PERSPECTIVE

The Celestial Fire of Conscience — Refusing to Deliver Medical Care

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An interview with Professor Charo can be heard at www.nejm.org.

Apparently heeding George Washington's call to "labor to keep alive in your breast that little spark of celestial fire called conscience," physicians, nurses, and pharmacists are increasingly claiming a right to the autonomy not only to refuse to provide services they find objectionable, but even to refuse to refer patients to another provider and, more recently, to inform them of the existence of legal options for care.

Largely as artifacts of the abortion wars, at least 45 states have "conscience clauses" on their books — laws that balance a physician's conscientious objection to performing an abortion with the profession's obligation to afford all patients nondiscriminatory access to services. In most cases, the provision of a referral satisfies one's professional obligations. But in recent years, with the abortion debate increasingly at the center of wider discussions about euthanasia, assisted suicide, reproductive technology, and embryonic stem-cell research, nurses and pharmacists have begun demanding not only the same right of refusal, but also — because even a referral, in their view, makes one complicit in the objectionable act — a much broader freedom to avoid facilitating a patient's choices.

A bill recently introduced in the Wisconsin legislature, for example, would permit health care professionals to abstain from "participating" in any number of activities, with "participating" defined broadly enough to include counseling patients about their choices. The privilege of abstaining from counseling or referring would extend to such situations as emergency contraception for rape victims, in vitro fertilization for infertile couples, patients' requests that painful and futile treatments be withheld or withdrawn, and therapies developed with the use of fetal tissue or embryonic stem cells. This last provision could mean, for example, that pediatricians — without professional penalty or threat of malpractice claims — could refuse to tell parents about the availability of varicella vaccine for their children, because it was developed with the use of tissue from aborted fetuses.

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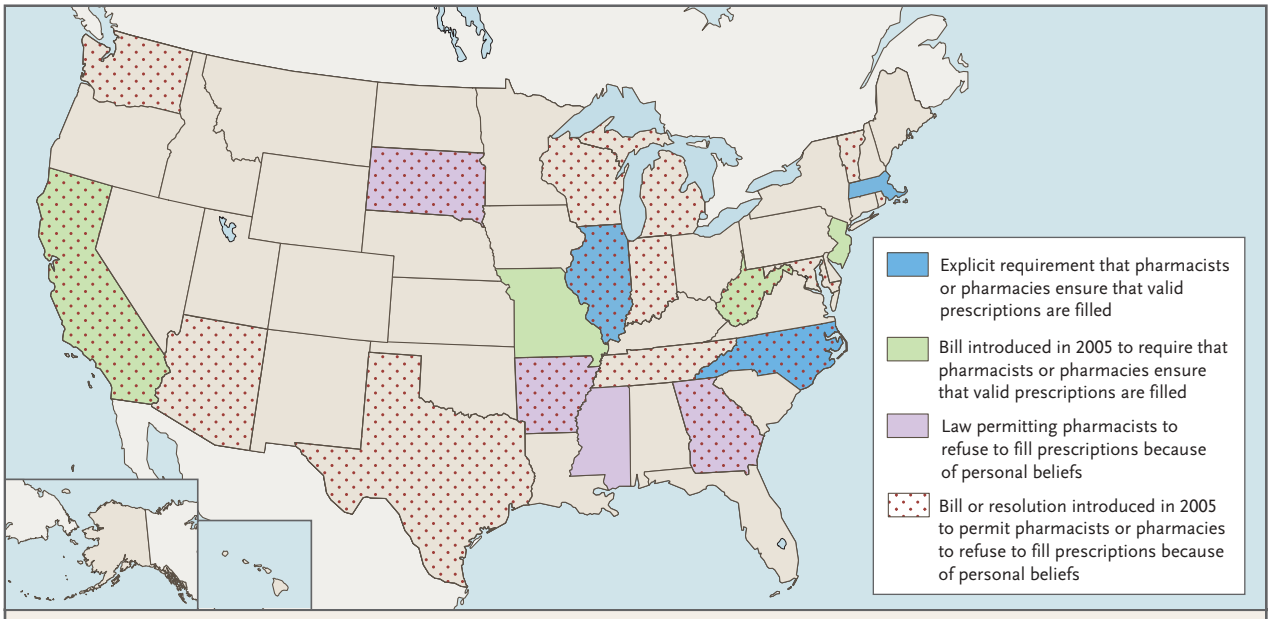
This expanded notion of complicity comports well with other public policy precedents, such as bans on federal funding for embryo research or abortion services, in which taxpayers claim a right to avoid supporting objectionable practices. In the debate on conscience clauses, some professionals are now arguing that the right to practice their religion requires that they not be made complicit in any practice to which they object on religious grounds.

Although it may be that, as Mahatma Gandhi said, "in matters of conscience, the law of majority has no place," acts of conscience are usually accompanied by a willingness to pay some price. Martin Luther King, Jr., argued, "An individual who breaks a law that conscience tells him is unjust, and who willingly accepts the penalty of imprisonment in order to arouse the conscience of the community over its injustice, is in reality expressing the highest respect for law."

What differentiates the latest round of battles about conscience clauses from those fought by Gandhi and King is the claim of entitlement to what newspaper columnist Ellen Goodman has called "conscience without consequence."

