Legal and Ethical Issues in Physicians Right of Conscientious Objection in Healthcare Service Delivery: A Comparative Reflection.

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INTRODUCTION

Many practitioners in the health care sector decline to render certain professional services to patients on the ground of having conscientious objection to such services. This has inevitably attracted hot debates and controversies. Some believe it is not consistent with the professional responsibilities and ethics of health care professions for practitioners to deny necessary (therapeutic) treatment to patients while some others hold the view that it is indeed illegal and contravenes constitutional rights of patients to have access to medical care. Concerned practitioners argue on the other hand that they are as entitled as any other person to refrain from participating in any procedure to which they object on the ground of conscience and that the fact of their being in the care sector does not obliterate their constitutional right to conscience and to make reasonable private choices that guarantees the dignity and security of their person.

In Nigeria, as in most parts of the developing and developed world, the health professions are statutorily regulated and practitioners are subject to specific rules and code of professional conduct.[1] I examine in this paper the dilemma raised by conscientious objection that healthcare service providers (HSPs) or health care practitioners (HCPs), particularly doctors.[2] Services to which HCPs may object on the basis of conscience includes, but are not limited to, abortion,

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[1] Refer, for instance, to Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria made by the Medical and Dental Council of Nigeria by virtue of its powers and responsibilities under the Medical and Dental Practitioners Act 1988.

[2] Medical doctors, Nurses and Pharmacists shall be taken as representative of the broad category of health care service providers or health care practitioners in this paper. Emphasis shall however be placed on medical doctors in this paper for reasons of space and convenience. To a large extent however, whatever applies to medical doctors in this regard would suffice for pharmacists and nurses.

contraception, euthanasia, assisted reproductive technology procedures as well as purely cosmetic surgery or sex reconstruction. How does such objection balance with their legal and ethical duties to care for patients, respect the autonomy and privacy of the patients and the principle of beneficence? On the other hand, are HCPs legally or ethically bound to render professional duties without regard for or due respect paid to their own moral, religious or conscientious stands, or constitutional rights?

I hold the view and argue in this paper that medical doctors (for HCPs generally) in Nigeria, as elsewhere, have heavy responsibilities to patients that cannot be excused on flimsy grounds. I equally hold however, that strongly held conscientious objection cannot be described as flimsy, unreasonable or inconsistent with professional ethics or legally imposed duties and obligations of practitioners. I reason that 'conscience' is an integral part of the total person and that fairness and justice demands that rights recognized for patients cannot be justifiably withheld from practitioners. I conclude that the obligation to refer or give some measure of treatment to patient, despite the conscientious objection, is arguably a necessary compromise but is nevertheless a compromise that may only be compelled in emergencies where the life of the patient might be saved by such an intervention.

DUTIES AND OBLIGATIONS OF HEALTH CARE PRACTITIONERS

Once a professional relationship exists between a medical doctor and a patient, a duty of care arises requiring the practitioner to employ appropriate degree of skill, care and professional competence with regard to the health need of the patient.[3] Failure on the part of the

[3] This relationship is brought into existence in a number of ways the commonest of which is a coincidence of request for treatment by or on behalf of the potential patient and an acceptance or undertaking on the part of the health care practitioner to render the services. For a view that practitioners, especially doctors, may still be under a legal or professional duty to render assistance if requested, even if the person in need is not their patient, see, Gerald Robertson, Negligence and Malpractice, in Downie, J., et al, Canadian Health Law and Policy, 2nd ed. (Canada: Butterworths, 2002), pp. 91-92; see also, s.18 of the Canadian Medical Association Code of Ethics which states that doctors have an obligation to 'Provide whatever appropriate assistance you can to any person with an urgent need for medical care' (emphasis, mine).

practitioner to measure up to the expected standard of care or degree of professional competence, amounting to a breach of his/her legal duty and resulting in injury to the patient may lead to liability in negligence.[4] Negligence may also be inferred where a practitioner who does not have access to particular equipment fails to refer the patient to another facility which does or where the care required by the patient exceed his competence, he fails to refer the patient to the appropriate specialist or to inform the patient of the availability of required care elsewhere.[5] Similarly, a practitioner may make himself/herself liable for negligence or malpractice action where he/she abandons a patient or fails to timeously attend to the need of the patient.

Perhaps the most significant concept to have influenced contemporary medical law and ethics is that of patient autonomy. The concept requires that individual patients should have control over their own bodies and should make their own decisions relating to their medical treatment.[6] The concept is a broader counterpart of the common law doctrine of informed consent or informed decision making the basis of which is that every person has a right to self determination, personal agency and respect for his or her choices.[7] The exercise of this cluster of rights depends on adequate information being given by the physician to the patient with respect to the nature, expected benefits, material risks and side effects of the proposed treatment.[8] It also extends to information regarding alternative

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[4] For a detailed discussion of medical negligence and malpractice issues, see, Gerald Robertson, ibid; see also, Mason, J.K., and Laurie, G.T., Law and Medical Ethics, 7th ed, (Oxford: Oxford University Press, 2006) pp305-21.

[5] See, Gerald Robertson, op cit, p.95.

[6] See, Mason and Laurie, op cit, pp 6-7.

[7] See, Schloendorff v Society of New York Hospital 211 N.Y. 125, 105 N.E 2d 92 (N.Y. Ct. App. 1914) where Justice Cardozo stated that 'every human being of adult years and sound mind has the right to determine what shall be done with his own body', at p.93. See also, Dr. Rom Okereke v. Danjuma Tanko [2002] 9-11 SCNJ, 1; Medical and Dental Practitioners Disciplinary Tribunal v. Dr. J.E.N. Okonkwo [1999] 9 NWLR (Pt 617), 1.

