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Philosophy and Theology: Physicians, Not Conscripts: Conscientious Objection in Health Care

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PHILOSOPHY AND THEOLOGY

In their *New England Journal of Medicine* article, “Physicians, Not Conscripts: Conscientious Objection in Health Care,”¹ Ronit Stahl and Ezekiel Emanuel argue that health care professionals who are unwilling to perform medical interventions to which they conscientiously object, such as abortion, should be forced to stop practicing medicine. They write, “Health care professionals who are unwilling to accept these limits have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession.”² What are their grounds for taking away rights of conscientious objection from health care professionals?

Stahl and Emanuel argue that an appeal to conscientious objection in the military historically justified and legitimated conscientious objection in health care. Consequently, they draw disanalogies between military service and health care to delegitimize conscientious objection in medical practice. According to Stahl and Emanuel, conscientious objection in health care differs from conscientious objection in the military in five important ways: “first, it objects to professional practices, not state-mandated conscription; second, it occurs within the context of a freely chosen profession; third, it allows selective objection to professionally accepted interventions; fourth, it accepts objection without external scrutiny; and fifth, it shields the objector from all repercussions and costs.”³ On their view, these five differences undermine the case for allowing health care professionals to decline to perform requested interventions.

1. Ronit Y. Stahl and Ezekiel J. Emanuel, “Physicians, Not Conscripts: Conscientious Objection in Health Care,” *New England Journal of Medicine* 376.14 (April 6, 2017): 1380–1385, doi: 10.1056/NEJMsb1612472.

2. *Ibid.*, 1383.

3. *Ibid.*, 1381.

The case of US Army corporal Desmond T. Doss calls into question much of Stahl and Emanuel's argument. The movie *Hacksaw Ridge*⁴ tells the true story of Corporal Doss, who volunteered to serve in the infantry during World War II. Because of his personal beliefs as a Seventh-day Adventist, Doss refused to kill or even carry a weapon in combat. Consequently, he was assigned to serve as a medic. He received the Bronze Star for his heroic service on Guam and in the Philippines. During the Battle of Okinawa, Doss single-handedly lowered seventy-five wounded servicemen from Hacksaw Ridge to safety. He became the only conscientious objector during World War II to receive the military's highest award for valor, the Medal of Honor.

Cases such as Doss's undermine several key claims of Stahl and Emanuel's argument. First, Doss objected to normal professional military practices—for example, carrying weapons and killing enemy soldiers—and he was not subject to state-mandated conscription. Second, Doss freely chose military service. Third, Doss selectively objected to professionally accepted interventions by refusing to kill the enemy while still performing all other duties compatible with his religious beliefs.

Stahl and Emanuel suggest a fourth difference between military and medical conscientious objection. Unlike conscientious objectors in the military, medical conscientious objectors are not scrutinized about the sincerity of their beliefs. This difference makes sense. In the case of military service, someone may lie about his opposition to killing because of a fear of death or injury rather than a sincere ethical belief. The motivation to lie to avoid personal injury or death in battle is not present in the medical profession. There is a very obvious ulterior motive for lying in the case of military service but not in the case of medical service. Therefore, scrutinizing a claim of conscientious objection makes sense in the military but not in the medical profession.

And what of the fifth and final difference, that medical objectors are shielded from all repercussions and costs, but military objectors are not? If *Hacksaw Ridge* is to be believed, Doss certainly was not shielded from all repercussions and costs. In addition to being harassed and even physically assaulted, he was officially disciplined for his conscientious objection. It is questionable whether such treatment is justified even in the military. If it is not, then the precedent it sets cannot justify extending such costs into the medical profession.

In any case, is it true that health care professionals who conscientiously refuse to provide abortions are shielded from all repercussions and costs? No, conscientious objectors incur financial opportunity costs, because they do not receive the payment they would have received for performing abortions and they must forgo certain job opportunities, such as working for Planned Parenthood. Moreover, to the degree that abortion is a medically accepted practice, conscientious objectors risk social stigmatization in the profession. They may also jeopardize professional relationships with patients, colleagues, and hospitals. As things now stand, it is not accurate to claim that conscientious objectors in medicine do not suffer for their beliefs and actions.

