

*Virtual Mentor*  
American Medical Association Journal of Ethics

March 2013, Volume 15, Number 3: 183-280  
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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 185-187.

## FROM THE EDITOR

### An Examination of Conscience

“There seems to be no rational way of securing moral agreement in our culture,” mourns Alasdair MacIntyre in the second edition of *After Virtue* [1]. In place of a common dialogue, we find a fragmented morality made up of individual commitments—commitments whose incommensurability lends, he argues, to the “shrill tone of so much moral debate.” MacIntyre continues, “The rival premises are such that we possess no rational way of weighing the claims of one as against the other” [2].

The need for protection of conscience within medicine is evidence of precisely this kind of moral fragmentation. Bound by a common profession and motivation to heal, we still can be moral strangers. Physicians seek protection when encountering divisive issues, such as abortion or physician-assisted suicide. The problem is not so much that these disagreements are intractable, but that they embody different (often implicit) conceptions of the ends of medicine. There is a rift at the foundation; and so it is necessary to ask again what medicine is for, what the role of healer is. (Even the word “conscience” itself can suffer from such a divorce. Is it a personal judgment, based mainly on emotion, or is it a relationship to truth?) We currently have a professional agreement to honor certain claims of conscience and not to penalize those who exercise such claims. At the same time, it falls to those wishing to exercise these claims to do so in a way that does not alienate or abandon those seeking care.

This month’s *Virtual Mentor* takes this fragmentation as a starting place and works toward a deeper understanding of the premises that underlie claims of conscience. The authors, hailing from different backgrounds and areas of expertise, all address different facets of the same questions: What is conscience? What is its place in the delivery of health care? What are some of the responsibilities of those who exercise such claims, especially regarding the formation of one’s conscience, communication of moral commitments to patients, and commitment to patients’ well-being?

Several threads run through the issue. The first is the pursuit of a more rigorous definition of conscience in medicine. In the Medical Education section, Warren Kinghorn argues that, rather than separating the moral and procedural spheres, we would do better to understand conscience as a species of clinical judgment. Alvan A. Ikoku’s Journal Discussion examines the evolution of Julian Savulescu’s concepts of conscience and values. In her case commentary, Lori Arviso Alvord draws upon her experience to look at claims of conscience integrated with cultural background. And in their policy forum, Cameron Flynn and Robin Fretwell Wilson turn to conscience

claims by institutions, analyzing the current struggle to balance rights of access and rights of conscience.

Other authors look at the role of physicians in conscientious medicine. Robert Orr gives a brief overview of conscientious claims in medicine in the Medicine and Society section. James K. Boehnlein provides commentary about the participation of physicians in state-ordered executions in his Policy Forum article, highlighting ways that physicians interact with societal norms and encouraging responsibility in such interactions. This month's excerpt of the *AMA Code of Medical Ethics* explains the profession's current consensus on physician participation in the contested areas of abortion, assisted reproduction, and physician-assisted suicide. And Lauren Sydney Flicker looks at the 2012 Affordable Care Act mandate that, with a few exceptions, requires employer-sponsored health insurance plans to cover the cost of contraception.

Two sets of authors write to our second theme: the application of conscience in practice. In their op-ed piece, Margaret Little and Anne Drapkin Lyerly defend a limited role for conscientious objection that meets stringent standards. And in a complement to that argument, Brooke E. Jemelka, David W. Parker, and Sr. Renee Mirkes demonstrate in their State of the Art and Science article how specialists in ob/gyn who object to assisted reproduction technology can provide a broad range of effective care for patients through NaProTECHNOLOGY.

Mark Wicclair introduces the third major theme in his case commentary about “negative” and “positive” claims of conscience. He argues that, traditionally, “negative” claims (refusals) have been privileged over positive ones (a perceived imperative to act). Christopher O. Tollefsen explores another facet of that difference in his Policy Forum, arguing that wholesale protection of positive claims of conscience would, in effect, abolish the religious liberty of the very communities that make the practice of conscientious medicine sustainable.

The remaining articles suggest dialogue and narrative as ways of navigating conscientious objections within a physician-patient relationship. The second ethics case, with commentary by William J. Hogan and Juan R. Velez, explores a hypothetical conversation between a patient and physician with a longstanding relationship, exploring the ways in which clinical and moral concerns come into play in a personal relationship. Alvan A. Ikoku's piece for the Art and Medicine section explains how a work of fiction—Herman Melville's famous novella “Bartleby, the Scrivener,”—teaches us about conscientious refusal and elicits our sympathy both for the refuser and the person most affected by it.

As a whole, the issue explores the ways that conscience is enmeshed in clinical practice. The authors each contribute to the larger question of *how* conscientious claims may spur the profession onward to continually more compassionate care, seeking together, through dialogue, a greater transparency and sincerity at the interface of ethics and medical practice.

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## Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 188-192.

### ETHICS CASE

#### Positive Claims of Conscience and Objections to Immigration Law

Commentary by Mark R. Wicclair, PhD

Dr. Prado flipped the hallway flags outward and pushed his shoulder into the door. Inside the room a man and woman sat, the woman manifestly pregnant. They bowed their heads shyly as he entered and then looked up at him expectantly.

Dr. Prado sat. “Senora, buenas tardes. Senor.”

The woman smiled at his articulation, clumsy but sincere.

“Todo parece bien. Su bebe esta...creciendo bueno. Er, bien.”

All three laughed. The couple pleased, as they should be; they awaited good news with all the anxiety of first-time parents.

They proceeded through the visit without incident, and Dr. Prado assured them that he would be there when she finally went into labor. When they rose to leave, the man hesitated for a moment and looked at the doctor. He was on the verge of a question.

“Yes?” Dr. Prado asked. The man explained something quickly, in Spanish. Dr. Prado frowned for a moment, struggling to translate. “Papeles,” the man said, shaking his head and gesturing to his wallet.

“Ah. No.” Dr. Prado shook his head. “I don’t report. No reporto.” He wasn’t concerned that patients like these seemed to find him more or less regularly, and he considered it part of his duty to treat them regardless of their immigration status. Often they would find a way to pay, sometimes not. He had never asked for documentation, and preferred not to cast his relationship with his patients in an atmosphere of suspicion. It was somewhat unclear whether his actions were legal; state law prohibited him only from providing sanctuary for the immigrants, without requiring him to report them.

As Dr. Prado was returning to his desk, another physician in the practice, Dr. Hartz, intercepted him. “Listen,” he said, “I don’t want you endangering this practice.”

Dr. Prado sat back from his computer, but remained silent. Dr. Hartz glared. This wasn’t the first time he had confronted Dr. Prado about some of the patients he took, but the intensity of his criticism had grown in recent months.

“Be a doctor, not a zealot,” he said evenly.

Dr. Hartz turned and walked away. Dr. Prado watched him go, then turned back to the open chart on his desk.

### **Commentary**

The worry that physicians who provide services to undocumented patients may be subject to legal sanctions cannot be dismissed as a paranoid’s nightmare. Section 202 of the Border Protection, Antiterrorism, and Illegal Immigration Control Act of 2005 (HB 4437) [1], which passed in the U.S. House but not in the Senate, included provisions that, according to some commentators, would have prohibited health care professionals from providing services to “illegal aliens.” In 2011, two states, Alabama and Georgia, enacted laws (HB 56 and HB 87, respectively) that prohibit “concealing, harboring, or shielding” undocumented immigrants (referred to as “aliens” in the Georgia law and “illegal aliens” in the Alabama law) [2, 3]. Unlike the Alabama law, the Georgia statute provides an exemption for “a person providing emergency medical service,” but neither includes a general exemption for health care professionals.

The scope of these laws is somewhat vague, which leaves considerable room for prosecutorial discretion. If Dr. Prado’s practice is in Alabama or Georgia, an aggressive prosecutor might charge him with violating state immigration law. The U.S. Court of Appeals for the 11th Circuit enjoined enforcement of the sections of the Alabama and Georgia statutes that prohibit concealing, harboring, or shielding “(illegal) aliens,” and one of the court’s stated grounds was a concern about excessive prosecutorial discretion because it was “the intent of Congress to confer discretion on the Executive Branch [not on the states] in matters concerning immigration” [4].

One might argue that health care is so important that any obstacles that are likely to interfere with a patient’s access to it are unjustified. Accordingly one might well question whether, as a matter of public policy, immigration laws should exempt health care professionals so that physicians like Dr. Prado do not have to fear prosecution when they provide medical services to undocumented patients.

However, I want to address another, equally important question: If immigration laws do not provide general exemptions for health care services, should they at least provide exemptions for health care professionals who cannot in good conscience comply with the law because they believe they have an ethical obligation to treat patients without regard to their immigration status?

To answer this question, it first is necessary to consider reasons for protecting the exercise of conscience. The primary reason is to protect a person’s moral integrity [5]. Most of us have core moral beliefs—i.e., beliefs that are part of our understanding of who we are and are integral to our self-conceptions or identity. Maintaining one’s moral integrity requires acting in accordance with these core

moral beliefs. Acting against one's conscience and failing to maintain one's moral integrity can result in substantial moral harm, such as loss of self-respect and feelings of guilt, shame, and remorse. There are several additional reasons for protecting the exercise of conscience and enabling people to maintain their moral integrity: (1) maintaining moral integrity—being able to act in accord with one's core moral values—can be an essential feature of a person's conception of a good or meaningful life; (2) acting against one's conscience can destroy or seriously weaken one's long-term commitment to moral principles; (3) respect for persons, an important ethical principle, requires us to allow others to act on the basis of their personal values and beliefs and thereby maintain their moral integrity; and (4) although there are exceptions, for example when a person's core values require a commitment to invidious discrimination or senseless cruelty, moral integrity generally is considered valuable and a virtue.

Typically, federal and state health care “conscience clauses” and institutional conscientious objection policies protect health care professionals from sanctions for conscience-based refusals to provide goods and services, such as abortion, sterilization, (emergency) contraception, and sedation to unconsciousness. Such policies on conscience-based *refusals* protect *negative* conscience claims. If physicians are legally required to question patients about their immigration status and report (suspected) undocumented immigrants to the authorities, and Dr. Prado believes that it is ethically wrong to satisfy that requirement, he might exercise a negative conscience claim and refuse to do so. If the law were to include a conscience clause that protects such negative conscience claims, Dr. Prado could maintain his moral integrity without being subject to legal penalties.

But suppose physicians are legally prohibited from treating undocumented immigrants: for example, a law that prohibits concealing, harboring, or shielding “(illegal) aliens” is interpreted to authorize the prosecution of physicians who treat undocumented patients. If Dr. Prado believes that he has an ethical obligation to provide services to all patients regardless of their immigration status, no conscience clause limited to protecting negative conscience claims would enable him to maintain his moral integrity without facing legal penalties. Protecting his moral integrity would require a different type of conscience clause—one that protects *positive* conscience claims by permitting individuals to perform actions that are otherwise prohibited by legal or institutional rules.

Insofar as enabling people to maintain their moral integrity is the primary reason for protecting the exercise of conscience, not protecting positive conscience claims does not appear to be justified [5, 6]. One's moral integrity can be compromised either by performing an action that is contrary to one's core ethical beliefs or by failing to perform an action that is required by those beliefs. Consider the following two cases: (1) Physicians are legally required to report suspected undocumented patients, and Dr. X believes that it is seriously wrong to do so. (2) Physicians are legally prohibited from treating suspected undocumented patients, and Dr. Y believes that it is seriously wrong to fail to do so. Just as a failure to respect a negative conscience



claim by physician X can be injurious to her moral integrity, so, too, a failure to respect a positive conscience claim by physician Y can be injurious to his moral integrity. Accordingly, positive conscience claims can have moral weight and can merit protection for the same reasons as negative conscience claims.

Although there is insufficient evidence to conclude that the selective recognition of negative conscience claims is politically motivated, it is at least worth noting that in the current U.S. social and political context, the exclusive protection of negative conscience claims has tended to privilege “socially conservative” positions—such as the opposition to legally permitted practices like participating in abortions and dispensing emergency contraception. The result has been to disregard positive conscience claims that might be more consistent with positions of “social liberals,” such as honoring the living wills of pregnant women, providing unrestricted access to (emergency) contraceptives, performing abortions [7], providing counseling concerning reproductive options, and providing health care services to people without regard to their immigration status.

There are two possible objections to protecting positive conscience claims. First, it can be objected that recognizing positive conscience claims may require condoning and enabling law breaking. For example, if it is illegal for physicians to treat undocumented patients, protecting the moral integrity of a physician who believes there is an ethical obligation to treat them would require condoning law breaking. This objection begs the question because the issue is precisely whether the law should recognize and protect such conscience claims. If a law prohibiting the treatment of undocumented patients were to grant an exemption for physicians with conscience-based objections to it, physicians who treat such patients would not be breaking the law.

A second objection alleges that protecting positive conscience claims will result in the infringement of important patient rights. This objection applies in some, but not all, cases. For example, it applies to physicians who are conscientiously opposed to forgoing medically provided nutrition and hydration in compliance with advance directives because they believe that they have an ethical obligation to provide it. However, this objection does not apply to a positive conscience claim in relation to treating undocumented patients. Arguably, protecting a physician’s positive conscience claim in this context would enable the physician to respect the rights of such patients.

Even if it is acknowledged that there are good reasons to protect both negative and positive conscience claims, to determine whether they should be accommodated, it is necessary to consider competing interests and values. If accommodating Dr. Prado and other health care professionals with similar conscience-based objections would have a significant impact on the effective enforcement of legitimate immigration law, it would be necessary to weigh two conflicting values: (1) the value of protecting the moral integrity of health care professionals such as Dr. Prado and (2) the value of maximally effective enforcement of legitimate immigration policy.

Unfortunately, there is no established algorithm for making such challenging ethical judgments.

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### Related in VM

[Protecting Positive Claims of Conscience for Employees of Religious Institutions Threatens Religious Liberty](#), March 2013

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 193-197.

## ETHICS CASE

### Invoking Shared Beliefs in End-of-Life Decision Making

Commentary by William J. Hogan, Jr., MD, and Juan R. Velez, MD

Mr. Getty's polycythemia vera had progressed dramatically over the last few months, even as he slowly regained function from his recent stroke. Mr. Getty had expressed more than once—emphatically—that he didn't want to do hospice at home. This meant that, when the time came, Dr. Burks, his longtime physician, would oversee his care in the several-hundred bed hospital a few miles away. The doctor had been able to persuade Mr. Getty to allow him to visit him at home every month or so, a rare concession on the part of the old cattle rancher.

Mr. Getty's wife stood at the door and swung it open as the doctor approached. He smiled. "Where's the young man?"

"None here!" came a voice from the other room. Dr. Burks and Mrs. Getty moved from the kitchen into the room in back, where Mr. Getty sat in an armchair in front of the television. He reached across for the remote and turned off the set. Dr. Burks reached down and shook his hand, then pressed his shoulder. For a moment the two men held each other in silent regard.