[8] It will be professionally negligent, for instance, for a medical or dental practitioner to fail to give proper advice to a patient on the risks that are

courses of action open to the physician and the likely consequences of not having the treatment.[9] In the words of Prof Bernard Dickens,

> The legal role of information is to serve the patient's autonomy, permitting the patient to exercise choices among feasible options that accord with his or her own wishes……Autonomous persons may direct themselves by their wishes even when these may conflict with their apparent interests; they do not live in a therapeutic state in which cadres of medical or other professionals may determine and impose upon them their 'best interests'.[10]

The concept of respect for patient autonomy is also an integral part of the general principles of medical ethics or bioethics. It specifies that individuals must be respected as independent moral agents with the right to choose how to live their own lives.[11] Other principles in this category includes, beneficence (one should try to do good where possible), non-maleficence (one should avoid doing harm to others) and justice (people should be treated fairly).[12]

It is also relevant to state that professional bodies often times specify ethical rules that govern their members in the discharge of their responsibilities and may impose sanctions on those who contravene such rules.[13] In this regard, the Medical and Dental Council of Nigeria made some rules guiding professional conduct for medical

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[9] attendant to a particular course of treatment or operation', see, Rule 10 (d), Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria, supra.

[10] See, Hoffman, B., The Law of Consent to Treatment in Ontario, 2nd ed, (Toronto & Vancouver: Butterworths, 1997), p. 8.

[11] See, Dickens, B.M., Informed Consent, in, J. Downie et al, op cit, p 130.

[12] Beauchamp, T.L. and Childress, J.F., Principles of Biomedical Ethics, 5th ed, (New York: Oxford University Press, 2001), pp. 57-77.

[13] Ibid, pp57-272; see also, Mason, J.K., and Laurie, G.T., op cit, pp4-5.

and dental practitioners in the country.[14] According to the Rules, prospective medical and dental practitioners are expected to make a Declaration that: 'I shall exercise the several parts of my profession to the best of my knowledge and ability, for the good, safety and welfare of all persons committing themselves to my care and attention….' (emphasis mine). They also subscribe to the Physician's Oath which states, inter alia:

> …The Health of my patient will be my first consideration, I will not permit considerations of religion, nationality, race…to intervene between my duty and my patient, I will maintain the utmost respect for human life from conception;…[16]

Practitioners are expected to be strictly guided by these declarations and other rules of conduct as prescribed by the professional regulatory bodies. Similar rules govern practitioners in other countries. For example, the Canadian Medical Association stated in its Code of Ethics, that Canadian physicians should among others, consider first the well-being of the patient,[18] practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect,[19] resist any influence or interference that could undermine their professional integrity,[20] refuse to participate in or support practices that violate basic human rights,[21] promote and maintain their own health and well-being,[22] inform patients when personal values would influence the recommendation or practice of

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[14] See note 1 above. The key objectives of the Rules are to 'enable medical and dental practitioners in Nigeria maintain universally acceptable professional standards of practice' and to meet the demands of the Council 'with regard to ethics and quality of professional practice'; see Rule 1.

[15] Ibid; Rule 3.

[16] Ibid. See also Rule 5 which partly states that 'A doctor must always bear in mind the obligation of preserving human life…'. Other relevant rules will be examined later in this paper.

[17] See, Canadian Medical Association (CMA) Policy, CMA Code of Ethics (Ottawa: Canadian Medical Association, Update 2004).

[18] Ibid, s. 1.

[19] Ibid, s. 2.

[20] Ibid, s. 7.

[21] Ibid, s. 9.

[22] Ibid, s. 10.

any medical procedure that the patient needs or wants;[23] avoid discriminating against any patients on grounds such as age, gender, marital status, medical condition, religion and so on;[24] continue to provide medical services to patients for whom they have accepted responsibility until the services are no longer required or until another suitable physician has assumed responsibility for the patient or until the patient has been given reasonable notice that the physician intends to terminate the physician-patient relationship;[25] provide patients with the information they need to make informed decisions about their medical care,[26] respect the right of a competent patient to accept or reject any medical care recommended.[27] The Association stated that the specified codes are 'based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability.'[28]

Professional codes of ethics especially as specified by responsible bodies in the regulated health care professions cannot be treated lightly and actions based on them are given the force of law.[29] Some of the issues covered by the codes, especially comprehensive ones like the CMA Code of ethics, are subjects of statutory provisions and constitutional guarantees which give added strength to them.[30] Health care service delivery, especially membership of the professions falling in the health care sector, is usually and oftentimes heavily regulated by the government/ state. In Canada this is covered under the Health Care Act and other statutes,[31] while in Nigeria the provisions of Medical and Dental Practitioners Act[32] applies to the medical and dental professions. This has important implications for

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[23] Ibid, s. 12.

[24] Ibid, s. 17.

[25] Ibid, s. 19.

[26] Ibid, s. 21.

[27] Ibid, s. 24.

[28] Opening statements to the CMA Code of Ethics, note 17 supra.

[29] See note 13 supra.

[30] See the Canadian Charter of Rights and Freedoms, 1982 and footnotes 33-37 below.

[31] For a comprehensive discussion of the nature and extent of the regulation of health care system in Canada, see, Flood, C.M., The Anatomy of Medicare, in, J. Downie, et al, Canadian Health Law and Policy, op cit, pp, 1-54; Linette McNamara, et al, Regulation of Health Care Professionals, in, J. Downie, et al, op cit, pp. 55-80.

