 2016).
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