"How are your sores?"

"They hurt."

Dr. Burks listened to his heart, looked closely at his fingernails and hands for signs of bruising. He sat on the chair Mrs. Getty had set for him and crossed his legs.

"Looking all right, Mr. Getty," he said, opening his briefcase.

"Jan, grab those papers, will you?" said Mr. Getty. When she returned, the doctor took them into his hands and flipped through them. "Great, OK, advance directives..."

On the last page was a brief checklist. Suddenly the doctor was conscious of the print his wet finger was making on the page.

"Everything OK, Doc?" Mr. Getty looked at him.

"Uh, yes. Fine." But really he felt cold. Dr. Burks looked again. "Are you sure about this part?" he asked, pointing to the middle of the page.

Mr. Getty waved his hand in dismissal, or absolution. “Ah, I’m an old man, doc. I don’t want to be a burden on anyone. If it’s my time, it’s my time.”

The doctor stole a look over to his patient’s wife. She sat in the chair listening, then met his gaze. For a flash Dr. Burks was back at the bedside of his dying grandfather, feeding him ice cubes. Dr. Burks had been much younger then; his family had decided to withdraw his grandfather’s feeding tube for reasons he’d long since forgotten. Even in his obtunded state, far past coherence, his grandfather had lunged for the cubes, sucked on them desperately with noisy gulps. Dr. Burks looked down again and read through the conditions listed on the page: “...or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes...” His eyes lingered on the blue check mark next to the option, in that clinical language to which he had never grown accustomed: I do not want artificial nutrition and hydration.

Almost automatically, he finished the exam, shook Mr. Getty’s hand, and exchanged a few more kind words. He slipped the copy of the document into his briefcase. Mrs. Getty walked him to the door. “You know, Dr. Burks, you have been such a blessing for us,” she said. “I don’t know what we would do without you. And even if he doesn’t say it—” she glanced with a kind smile to the other room, then pressed closer, “it means so much to Dan that you’ll be the one there for him if anything happens.”

As he drove, the radio low, his mind lingered over the documents in his briefcase. He became more and more certain that it was a directive with which he could not comply.

### **Commentary**

Dr. Burks was saddened by his patient’s remarks, yet it occurred to him that their conversation about his wishes for his care at the end of his life had just begun. As he made the trip back to his office, he considered his options: continue his care of Mr. Getty, follow the specifics of his advance directive, and so violate his moral principles, or tell Mr. Getty that in conscience he could not in every circumstance withhold nutrition and hydration from a patient and so had to recuse himself from his patient’s care. Burks had already ruled out the former and did not want to pursue the latter until he was certain he and Mr. Getty really could not agree. In fact, Burks realized there was a third option: initiate a dialogue with Mr. Getty, his wife, and his children, to explore their fears regarding suffering and incapacitation at the end of life. He would then share with them his thoughts on advance directives, the provision of nutrition and hydration, and the role of a physician’s conscience in his or her care of a patient.

While he had had this kind of conversation before with patients of different faith traditions and varying intensity of religious practice, this was different; he and Mr. Getty shared the same faith and moral tradition. Dr. Burks, in accord with Catholic moral teaching, considered the provision of nutrition and hydration not medical

treatment, but ordinary, humane care that should be given to patients unless its administration posed particular hardships and failed to provide any benefit. Usually the cost and effort involved are proportionate to the benefit foreseen, i.e., protecting a person from the discomfort of hunger and dehydration. If death were not imminent due to deteriorating clinical status, the cause of his death would be dehydration. And if depriving the patient of this ordinary care led to his death, it would constitute euthanasia [1, 2].

Dr. Burks reasoned that, when the wishes of a patient and a physician differ in significant moral decisions, both need to seek what is “morally right,” which at times does not coincide with one’s “wishes.” In his experience, when a physician and patient have the same moral framework it is easier to arrive at a shared judgment about the morality of a given medical action. Sometimes it will be up to the physician to point out what is morally right; at other times it will be the patient who makes the correct moral argument.

After thinking and praying a bit more about the situation, Dr. Burks collected some reading material he had previously given patients about advance directives and health care proxies (durable medical power of attorney), as well as on “ordinary” and “extraordinary” care (also known as “proportionate” and “disproportionate” care), especially as it related to nutrition and hydration—food and water—toward the end of life. He mailed this to Mr. and Mrs. Getty, along with a note that he looked forward to discussing these issues at his next visit.

Over the course of the next few weeks, Dr. Burks mentally prepared the topics he planned to address with Mr. Getty and his family:

- He would explore Mr. Getty’s fears regarding his physical deterioration as his polycythemia vera progressed. Dr. Burks wanted him to understand that his goal as Mr. Getty’s physician was to cure when possible, to always strive to ease his suffering, but not to unnecessarily prolong his life at all costs. Dr. Burks saw his role not as dictating what was to be done but rather as advising Mr. Getty of the best medical options. At the same time, he wanted Mr. Getty to know he could not comply with a patient’s wishes if they involved violating his moral commitment to never participate in ending a human life. For Dr. Burks, it was not a matter of his moral principles competing with his patient’s desires, but rather a challenge for both patient and physician to apply their shared understanding of the good to the specifics of the patient’s condition.
- Dr. Burks wanted Mr. Getty to consider the possible implications of his current desire to refuse nutrition and hydration were he to enter a minimally conscious state. He would tell Mr. Getty his memory of his own grandfather’s severe thirst and that provision of nutrition and hydration had been shown in a number of clinical situations to improve patients’ quality of life at its end [3]. In fact, the clinical scenarios in which nutrition and hydration cause harm are rare indeed. By referring to harm done when

excluding hydration of a patient and the rare occasions that a judicious use of fluids is harmful, the doctor can clarify the worries of a patient.

- Dr. Burks wanted Mr. Getty to consider replacing his advance directive with the naming of a health care proxy. Advance directives are by necessity very general statements that, given the multiplicity of clinical scenarios possible for any given patient, may or may not accurately reflect what the patient would have wanted in an unforeseen situation. As a result, implementation of an advance directive always requires *some person to interpret* the application of that directive to the specific clinical situation of the patient. Therefore, Dr. Burks considered the naming of a health care proxy very familiar with Mr. Getty's wishes, such as his wife, as a more appropriate and effective way to name the interpreter of his wishes were he to become mentally incapacitated. Dr. Burks would need to make it clear to Mrs. Getty that, if in the case of her husband's incapacity she asked for removal of fluids from her husband, he would only be able to do so if he considered that providing fluids would occasion Mr. Getty with a special burden.

Dr. Burks arranged his next visit to his patient's ranch for an evening so as to have more time to speak with Mr. and Mrs. Getty. They appreciated this gesture and the reading material and his explanation of his views regarding Mr. Getty's situation and options. Mr. Getty articulated his fear not only of pain, but of lingering for an extended period of time, unable to have some mobility and ability to communicate. He was reassured by his longstanding relationship with Dr. Burks and Dr. Burks' expression of his understanding of his role as a physician to cure when possible and alleviate suffering when curing is not possible. Mr. Getty understood that Dr. Burks had firm moral convictions regarding the care of dying patients and considered it unfair to oblige him to contradict those convictions [4].

At the conclusion of their visit, Mr. Getty expressed his willingness to reconsider his advance directive to refuse nutrition and hydration were he to enter a minimally conscious state, and to name his wife his health care proxy. Dr. Burks was reassured that he would not be required to compromise his conscience in his further care of Mr. Getty. Their open communication had helped both physician and patient appreciate the freedom and rights corresponding to their relationship. A physician is always free to decline to act in a way that violates the moral principles that he thinks are correct and binding. This freedom is protected by rights recognized in U.S. law, namely, the right to conscientious objection. A patient also has the right to choose his physician and to decline certain tests or treatments. This right has been recognized as patient autonomy and specifically as "informed consent" in all major ethics policy since the 1970s. Conflicts regarding moral decisions that arise in patient-doctor relationships can be resolved by a better understanding of the medical choices at play, the moral obligations of the two parties, or at times by a discontinuation of a given patient-doctor relationship.

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American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 198-201.

## ETHICS CASE

### Medical School Accommodations for Religious and Cultural Practices

Commentary by Lori Arviso Alvord, MD

Joni had looked forward to her second-look medical school visit with excitement; this school had been her top choice throughout the application process. The first in her family to finish college, Joni felt as if she was carrying enough hopes and expectations for ten people. She was pushing through her last courses with characteristic tenacity. And every day this week, she had worn the silver and turquoise squash blossom necklace that her grandmother gave her before she left for school.

Now, she stood with her fellow accepted students in a cold room with tiled floors, necklace stashed away and her long black hair tied back. The students were passing around a prosection that one of the teaching assistants had given them. It was small and firm, a dusky red—as it got closer, Joni could see that it was a heart. When it got to her, she felt her gloved hands leave her side almost automatically. Then she stopped, quickly shook her head and motioned to the student next in line. Her classmate hesitated for a moment and stood holding the heart, but after a moment passed it in front of Joni to the next student at the tank.

Later that day Joni walked into the lab director's office. She shook his hand and introduced herself.

“Welcome. Hope you've had a good day so far. What is it you would like to talk to me about?” he asked.

Joni was quiet, then gathered her courage. “I'm Navajo. Our cultural beliefs do not allow us to touch dead bodies,” she said gently.

The lab director seemed genuinely puzzled. “Well, I don't think that this is something that we have encountered before. We have had one or two students find out that they were bothered by the lab, but we always worked through that discomfort...it was an important learning experience.”

## Commentary

This case illustrates a dilemma that many Navajo students face when they train to become physicians or health professionals. This commentary describes the challenges associated with this dilemma and provides a framework for it.

The most common method of teaching anatomy in medical schools involves the use



and dissection of human cadavers. Navajo students from families that still retain traditional practices will find it disturbing to handle cadavers. It is said that spirits are present near the bodies, and that the evil, or negative part of a person stays with the body. Some will also have difficulty being in places where death resides, and some will be unable to participate because of their beliefs. Clearly, this scenario raises difficulties for the student and the instructor as well as for the school. How does the student continue with her training without violating the beliefs of her culture? Does this constitute a conscience-based objection (CBE)? Is her request a reasonable one?

Most discussions of conscientious objections in medicine have focused on issues such as animal rights, abortion, family planning, and other matters based on an individual's religion. For the case in question, the student's objection is similar to an objection on the basis of religion; in the Navajo worldview, culture and religion are tightly intertwined, making this a conscience-based objection. The practice of using cadavers is in direct opposition to traditional Navajo cultural and religious beliefs that dead bodies should not be handled.

This dilemma has prevented some Navajo students from attending medical school because they would not be able to touch a cadaver. They may be unaware that there are alternative ways to teach anatomy without using cadavers, and they do not expect that anyone (who is not Native) would make an effort to understand their culture and beliefs. The history of interactions between western civilizations and indigenous cultures has only recently attained a level of tolerance and inclusion.

A denial of this student's request would force the student to make a choice between giving up pursuing her profession and violating the rules she lives by. Navajo students who make the choice to handle a cadaver may find themselves facing significant psychological struggles, at the very time when their energy is needed to focus on their classes. At a more subtle level, students will find it difficult to be fully themselves.

Students from many minority communities may experience daily challenges related to the cognitive dissonance associated with navigating multiple cultures at the same time. Mark Wicclair writes that "denying students' requests for CBEs fails to respect, and threatens to undermine, their moral integrity, and that respect for persons requires respect for moral integrity...[and] maintaining moral integrity requires adherence to a person's core ethical beliefs—beliefs that in part define one's identity or self-conception, and its loss can be experienced as self-betrayal and diminished self-respect" [1].

When schools refuse to accommodate Navajo students, it presents a real barrier to their entering the profession of medicine and to furthering the school's, and the profession's, diversity. Wicclair also states that a policy of categorically refusing all requests for CBEs can undermine the goal of maintaining a diverse student population, and thereby may present a barrier to achieving diversity in the medical profession [1].

It is quite possible that some faculty and administrators in academic medicine may not be willing to provide accommodations for Navajo students and the use of cadavers. They may be inclined to consciously or subconsciously discount the beliefs of people from indigenous tribes. Historically, there has been a moral superiority exhibited by western civilizations toward indigenous tribes, and traces of it remain. But there may have been very rational reasons for tribes to choose to avoid cadavers. Death is associated with disease, and disease is sometimes contagious. Smallpox and measles were intentionally transmitted to Native American tribes, shortly after contact, when colonists realized that American tribes did not have immunity to these illnesses. During such times, any possible vector may have been avoided.

It is also worth noting that each culture has beliefs and customs that may seem strange to others. Imagine the reaction if medical schools were to decide to routinely have classes on Saturdays and Sundays. How many students from dominant cultures would we lose? Imagine the reaction if winter break did not coincide with the Christmas holiday. And American culture has other traditions that are such an integral part of our consciousness they are never questioned. We never question the fact that men wear strips of cloth that wrap around their necks and hang down their chests as formal dress. Or that it is 'normal' for women to pierce their ears, but to pierce any other part of the body is still seen by many as counterculture symbol. I raise these parallels to illustrate that culture is woven into everything we do, and what is normal is a matter of perspective. The Navajo avoidance of cadavers is at the far end of a continuum and yet it isn't—it is extremely uncomfortable for most people to touch a cadaver.

In recent years, there has been a shift in some medical schools, away from the use of cadavers toward other methods of teaching anatomy, primarily due to the difficulty and expense of obtaining and keeping cadavers [2]. Some have argued that nothing can replace the dissection of a cadaver in the teaching of anatomy, but it does appear that medical schools vary in their approach. Some medical schools have already made the decision that anatomy can be taught without cadavers. This indicates that not all in the medical profession believe that cadavers are required to teach anatomy.

The University of Arizona has a long history of working to provide an environment that accommodates Navajo students. Arizona College of Medicine - Tucson faculty, including Jack Knolte, MD, and Carlos Gonzales, MD, have worked to minimize exposure to cadavers and even to arrange for Navajo ceremonies for cleansing and purification for students. Navajo students applying to medical school might benefit from knowing which schools do not use cadavers or, if they do, will work to accommodate them.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 202-205.

## MEDICAL EDUCATION

### Conscience as Clinical Judgment: Medical Education and the Virtue of Prudence

Warren Kinghorn, MD, ThD

The degree to which “conscience” should guide physician practice has been frequently debated in recent years within medicine, bioethics, and health policy circles [1-3] and has found new life in the debate about various “conscience protection” rules issued by the G. W. Bush and Obama presidential administrations. In these debates, physician “conscience” has been invoked in the medical literature almost exclusively in cases in which physicians attempt to avoid or to decline participation in practices or procedures that they find morally objectionable, often because such practices violate the physician’s religious or cultural practices. In this debate, “conscience” is therefore often associated with religious belief or, at least, with deeply held “values” of the physician in question [4, 5].