[32] Op cit.

practitioners with respect to the exercise of their duties and obligations as may be specified in the relevant statute. In addition to this, Constitutional provisions which guarantee rights and freedoms to individuals are applicable to doctors and other health care practitioners as much as everybody else.[33] The 1982 Charter and the 1999 Constitution guarantees to everyone in Canada and Nigeria, respectively, rights and freedoms of conscience and religion,[34] life, liberty and security of the person,[35] equality and freedom from discrimination[36] and so on. The legality or otherwise of private individual's and institutions' as well as state actions or omissions are measured by their compliance or consistence or departure from the provisions of the Charter or the Constitution as the supreme law of both countries.[37]

It is in the light of the above that I assess in this paper the issue of HCPs conscientious objection to rendering certain professional services required or wanted by their patients.

CONSCIENTIOUS OBJECTION IN HEALTHCARE DELIVERY

Conscious objection arises in situations where a medical practitioner or other healthcare practitioners (HCPs) decline to perform or render or participate in certain clinical, medical or associated procedures required or desired by a patient on the ground that such performance, rendering or participation conflict with his or her values and dictate of conscience. Although religion or convictions of faith is always referred to as the basis of conscientious objection, it could also be founded on moral convictions, dictates of

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[33] See, Canadian Charter of Rights and Freedoms, 1982 and the 1999 Constitution of the Federal Republic of Nigeria.

[34] Ibid, s. 2(a) Canadian Charter and s. 38, 1999 Constitution of Nigeria.

[35] Ibid, s. 7, Canadian Charter and ss. 33, 34 & 35, 1999 Constitution of Nigeria.

[36] Ibid, s. 15 (1) & (2), Canadian Charter and s.42, 1999 Constitution of Nigeria.

[37] Ibid, s. 52(1), Canadian Charter and s. 1 (1) & (3) 1999 Constitution of Nigeria.

conscience, ethical belief or personal values an individual has set to govern his or her affairs in life.

Certain medical procedures have historically attracted controversies, debates and ethical conflicts as to their rightness or wrongness. Abortion has been an issue from centuries. HCPs, physicians and surgeons, pharmacists and nurses, in particular, may object to performing or participating in abortion procedures because they believe it amounts to destroying human life, an activity with which they would not want to be associated. In the past, society has such strong view of abortion that it is usually prohibited with criminal sanctions for breach. Many countries have liberalized their abortion law to allow abortion with little or no restriction imposed, this fact in itself has not tempered emotion on the abortion divide. To some of the practitioners, a situation in which little or no premium is placed on the unit of human life enough to strip it of nearly all legal protection until birth offends their conscience to such an extent that they can not bring themselves to performing or participating in it.

Nearly as much as abortion and to some extent for the same or similar reasons, contraception is another health service that has attracted controversies. Some believe that many methods of contraception have the same effect as abortion or at least act to obstruct the ordinary process of fertilization, implantation and fetal development and for that reason unacceptable to them. This explains why dispensing or recommending emergency contraception has attracted controversies. As for barrier methods of contraception, such as condom and birth control pills, some hold the view that campaigns and promotions of their usage is like encouraging promiscuity and sexual immoralities with which they will not wish to associate.

Euthanasia, or physician assisted death, is another procedure that attracts claim of conscientious objection. Objecting practitioners hold the view that no medical situation is as hopeless as to deem it irreversible and even if a case is patently hopeless, natural death is preferable to hasting, assisting or aiding patient death. This is equated to murder or medical execution of patients. Such practitioner will object to any procedure to withdraw or withhold life sustaining treatment to patients or to turn off life sustaining machine and will decline to perform or participate in it.

The broad area of assisted human reproduction is replete with conscientious objection claims.[38] From the late 1960s to early 1970s when assisted insemination gained popularity, to 1978 when the first test tube baby, Louise Brown was born through the process of In Vitro Fertilization, up to the present time, there have been debates as to the proper role of medicine and health practitioners in assisted human reproduction. The processes of human reproduction ordinarily starts from sexual relations between males and females, results in fertilization and progressive fatal development within the inner recesses of the woman's body and ultimately leads to the birth of the baby.

These processes are to a large extent, in the early period of medical development, hidden from private eyes and human intervention. In modern times, following advances in medicine, they have become subjected to endless manipulation of medical scientists and technologists. There has been separation of sex and reproduction through assisted insemination by donors, in vitro fertilization and all its modern variants, and through surrogacy arrangements. The moral and ethical implications of these, including fundamental effects on the traditional family system are far reaching. The development of the technique of Pre-Implantation Genetic Diagnosis (PGD) has created opportunities for controversial procedures of sex- selection, genetic testing, selective abortion and so on. Allied with these are emerging issues in genetic engineering, stem cell research, xenotransplantation, creating animal-human (chimera) organs and tissues and such other procedures fuelled by advances in bio-medical science and technology. All these represent network of ethical complexities to many individuals including HCPs who has therefore chosen not to be involved in matters relating to them as issues they could not reconcile with or accommodate in their consciences.

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[38] In the U.K. there are two clear areas where statutes made provision for the exercise of conscientious objection, namely, refusal of practitioners to take part in abortion (by virtue of the Abortion Act, 1967) and to participate in technological procedures to achieve contraception and pregnancy (by virtue of the Human Fertilization and Embryology Act, 1990); see McHale, J., and Fox, M., Health Care Law: Text and Materials, (London: Sweet & Maxwell, 1997, p.140.

