Franz H. Messerli, M.D.
University Hospital
Bern, Switzerland
David D. Waters, M.D.
San Francisco General Hospital
San Francisco, CA

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Conscientious Objection in Health Care

TO THE EDITOR: Stahl and Emanuel (April 6 issue)[1] rightly differentiate between conscripts and physicians. Nonetheless, they state, "the profession . . . uses reflective equilibrium to self-correct. This dynamic process establishes professional obligations . . . regardless of . . . personal beliefs."[1] This point fails to recognize that conscientious objectors are engaging in the dynamic process from within the profession to counter problematic professional obligations and to correct mistakes. The medical profession no longer accepts eugenics and no longer views homosexuality as a disease because the voices of conscientious objectors eventually influenced the field. Without permission for individual dissent, the dynamic equilibrium becomes entirely static. Moreover, the authors give no reason to think that the dynamic equilibrium always moves the profession toward something approximating moral truth.

Second, since conscientious objection is disputed in the profession, it is unclear whether the arguments offered by the authors constitute personal or professional beliefs.[2,3] Can the authors conscientiously object to conscientious objection?

Finally, the authors misunderstand the obligations of the Jehovah's Witness surgeon to provide blood transfusions during surgery. As a religious person, the surgeon would refuse to personally receive blood.[4] The objection is not for others. This argument is irrelevant.

Lester Liao, M.D., M.T.S.
University of Alberta
Edmonton, AB, Canada
lesterl@ualberta.ca
Ewan Goligher, M.D., Ph.D.
University of Toronto
Toronto, ON, Canada

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TO THE EDITOR: We pose five questions to Stahl and Emanuel concerning conscientious objection. First, would the authors agree that physicians are in a mutual covenant with patients[1] that ensures that we never intentionally harm them, or has this covenant changed? Second, in putting patients first, does our patient–physician covenant demand that after an open and mutually respectful conversation that includes medical counseling, a physician may conscientiously decline to implement the patient's decision if the physician thinks the procedure would be harmful to the patient? Third, given that there is no place in medicine for a physician to decline to treat a patient because of his or her race, ethnic group, sex, or sexual orientation, is there a legitimate distinction between the physician's objection to the action requested by the patient and objection to the patient himself or herself because of any personal characteristic? Fourth, do both the patient and physician have a degree of autonomy that must be respected? Finally, is the consensus of the medical profession always ethical?

E. Wesley Ely, M.D., M.P.H.
Veterans Affairs Tennessee Valley Geriatric Research Education and Clinical Center
Nashville, TN
wes.ely@vanderbilt.edu
Charles L. Sprung, M.D.
Hadassah–Hebrew University
Jerusalem, Israel

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Margaret Somerville, D.C.L.
School of Medicine, University of Notre Dame Australia
Sydney, NSW, Australia

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TO THE EDITOR: Many physicians think that it is totally arbitrary to protect early human life only when it has passed from one end of the vagina to the other. Regardless of the political views of the American College of Obstetricians and Gynecologists or the editorial board of the *Journal*, for these physicians, participating in an abortion is being complicit in the killing of another human being. Intentionally ending a life violates the very core principles we have vowed to uphold in our profession.

It is very magnanimous of Stahl and Emanuel to suggest that physicians who oppose abortion should become radiologists rather than obstetricians and gynecologists. Perhaps if the American Medical Association decides that physician-assisted suicide is no longer "medically controversial," these same physicians will have to refrain from becoming internists and family physicians as well.

I think we should fully embrace the principle of conscientious objection in medicine. Americans would much rather accommodate the deeply held moral, ethical, and religious beliefs of individual physicians than exclude large segments of society from the practice of medicine. Physicians should reflect the cultural and religious diversity of the patient population that they serve.

Thomas J. Perille, M.D.
Saint Joseph Hospital
Denver, CO

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THE AUTHORS REPLY: Humans are imperfect. Hence, human institutions are imperfect. The Supreme Court is the final arbiter of what is legal in the United States, and all Americans must abide by its decisions or face consequences. In *Dred Scott v. Sandford*, *Plessy v. Ferguson*, *Lochner v. New York*, *Korematsu v. United States*, and *Bowers v. Hardwick*, the Court rendered fundamentally flawed decisions that many persons disputed until subsequent decisions or legislation overturned them.

On the basis of this reasoning, we disagree with Liao and Goligher and answer Ely et al. The medical profession is not perfect. It has promoted unethical practices. However, reflective equilibrium reversed these errors through ongoing professional debate.

Liao and Goligher's claim that conscientious objection is necessary to promote dissent is wrong. Debate occurs even amid mandatory compliance. The Supreme Court ruled that citizens must pay taxes that support activities they deem unethical, yet vigorous arguments about the use of taxes persist. Catholic priests who disagree with the celibacy requirement of the Church can voice their dissent but must remain celibate.

Similarly, limiting conscientious refusal in health care does not quash dissent or debate. Providers can argue with their colleagues, write op-ed pieces, contribute to organizations, and express their views in public and private spaces. What they cannot do, however, is deny services to patients on the basis of personal beliefs rather than professional medical standards.[1] Indeed, despite Perille's claim that Americans prefer that physicians act according to their personal beliefs rather than according to professional standards of care, surveys suggest that most American women expect all hospitals — even Catholic ones — to provide comprehensive health care, including contraception and abortion.[2]

We disagree with Ely and colleagues: the physician–patient relationship is not a relationship of equals and cannot be a mutual covenant. Physicians wield power over patients as licensed medical gatekeepers who can provide or withhold expertise, information, and care.[3] It is therefore incumbent on providers, as Cantor[4] once noted, to prospectively self-select "specialties that are not moral minefields for them." Alternatively, they can follow the lead of U.S. Army Chief of Chaplains Kermit Johnson, who resigned from his commission in protest of President Ronald Reagan's nuclear policy.

Finally, Liao and Goligher misunderstand the relevance of the practices of Jehovah's Witnesses.

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Conscience clauses do not require doctrinal foundations; thus, Jehovah's Witnesses could impose their views on patients. Nevertheless, the Governing Body of Jehovah's Witnesses recognizes that its stance on blood transfusions is "a religious issue rather than a medical one" and advocates that physicians abide by their patients' values; this discourages the imposition of conscientious objection to blood transfusion on patients.[5] This stance aligns with our argument: in the clinic, the patient comes first, which means the patient's conscience and autonomy receive priority over those of the physician.

Ronit Y. Stahl, Ph.D.
Ezekiel J. Emanuel, M.D., Ph.D.
Perelman School of Medicine at the University of Pennsylvania
Philadelphia, PA
rystahl@mail.med.upenn.edu

Since publication of their article, the authors report no further potential conflict of interest.

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