Medical educators and physicians, however, do not typically invoke the language of “values” or “conscience” in the context of ordinary medical practice: decisions, for example, about whether to prescribe a benzodiazepine for an anxious patient or an antibiotic for an upper respiratory tract infection are framed as a matter of “clinical judgment” but rarely as a matter of “values” or “conscience.” As a result, it is easy to assume that everyday medical practice does not require either, unless problems or disagreement arise. Conscience, that is, is conceived not as constitutive of and routine within the practice of medicine, but rather as some sort of external referee that interjects itself when clinicians believe particular practices to be morally objectionable.

This bracketed and externalized conception of physician “conscience” reflects more generally the pervasiveness of the fact-value (and science-ethics) divide within modern medicine: ordinary medical practice is an applied science (dealing with “facts”); “values” are, in contrast, the province of ethics, and need to be interjected from the outside, either from the patient (in the form of “autonomy”) or from the physician (often in the form of “paternalism”). Modern medical ethics has grappled at length with *whose* values ought to guide medical practice, but has only rarely challenged the fact-value distinction within which such debates (e.g., between “autonomy” and “paternalism”) are enshrined [6-8]. The recent debates over physician conscientious objection have largely echoed these broader bioethical debates, with similarly inconclusive results.

What would be the implications for medical ethics, however, if “conscience” were not some sort of external moral faculty that trafficked in “values” (rather than

“facts”) but, rather, were a quite ordinary part of human decision making, inseparable from the living of everyday life and from the routine, day-to-day practice of medicine? Such a conception of conscience would render it more mundane and unremarkable but would, on the other hand, raise awareness of its quiet but important presence within the daily lives of physicians and medical practitioners. As it turns out, this more integrated conception of conscience was common in premodern moral philosophy. In this brief essay, I will outline the account of conscience given by the premodern philosopher and theologian Thomas Aquinas (~1225-1274), whose work was important in extending the thought of Aristotle into the medieval era, and will briefly suggest how Aquinas’ thirteenth-century conception of conscience might apply to modern bioethics and to the modern education of physicians.

In his work on moral philosophy, Aquinas presents a complex and detailed account of human action which, though dated in some ways by Aristotelian assumptions about biology, is still relevant today. Human knowing, Aquinas stated, can be directed in two ways: speculatively, with regard to what is true (for example, the law of noncontradiction), and practically, with regard to what is good, or what should be done. What is true and what is good are, of course, closely linked to one another, and in fact Aquinas believed that humans are equipped with a disposition (called *synderesis*) to know certain self-evident abstract practical truths, such as that “the good is to be done, and evil avoided.” [9].

But abstractions like that can only go so far: the biggest challenge in acting well is not formulating abstract moral principles but, rather, applying those principles to concrete situations in the complex context of everyday life. And this relating of abstract principles to real-life situations, the figuring out of what “the good” is in any particular setting, is what Aquinas refers to as conscience (*conscientia*), the application of knowledge to a particular case [10]. Conscience, then, is for Aquinas not even a power or a faculty at all—it is simply the act by which the action-guiding practical intellect identifies the good (i.e., that which should be pursued) in a particular situation. Applied to medicine, instances of “conscientious objection” (for example, refusing to participate in torture) would certainly involve acts of conscience—but so would instances of prescribing an antibiotic for pneumonia, or counseling a teenager to quit smoking, or operating on an acute abdomen. Conscience in this view turns out to be nothing more, and nothing less, than clinical judgment—identifying what course of action is appropriate in a specific patient case.

Just as modern medical educators know that clinical judgment is neither innate nor infallible, but must be formed and refined over months and years in the context of supervised medical training, so also Aquinas knew that conscience was not infallible either. The ability to exercise conscience appropriately—to consistently recognize courses of action that are good or fitting in particular situations—is in fact a hard-won achievement which Aquinas describes as the virtue of prudence (*prudentia*). Prudence in Aquinas’ sense, in contrast to a common modern use of the term, does not connote timidity or excessive caution. The prudent physician, in Aquinas’ sense, is not one who is painstakingly risk-avoidant or conservative in decision-making but,

rather, one who consistently knows what to do in complex clinical situations: the prudent physician shows consistent “presence of mind” [11].

But this clinical presence of mind (prudence), which names the consistent presence of good clinical judgment (conscience) in the practice of a physician, is not easily achieved. It requires a person to cultivate virtues like courage, self-control, and justice that help orient him or her to things that are truly good, rather than things that only seem so [12]. It requires years of iterative practice and openness to correction by more experienced teachers [13]. And it requires that medical decision making not be reduced to algorithm.

Extending Aquinas’s thinking equating conscience with clinical judgment and vice-versa would have several important implications for medical education and for modern debates about “conscientious objection” within medicine.

First, “conscience” would no longer be understood as a separate decision-making faculty that comes into play only with regard to morally or socially controversial situations: it simply *is* clinical judgment. The physician who declines to prescribe oral contraceptives because, for religious reasons, he or she judges that the patient would be harmed by these medications, is exercising clinical judgment, and, conversely, the physician who prescribes a statin for hypercholesterolemia is exercising conscience. Such a reconceptualization does not, of course, resolve the issue of whether the first physician *ought* to be allowed to decline oral contraceptive prescription, or whether the physician is correct in his or her judgment, but it at least makes clear that physicians who are required to act contrary to conscience are *eo ipso* being required to act contrary to their clinical judgment—a very serious matter for physician professional identity.

Second, equating conscience with clinical judgment would challenge the way that ethics is marginalized (and marginalizes itself) within contemporary medical educational institutions and their teaching curricula. “Ethics” is not a specialized and esoteric discipline to be invoked only in moments of crisis or “dilemma”; it is, rather, simply an account of what good medical practice looks like in particular situations, even when these situations are pedestrian and uncontroversial. Daily bedside teaching rounds are pervasively about “ethics” even when that word is never mentioned.

Third, equating clinical judgment with conscience makes clear that medical education is at root a process of moral formation, in which promising but naive clinicians who lack the ability to discern the good in particular clinical situations (that is, whose acts of conscience are unreliable) are formed, through hard study and iterative practice under the guidance of competent teachers, to become clinicians capable of consistently knowing and doing the good. Medical education, in other words, is *essentially* a training of conscience. The consistent and reliable display of rightly-formed conscience over the course a medical career, furthermore, is

prudence—arguably the most important characteristic that any physician can ever display.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 206-207.

## THE CODE SAYS

### **The American Medical Association *Code of Medical Ethics*' Opinions on Physician Participation in Abortion, Assisted Reproduction, and Physician-Assisted Suicide**

#### **Opinion 2.01 - Abortion**

The "Principles of Medical Ethics" of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

Issued prior to April 1977.

#### **Opinion 2.055 - Ethical Conduct in Assisted Reproductive Technology**

The following guidelines are intended to emphasize the value of existing standards to ensure ethical practices in assisted reproductive technology (ART):

- (1) The medical profession's development of technical and ethical guidelines for ART should continue. Education of the profession and patients should be pursued through widely disseminated information. Such material should include information on clinic-specific success rates.
- (2) Fertility laboratories not currently participating in a credible professional accreditation program are encouraged to do so. Professional self-regulation is also encouraged through signed pledges to meet established ethical standards and to comply with laboratory accreditation efforts. Physicians who become aware of unethical practices must report such conduct to the appropriate body. Physicians also should be willing to provide expert testimony when needed. Specialty societies should discuss the development of mechanisms for disciplinary action, such as revocation of membership, for members who fail to comply with ethical standards.
- (3) Patients should be fully informed about all aspects of ART applicable to their particular clinical profile. A well-researched, validated informed consent instrument would be useful for the benefit of patients and professionals. Payment based on clinical outcome is unacceptable.
- (4) Physicians and clinicians practicing ART should use accurate descriptors of available services, success rates, and fee structure and payment obligations in promotional materials.

If legislation on regulation of ART laboratories, advertising practices, or related issues is adopted, it should include adequate financial resources to ensure the intended action can be implemented. Improved legislative protection may be needed



to protect physicians and their professional organizations when they provide testimony on unethical conduct of colleagues.

Issued December 1998 based on the report “Issues of Ethical Conduct in Assisted Reproductive Technology,” adopted June 1996.

**Opinion 2.211 - Physician-Assisted Suicide**

Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Issued June 1994 based on the reports “Decisions Near the End of Life,” adopted June 1991 and “Physician-Assisted Suicide,” adopted December 1993; updated June 1996.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 208-212.

## JOURNAL DISCUSSION

### Conscience, Values, and Justice in Savulescu

Alvan A. Ikoku, MD

**Savulescu J. Conscientious objection in medicine. *BMJ*. 2006; 332(7536):294-297.**

#### Introduction

Savulescu's 2006 article in the *British Medical Journal* takes up perennially unfinished work on the nature and place of conscience, carried out against the background of contested laws shaped by states and their institutions as well as peoples and their professions. His writing on conscientious objection essentially returns to and intervenes in an extended conversation made possible by continued shifts in relations between individual citizens and loci of authority; shifts that characterized the mid-to-late decades of the twentieth century, when debates about war, civil rights, reproduction, and capital punishment made objection a vital mode of participation and engendered fields of practice and scholarship organized around the mission to decentralize decision making [1, 2].

Yet if a central preoccupation of contemporary bioethics has been to increase the say of patients in medical decisions, the field has also taken up the voices of physicians concerned about the substitution of patients' values for their own, particularly when that substitution entails a repeated insistence that they provide services their professional and personal ethics have taught them not to offer. From the late twentieth century on, conscience has increasingly been seen as a way to reclaim space for physicians, as a possible opt-out—or at least a pause—in bioethics' emplotment of ethical progress as the empowerment of patients and their families. In a historical irony, conscientious objectors in medicine have been figures of authority.

#### Grounds for Objection

Savulescu opens the article with a line from Shakespeare's *Richard III*, when the king-protagonist declares conscience to be "but a word cowards use, devised as first to keep the strong in awe" [3]. Opening his *BMJ* article with this line seems like a rhetorical move, an overstatement intended to draw attention to a less extreme main argument to come. But Savulescu uses Shakespeare to emphasize instances in which the evocation of conscience may be mere pretext for the avoidance of duty. Objecting to true duties, he argues, should be wrong and immoral and doing so in the case of grave duties ought to be illegal. The examples mentioned do and do not range widely. They include patient requests that painful or futile treatments be withheld or withdrawn, but also the termination of pregnancy, the provision of emergency contraception for victims of rape, advice on alternative modes of fertilization for

single women or same-sex couples, and the employment of therapies developed with the use of fetal tissue or embryonic stem cells.

The majority of these examples come from the contested field of reproductive rights and medicine, to which proponents of universal access often refer when ascertaining physician and state commitment to providing ethically examined care [4-7]. And that citational practice is central to Savulescu's handling of representative cases as he makes his remarkably strong argument that a doctor's conscience should have little space in modern medicine [8]. What should stand in its place is consensus about the just distribution of medical resources to meet patients' needs—a consensus arrived at only via the law, medical practice, public health economics, and informed reflection. The conclusion seems as natural as it is resolute. "If people are not prepared," Savulescu insists, "to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors" [9].

The exceptions Savulescu allows to this stance are limited. Only when there are sufficient numbers of physicians willing and able to provide the care in question can objection be conscientious in both intent and effect—and only, too, when referrals actually mitigate harm to the patient. Furthermore, an efficacious review system should be in place to adjudicate cases in which physicians compromise delivery of medical services on conscience grounds. Then, and only then, may society begin to recognize, even foster, the rights of would-be objectors.

The exceptions are developed by Savulescu in good faith, but there is also a sense that these exceptions remain hypotheticals, each requiring substantial societal effort to become uniformly real. And they are essentially pragmatic concessions. More substantive conceptual weight is reserved for efforts to reduce inefficiencies, inconsistencies, and inequities that Savulescu suggests would be the unjustifiable and natural byproducts of physician's selective refusals—for example, patient referral among obstetricians who refuse to provide abortions at 13 weeks for career reasons [10].

The rights of objectors are thus opposed to a more robust sense of justice, and what becomes clearer as the article progresses is the extent to which distributive justice serves as a guiding concept for Savulescu, a principled emphasis that does not allow religion to retain its special status as justification. "Other values," he continues, "can be as closely held and as central to conceptions of the good life as religious values"—*other* values have been individually, personally, and carefully developed, without the cultural and social purchase of organized religion [8]. To treat as special, to understand as a singularly worthy basis for objection, a set of Christian precepts—about doing good, taking life, or inflicting moral harm to self and others—would in essence be to "discriminate unfairly against the secular" [8].

### **Objection as Debate over Conscience or Values**

Yet in the United States "religious exception"—as principle, practice, and catchphrase—*has* been singularly successful in sustaining objection as an option for

clinicians. The responses to Savulescu's *BMJ* article have centered largely on that very point, despite his attempt to obviate the need to do so, and the ensuing debate is perhaps most effectively taken up by Farr Curlin and Ryan Lawrence [14]. In a 2007 *American Journal of Bioethics* article, for instance, they reaffirmed through a set of studies the unsurprising finding that disagreements about physician obligations—even to educate and refer—are overwhelmingly expressed along religious lines [15]. Yet, for Curlin and Lawrence, the findings point not to irreconcilable differences, but to often unspoken and unexamined differences in the definition of conscience, differences that are certainly theological and philosophical but also of practical import when they inform policy and impede its success.

Curlin and Lawrence therefore argue for attention to what is being left unsaid where consensus could be generated: on the information consciences should convey, on the ways consciences should be informed, and on the understood consequences of not following one's conscience [16]. Building this consensus, they argue, or discussing its possibilities, should be a precondition to making policy, and it should certainly be part of the work of experts in fields like bioethics, who regularly profess a certain facility at balancing theory and practice. Curlin and Lawrence thus recommend a process shift in future reform of professional and institutional ethics—that it have as a focal point discussions about the *nature* of conscience in medicine, and not just its place or function [17].

As is typical of these kinds of exchanges, Savulescu's response to Curlin and Lawrence produces a number of important clarifications. First, he foregrounds his own earlier writing, in which he had delineated the duties of an objector to teach patients about the care he or she would not provide [18, 19]. These articles defined a set of theoretical principles for reaching the balance physician and patient must achieve in shared decision making [20]. Savulescu's return to such writing doubles as a subtle rejoinder to Curlin and Lawrence, a move that by implication diminishes the new centrality of policy conversations in ethics, to make room, once again, for the kind of dialogue needed at the moment of practice and referral.

This rejoinder forms the basis for a second clarification when, as a corrective to Curlin and Lawrence, Savulescu suggests that impassions on conscientious objection arise not from a reluctance to discuss differences in the nature of conscience, but from an impoverished means of discussing patient and physician values [21]. What he offers here is more than a mere substitution of advanced policy conversations with sensitive dialogue between patient and objecting physician. He also proposes a renaming of the object for discussion—from conscience to values—a move that may be relativizing, but one that nonetheless crystallizes for us an alternative locus of reform [22].