Several other medical procedures attract or could attract varying degrees of conscientious objections from HCPs. Human medical experimentation or research is a case in point. Many practitioners object to the use of human beings (including human fetus or embryo) for non-therapeutic medical experimentation, the application of innovative drugs or procedures to individuals in the absence of prior knowledge about the risk this might pose to them or any other form of medical experimentation or research in which human beings are used as means to an end rather than treated as ends in themselves. Another good example is (surgical) cosmetic enhancement or non-therapeutic physical reconstructions. The latter is not limited to common procedures of breast enlargement or reduction, sex changes/reconstructions, facials or liposuction but includes drastic procedures such as was reportedly done for the so called 'pillow-angel', Ashley. Ashley was a girl who was suffering from a medical problem which impairs her mental and cognitive development and consequently her ability to manage herself. This makes her entirely dependent on her parents for virtually everything, including mobility.

Her parents decided on a medical procedure involving hysterectomy, removal of her breast bud and hormonal treatment to stunt her natural growth with the goal of keeping her small and manageable. The procedure was performed at a Children's hospital but it has attracted ethical controversies as to whether it was done for her own good or the convenience of her parents, whether it respects her dignity as a person or infringes her right as a disabled person. The professional judgment and ethical standard of the participating physicians and the ethical board of the hospital which approved the procedures have been questioned while some justified the decision to go ahead with the procedures.[39] It is therefore possible for HCP's to object to participating in such procedures on the basis of its incompatibility with their conscience.

I have so far examined some instances where HCPs could claim conscientious objection from performing or participating in some procedures. More often than not, as highlighted above, such objections are founded on convictions that the procedure objected to improperly treats or deal with human life; that it promotes in an objectionable way sexuality, or sexual promiscuity or immorality;

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[39] To read more about this case and comments on it, see, http://ashleytreatment.space.live.com . (Last visited 5th March, 2007).

that it amounts to experimenting with nature, natural selection or in short, that it amounts to humans playing God; that the procedure objected to fiddles with human life in circumstances that the consequences are unpredictable and may potentially harm the society; or simply that it does not sit well with their conception of human dignity, preservation of the family institution or their own physical, psychological, emotional or spiritual health and well being.

Some people may readily concede right to conscientious objection to general members of the society but they might find it totally unacceptable as far as HCPs are concerned. The reasoning is that professional and ethical responsibilities of that category of people preclude them from making any value judgment as to the medical needs or desires of their patients. Opponents of the idea sees conscientious objection as a subtle reintroduction of medical paternalism which has been discredited and discarded in favour of respect for patient autonomy. It is no longer fashionable or legally allowable, one could argue, for a HCP to condemn patient's choice, substitute his or her own decision for that of the patient or to seek to determine for the patient what he or she considers as good for the patient or in the patient's best interest. Under the principle of autonomy, patients' liberty of choice cannot be curtailed or impeached on the basis of, from the viewpoint of the HCPs, alleged irrationality, immorality, 'sinfulness' or unreasonableness.

Someone who opposes the idea of conscientious objection and who attributes its exercise to religious persuasion may argue that the present society is multi cultural, multi ethnic and multi religious, it is therefore impermissible for a HCP to impose the burdens or precepts of his or her religion on others who may not share it or subscribe to any religious views at all.[40] The argument could further be

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[40] Consider for example the position taken by the trial judge in Smeaton v. Secretary of State for Health [2002] 2 FLR at page 146 to the effect that conscientious objection is not allowed for professionals in public health service because objectors cannot exercise their religious freedom in a way that imposes their religious belief on others and even if their religious beliefs are respected, 'they can manifest those beliefs in many ways outside the professional sphere'. This case relates to a challenge brought on behalf

strengthened by the fact that the law, the 1999 Constitution of Nigeria and the Canadian Charter of Rights and Freedoms, for instance, guarantees to everyone fundamental freedom of conscience and religion and prohibits discrimination against anyone on the basis of their religion or lack of it. Conscientious objection founded on religious belief may therefore conflict with Constitutional or Charter rights if it results in discrimination against a patient.

The place of conscientious objection in health care systems that is state funded and regulated is also questionable. As observed earlier in this paper, Canada operates a highly regulated Medicare system with the government investing heavily in funding the medical insurance system and in promoting across the provinces certain core values which includes universality, comprehensiveness and accessibility.

Any recognition given to purported right of conscientious objection, it may be argued, will work not only contrary to these goals but may have the unsavoury effect of denying cares that is legally allowed or covered by medical insurance funding in the country.[41] Nigeria has also started the National Health Insurance Scheme (NHIS) where individuals make contributions toward their health care needs. It therefore raises questions whether someone can be denied desired care for which he or she is entitled under the scheme on account of conscientious objection of the health care professionals expected to render such care.

Others have made the case that conscientious objection may also work against public health goals particularly in the area of abortion and contraception. Where qualified HCPs decline to perform medical/surgical abortions, objected to administering emergency contraception, or indeed to distributing condom or give proper contraceptive counseling to patients, especially adolescents, the resulting consequences may be bad for public health. With an increasing sexually active population, failure to counsel or render appropriate contraceptive advice may ultimately have terrible unintended social consequences. Unwanted (teenage) pregnancies

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Of the society for the protection of Unborn Children (SPUC) to a directive reclassifying emergency Contraception as a non prescription drug on the ground that encourages abortion to which they are objected on the basis of their religion. See a discussion of the case in Cook, R.J., and Ngwena C.G., 'women's Access to Health Care: *The Legal Framework', International Journal of Obs. And Gyn,(2006), p.1 at 2.*

[41] See note 31 above.

will increase, sexually transmissible diseases, including HIV/AIDS, will increase, young people of school age may drop out as a result of pregnancy, and where HCPs object to performing legal abortions or administering emergency contraception on the ground of conscience, public health system will then be faced with the consequences, among others, of abortions performed by non-qualified personnel, including death or potentially damaging health problems.[42]