And of course, the professionals involved seek to protect only themselves from the consequences of their actions — not their patients. In Wisconsin, a pharmacist refused to fill an emergency-contraception prescription for a rape victim; as a result, she became pregnant and subsequently had to seek an abortion. In another Wisconsin case, a pharmacist who views hormonal contraception as a form of abortion refused not only to fill a prescription for birth-control pills but also to return the prescription or transfer it to another pharmacy. The patient,



State Requirements Governing the Refusal by Pharmacists to Fill Certain Prescriptions.

Illinois has a regulation that requires pharmacies to fill valid contraception prescriptions in a timely manner, but a resolution has been introduced to permit refusals. Massachusetts has a pharmacy-board policy that requires pharmacists to fill valid prescriptions in a timely manner. North Carolina has a pharmacy-board policy that requires pharmacists to ensure that valid prescriptions are filled in a timely manner. Wyoming has a bill that would permit providers to refuse to abide by advance directives that might, in some scenarios, apply to pharmacists who refuse to fill certain prescriptions. Adapted from a map compiled by the National Women's Law Center.

unable to take her pills on time, spent the next month dependent on less effective contraception. Under Wisconsin's proposed law, such behavior by a pharmacist would be entirely legal and acceptable. And this trend is not limited to pharmacists and physicians; in Illinois, an emergency medical technician refused to take a woman to an abortion clinic, claiming that her own Christian beliefs prevented her from transporting the patient for an elective abortion.

At the heart of this growing trend are several intersecting forces. One is the emerging norm of patient autonomy, which has contributed to the erosion of the professional stature of medicine. Insofar as they are reduced to mere purveyors of medical technology, doctors no longer have extraordinary privileges, and so their notions of extraordinary duty — house calls, midnight duties, and charity care — deteriorate as well. In addition, an emphasis on mutual responsibilities has been gradually supplanted by an emphasis on individual rights. With autonomy and rights as the preeminent social values comes a devaluing of relationships and a diminution of the difference between our personal lives and our professional duties.

Finally, there is the awesome scale and scope of the abortion wars. In the absence of legislative options for outright prohibition, abortion opponents search for proxy wars, using debates on research involving human embryos, the donation of organs from anencephalic neonates, and the right of persons in a persistent vegetative state to die as opportunities to rehearse arguments on the value of biologic but nonsentient human existence. Conscience clauses represent but another battle in these so-called culture wars.

Most profoundly, however, the surge in legislative activity surrounding conscience clauses represents the latest struggle with regard to religion in America. Should the public square be a place for the unfettered expression of religious beliefs, even when such expression creates an oppressive atmosphere for minority groups? Or should it be a place for religious expression only if and when that does not in any way impinge on minority beliefs and practices? This debate has been played out with respect to blue laws, school prayer, Christmas crèche scenes, and workplace dress codes.

Until recently, it was accepted that the public square in this country would be dominated by Chris-

tianity. This long-standing religious presence has made atheists, agnostics, and members of minority religions view themselves as oppressed, but recent efforts to purge the public square of religion have left conservative Christians also feeling subjugated and suppressed. In this culture war, both sides claim the mantle of victimhood — which is why health care professionals can claim the right of conscience as necessary to the nondiscriminatory practice of their religion, even as frustrated patients view conscience clauses as legalizing discrimination against them when they practice their own religion.

For health care professionals, the question becomes: What does it mean to be a professional in the United States? Does professionalism include the rather old-fashioned notion of putting others before oneself? Should professionals avoid exploiting their positions to pursue an agenda separate from that of their profession? And perhaps most crucial, to what extent do professionals have a collective duty to ensure that their profession provides nondiscriminatory access to all professional services?

Some health care providers would counter that they distinguish between medical care and nonmedical care that uses medical services. In this way, they justify their willingness to bind the wounds of the criminal before sending him back to the street or to set the bones of a battering husband that were broken when he struck his wife. Birth control, abortion, and in vitro fertilization, they say, are lifestyle choices, not treatments for diseases.

And it is here that licensing systems complicate the equation: such a claim would be easier to make if the states did not give these professionals the exclusive right to offer such services. By granting a monopoly, they turn the profession into a kind of public utility, obligated to provide service to all who seek it. Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust — all the worse if it is not in fact a personal act of conscience but, rather, an attempt at cultural conquest.

Accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences. It does, however, necessitate ensuring that a genuine system for counseling and referring patients is in place, so that every patient can act according to his or her own conscience just as readily as the professional can. This goal is not simple to achieve, but it does represent the best effort to accommodate everyone and is the approach taken by virtually all the major medical, nursing, and pharmacy societies. It is also the approach taken by the governor of Illinois, who is imposing an obligation on pharmacies, rather than on individual pharmacists, to ensure access to services for all patients.

Conscience is a tricky business. Some interpret its personal beacon as the guide to universal truth. But the assumption that one's own conscience is the conscience of the world is fraught with dangers. As C.S. Lewis wrote, "Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."

Taking Their Own Lives — The High Rate of Physician Suicide

Eva Schernhammer, M.D., Dr.P.H.

When I was an oncology fellow in Vienna, a colleague who had attended rounds with me on the ward went home afterward and strangled herself. Only later was it learned that she had suffered from depression. In the course of that same year, three more physicians in my immediate circle — two residents and a department head — took their own lives. This stunning series was my first encounter with physician suicide, and it left many of us doctors with an important message: we must care not only for our patients but also for ourselves. In an effort to prevent further such tragedies, a program

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