And here we come to a third point of clarification, possibly an outright shift or self-correction. In the portrait of medicine and public health Savulescu currently advances, it is no longer an edict that a doctor's conscience (renamed "values") should have little place in modern medicine. Rather, its place should be openly

declared and discussed. The exception, then, for conscientious objection—the way it may gain rigorous and sustained ethical import—is in making *unexceptional* full dialogue among physicians, patients, and families about the reasons for not providing care and for not carrying out a duty that others in the medical profession reasonably expect and are willing to do. To describe this kind of dialogue as both delicate and difficult would be a clear understatement. But it has for several scholars and practitioners been an important statement to make, a way of clearing space for contributions from nonclinical and nonscientific ways of attending to facets of human existence—from the humanities in particular, its literature and methods that have over the past several decades coalesced into a subfield of dialogic ethics, whose insights should prove important for future work by Savulescu, Curlin, Lawrence and others concerned with developing an ethical means of handling objection [23].

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# Virtual Mentor

American Medical Association Journal of Ethics  
 March 2013, Volume 15, Number 3: 213-219.

## STATE OF THE ART AND SCIENCE

### NaProTECHNOLOGY and Conscientious OB/GYN Medicine

Brooke E. Jemelka, MD, David W. Parker, MD, and Renee Mirkes, OSF, PhD

In the last 50 years, a surge of reproductive technology has revolutionized the practice of obstetrics and gynecology. First, effective hormonal contraceptives were made available to the public in the 1960s and, since their debut, have been used to treat almost every gynecologic abnormality [1]. Second, in the past 30 years, infertility has largely been managed using assisted reproductive technologies (ART), primarily intrauterine insemination (IUI) with recourse to in vitro fertilization (IVF) when insemination fails [2]. As a result, the modus operandi in mainstream gynecology has been to suppress, or to bypass, the woman's fertility cycle.

Physicians and patients who (1) conscientiously object to the therapeutic use of hormonal contraceptives on the grounds that it subjects patients to ineffective treatment of symptoms rather than treating their underlying disease and (2) morally oppose the ART approach to infertility on the grounds that it jettisons a loving act of marital intercourse, the one context worthy of the conception of a new human being, are now able to pursue an alternative approach that accords with their consciences. NaProTECHNOLOGY (an acronym for natural procreative technology) is a woman's health science that encompasses a unique medical and surgical application of gynecology. The foundation of NPT is the Creighton Model FertilityCare System (CrMS), the only prospective and standardized means of monitoring the various patterns of a woman's menstrual and fertility cycle for the natural regulation of fertility.

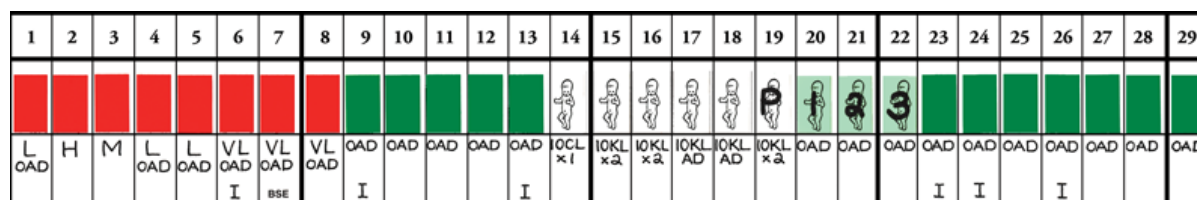


Figure 1. The chart of a woman who has a normal vulvar mucus cycle of regular length (i.e., between 21 and 38 days). The cycle begins with menses. The days of menses, marked on the chart with red stamps, are followed by infertile days, marked with green stamps, indicating the patient observes neither bleeding nor cervical mucus. The infertile days are followed by fertile days, marked with white baby stamps, indicating she observes cervical mucus at the vulva. The woman marks the last day of vulvar mucus discharge that is clear, stretchy, or lubricative with a "P" to indicate the peak day of cervical mucus and the peak day of her fertility. The fertile days are followed by infertile days, marked with green stamps, when the woman no longer observes cervical mucus.

Couples effectively use the CrMS of charting for family planning, i.e., to achieve or avoid a pregnancy. But NPT employs the woman's charts, with their wealth of gynecologic data, as a first step to assessing health, guide diagnostic testing, and initiate treatments. Whether addressing infertility, abnormal bleeding, premenstrual syndrome, recurrent ovarian cysts, or dysmenorrhea, NPT uses the CrMS to integrate reproductive *and* gynecologic health.

For example, because it views infertility as a symptom rather than a disease, NPT seeks to diagnose and treat the underlying causes of infertility so that the couple can more successfully conceive within their own acts of intercourse, especially during peak-day-focused intercourse. NPT infertility protocols depend on patient-specific charting data. Some observations during the fertility cycle—dry, limited, or continuous mucus; short or variable post-peak phase; premenstrual spotting or tail-end brown bleeding—are external signs of possible underlying disease processes.

A medical interpretation of these abnormal CrMS observations leads to a targeted biochemical and hormonal evaluation, which in turn identifies target organ dysfunctions: decreased production of estrogenic cervical mucus, intermenstrual bleeding or spotting, short or variable luteal phases, and suboptimal levels of the ovarian hormones (estrogen or progesterone). Common treatments for these pathologies include induction or stimulation of ovulation, medications to enhance cervical mucus, and hormonal support in the luteal phase. When these NPT medical approaches to infertility were used in a study of 1,239 infertile couples, they resulted in a live birth rate similar to that of cohort ART treatments [3].

In many cases, medical applications of NPT are sufficient to treat infertility successfully; in other cases, surgical intervention is also required. Surgical NPT is a specialized form of gynecologic surgery the primary aim of which is to reconstruct the uterus, fallopian tubes, and ovaries. The ovarian wedge resection (surgical removal of a portion of an enlarged ovary to restore its normal size), for example, is effective in healing polycystic ovaries (contributing to the long-term treatment of some of the endocrine and menstrual cycle abnormalities associated with polycystic ovaries). It also brings the patient a 70 percent chance of pregnancy i.e., it is twice as effective as clomiphene [4].

A significant benefit of surgical NaProTECHNOLOGY is “near adhesion-free” surgery. One of the biggest pitfalls of surgery, of course, is the formation of postoperative adhesions, which can decrease tubal motility (adversely affecting fertility) and cause small bowel obstructions (that frequently require emergency reoperation) [5]. To prevent these complications, NPT surgical techniques pay meticulous attention to detail, take a systematic approach, and use Gore-Tex adhesion barriers [6]. Published Gore-Tex protocols reveal a statistically significant decrease in subsequent adhesion scores on second-look laparoscopy [7]. For some reason, the use of Gore-Tex has been overlooked in even the most recent adhesion prevention reviews [8]. One even laments that adhesion prevention is a “surprisingly



neglected aspect of the treatment of endometriosis,” but the reviewers make no mention of the use of Gore-Tex as an adhesion barrier [9].

Other techniques of surgical NPT include laser vaporization and pelvic excision and repair surgery (PEARS) of peritoneal or ovarian endometriosis. PEARS is a form of plastic reconstructive surgery of the pelvis with the primary intent of removing diseased tissue within the pelvic organs and repairing organs in a way that does not form pelvic adhesions. PEARS can entail robot-assisted laparoscopy or laparotomy, minimizing postoperative adhesions and optimizing the patient’s chances for pregnancy.

The effectiveness of treating infertility with medical and surgical NPT is comparable to that of ART interventions. The cumulative live birth rate in patients receiving IVF is between 45-55% [10]. In a study population of 1,045 patients treated with NPT infertility protocols, more than 60 percent became pregnant within 24 months and nearly 70 percent within 36 months [11]. The overall “per-woman” NPT pregnancy rate is higher than that of ART due, in part, to the high rate of dropout or discontinuation in patients who undergo IVF treatment [12]. In addition, a meta-analysis comparing conventional surgery and IVF for treatment of endometriosis-related infertility found that the per-woman pregnancy rates with surgery were 55.3 percent while those with IVF were 9.9 percent [13]. However, while it is true patients treated with NPT have significantly lower overall fecundability (a 3.13 percent chance of conceiving within a given period) than those treated with IVF (13.3 percent), it is also true that the number of women who ultimately achieve a pregnancy with NPT is higher than the number who get pregnant using ART [14]. Thus, although achieving a live birth with NPT may take longer, it has a greater chance of occurring than with IVF.

For those interested in training in NPT, the Pope Paul VI Institute and Creighton University School of Medicine offer educational programs for those in primary care or ob/gyn (including fourth-year medical students) to train in the medical applications of NaProTECHNOLOGY [15]. They also offer a 1-year fellowship in the surgical applications of NPT for ob/gyns who have completed their residencies [16].

### **The Ethos Grounding NaProTECHNOLOGY**

The previous thumbnail sketch of some of NPT’s protocols demonstrates NaProTECHNOLOGY’s distinctive medical and surgical infertility applications. But they are just one of its hallmarks. The ethical grounding of NPT’s infertility praxis is also distinctive.

NPT’s moral evaluation of fertility interventions is grounded in the following principles and values articulated by the Roman Catholic tradition, rooted in the nature of medicine, Aristotelian/Thomistic philosophical anthropology, and a personalist procreative ethics [17-27].

In this view, the human person is a body-soul unity. The human body is not regarded as some sort of subpersonal or “lower” bodily nature, detached from the higher spiritual powers of reason and will; we are not persons who have or use our bodies. We are our bodies. The human body is considered one of the realities of personhood, and the human person a bodily one. This view understands human persons, then, as unitary, but composite, beings: embodied, intelligent, and free, with dignity grounded in their capacities, within the concrete circumstances of their lives, to pursue the true good and avoid evil through rational, intelligent, and free choices.

Accordingly, fertility and sexuality are essential aspects of human embodied nature to be used to pursue good. This understanding of the human person means that marital sexual acts, too, unite the bodily and the spiritual. Marital sexual acts have, at once, a bodily or procreative significance—they are bodily acts capable of procreating a new human being—and a spiritual or unitive significance—they are acts of loving union. For the marital act to respect this united nature, husband and wife must engage in sexual intercourse in a way that incorporates both of its meanings (love and procreation), neither procreating like the lower animals—driven by instinct rather than by intelligent love—nor producing life through reproductive techniques that jettison personal bodily union.

Only marriage is considered an appropriate context for the conception of a new human person. The child who is to be conceived is understood to have the right to be conceived, gestated, born into, and raised within marriage, and marriage is understood to entail only becoming a parent with one’s husband or wife. Intrauterine insemination (IUI) and in vitro fertilization (IVF) deprive the child of these circumstances of conception, and, when assisted reproduction techniques use donor gametes, they prevent the couple from becoming parents only through each other. Furthermore, IVF also fails to respect these concepts of human life and bodily integrity by destroying embryonic human beings because of their morphological or genetic abnormalities and by suspending lives through cryopreservation [20]. Upholding this rationally intelligible context for human procreation defines the parameters of NaProTECHNOLOGY.

This procreative ethics requires husband and wife to use their procreative capacities virtuously and responsibly, that is, in a way that furthers relevant concepts of the good. If a couple conscientiously judge the infertility treatment they are considering moral—if they believe it promotes their human flourishing by enabling them to conceive within their own acts of loving bodily union and, therefore, respects their dignity, that of the child to be conceived, and that of their marital acts—they should pursue it. But should the couple conscientiously decide the infertility treatment they are considering is immoral—that it represses their human flourishing by consigning human procreation to an impersonal, sterile and, in the case of IVF, extra-bodily technical process—they should not pursue it.

Similarly, if a physician conscientiously judges that he or she should not provide IUI, IVF, and their variations since these reproductive techniques wrest human

procreation from the marital act of intercourse, he or she should avoid it. NPT medical and surgical infertility protocols, on the other hand, accord with these concepts of the personal and procreative dignity of the infertile couple, since they enable them to conceive within their own acts of intercourse.

So, the good news is this: It is possible for physicians who hold the beliefs we detail here to practice medically sound obstetrics and gynecology in line with their well-formed consciences and those of their patients. It is possible to provide medically effective reproductive interventions that also genuinely promote this concept of bodily-spiritual well-being for both patient and physician. In other words, it is possible for physicians who hold these beliefs to honor the capital principle of beneficence that medical codes of professional ethics insist is central to the physician-patient relationship.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 220-225.

## HEALTH LAW

### Religious Employers and Exceptions to Mandated Coverage of Contraceptives

Lauren Sydney Flicker, JD, MBE

The Patient Protection and Affordable Care Act (ACA) has been one of the most divisive pieces of legislation in the last few years [1]. And the most controversial component of the ACA has arguably been the mandate that group health plans cover contraception costs. The contraception mandate, part of a seemingly straightforward effort to enhance preventive care for women, has elicited backlash from religious and conservative groups who believe it violates certain employers' religious freedoms.

#### The Contraception Mandate

The ACA, signed into law in March 2010, mandates that group health plans, including self-insured plans (in which an employer is the insurer of its employees and assumes financial risk for the plan), cover the cost of preventive care for women without requiring cost-sharing from beneficiaries [2]. These preventive services, recommended by an Institute of Medicine expert committee in women's health and prevention, include annual well-woman visits, screening for sexually transmitted infections (STIs), domestic violence counseling, and coverage for contraceptives for women with reproductive capacity [3, 4]. All plans that are not grandfathered (i.e., the plan has not covered at least one person continuously since March 23, 2010) or otherwise exempt (discussed in detail below) must comply [3, 4].

The federal mandate does not pose as significant a change to health care coverage in the United States as some believe. Prior to the ACA, 28 states already had laws that required insurance policies that covered other prescription drugs to cover FDA-approved contraceptive drugs and devices [5]. Although these state laws did not affect self-insured employer plans, a 2000 ruling by the United States Equal Employment Opportunity Commission (EEOC) held that employers who provided coverage for other prescription drugs but not for contraceptives were in violation of Title VII of the Civil Rights Act [6]. The ACA then, did not create a sweeping change as much as it extended earlier legislation to all states and included self-insured employer plans.

#### Religious Exemptions

In the wake of the objections that covering contraception costs would violate some employers' religious freedoms, interim final rules were published in August 2011 announcing that churches, but not religiously affiliated groups such as religious schools or hospitals, would be exempt from the contraception mandate [4]. The interim final rules defined a religious employer eligible for exemption as "one that (1) has the inculcation of religious values as its purpose; (2) primarily employs

persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under the Internal Revenue Code” [4]. This narrow exemption appeased some, but left many religious employers seeking further accommodation.

In January 2012, the Department of Health and Human Services announced a compromise [7]. Although HHS continued to guarantee that all women with health insurance would have access to contraception coverage without cost sharing, it provided a 1-year extension to nonprofit employers who, on the basis of religious beliefs, do not cover the cost of contraception. While other employers would be bound by the mandate starting in August 2012, these religious employers were given until August 2013 to comply [7]. HHS Secretary Kathleen Sebelius stated that “this proposal strikes the appropriate balance between respecting religious freedom and increasing access to important preventive services” [7]. This compromise did not satisfy many religious groups, who felt that the extension merely gave religious employers an extra year to “figure out how to violate [their] consciences” [8].