Lastly, provision of adequate and necessary information to a patient with respect to his or her health need is not only an ethical duty but a professional responsibility of HCPs. As an incidence of the patient's right to make informed decision they are to be furnished with information that will help them in making autonomous decisions. This is a duty which cannot be excused for any HCPs. The argument therefore is that where a HCP objects to the performance of a procedure needed or wanted by a patient, he will still be obliged to adequately inform the patient of his or her position and give sufficient information that could help the patient seek alternative help.[43] This leads to the issue of duty to refer the patient to another

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[42] According to Erdman, J.N. and Cook, R.J., 'unintended pregnancy and abortion entail physical, emotional, social, and economic risk for women. Unintended pregnancy is associated with higher maternal morbidity, a greater risk of depression, maternal and child abuse, and social and economic hardships. Adolescent pregnancy carries an increased risk of obstetrical complications and premature delivery……young women with unintended births are more likely to terminate their schooling and to require social assistance'. Consequently, as they reasoned, 'A key strategy for decreasing the rate of unintended pregnancy, and thereby the need for abortion, is to reduce barriers to access to contraceptives', exercise of conscientious objection is usually seen as one of such barriers; see, Erdman, J.N. and Cook, R.J., Protecting Fairness in Women's Health: The Case of Emergency Contraception, in Flood, Colleen M., ed, Just Medicare: What's In, What's Out, How We Decide (Toronto: University of Toronto Press, 2006, p.157/8.

[43] This is consistent with the professional duties of Physicians to inform patients when personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants and to continue to provide medical services to patients for whom they have accepted responsibility until the services are no longer required or until

healthcare facilities or practitioners who does not have such objection so that the patient could be attended to.

Some would readily concede that objecting HCPs may be excused from personally performing or participating in procedures to which he or she objects subject to compliance with the duty to refer and provided there is no immediate threat to the life of the patient. Opponents of HCPs exercising a right or claim of conscientious objection are not prepared to make such concession, insisting that there is no place at all, in professional ethics as well as in law, for conscientious objection in health care service delivery. I will therefore briefly address this insistence and consider whether some conscientious objection could be justified and whether some compromise is afforded by the requirement to refer.

IS THE 'RIGHT' OF CONSCIENTIOUS OBJECTION RIGHT?

Is the right to conscientious objection by HCPs can be justifiable, in ethics or in law? I am of the view that HCPs can properly assert a right to object to performing or participating in procedures that is against their conscience. To argue, as some do, that HCPs, by virtue of their choice of profession have waived or have no right to conscientious objection is in fact to deny them a vital component of their humanity or personhood. It also betrays a fundamental misconception of the term. What influenced the career choice of some practitioners in the health care sector is a desire to help and heal, to alleviate suffering and make people as comfortable as possible. Conscientious objection is not incompatible with the goal of compassion as well as professional and ethical responsibility expected of a competent and humane practitioner. As a matter of fact, the Physician's Oath to which prospective medical and dental practitioners subscribe enjoins them to practice the profession 'with conscience and dignity'.[44] Much of the contention and debate surrounding conscientious objection are founded on a wrong perception of the term 'conscience' as a value primarily or mainly related to religion.[45] However, conscientious objection may be

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another suitable physician has assumed responsibility for the patient or until the patient has been given reasonable notice that the physician intends to terminate the physician-patient relationship, see footnote 25, page 6, above.

[44] See notes 1, 14 and 15 above.

[45] In Smeaton v. Secretary of State for Health [2002] 2 FLR at page 146 for instance, the trial judge opined that conscientious objection is not allowed for professionals in public health service because objectors cannot exercise

claimed by someone who does not subscribe to any religion at all; it may be based on strong personal set of beliefs, value system, moral and ethical ideals or ideas of social justice.[46]

Again, those who oppose exercise of conscientious objection by HCPs usually centre their consideration on impact of such exercise on access to reproductive and sexual health 'right', particularly access to abortion and/or contraception[47] whereas it goes beyond such matters. A health care practitioner may well exercise a right of conscientious objection in manners that promote or protect patient rights. For example, a doctor may object on the ground of conscience to deliberately maim patients' even if such a course was authorized as punishment for a crime. As a further illustration, assuming a human trafficker assembled young women to be taken abroad for prostitution but sought the assistance of a medical practitioner for hysterectomy[48] to be performed on them to guarantee their devotion to work without the risk of pregnancy. Even where the women were mature and/or competent to consent to such operation and appeared to so consent, the medical practitioner may decline or object to perform the operation on ground of conscience. This is a step that would most likely be applauded by all. A HCP may have objection to participating in certain procedures but this is unlikely to hinder competent and full discharge of his or her professional responsibilities in other respects, it may indeed turn out to be a decision that should be applauded or commended. This stresses the importance of recognizing the right of conscientious objection as

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their religious freedom in a way that imposes their religious belief on others; see note 38 above.

[46] The Rule which requires medical practitioners to inform patients when personal values would influence the recommendation or practice of any medical procedure that the patient need or want (see note 23, page 5 above) implies practitioners are expected to have personal values that may influence their practice.

[47] See Cook, R.J., and Dickens, B.M., Considerations for Formulating Reproductive Health Laws, 2nd ed, Geneva, World Health Organization, (2000), p.32-33.

[48] Hysterectomy is a method of female sterilization, which may be permanent or irreversible, involving drastic surgical procedures where the fallopian tubes may be cut or the uterus may be removed.

capable of beneficial usage rather than a wholesome condemnation of the exercise of the right based on few instances when it is felt to result in hardship on patients.