A further compromise on institutional exemptions to the contraception mandate came from the federal government on February 10, 2012. The “Final Rule” provided a second level of exemptions [9, 10]. In addition to the complete exemption for churches and other employers who fell into the guidelines established in August 2011, HHS granted a further compromise to not-for-profit employers such as hospitals, universities, and charities that object on religious grounds to the provision of contraceptive services. Under the final rule, this second group of employers would not be forced to pay for contraceptives themselves. Instead, their insurance providers would directly pay for the services [9, 10]. To some, this compromise seemed hollow because it required religious employers to be complicit in behavior that they believed to be morally wrong [11]. This compromise addresses neither self-insured nor for-profit companies with religious objections to contraception service.

Finally, on March 21, 2012, HHS released an Advance Notice of Proposed Rulemaking that requested comments on how to accommodate self-insured religious institutions, while ensuring that women receive contraceptive coverage [9]. For these institutions, HHS proposed that “a third-party administrator of the group health plan or some other independent entity assume this responsibility” [9]. These proposals have not yet been finalized, and, in the meantime, multiple lawsuits have been filed.

### **Challenges**

Dozens of lawsuits have been filed in federal court in recent months challenging the contraception mandate or seeking injunctions against it [12]. Lawsuits have been filed by for-profit institutions that have been given no exemptions to the contraception mandate and nonprofit institutions that do not believe that the accommodations made by the government have sufficiently protected their interests.

Lawsuits have been filed on behalf of for-profit companies ranging from those with a clear religious purpose such as Tyndale Publishing House, a Christian publishing

company [13], to seemingly secular organizations founded by deeply religious individuals, such as Hobby Lobby, a national chain of craft supply stores [14]. The outcomes of these cases have varied significantly.

In *Tyndale House Publishers v. Sebelius*, the plaintiffs succeeded in winning an injunction against having to pay for intrauterine devices (IUDs) and Plan B (an oral emergency contraception), which the plaintiffs consider to be abortifacients. The court found that the government had not demonstrated that these specific contraceptives furthered the government's interest in promoting public health. The court further noted that, "when the beliefs of a closely-held corporation and its owners are inseparable, the corporation should be deemed the alter-ego of its owners for religious purposes" [13]. This view is not shared by all district court judges.

The plaintiffs in *Hobby Lobby Stores v. Sebelius*, who also sought an injunction specifically against providing Plan B and IUDs, were unsuccessful after the judge held that Hobby Lobby is not a religious organization and that the government has a compelling interest in ensuring that all women have access to contraceptive services [14].

While these decisions seem to be unpredictable, companies with a clear religious purpose, even when for-profit, are more likely to be successful in their challenges. As Judge Heaton said in *Hobby Lobby*, "The court has not found any case concluding that secular, for-profit corporations...have a constitutional right to the free exercise of religion" [14].

Many of the lawsuits brought by nonprofit institutions have been filed on behalf of Catholic and Christian colleges, such as Belmont Abbey College [15], Wheaton College [16], East Texas Baptist University [17], and Colorado Christian University [18]. Unlike the lawsuits filed by for-profit companies, the suits filed by nonprofits have been largely unsuccessful. Most have been dismissed for being premature because, unlike for-profit companies, which were required to comply with the mandate as of August 2012, plaintiffs at nonprofits have until August 2013 to comply and have not yet been able to demonstrate that they have been harmed by the mandate. However, there has recently been a major change on this front.

On December 18, 2012, the D.C. Court of Appeals ruled that the Belmont Abbey and Wheaton College cases should not have been dismissed [19]. In oral arguments, the federal government stated that it was never planning on enforcing the contraception mandate against religious colleges and institutions and that HHS would be publishing a Notice of Proposed Rulemaking in the first quarter of 2013 and issuing a new Final Rule by August 2013 [19]. The court promised to hold the government to its word, and lawsuits against the contraception mandate are pending until HHS has amended its rules. As an enforcement mechanism, the court has ordered that HHS must file status reports with the court every 60 days [19].



## The Current Status of the Mandate

Employers who do not believe that the compromise is sufficient have sued and will continue to sue the federal government. Because these cases are decided on an ad-hoc basis and affect individual companies rather than the general applicability of the contraception mandate in general, their outcomes have varied significantly. The lower court cases have affected individual companies but have not affected the general applicability of the contraception mandate. However, the December 18, 2012, opinion by the D.C. Circuit Court ushered in significant changes.

In response to the court ruling, the Department of Health and Human Services issued a Notice of Proposed Rulemaking in February 2013. The proposed rules [20] expand compromises to nonprofit religious institutions such as colleges and hospitals. Under the proposed rules, these institutions would be completely removed from the process of providing contraceptive coverage to enrollees. Not only would these institutions be exempt from directly paying for contraceptive coverage, but they would not have to contract with or arrange for contraceptive coverage by insurance companies. Instead an institution would self-certify as a nonprofit religious organization that opposes providing contraceptive coverage on religious grounds. The organization would submit this self-certification to its insurance provider, which would then notify enrollees and provide them separate contraception coverage at no cost to the employer or to the enrollee. Similarly, the employees of religious organizations that are self-insured would be covered by an insurance provider arranged for by a third-party administrator. The proposed rules are open to public commentary through April 2013.

It is likely that there will be further adjustments to the contraception mandate down the road.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 226-235.

## POLICY FORUM

### **Institutional Conscience and Access to Services: Can We Have Both?**

Cameron Flynn, JD, and Robin Fretwell Wilson, JD

It appears, at times, that health care and religion do not mix. Consider the sterilization and contraception coverage mandate under the Patient Protection and Affordable Care Act. The mandate requires nearly all employers and health insurers to cover as “essential health care services” certain sterilization procedures and contraceptives, including emergency contraceptives [1]. Members of the Catholic, evangelical Christian, Mennonite, and Muslim faith communities [2] say that the mandate places them “in the untenable position of having to choose between violating the law and violating their consciences” [3].

The Obama administration made a series of attempts to meet this objection. Speaking for the White House, Domestic Policy Director Cecilia Munoz emphasized the administration’s commitment to “both respecting religious beliefs and increasing access to important preventive services” [4]. The administration promised to delay enforcement of the mandate until at least August 1, 2013 [5-7], but critics dismissed the concession as “kicking the can down the road” [8]. The administration then proffered its controversial accommodation requiring insurers rather than objecting employers “to reach out and offer the woman contraceptive care free of charge without co-pays, without hassle” [9]. Objectors also found this accommodation “unacceptable,” saying it hides a “grave violation” of religious liberty behind a “cheap accounting trick” [10].

The Obama administration followed through on its offer to accommodate objectors with proposed regulations that provide enrollees contraceptive coverage with no copays and reimburse insurers for costs of contraceptive coverage through credits on fees the insurers owe the government [11]; objectors covered by the regulation would not have to pay for the objected service or notify enrollees of it [11]. These proposed changes did not satisfy religious objectors, who still oppose the mandate [12, 13].

Objecting religious organizations—representing a host of faith groups [14]—have filed dozens of lawsuits opposing the mandate on religious liberty grounds [15]. These suits are slowly working their way through the courts [15]. On November 26, 2012, the U.S. Supreme Court directed a federal court of appeals to reconsider its decision in one lawsuit over the mandate in light of the Supreme Court’s June 2012 decision upholding the constitutionality of portions of the federal health care reform law [16].

The collisions between faith and the demands of medical practice take a number of forms. They are often most in tension when institutions assert conscience objections. Nonetheless, policy makers have a number of options that allow them to respect moral and religious objections while preserving access to needed medical services.

### **Burgeoning Collisions between Conscience and Medical Access**

Reaction to this mandate is not the only collision that religious objectors identify between the demands of faith and the need for services. More than a dozen nurses from two institutions filed suit after being punished, they say, for refusing on religious grounds to assist with or train for abortions—a procedure the nurses see as ending a life [17-19]. The nurses alleged that they were threatened with professional discipline and termination if they did not assist with the contested service despite federal conscience protections in place since *Roe v. Wade* [17, 20, 21]. In both suits, the nurses ultimately received the protection they were promised under federal and state laws [17-19]. Like these nurses, both facilities and individuals have strenuously opposed duties to dispense emergency contraceptives that objectors believe are “abortion-inducing drugs” [22, 23].

Religious objections are hardly limited to contraceptives and abortion, however. Clinicians have objected to an expanding number of practices, ranging from circumcising babies to participating in physician-assisted suicide and providing assisted reproduction services [24]. In any of these contexts, two very different parties may be asserting the need for accommodation of their religious beliefs: individual clinicians *and* health care institutions.

### **Institutions Have a Conscience**

Abortion conscience clauses, dating back to *Roe v. Wade* [21] in 1973, have always insulated both individuals and institutions. While it is easy to understand how an individual may hold a religious or moral belief that can be in tension with the demands of the law, some find it difficult to fathom how an *institution* can have a moral conscience or “belief.” Some commentators argue that “[a] vibrant liberty of conscience requires morally distinct institutions, not just morally autonomous individuals,” and that, therefore, the state should recognize that institutions also have a conscience claim [25].

In two recent decisions, the U.S. Supreme Court has extended protections normally associated with individuals, like free speech and free exercise of religion, to institutions [26, 27]. In *Hosanna Tabor Evangelical Lutheran Church and School v. EEOC*, for example, the U.S. Supreme Court concluded that “the Free Exercise Clause...protects a religious group’s right to shape its own faith and mission through its appointment” of ministers [27]. It noted that “[a]pplying the protection of the First Amendment to roles of religious leadership, worship, ritual, and expression focuses on the objective functions that are important for the autonomy of any religious group, regardless of its beliefs” [28]. Although these decisions are controversial, they show a great respect for institutions’ rights and interests.

While protections for individuals and institutions both receive support in the law, protecting each requires markedly different tradeoffs by policy makers, as we explain next.

### **Balancing Conscience Protections with Access**

When deciding to accommodate a conscience-based objection to providing a service that is legally available, legislators and agencies have to balance at least two equally compelling values: respect for conscience and access to needed services. Some assert a third value, patient choice. Patients only have a meaningful choice, patient-choice advocates say, when institutions can choose not to provide a specific contested service. Just think of the patient who seeks a clinician with common values—for instance a pro-life reproductive specialist [29]. While policy makers may want to foster diversity among clinicians, institutional providers who cannot—consistent with their faith commitments—provide services pose a special challenge because institutions control large swaths of the market. As we argue below, respect for conscience should never allow a provider to be in a “blocking position,” which is far more likely to be the case with a large regional hospital than with an individual specialist.

An absolute, unfettered right to refuse to provide a contested service could significantly threaten the public’s ability to receive services—especially if few or no others were willing to perform it [30, 31]. An unqualified institutional accommodation will almost always wipe out access for huge numbers of people because institutions serve huge numbers of people. Precisely because Catholic hospitals across the country account for 17 percent for all hospital admissions [32], many are rightly concerned when Catholic hospitals receive protection against dispensing emergency contraceptives [33]. Compounding this, many hospitals seeking religious protections possess monopoly power in their relevant communities. Indeed, Catholic hospitals are the sole hospital in 91 counties in the U.S. [34], a number that will surely grow as Catholic hospitals continue to acquire and merge with non-Catholic health systems [35].

Given all of these facts, one might believe that legislators would be loath to give institutional protections rather than individual conscience protections. Yet institutional accommodations may be easier to secure than individual accommodations because hospitals are powerful organizations that can lobby for their interests. Moreover, the market power that raises the specter of reduced access also favors the granting of institutional protections. Why? Many religious leaders have said they will close their institutions before violating their religious commitments. On the heels of the mandate, for instance, Cardinal Francis George, the Archbishop of Chicago noted that the Archdiocese’s directory of holdings contains “a complete list of Catholic hospitals and health care institutions in Cook and Lake counties,” and ominously warned, “two Lents from now, unless something changes, that page will be blank” [36].

Policy makers should take seriously institutions' threats of closing, which elsewhere we have described as the "nuclear option" [23]. In other contexts, religious objectors have acted on their promises to close. For example, Catholic Charities of Boston closed its adoption services after 103 years of placing kids for adoption when an exception to rules requiring them to place children with same-sex couples was not forthcoming [37, 38]. In Washington, D.C., Catholic Charities discontinued insurance coverage for spouses of new employees when faced with laws that would require them to cover spouses in same-sex marriages in violation of their religious beliefs [39]. Objectors are taking the nuclear option elsewhere, too [40-42].

Of course, threats of closure should not be the end of the analysis. Legislators and regulatory bodies would be wise to consider a range of factors when evaluating claims for an accommodation, including the existing market share, market concentration, the scarcity of other providers, the likelihood that the owner would sell a facility rather than shutter it, the likelihood of the government's or a private buyer's acquiring the facility in advance of any shut-down, how long any transition would take, and how likely it might be that the objector would bend to civil strictures rather than exit the market [43]. With Catholic-affiliated hospitals accounting for so many inpatient admissions nationally [44], and with many markets served exclusively by a sole Catholic-affiliated hospital [34, 35], policy makers may well be unwilling to engage in a high-stakes game of chicken [23].

### **Creative Methods for Balancing Access and Respect for Conscience**

Importantly, most difficulties patients experience in getting a controversial health care service are not real access issues, as in "No accessible person or institution will perform an abortion (or other procedure) for me" [31]. Instead, they are information problems—in other words, the patient has no idea how to find the person who is willing to provide the abortion or other procedure for her. Such information problems pose a more significant hurdle for lower-income patients [45].

Many states have responded to precisely this kind of knowledge gap about access to controversial services through formal and informal "information networks." For example, Oregon and Washington give an unqualified right to refuse to participate in physician-assisted suicide to pharmacists, physicians, and hospitals that are religiously opposed to facilitating it. State policy makers did not stop there, however. They ensure patient access with lists of willing providers on the Internet, through hospice organizations and other information networks [46, 47]. Such information networks allow the patient seeking the service to get it without great dislocation, while allowing unwilling providers to live by their convictions [48].

### **A Qualified Right to Object**

More fundamentally, policy makers can accommodate most religious objections while preserving access to needed services by giving a qualified right to object. In this scheme, religious objectors are permitted to step aside from a service they find morally or religiously objectionable when doing so would not cause hardship to patients—typically when another willing physician or institution can just as easily

provide the service. Federal conscience protection need not jeopardize patient access to abortions because an extensive network of abortion providers exists across the United States [31]. Qualifying conscience protections with hardship-minimizing requirements would prevent institutions with religious objections from acting as a choke point on the path to services. Instead it would require the institution to inform patients about where to obtain the service. For institutions, this may require advance research about where to refer patients so that medically necessary services are made available to all patients who need them. This scheme not only accommodates religious objections, but it promotes access to the necessary service, solving the informational problems that patients frequently face. A duty to refer respects institutions that say such interventions are contrary to their mission. While a religious objector may claim that providing information about an objectionable service facilitates the objectionable service, information in medicine is so central to patient care that the duty to provide accurate information should be nonnegotiable [49]. A Catholic hospital seeking to open in a rural community can abide by its conscience and ensure patient access by joining forces with another clinic that provides the objected-to services. A little creativity and planning can go a long way in respecting religious and moral objections *and* the legitimate needs of the public for services.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 236-239.

## POLICY FORUM

### Protecting Positive Claims of Conscience for Employees of Religious Institutions Threatens Religious Liberty

Christopher O. Tollefsen, PhD

An important good for doctors, nurses, and other health care professionals could be described as that of “professional freedom.” This is the good of being able to bring one’s professional medical knowledge and one’s commitments to the norms and values of the medical profession to bear on one’s professional judgments and actions. This is, after all, one of the important aspects of being *in* a profession: professionals are not merely technicians performing the same routine tasks over and over, nor are they functionaries, blindly carrying out orders from above with little or no discretion on their part.

It is partly for this reason that stories of doctors or nurses who are prevented from, or punished for, carrying out their professional judgment in a clinical setting can seem so problematic. There are other reasons, of course: when a patient suffers because a physician has been prevented from doing what he or she thought was the right thing, then there is clearly a problem. But even apart from that, there seems to be a violation of professional freedom when doctors are prevented from acting in accordance with their best judgment.

This sense of violation is increased when we consider that a doctor’s best judgment, in the circumstances, and guided by her commitment to her own and the profession’s values and norms, is in fact a judgment of *conscience*. For judgments of conscience are just the work of practical reason being brought to bear on a concrete situation and issuing in a determination of what one *ought* to do: to perform this procedure, to make this recommendation or referral, to provide this medication [1]. And so a doctor’s inability to carry out a procedure she has determined to be required, or to make a recommendation she thinks warranted, or to provide the appropriate medication, can seem not just an infringement of professional freedom, but of conscience.

Clearly such infringements are on occasion justified, and proposals to allow medical professionals to carry out *all* judgments of conscience are unreasonable: a sincere but not clinically justified judgment to sterilize a poor woman against her will, or to provide a Jehovah’s Witness with a blood transfusion against his will, are both judgments of conscience that are prohibited at law, even when a doctor believes that the action in question is not simply permissible but obligatory. In such cases, the patient’s rights to bodily integrity and religious liberty, respectively, are thought to override the right to professional liberty on the part of the doctor.

The considered judgment of the profession itself also is allowed to trump individual judgments; when a procedure has been judged contrary to the goals of medicine by the vast majority of the profession, then the judgment of the profession is taken to have normative authority for all professionals; moreover, that authority might itself eventually be translated into a legal judgment. Thus, subsequent to widespread medical denunciation of female genital circumcision, now more commonly called female genital mutilation, the U.S. Congress passed a law forbidding such a practice on girls younger than 18 [2].

What, though, of the professional freedom of doctors and nurses in religious institutions? Their freedom has typically been thought to be rightly limited: such institutions can specify a range of procedures that are forbidden to its employees and enforce their bans with some degree of sanction and coercion. Perhaps the most prominent case in recent years is the Phoenix abortion case, in which an abortion was performed in a Catholic hospital on a young mother with pulmonary arterial hypertension, with subsequent punishments exacted by the bishop of the diocese [3]. Doctors in that case may plausibly be thought to have asserted what Mark Wicclair has called a “positive” right of conscience to perform an abortion the patient has consented to, an assertion clearly in line with the right of “professional freedom” I have outlined above [4].

The Phoenix case raises a larger issue, however, one brought to prominence in Wicclair’s essay: should positive rights of conscience—rights to exercise one’s professional and moral judgment in a committing a prohibited act—be protected for employees of religious institutions whose views conflict with that institution’s norms or ethics? Ought a doctor who believes she should recommend or perform an abortion, or prescribe or provide emergency contraception, for example, be allowed to do so, even if it would be contrary to the stated norms and policies of the religious institution for which she works?

Abstracting from the specifics of the Phoenix case, I believe the answer here is no: to broaden conscience protections of individuals within religious institutions that enforce the norms and proscriptions of a given religion would be a fatal blow to the good of religious liberty and, in fact, to the good of professional freedom as exercised by religious groups and institutions.

Consider first the good of religious liberty: the good of being able to determine what one’s religious vocation is, and how, and with whom, that vocation is to be pursued. For some not insignificant number of Christians, for example, that vocation is to minister to others as Christ did, whether in the field of health care or in some other domain of apostolic work. Moreover, their vocation is to do that *in community with others*, joining together in a cooperative venture to provide health care to the needy in accordance with the tenets of their religious faith.

The good of religious liberty is among the most valued goods that reasonable political states exist to protect. And while it is true that infringements of this liberty

can be justified, justification for a significant infringement of religious liberty must itself be significant: the common good must make a very strong demand that cannot be met in any other way [5].

But a law that created general conscience protections for “positive” rights of conscience would be, in effect, a law that destroyed the ability of religious groups to govern themselves in accordance with their religious convictions in the field of health care. Catholic health care professionals share a normative judgment that views unborn life as sacred and that involves a refusal to kill anyone, including an unborn child. Catholic institutions formed around shared commitment to this norm thus prohibit direct abortion, and try, though perhaps not as hard as they should, to insure that all who undertake the mission of the institution are on board with that institution’s commitments regarding human life. To protect judgments and actions within the institution that are radically contrary to those commitments, however, is to deny the institution the liberty necessary to act socially for the sake of those shared commitments; hence it is to violate the religious liberty of the group.

Moreover, those judgments, though specifically Catholic, are *also* health care judgments. That is to say, medical professionals who are Catholic, and who join together to provide Catholic health care, understand what they are providing as genuine health care. They understand abortion not simply as wrong from a Catholic standpoint, but as a violation of their health care vocation: it is anti-health. Similarly, many also see the provision of contraceptives as contrary not just to their Catholic morality, but as contrary to the ethos of medicine: contraceptives do not address any medical condition, and in fact act contrary to what is, strictly speaking, the healthy and normal functioning of the body. So positive conscience protections afforded to dissenters from this view who nevertheless work within institutions whose guiding presuppositions track this line of thought would also undermine the freedom of Catholic health care professionals to be professional in the way that they see fit. It would become impossible to sustain an institutional existence predicated on the Catholic conception of health and health care.

Of course, in extreme cases a religious institution’s ethical and medical judgments might be positively damaging to the common good: if that institution refused to serve women, or worked on the basis of a demonstrably false conception of medical science. Such institutions would and should be subject to a range of legal and professional sanctions. But Catholic judgments about abortion and contraception fit neither description: they are contested morally, to be sure, but they are not in the domain of irrational prejudice; nor are they scientifically obscurantist. What health is, and what its requirements are, are, at their boundaries, contested ideas, even among health care professionals. In the absence of a much more robust consensus than currently exists in the medical profession, it is consistent with professional comity to allow reasonable disagreement to shape difference of practice within the profession. That is an aspect of legitimate professional freedom.



Accordingly, I believe the idea of protections for positive rights of conscience for health care workers in Catholic (and many other religious) institutions, where the judgments of conscience in question run contrary to the foundational commitments of the institution, to be a non-starter: its facial deference to the rights of conscience actually conceals a deeper antipathy to the rights of conscience and religious liberty that are exercised not just by individuals acting in isolation from others, but by individuals acting cooperatively together with others to serve essential goods in accordance with their deepest religious and professional convictions.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 240-243.

## POLICY FORUM

### Should Physicians Participate in State-Ordered Executions?

James K. Boehnlein, MD

Physician involvement in state-ordered executions has emerged as a controversial issue in medical ethics in the United States over the past couple of decades, due primarily to the increased, and now virtually exclusive, use of lethal injection for capital punishment. Although executions over centuries have employed firing squads, hanging, electrocution, and gas asphyxiation, lethal injection is now the sole method of execution accepted by courts as humane enough to satisfy Eighth Amendment prohibitions against cruel and inhuman punishment, as confirmed by the Supreme Court in *Baze v. Rees* [1].

Physician participation is central to execution by lethal injection because medical knowledge and skills are integral to conducting the procedure effectively. This means, however, that medical technology and physician expertise are utilized to end life rather than to sustain it. Those who believe that there should be medical participation in lethal injection argue that, since executions are a legal way for society to carry out retributive justice for those who have been convicted of heinous crimes, and since the execution will occur anyway, the participation of medical personnel is essential to minimize the suffering of the condemned prisoner.

If not done properly, the sequential use of sodium thiopental for anesthesia, pancuronium bromide for paralysis, and potassium chloride to cause cardiac arrest can go awry at any stage. For example, before the 2008 U.S. Supreme Court ruling upholding the constitutionality of capital punishment by lethal injection, a number of prisoners executed in California had not stopped breathing before technicians had given the paralytic agent, raising the possibility that they had experienced suffocation from the paralytic and felt intense pain from the potassium bolus [2]. Following a number of these botched executions, physicians and other health care professionals have increasingly been sought to provide consultation, place intravenous lines, mix and administer drugs, and monitor results [3]. But even evaluation of lethal injection drugs and procedures by various states has been problematic because none of the drug protocols were ever tested in animals before they were employed, and ongoing evaluation of drug protocols and devices resembles human subjects research, but without the usual established protections [4].

Those who are opposed to physician participation in lethal injection argue that it is unethical on several counts: physician skills and procedures that contradict established medical practice are being used to carry out government mandates; a previously nonmedical social and judicial act is being medicalized; executions by

lethal injection are carried out in a quasimedical setting and give the impression that a medical procedure is being administered [5]; and the doctor is using knowledge and skills attained during medical education and is recognized by society as possessing and using those specific skills that are normally used to sustain and enhance life [6].

Those who argue for the validity of physician participation point out that professional medical organizations should not interfere with a doctor's personal beliefs about the suitability of capital punishment [7]. They refer here to the American Medical Association's (AMA) *Code of Medical Ethics*, which states that an individual's opinion on capital punishment is his or her personal moral decision but that "a physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution" [8]. In other words, a physician, just like any other individual in society, is entitled to his or her own opinion on specific ethical issues, but when he or she is utilizing medical knowledge or skills as a physician in any social realm, professional ethical standards should apply. To put it in stark terms, as Truog does, this would not prohibit physicians from participating in a firing squad (in their role as citizens), but it would prohibit their participation in lethal injections (in their role as physicians) [9].

An argument is sometimes raised that these professional standards may not apply to lethal injection because there is no established doctor-patient relationship. But the lack of such a relationship does not lessen the doctor's responsibility; even though a therapeutic relationship does not exist, the physician is still using medical knowledge and skills and still viewed by the corrections system, the state, and as society as functioning in a medical role. In addition, the condemned prisoner is not in a position to consent to or refuse what would normally be a medical procedure conducted by a physician (insertion of an IV and injection of drugs).

This leads to another important point of argument and discussion. Those who argue for a more permissive role for physicians in lethal injection assert that professional norms are not exclusively internal to the profession of medicine, but must be negotiated with society at large [7]. They point to the diversity of attitudes within the profession towards physician participation in assisted suicide and abortion, despite prohibition of the former by national professional organizations, as evidence of a more fluid interface between professional and social ethical norms. These proponents of physician choice on participation have a strong argument regarding the apparent inconsistency between professional standards that sometimes view physician-assisted suicide favorably [10] and physician participation in lethal injection unfavorably. However, their permissive argument breaks down in the context of consent—in lethal injection there is no consent by the condemned prisoner and there is no doctor-patient relationship as there is in physician-assisted suicide.

So a number of ethical issues make physician participation in lethal injection problematic. These include the medicalization of what is essentially a civil and legal

procedure related to retributive justice and undertaken primarily to serve the goals of the state [9]. The fact that there is no patient-physician relationship and no consent to treatment actually supports the argument against participation rather than the one in favor of it. Even if there were a physician-patient relationship, which there is not, the result of an execution clearly harms the executed person without offsetting benefit [11]. Even though proponents of execution by lethal injection argue that it causes the condemned prisoner less suffering than other methods of execution [2], the end result is still the irrevocable death of the condemned prisoner. Furthermore, it is not the responsibility of medicine to ensure that executions take place—the use of and method for capital punishment are political and legal questions [12].

A coherent and internally consistent set of norms for ethical conduct for physicians can be constructed based upon the goals of medicine, and these norms (drawn for centuries from widely accepted sources such as the Hippocratic Oath, which specifically states “I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan” [13]) prohibit the involvement of physicians in state-sponsored killing [9]. Today that tradition includes the stance that it is immoral to develop humane methods to kill people legally [14].

Professional values in medicine evolve in dynamic interaction with social norms. But defining one’s professional role exclusively by societal norms diminishes individual professional responsibility to appropriately use the knowledge and skills of healing that are attained during medical education and training [6]. The physician needs to be cognizant of how his or her role is viewed by society in any given era and at the same time be able to clearly understand how the profession of medicine has developed and defined appropriate professional norms regarding physician behavior in actions related to life and death. This awareness must begin early in medical education and continue throughout professional life. This examination is not an easy task but it is essential to maintain individual and collective professional integrity in complex social situations that involve medical ethics.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 244-248.

## MEDICINE AND SOCIETY

### Autonomy, Conscience, and Professional Obligation

Robert D. Orr, MD, CM

*“No provision in our constitution ought to be dearer to man than that which protects the rights of conscience against the enterprises of the civil authority.”*

*Thomas Jefferson, speech to the New London Methodists, 1809 [1]*

Health care professionals have a fiduciary relationship with their patients; i.e., because they have greater knowledge and authority than their patients, they have an obligation to be trustworthy and to serve patients’ best interests. This has been taught since the era of Hippocrates and continues in contemporary medicine, as stated, for example, in the American Medical Association’s Principles of Medical Ethics [2].

At the same time, health care professionals are individuals, each with a conscience. Sometimes conscience requires the individual to perform or not perform a particular action. The right of conscience is the right of an individual to refuse to do something requested by another based on his or her own conscience or religious beliefs. An example would be the conscientious objector to war who is unwilling to engage in combat, or sometimes even in a supportive military role.

This right of conscience is not a new idea. Recognized by theologians for centuries, this right of conscience began to gain credence in secular circles during the Enlightenment, as noted by Thomas Paine [3] and Thomas Jefferson [4]. The right of conscience was clearly stated in early drafts of Madison’s first amendment to the U.S. Constitution [5], though somewhat obscured in the shortened final version [6].

The right of a physician to refuse to provide a requested treatment similarly has ancient roots. Hippocrates, in writing about the goals of medicine 2,500 years ago, defined good medicine as “doing away with the suffering of the sick, lessening the violence of their diseases, and refusing to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless” [7]. Though physicians who practice modern palliative care would quibble with his assertion that medicine is powerless when a patient is dying, nevertheless the father of Western medicine recognized and taught that there are limits to what can be done, and that physicians should be willing to “just say no.”