Aside the point raised above, the law of the land affords to every individual the right of conscience and religion.[49] Abandonment of conscience, religious or moral standards cannot be a prerequisite for membership of the health care profession. While there is substance in the argument that HCPs cannot impose their own moral or religious stands on others, it stands to question whether this is what happens when a HCP claims to be exempted from participating in procedures objectionable to his conscience. He or she cannot prevent whatever the patient wants to do; the claim is that he does not want to be involved in it as a safeguard for his or her own health and well-being. It can be argued that HCPs who object on the basis of conscience to participating in abortion or euthanasia, for instance, are not doing it for the protection of fetus or human life, or as a way to pass moral judgment on those who seek it. They may have taken such a stand to avoid suffering emotional, mental or psychological after effect of such participation on them. Consequences such as trauma, depression, guilt, disorders and other possible dysfunctionalities that HCPs may suffer in being compelled to act against their consciences have been completely taken out of the picture by those who argue that conscientious objection have no place in healthcare delivery.

Such arguments cannot be maintained as long as the health care system is being run by human beings. Conscientious objection is a value judgment and human beings will always make value judgments, one way or the other. The idea of an individual, medical doctor, or public officer or indeed an average man on the street, who will execute his or her duties without making value decision, is wholly unrealistic. As for the view expressed by the trial judge in Smeaton that even if religious beliefs of HCPs are to be respected ‘they can manifest those beliefs in many ways outside the professional sphere’,[50] the proper response is that an opinion which treats religious belief, or any other value system, as severable or detachable from every or any sphere of a person's life, including professional, is fundamentally faulty. Such beliefs define in most cases the total being and persona of those who hold them and dictate their attitude to life and relationship with others in general.

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[49] Section 38, 1999 Constitution of the Federal Republic of Nigeria.

[50] See note 40 above.

It may also be stated that the legal system that gives the right of personal autonomy to patients cannot deny it to practitioners. Patients for instance have a right to reject life saving treatment (blood transfusion) on the ground of conscience or indeed, religion.[51] Ordinary ideas of fairness and justice demands that rights recognized for patients cannot be justifiably withheld from practitioners. If the right to personal autonomy, to the security and dignity of the human person, the pursuit of happiness and to be free from discrimination are to be meaningful, they must be extended to HCPs by recognizing their right to conscientious objection. Conscientious objection claims cannot be described as flimsy, unreasonable or inconsistent with medical/professional ethics. For example, as observed earlier in this paper, the Canadian Medical Association stated in its Code of Ethics, that Canadian physicians should 'resist any influence or interference that could undermine their professional integrity' and 'promote and maintain their own health and well-being'.[52] Perhaps, depending on the locality of practice and the area of specialization, a practitioner could argue that certain procedures are objectionable to him/her because it potentially would compromise his/her professional integrity and adversely affect his/her health and well-being which broadly interpreted could include mental, psychological, emotional, physical, social and spiritual health and well-being. In line with this, the Rules of professional conduct for medical and dental practitioners in Nigeria mandates practitioners to accept responsibility for the results obtained under their management and states further that a practitioner 'must refrain from doing anything repugnant to his sense of honour or against his considered judgment…'.[53]

THE REQUIREMENT OF REFERRAL

The law in Nigeria and in Canada, as in most civilized countries of the world, guarantees rights and freedoms to individuals subject to

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[51] See the Nigerian Supreme Court decision in Medical and Dental Practitioners Disciplinary Tribunal v. Dr. J.E.N. Okonkwo [1999] 9 NWLR (Pt 617), 1.

[52] See pages 5-6, above.

[53] See Rule 7, 'rights and Responsibilities of Members of the Medical and Dental Professions'.

such reasonable limits as can be demonstrably justified in a free and democratic society.[54] Such limits may be set directly by law or by necessary implication of law. The right to conscientious objection by HCPs is not absolute and must be exercised within necessary limits. The exercise of conscientious objection must be balanced with the burden it may impose on others and it must take cognizance of the absolute reliance of patients on professional knowledge and competence of practitioners in the health care sector. An objecting HCP should, as a matter of ethics and law, give some options to the patient. This is the essence of the requirement for a referral.[55]

Aside the claim of conscientious objection, HCPs have professional and ethical obligations to refer their patients to other facilities or professionals if for any reason they could not render the required service to the patient.[56] This could be the case where the need of the patient requires attendance by a specialist or the practitioner lacks necessary equipment or materials to properly take care of the patient.[57] For example, a private practitioner who is not trained in the area of obstetrics and gynaecology may not be able to handle cases in that area but has an obligation to refer a patient who seeks related services. Where he is trained in the area but has conscientious objection to the particular request of a patient, an obligation to provide an appropriate referral may be inferred from his duty to provide necessary information to enable the patient make an autonomous decision. Given the lack of a clear legal position on the exercise of conscientious objection in Nigeria, HCPs may incur liability in civil or criminal negligence, or for professional misconduct where without doing more he or she just turn back the patient on the basis that he/she has conscientious objection to the

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[54] See, s. 1, Canadian Charter of Rights and Freedoms, 1982.

[55] See, Dickens, B.M., 'Conscientious Objection: A Shield or a Sword?' in, McLean, S.A.M., ed, First Do No Harm: Law, Ethics and Healthcare, Aldershot, U.K.: Ashgate, 2006, 337-351; for a detailed consideration of the author's views on the use of conscientious objection by health care practitioners.