For centuries physicians took a primarily paternalistic approach to patient care. In the 1960s and ’70s, a societal consensus supporting individual autonomy emerged in Western culture—individual rights, women’s rights, minority rights, consumers’ rights, and yes, patients’ rights. Many felt that patients should have greater say in

their own medical care. When the locus of decision making shifted at least partially from physician to patient, many thought that the patient could not only refuse but also demand treatment. Only in this autonomy-oriented setting has the physician's right of conscience been at issue.

The concern about the right of conscience in health care is most often raised in relation to abortion. The American Medical Association recognizes and supports the right of conscience in its statement on abortion [8]. However, this right is also a factor in other aspects of the practice of obstetrics and gynecology (sterilization, contraception, assisted reproductive technology) and in other medical areas as well (end-of-life care, prisoner interrogation, capital punishment, research, and more).

It is a common misconception that patients have an autonomous right to demand, as well as refuse, treatment. But this is not so. Negative autonomy—the right to refuse medical treatment—has been clearly established as nearly inviolable through a series of court cases [9, 10] and the practical difficulty of forcing treatment on someone who resists it. There must be a very strong justification for overriding a patient's refusal. An example would be a young man injured in a motor vehicle accident, sustaining a severe facial injury that threatens to take his life if his airway is not immediately reestablished. If a person in such a situation physically resists intubation, it is generally considered ethically justifiable to assume the refusal was influenced or caused by hypoxia and panic, hold him down, and insert an endotracheal tube over his objection in order to restore his airway and save his life. Apart from such uncommon exceptions, physicians are almost always obligated to comply with the refusal of even life-sustaining treatment by a competent patient who has been adequately informed of the consequences of refusal and has applied his or her own values in making the decision to refuse.

On the other hand, the case for positive autonomy—that a patient's demand obligates a physician to provide a treatment—is not nearly as compelling. The paradigm here is the professional's right to refuse to provide a requested abortion if doing so would violate the professional's conscience. This right of the physician to refuse is well established in U.S. federal law [11], U.S. state laws [12], and international law [13]. In addition, this right of conscience is upheld by other professional position statements, e.g., that of the American Academy of Pediatrics [14].

It is noteworthy that physicians are allowed without question to decline to provide procedures or services for other reasons, but if they use the right of conscience as justification, this right to refuse is not infrequently challenged [15]. For example, physicians are “allowed” to refuse on the basis of a legal standard (e.g., a request for a nonapproved drug), a professional standard (e.g., a request for nonbeneficial treatment such as hyperbaric oxygen for a completed stroke), clinical judgment (e.g., a request for an antibiotic to treat a viral infection), or even a personal choice (e.g., in non-emergency situations, doctors are free to refuse patients for nondiscriminatory reasons). But if the physician says “I am unwilling to do this elective abortion because it would violate my conscience,” some support the physician's right of

conscience and others argue this is insufficient justification for refusing a patient request and might even assert that such a physician should not be licensed to practice medicine [16]. The presumption here is that because the state has the authority to grant a medical license, it also has the right to require that an individual physician provide all legally available procedures or treatments that are within his or her specialty. This presumption is contrary to the well-established support outside of medicine for an individual's right of conscience.

In 2007 the American College of Obstetrics and Gynecology (ACOG) developed a position statement on "The Limits of Conscientious Refusal in Reproductive Medicine" [17], which states that, in resource-poor areas, physicians who are unwilling to provide all reproductive services should "practice in proximity to individuals who do not share their views or ensure that referral processes are in place." Does the professional who declines a request based on conscience have a duty to refer to another professional who is willing? One physician may be unwilling to do an abortion, but willing to refer; another may be unwilling to refer, believing that makes him or her complicit in an immoral act. One nonprofessional may be unwilling to work in a general ob/gyn clinic where abortion is one of the services offered, while another may be willing to work there but decline to participate in any aspect of the procedure, feeling sufficiently removed from it and able to care for other patients. In thinking about the issue of moral complicity, I have previously written that many factors may enter into one's perception of involvement: timing, proximity, certitude, awareness, and intent [18]. A particular focus or emphasis, for example, may lead different people to draw different lines of moral complicity.

So is there a consensus on whether refusal to refer is justifiable on the grounds of conscience? In a large cross-sectional, stratified survey of physicians in several specialties, Curlin et al. found that 71 percent of respondents believed that a physician who refused a request for a legally available service was obligated to refer the patient to a willing professional [19]. Even 56 percent of the physicians self-described as having high intrinsic religiosity supported this obligation to refer, whereas 82 percent of those with low intrinsic religiosity did. As with any yes-no voting procedure, the fact that one position gains a majority of votes tells nothing about the rightness or wrongness of the minority position. Here, it says only that different professionals draw different lines for complicity in immoral actions.

Disagreement about the right of conscience in medicine has led to a spectrum of belief ranging from those who support the right of the health care professional to express and exercise that right, to those who believe the societal obligation to provide service to patients outweighs his or her obligation to personal conscience.

While I earnestly support the right of conscience, I recognize that some individuals who articulate this stance have made invalid claims. An example would be a pharmacist who refuses to fill a prescription for an abortifacient (in my view, a valid refusal if based on conscience) but goes further and confiscates the written prescription, refusing to return it to the patient. While he or she might claim civil



disobedience as justification, this has stepped over a line to obstruction of the patient's legal right. At the other end of the spectrum are those who assert that a physician who is unwilling to provide a legitimate service should no longer be licensed to practice medicine. Such a stance implies that the physician is merely a technician who either has no moral boundaries or is prohibited from exercising them.

In summary: the right of conscience in medicine is longstanding and based on a clear understanding of individual autonomy. Questioning of the right of conscience in medicine has, to date, relied on (a) an incomplete examination of the relationship between negative autonomy and positive autonomy, (b) an invalid presumption that a licensing body has the authority to mandate a physician's scope of practice, and (c) valid reactions to the occasional abuse of the right of conscience by some physicians.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 249-256.

## IMAGES OF HEALING AND LEARNING

### Refusal in “Bartleby, the Scrivener”: Narrative Ethics and Conscientious Objection

Alvan A. Ikoku, MD

#### Introduction

In 1853 Herman Melville published “Bartleby, the Scrivener,” his now most well-known piece of short fiction, which over a century and a half later we can certainly read as an illuminating dramatization of conscientious objection [1]. There are, of course, important differences between Melville’s approach to refusal and how we have come to discuss it in medical ethics. The story’s setting, for instance, is not clinical; the central exchanges are between the head of a law office and an employee who politely but insistently refuses to carry out his understood duties. The stakes of each demanded task are not as clear and urgent as those in medicine. But Melville was writing figuratively here, at a moment in his own career when he decided *not* to write the kind of fiction expected of him and *not* to fulfill the presumed duties of his profession [2-5]. He persisted, instead, in making his case for literature as a means to explore the period’s more vexing philosophical questions. And his mode of objection—a literary one—produced for readers of his time and ours an opportunity to understand the texture of refusal and to examine its moral dimensions in the formal setting of narrative.

Melville’s objection also has ethical resonances for scholars of the mid-to-late nineteenth century, who have regularly emphasized how central conscience, duty, and religion were to the period’s debates on slavery, war, and capital punishment [6-8]. It is no coincidence, then, that by the time of his death in 1891 Melville had been more openly thematizing conflicts between individual character and societal obligations. His work in this vein is often identified in *Billy Budd*, a last unfinished novella [9], in which moral conflict is set at sea in the struggles of a ship captain to abide by the law and execute a comparatively innocent, though legally mutinous, sailor [10]. In this novella we are taken through a series of deliberations to something like a culminating insight on consciences, that though they remain “as unlike as foreheads,” each and every intelligence, “not excluding the Scriptural devils who ‘believe and tremble,’ has one” [11, 12].

Melville’s narrator here famously recognizes the plural nature of conscience, its relationship to intelligence, its place alongside religion, and the universal access to it humans are meant to enjoy. But that insight is also fleeting, and there remains a sense that Melville’s work on the matter was unfinished, that in its unresolved qualities his novella describes the unfinished project of post-Civil War society, that it prefigures an ongoing effort to ascertain the conditions under which one may

exercise private morality in the setting of contested law, and that it maps out fiction's promise as a method for further deliberation. It is a promise carried through by present-day scholars in the field of law and literature, who have taken up the novella as a source text for a branch of ethics examining the moral limits of professional obligations and the moral costs of dutifully attending to what one may not believe to be right [13].

As may be clear already, there is much that the field of literature and bioethics can say on the matter of conscience. My own comments will center on the contemporaneous intervention of narrative ethics in bioethics and medicine, and then on the insights a further reading of Melville could offer to our current discussions of refusal for conscience reasons.

### **Narrative Ethics and the Dialogic Imagination**

The debate on conscientious objection raises a number of contentious issues: namely, questions about the form and content of what we may define as a rigorously ethical referral—questions, that is, about the extent of an objector's responsibility to not only fully inform but also empower a patient to access care elsewhere; questions, too, about aspects of authority conceded by a physician when explaining refusal in both medical and moral terms; and questions about the different quality of duty met when objecting clinicians remain open to persuasion by patients. I would argue that addressing these questions would be difficult without an approach to dialogue that has for some time been illuminatingly characterized in literature and its theorization—in humanistic writing that has since the nineteenth century not only honed several literary means for dramatizing the complexities of conversation in the setting of refusal but also thought through the obligations to engage with an *other* in ways that dutiful forms of dialogue demand [14-16].

The claim I am making here is central to the fields of literature and medicine, narrative medicine, and narrative ethics, in which scholars and practitioners such as Howard Brody, Tod Chambers, Rita Charon, Arthur Frank, and David B. Morris have endeavored to translate ethics insights from literary study to the clinical encounter [17-21]. Their projects are admittedly disparate and evolving, but they share the effort to bring literary attention to bear at moments when medical narratives are listened to, written, and read—the effort, in other words, to do for discourse in the clinic what theorists like Mikhail Bakhtin have done for discourse in the novel [22, 23].

The general temptation has been to conflate advances in narrative ethics with advances in teaching communication and cultural competence at medical schools and residencies. This temptation, and its power, emerge from medicine's understandable emphasis on procedural skills to be perfected and incorporated rather than on theoretical insights that call for profound shifts in practice and approach. That emphasis has helped generate ways to make narrative ethics immediately useable by physicians and more easily folded into established methods for handling the difficult conversations conscientious objection may now require. Yet the reduction of

narrative ethics to a set of extractable skills comes at a great loss, particularly when the reading of its source texts—literature—no longer seems essential. The more difficult and potentially instructive goal would be to have dialogue remain a site of interdisciplinary engagement, where several understandings of the term *dialogic* (derived from scholarship in the ethics of reading as well as the ethics of medicine) may intervene on equal footing and thus make clear the critical value of the medical humanities [24, 25].

To put it another way, the more robust response of narrative ethics to the questions raised by the conscientious objection debate would be to insist that ethical conversations between physicians and patients are not possible without a concern for how we responsibly engage with others in person and in representations. That the hoped-for shift in contemporary bioethics away from universalizing principlism to microethics, away from applying broad precepts to enabling individuals to think through the particularities of their positions, necessitates not just an exchange of values but also a translation of their meaning—and that this ideal dialogue cannot easily occur in the absence of an exercise in reading *or* of the imagination. Nor can physicians and bioethicists become adept at it without continually returning to literature.

If we were to accept this strong argument for narrative ethics, we would take up as a clarifying example Melville's open invitation to read his fiction allegorically, and reexamine the dynamics of conscientious objection with "Bartleby, the Scrivener" as a focalizing lens. Again, literary criticism teaches us to approach the story as a dramatization of refusal that is no less conscientious for the mysterious nature of its rationale. Bartleby famously communicates little more than what he "prefers not to do." Yet the presumption of the narrative, and of the lawyer who tells this case, is that there is a temporarily inaccessible reason for Bartleby to not "come forth and do [his] duty," and to not comply with a request made "according to common usage and common sense" that he serve as scrivener and carefully reproduce the expected discourse of the profession.

There is value, then, in maintaining a reader's sympathy with the lawyer, who responds to Bartleby's refusal in the terms and stages given to him by a professional code of expectations, moving from surprise and query and complaint to indifference and preoccupation, repulsion and pity, departure and return, dismissal and punishment. What comes next is death: by the story's end, Bartleby has refused to do his duties, refused to leave the premises (or profession), been arrested as a vagrant and sent to the Tombs, where on being visited by his former employer he refuses to eat.

This is obviously refusal pushed to an unlikely extreme by Melville, but it magnifies for us aspects of professions that reproduce profound failures in handling objection and the fact that these failures recur even when—or especially when—the intent is an exchange of reasons and values. "Bartleby" makes evident the impasse that arises when opposing attitudes to dialogue meet and the consequences of that impasse in

the absence of any overlap in understanding. Fiction here does not imagine away the way structural relations within professional communities frame dialogue or how our handling of those relations may be reproduced when the profession meets with outside society. And given privilege of place is the poignancy—felt at the end by lawyer and reader—of dismissing from the profession members who do not reach or participate in consensus [26]. In this reading, Bartleby’s death would not represent the actual passing of an objector, but it does crystallize the moral injury of marginalization as borne by the refuser and the profession that rejects him.

Still, to read “Bartleby” only as a negative example would be to miss the critical reading and writing practices the story demands and the lawyer models, the insights about form and language they both provide, and the opportunity to notice several aspects of what we may now readily see as the ethical texture of refusal: namely that Bartleby’s repeat objection disrupts the normal proceedings of a profession (one central definition of an ethics case) [23], that his willed death haunts the conscience of a professional (another core definition) [27], and that both compel the lawyer to reflect via narration, to review his encounters with Bartleby using an alternative mode of analysis, employing conventions of telling not commonly understood as legal, and producing writing that no longer fits within the professional discourse he had repeatedly asked Bartleby to reproduce.

The story itself therefore enacts a discursive irony and reversal, an unraveling of the lawyer’s established ways of writing, and if we were to follow this reversal from the story’s chronological end back to the textual beginnings, we would be reminded of its central place in the lawyer’s own ethical turn. We would notice that though he sets out to give account of a “more than ordinary contact” with the “strangest” scrivener he had ever seen, he frames the account to follow with an acknowledgment of its incompleteness, of his inability to provide “a full and satisfactory biography of this man,” and of the “irreparable loss to literature” that the lacuna represents [28]. Loosened from the surety of legal contract and case, the lawyer admits to the fallibility of his representation, and he does so as an early act of responsibility to Bartleby. So in lieu of a biographical history explaining Bartleby’s recalcitrant nature comes the setting of a different scene—an extended review of “my life, my employe[e]s, my business, my chambers, and general surroundings”—a laying out of his profession that he provides because it is now “indispensable to an adequate understanding of the chief character about to be presented” [28].