[56] For example Rule 6 (9) of the Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria enjoins practitioners not to hesitate to 'seek the consultation of more experienced or appropriate specialist colleagues whenever they are in doubt or lacking competence'; rather than just consult, a practitioner in such a situation may simply refer the patient to such colleagues.

[57] See, second to the last paragraph of Rule 7, Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria, supra.

procedure the patient requested or required. This is even more indefensible if the patient has been in the care of the HCP before the objectionable issue arose.[58]

It is noteworthy however that the requirement to provide a referral in the face of conscientious objection is not itself free from controversy. It is usually held out as a necessary compromise between respect for the right of HCPs to object to certain procedures and not to be compelled to participate in it, on the one hand and on the other, the right of the patient to have his or her health needs met in an atmosphere devoid of paternalism or disrespect for his/her autonomy. The HCP is expected to understand the difference between (and to separate) his conscientious objection to a particular procedure and an objection to participating in the procedure. HCPs may object to participating in a procedure on the ground of conscience but he cannot universally object to the procedure being available or accessible to the patient elsewhere. A referral is generally assumed to be the bridge in this scenario. In the words of Prof. Bernard Dickens:

> …a balanced legal and ethical requirement would be that those who invoke their own conscience to refuse participation in reproductive health services show equal respect for patients' consciences by referring them, in good faith, to sources of such services that do not conscientiously object to provide them. This requirement would preserve rights of conscientious objection as a legitimate shield of religious

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[58] It may be reiterated though that a practitioner has the right, arising from good cause, to withdraw service from a patient. However, according to the Rules, even when there is a reason for doing so on grounds of honour or self-respect, the patient should be properly handed over to another practitioner for further management. Doctors should not relinquish the management of a patient to the detriment of the patient. In a worst case scenario where the patient 'insists upon an unjust or immoral cause in the course of his treatment', the doctor may be warranted in withdrawing after due notice to the patient, allowing the patient to employ another doctor. See generally, Rule 18, Rules of Professional Conduct for Medical and Dental Practitioners, supra. The latter part of this Rule may be taken to imply that a doctor is not altogether precluded from making some moral judgment of the patient's desired course of treatment or medical need.

belief, but not permit its conversion into a sword to compel non-believers' compliance.[59]

A referral therefore is supposed to direct a patient to a place or practitioner where he or she can access the treatment or procedure to which a particular doctor objects or decline to participate on the ground of conscience. In the ordinary course of medical practice, a referral does not necessarily terminate the relationship between a doctor and a particular patient, nor does it necessarily disconnect the doctor from further participation in the management of the patient. Thus, it could be argued that a referral or the provision of meaningful information that can enable the patient access a procedure elsewhere cannot be neatly severed from participating in the actual procedure. At any rate, referral cannot work in an emergency.[60]

In the first case, a referral, contrary to the general perception, does not break the chain of causation. It directly links the practitioner with the procedure to which his conscience objects and may, to some degree, have the same effect as if he/she participated in it. To be of any practical meaning or usefulness a referral, according to the words of Prof. Bernard Dickens referred to above, requires the objecting practitioner to direct the patient to 'sources of such services that do not conscientiously object to provide them'.[61] This places an onerous burden and/or responsibility on the objecting practitioner by assuming and requiring that he would know sources that do not conscientiously object to the services. If indeed he must comply with such requirement, it means he is not completely disconnected from the services to which he objects though he is not directly participating in it. The compromise is however compelled on a practitioner so as not to leave the patient out on a limb.[62]

In the other case, a referral will not work in an emergency. Ethics and law demand that a HCP's belief, morality or conscience should not interfere with the provision of health care in emergencies, in other words, in life or death situations. Rule 6 (7) of the Rules of

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[59] Op cit, note 55 above, p. 345.

[60] A doctor must give emergency care as a humanitarian duty unless he is assured that someone is available to give such care. (Rule 5 (1) Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria, supra).

[61] Op cit, p. 345.

[62] See note 56 above.

professional conduct for Medical and Dental Practitioners in Nigeria states:

> Practitioners shall be at liberty to choose whom they will serve in rendering their professional service, but they shall endeavor to render service without discrimination in an emergency to the best of their ability and according to the prevailing circumstances.[63]

In this case, what qualifies as an emergency would be a question of fact. It must be a situation that requires immediate intervention to safeguard the life of the patient or to prevent potentially fatal damages to his or her health.[64] Treating a patient in an emergency, in the opinion of Cook and Dickens, does not violate the conscience of providers in many cases involving abortion or sterilization because of the ethical and religious principle of 'double effect'.[65] For instance, a HCP that does not ordinarily get involved in abortion may be required to administer first aid or life saving treatment to a woman who suffers bleeding resulting from attempted abortion. On the other hand, a HCP may decline to administer 'emergency' contraception to a patient because no true emergency exists in such situations and non intervention does not pose any immediate threat or danger to life of the patient.

CONCLUSION

Medical ethics requires HCPs to respect the autonomy of their patients and to treat them with dignity but not in a way that is blind to the fact that HCPs are also moral agents that has every right to the protection of their professional integrity and preservation of their

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[63] See also paragraph 8 of the same Rule.

[64] According to Cook and Dickens, op cit, note 47, 'Laws on conscientious objection are normally inapplicable in emergency circumstances, such as when their (patients') lives or permanent health are at risk', p.32-33.

[65] Ibid. The principle, according to the authors, provides that an action that has a good objective, such as preserving a patient's life, may be performed despite the fact that the objective can be achieved only at the expense of an unavoidable harmful effect.