This is an archetypically narrative convention, and the move sets aside the desire to ascertain the characterological origins of Bartleby’s objection for the more self-reflective project of describing its conditions. And what it places on display, what it permits us to recognize and examine, are the various rhetorical forms objection can assume; the effect of expressing refusal as Bartleby does, in terms of a negative preference; how this nuanced resistance serves as an entry point, a way in which objection has often been introduced into professions; how it serves as a means of negotiating past the powerful rhetoric of policy and duty to articulate an internal critique; how, too, such language alters the scene of practice, permeates the diction

of colleagues, and eventually becomes essential to the lawyer's means for shaping his own ethical voice and conscience. Here below is a notable passage, worth quoting at length because it effectively dramatizes how confluent moral provocation and moral deliberation become in scenes of objection:

Nothing so aggravates an earnest person as a passive resistance. If the individual so resisted be of a not inhumane temper, then, in the better moods of the former, he will endeavor charitably to construe to his imagination what proves impossible to be solved by his judgment. Even so, for the most part, I regarded Bartleby and his ways. Poor fellow! thought I, he means no mischief; it is plain he intends no insolence; his aspect sufficiently evinces that his eccentricities are involuntary. He is useful to me. I can get along with him. If I turn him away, the chances are he will fall in with some less indulgent employer, and then he will be rudely treated, and perhaps driven forth miserably to starve. Yes. Here I can cheaply purchase a delicious self-approval. To befriend Bartleby; to humor him in his strange wilfulness, will cost me little or nothing, while I lay up in my soul what will eventually prove a sweet morsel for my conscience [29].

There is here both the reenactment of forms of reasoning provoked by instances of refusal *and* the overlay of belated insight produced upon retelling and revisiting the encounters. Both kinds of thinking are often placed under the rubric of "ethics," though it is the latter that makes it possible for the lawyer to *see* charity, judgment, self-interest, self-approval, conscience, mood, and even the imagination, to be able to review and assess these facets of encounter in a manner akin to the processes of critical reflection advocated by "medical ethics." The belated nature of the lawyer's review points to a number of missed opportunities, a different set of admissions to have made to Bartleby, and a different way to have entered into conversation. Yet the insight also readily reveals how ethical understanding during actual encounters is often articulated in silence in large part because it is often *being* produced at that moment, as an integral part of the response to, and being in relations with, an other.

Melville's story essentially narrativizes the development of a moral imagination through the act of fallible, nonprofessionalized, and self-aware representation. Reviewed in this way, dialogue in the setting of refusal no longer features an ethics of the self, distinct from the other, nor does it rely on a set of personally held values to be explained and exchanged. Conscience, however varied its manifestation, is formed and reformed in relation. And this is another fact of conversation that "Bartleby" refuses to let readers imagine away or as a qualification. Extrapolated out from fiction, then, the conditions for a productive and ethical instance of conscientious objection would start with an acknowledgement of the values being constituted at moments of encounter.

## Conclusion

“Bartleby, the Scrivener” ends with the lawyer’s gaining something like empathy and understanding—his oft-quoted insight into humanity—when he learns of Bartleby’s previous employment in the Dead Letters Office, where his duties would have been to burn correspondence that hadn’t reached its intended destination. Much has been written about the possible content of that understanding, but I would again focus on the methodological import of that moment and on the characteristically literary insights it offers to our ongoing discussion of conscientious objection. The bleak light at the demise of Bartleby certainly exemplifies for readers a kind of conscience and consciousness that may develop when an exchange of values has failed, when death has resulted instead of care. But it is also worth reiterating that the lawyer arrives at that place via a textual shift in practice and an imaginative shift in perspective. Giving account of self and Bartleby in an alternative mode has awakened in him an ethical form of “curiosity” to think through an imagined circulation of texts, in order to consider the possible effects, even the meaning, of Bartleby’s placement and displacement within that circulation. This form of empathy is not simply interpersonal, though it cannot help but be, precisely because it is openly imaginative and enables the lawyer to both recognize and see past the contours of his struggle with Bartleby.

The mode of perception at Melville’s ending thus presents a model for developing different ways for society to handle refusal—the kind of reading and writing that could produce different endings to similar cases as they occur just outside the borders of fiction. The recent situation of Savita Halappanavar in Ireland, for example, only clarifies rather than confuses matters [30-32]. For even as—or if—inquiries make evident that no “Catholic ethos” factored into the nonprovision of care and that this was not a case of physicians uncertain of the legal consequences of carrying out either duty, the case still foregrounds the difficulty and even incapacity of law and medicine’s professionalized approaches to bring about the brand of dialogic ethics that care demands, which must occur simultaneously at the level of encounter and society.

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 257-262.

## OP-ED

### **The Limits of Conscientious Refusal: A Duty to Ensure Access**

Margaret Little, PhD, and Anne Drapkin Lyerly, MA, MD

What is the role of conscience in medicine? Some have argued that physicians who have conscientious objections to providing certain services have a responsibility to avoid entering specialties in which their objections would arise. Indeed, some argue more strongly that those who willingly enter a specialty knowing of conflicts have forfeited claims for protected refusal, since they would have been free to avoid the situation altogether by choosing another specialty [1]. After all, it is said, medicine is not just any business: it is a licensed monopoly, and with licensure comes heightened responsibilities.

Patients—especially those in rural areas or those in emergency situations—often lack the ability to choose who will care for them; and those who do have options should not have to face the burdens of finding—or suddenly shifting to—clinicians who can meet what the profession itself regards as a legitimate need. Given all this, fairness requires that patients be protected from the harms that clinicians' conscientious objections can engender by making provision of all services regarded as core by the specialty a condition of professional licensure.

We appreciate and applaud the desire to protect patients' access to important services, and we certainly agree that health care professionals have a responsibility to reflect on and explore ahead of time moral issues likely to arise in specialties when making career decisions. But we do not agree with such a stark interpretation of the terms of membership in a given area of practice. Medicine by its very nature intersects with some of the deepest matters in life about which good and reasonable people disagree. Provision of need through one lens is commitment of the gravest moral wrong viewed through another. We cannot expect to find canonical agreement on issues of perennial complexity; to limit the guild to those who concur with the full range of attributed rights of provision is, we believe, bad for medicine and the patients it aims to serve.

For one, it risks radically reducing the number willing to go into specialties that already face critical shortages [2]. Areas such as obstetrics and end-of-life care can ill afford to lose compassionate, talented, and skilled practitioners—some of whom have profound moral misgivings about interventions the profession as a whole endorses. Inclusion of such practitioners, moreover, is important to sustaining the field of medicine as a dynamic one, open to and benefiting from ongoing dialogue among its members about morally complex issues. Finally, patients who share moral objections to certain interventions may feel most comfortable being cared for by

like-minded practitioners. We risk alienating not just clinicians but patients with policies mandating that medicine be practiced only by those who are willing to act in accordance with a particular worldview.

Instead, we believe that society is best served by an approach that combines a progressive understanding of patients' needs, a nuanced determination of when those needs translate into claims of services from specific providers, stringent standards for genuine conscientious objection, and an approach that balances protection of minority views with the urgency of patients' needs.

### **When Do Patients Have a Reasonable Expectation of Provision?**

The first factor in discussing issues of conscientious objection is determining when patients have what is called a reasonable expectation of provision. There are some services that, if valued by certain patients, are not among those we regard as core health needs. Further, even when we believe a service is one that patients deserve access to, this does not yet mean they have reasonable expectation to receive it from a given clinician. For example, it is now widely agreed that patients with life-limiting illnesses deserve access to medical care supportive of dying at home; but patients without access to hospice specialists have a complaint against the medical system, not a right to receive home-based palliative care from their particular internists.

Determination of reasonable expectation is complex, but includes consideration of the nature of care offered, the burdens that declining would impose on patients given reimbursement structures and the like, and the realities of patient vulnerabilities in ongoing clinical relationships.

To illustrate, consider the widely discussed cases of contraception and abortion. Many of us believe that a woman's access to control over reproduction, in the form of contraception and legal abortion, should be a core part of medical services available to women. Having the option to control whether to gestate, to give birth, to become a parent is of central importance to women in maintaining bodily integrity and authorship over their lives. Further, data show that access to medical means of reproductive control can have profound effects on health, outpacing the importance of such basics as access to antihypertensives in determining health outcomes and improving lives [3]. The fact that contraception and abortion are options not approved of or sought by every woman does not lessen their centrality to those women who do seek them. For those who seek it, access to contraception can be as fundamental to well-being as access to adequate pain relief; access to supportive and compassionate legal abortion as fundamental as access to medical support at the end of life.

From whom do women have reasonable expectation of contraception and abortion provision? We would argue that patients clearly have a reasonable expectation of contraception provision from those who provide well-woman care, given the centrality of contraception to many women's lives. If a clinic offers well-woman care, it would be strange, and more than incidentally burdensome to many, to find

that one cannot get a prescription for contraception as part of this care. A woman who goes to a well woman clinic—who may have saved scarce dollars, taken time off of work or found child care, arranged transportation to travel across town, or who has established a relationship and level of comfort with the clinic—has a reasonable expectation that one of the things she will be able to get if desired is counseling about and a prescription for contraception.

Abortion is more nuanced, especially in the context of prenatal obstetric care. Some obstetricians and midwives see their role as partnering with women in the enterprise of growing and delivering a baby. To such practitioners, a woman's decision to abort because she has changed her mind about becoming a mother, for instance, may be seen as ending that particular *obstetrics* relationship—ending the enterprise they were jointly engaged in—rather than as opting for a procedure she is entitled to receive as part of that relationship.

But in truth, matters quickly get more complex. As seasoned practitioners know, factors can emerge within the obstetrics relation over the course of even a strongly desired pregnancy that may shift a woman's thoughts about the wisdom or desirability of continuing the enterprise as initially envisioned: a prenatal diagnosis of significant fetal abnormality; the development of health complications for the woman; tensions between the interests of one and the other with obstetrical complications, such as threatened endometritis at the threshold of viability. Some women who enter a pregnancy sure they would never terminate may decide differently when deliberating in the context of a vividly specific difficulty. Having partnered with her obstetrician to that point—having shared hopes, fears, questions, and concerns, having agreed to monitoring and screening tests—a patient faced with devastating news might well have a reasonable expectation that that caregiver would be by her side through a safe and compassionate abortion, if not by performing it, then by assuring it through partnership with physicians identified ahead of time.

### **What Are the Standards—and Limits—of Conscientious Objection?**

There are, then, many services that patients have reasonable expectation that a given clinician or clinic will provide. To say that a patient has a reasonable expectation of access either by direct provision or responsible assurance, though, is not yet to say that the patient has *right* of provision. Instead, it establishes a presumption of access to the service from the clinician, strongly limiting the kinds of reasons that are acceptable for declining. Mere preferences, or considerations of cost, are not sufficient basis. Instead, declining requires meeting the very high bar of genuine conscientious objection.

In our view, conscientious objection is a category that is often poorly understood, used broadly to refer to any sense of distaste or moral unease. If conscientious objection is to serve as a legitimate counter to reasonable expectations, though, it must be a category that brings with it stringent, specific, and compelling standards. In our view, conscientious objection should reflect a *deeply considered* position, not merely a gut feeling; based on a *scientifically accurate* view of the facts, not

assumptions about them; that provision or assurance would be a *grave wrong*, not just an ethical compromise. Further, that conclusion should be based on a moral position that can be accorded *respect*, even by those who disagree. This last is a substantive issue; its determination is as difficult as it is inescapable in a pluralist society and something that evolves with society's understanding of the contours of fundamental needs and rights.

Genuine conscientious objection, in short, is not something that can be lightly invoked. It brings with it a strong burden of reflection, exploration, and assessment, including cognizance of the diversity of views on the subject within one's moral or faith tradition. It carries with it responsibilities to confirm one's scientific understanding—for instance, of the causal pathways by which Plan B contraception actually works. Its legitimate exercise, moreover, brings very strong obligations in its wake. Those who would claim objector status take on strong and proactive efforts of disclosure, so that patient burdens are minimized and implied judgments about a specific patient's circumstance avoided.

Finally, we believe that there are limits to protection of even the most deeply grounded conscientious objection. One such limit is a requirement to provide accurate medical information. Patients have not just a reasonable expectation, but a right, to receive accurate information and counseling on all legal and medically safe options from their clinicians. The reason is a simple one. Core to medical communication is a fundamental asymmetry of knowledge between physician and patient; crucially, this is increased by a lack of knowledge on the patient's part about what she does not know. Patients are thus not in a position to be able to assess the import or implications of a clinician's disclosure that there is information their conscience precludes them from sharing. Medical professionals do not have the right to curtail the patient's knowledge or exploit its limits based on their moral worldviews.

Protection of conscientious objection, in our view, should also be limited by the urgency of an individual patient's situation. Consider, for instance, maternal-fetal medicine specialists (MFMs). Such physicians will predictably encounter women for whom continued pregnancy is literally as likely as not to lead to maternal death. One cannot reasonably become such a specialist, we believe, unless one is willing, at least, to assist patients in seeking abortions. Far stronger than mere referral, responsible assurance requires identifying ahead of time a willing and qualified physician who can provide timely and compassionate care. If the MFM cannot in conscience perform an abortion, he or she has an obligation to direct patients to qualified and willing physicians when pregnancy termination is chosen, assuring that they are well cared for in the process.

Or again, consider obstetricians on call in labor and delivery or emergency departments. A pregnant woman who goes to a hospital hemorrhaging badly at 20 weeks has not just a reasonable expectation but a right to be induced if she so desires and not wait hours—with its attendant risks of emotional trauma, infection,

transfusion—while a willing physician is searched for. If an obstetrician knows she will be the only qualified clinician in a situation, particularly such an emergent situation, he or she needs to be willing to perform medically indicated abortions with care and compassion or not place him- or herself in the position of gatekeeper.

Finally, disclosure of conscientious objection requires a model of the clinical encounter that is infused with compassion and respect. Communication of conscientious objection should be, first and foremost, a statement about the physician, not the patient or her circumstances. Discussions should be compassionate, respectful, and resolutely first-personal: for instance, “Based on my own faith tradition, I am not able to help you with that. What I can do is answer any medical questions you might have about the procedure, and give you information about its availability.” After all, a core premise for protecting conscientious refusal is that the issue at hand is one on which deeply good and reasonable people disagree. The clinician can indicate what her conviction disallows her from doing without questioning the integrity or moral stature of the patient.

The requirements for and limitations to conscientious objection are surely complex, shaped by myriad factors including how high the stakes are for the patient, how robust the provider’s grounds of objection, how predictable the conflict, to name just a few. Our point here is not to fully arbitrate the scope of the limits, but to argue that medicine will perforce need to confront them. For needs in medicine intersect with conflicts over values not just incidentally or occasionally, but deeply and persistently. Those conflicts, as vexed as they are, need to be faced with care—and mutual respect.

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## Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 263-277.

### Suggested Readings and Resources

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# Virtual Mentor

American Medical Association Journal of Ethics  
March 2013, Volume 15, Number 3: 278-280.

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