[66] By the same token, an ectopic pregnancy that endangers a woman's life can be removed without the procedure being regarded as an abortion; see, Cook and Dickens, ibid.

personal dignity, health and well being. This is precisely why a right of conscientious objection can be, and is rightly, recognized within the ethical landscape of healthcare delivery. In the same way, constitutional rights to self determination and freedom of religion and conscience, and freedom from discrimination are as available to HCPs as they are to every ordinary individual in the society.

Arguments that conscientious objection has no place in the health care sector, or that HCPs who accepted work in public hospitals or in the public health sector generally are precluded from claiming conscientious objection cannot be maintained. Some even argued that when HCPs choose to serve the public, it is unreasonable to expect those in need of health care to acquiesce to their personal convictions, thus implying that objecting practitioners should find employment elsewhere, 'in a religious community for example'.[67] Not minding the fallacy inherent in this position, its impracticality should be apparent. Even if this were practicable, it is ridiculous to say the least, because it means all HCPs in state/public employment being barred from adhering to religious, moral or conscientious stands, should resign en masse. Such a remedy, if it is one, sure exceeds the malady, it is tantamount to saying decapitation is the appropriate remedy to rid the head of lice!

There seems to be a commonplace misconception of what is involved when a HCP refuses on the ground of conscience to perform or participate in an operation. It is usually seen as passing a moral judgment on the patient or turning a dispensing or operating table to an altar for morality or religion. When a HCP refuses to participate on the ground of conscience, it is for his sake and his sake primarily. As patients have beliefs and values which may influence or dictate their medical choices and/or acceptance of or attitude to proposed medical treatment, health care professionals will have their own set of values which may influence their practice.[68] A practitioner's objection does no more than indicate that it is unacceptable for him to render a particular treatment, not that it is wrong for the patient to

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[67] See, Julie Cantor, J.D., and Ken Baum, M.D., J.D., The Limits of Conscientious Objection-May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?, N ENGL J MED, Nov. 2004, p. 351; available at: http://www.yale.edu/opac/docs/campuis/20041104_nejm.pdf (visited on 22/12/2006).

[68] See, McHale, J. and Fox, M., with Murphy, J., Health Care Law: Text and Materials, (London: Sweet & Maxwell, 1997), p. 140.

seek it. For example, if a doctor refuses to obey or follow an advance directive of a patient or to participate in euthanasia, he is not objecting to the patient's right to the procedure but to his own participation or involvement in it. It is unfortunate that arguments on this issue have left the realm of dispassionate consideration of constitutional rights and entitlements of patients and practitioners alike and had gone into that of politics, and like many issues of biotechnology and bioethics, have become core subjects of electioneering campaigns especially in the western world.

I have demonstrated that conscientious objection is available to HCPs but that it is a limited right. The limits to it however remain unclear. The obligation to refer, as I have argued, is a lopsided compromise while the obligation to administer treatment in emergency cases notwithstanding the conscientious objection a HCP may have is to be restricted to circumstances where the life of the patient might be saved by an immediate intervention, or a far reaching (grave) harm to the patient could be averted.

In a multi-cultural, multi-ethnic and multi-religious society as Nigeria where the doctor and patient are bound to have different value and belief systems, cases of conscientious objection to providing or to withholding certain treatments should be expected to occur with increasing frequency. However, uncertainties surround the exercise of the right of conscientious objection by health care practitioners in Nigeria at present and it is likely that such rights will simply be haphazardly and indiscriminately claimed or exercised.

The modern health care delivery system has moved away from the era when doctors, in particular, and health care practitioners, in general, were viewed as omniscient and omnipotent whose decisions are unquestionable to one in which patients are part of the decision making process. The development of patient right advocacy has modified the power balance in the doctor/patient relationship requiring greater measure of professional responsibility and accountability which makes HCPs' claim or exercise conscientious objection more contentious. Nevertheless, I believe that reasonable sensitivity to being involved in distressing procedures should be

permitted to ground legal and ethical exemption from such an involvement, subject to stated safeguards.

Finally, the uncertainties that surround the exercise by HCPs of the right of conscientious objection in Nigeria, or indeed anywhere else, indicates an urgent need for legal and policy measures to address this issue. In Nigeria, the Medical and Dental Council (MDCN) should come out with subsidiary rules of professional conduct or clear policy statement regarding exercise by medical doctors and dentists of the 'right' of conscientious objection, likewise should the Nigerian Medical Association (NMA).[69] Legislation that will specifically address this issue should also be made not simply with respect to abortion, contraception or euthanasia, but on a general note in healthcare sector across the states and at the federal level.[70] This will set the necessary boundaries to the exercise of conscientious objection by HCPs as has been done in some states in the United States.[71]

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[69] In the same way other professional bodies involved in the regulation of various arms of the health care professions, for example, the Pharmacy Council of Nigeria, the Nursing and Midwifery Council of Nigeria and so on should as a matter of urgency come out with specific statement on the exercise of conscientious objection by their members. The exercise of conscientious objection by nurses in the U.K., for instance, is clearly provided for by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in the Council's 1996 Guidelines for Professional Practice; see also, J. McHale, et al, op cit, p. 140-141.

[70] In Canada for example, interest groups are pushing for the enactment of such legislation by the Canadian government; see, Canadian Physicians for Life, Conscience Issues: An Open Letter to Canada's Health Minister, of August 15, 2001 available: http://www.physiciansforlife.ca/html/conscience/articles/openletter.html (accessed on 22/12/2006).

[71] See for example, Mississippi Health Care Rights of Conscience Act, 2004; see also, Conscientious Objection Law of Michigan at: http://www.legislature.mi.gov/documents/2003-2004/billengrossed/htm/2003-HEBH-5006.htm (visited on 22/12/2006).