4. *Hacksaw Ridge*, directed by Mel Gibson (2016; New York: Lionsgate, 2017), DVD/Blu-ray.

Stahl and Emanuel suggest that “health care conscience clauses are one-sided, protecting only those who refuse to treat patients, not those who conscience compels them to provide medically accepted but politically contested care.”⁵ Is this claim true? In fact, existing conscience protections for health care professionals serve even those who do not invoke them. First, conscience protections serve many patients who seek out health care providers with whom they share ethical values and religious beliefs. Many patients feel more comfortable sharing private and intimate details of their lives (as can be so important in health care) with like-minded health care professionals. Such trusting relationships promote the well-being of patients.

Second, conscience clauses protect the diversity of the health care profession, a concern widely shared by people inside as well as outside the profession. Women, Latinos, and African Americans are, on average, more religious than white men. Religious belief and practice often, but of course not always, motivate conscientious objection. If we want a medical profession that reflects the religious and ethnic diversity of American society, then we should protect the conscience rights of health care workers. Taking away these protections will, in effect, make the medical profession more white, male, and atheistic.

Moreover, health care conscience protections for individuals and institutions aid everyone, especially the disadvantaged, by preventing higher health care costs. For example, “615 Catholic hospitals account for 12.5% of community hospitals in the United States and over 15.5% of all U.S. hospital admissions.”⁶ Countless other physicians, nurses, and health care professionals share the Catholic opposition to abortion. If these individuals are forced to provide abortions or stop providing health care, then many of these individuals and institutions will be forced out of the health care profession, as Stahl and Emanuel seem to desire. At a time when health care demand is increasing, the Stahl–Emanuel proposal would decrease health care supply. Higher costs and more difficulty in obtaining health care harm everyone, including women seeking abortions, who may find that their chosen doctors not only do not provide abortions but also do not provide cancer screenings, oral antibiotics, or asthma inhalers.

Stahl and Emanuel claim that the conscience protections do not protect those whose consciences impel them to provide requested interventions. The authors may have in mind doctors who work at Catholic hospitals and want to procure abortions. But there is an important way in which their case and the case of doctors who do not want to perform abortions are not analogous. There is a radical difference between not practicing medicine in a particular hospital and not practicing medicine at all.

Stahl and Emanuel remind their readers, “All [the] professional health care societies accept the same professional role morality: patients’ well-being is their

5. Stahl and Emanuel, “Physicians, Not Conscripts,” 1381.

6. United States Conference of Catholic Bishops, “The Catholic Church in America: Meeting Real Needs in Your Neighborhood,” Catholic Information Project, 2006, available at https://www.supremecourt.gov/opinions/URLs_Cited/OT2010/09-751/09-751_3.PDF.

primary interest.”⁷ The authors note that the American Medical Association “insists that ‘physician’s ethical responsibility [is] to place patients’ welfare above the physician’s own self-interests.’”⁸ But obviously, the primacy of the patient is not an exceptionless principle, as if every patient’s interests trump every physician’s interests in every case. It is in the interests of patients to have medical care provided for free, but doctors do not have an obligation to work only on a voluntary basis. It is in the interests of patients to avoid the hassle and expense of visiting the doctor’s office, but physicians do not have an obligation to make house calls. It is in the interests of patients to have the doctor see them whenever they desire, but physicians do not have an obligation to always be available on request.

So how important are the interests of a doctor in not providing abortions? Well, most physicians who oppose abortion would see being forced to perform abortions as a much more serious infringement of their interests than making house calls, not charging patients for medical services, and providing medical advice after hours in social situations. House calls, free medical treatment, and mid-dinner consults are not matters of conscience for most people. They are not intrinsically evil or matters of grave ethical importance. So if we allow physicians to let their interests in a family dinner trump patients’ interests in medical advice, we should not force a doctor to perform abortions if he or she thinks abortion is the intentional killing of an innocent human being.

If there is an actual or perceived conflict between doctor and patient, who determines whose interests should prevail? According to Stahl and Emanuel, “the profession, rather than the individual practitioner, elucidates the interpretation and limits of the primary interest.”⁹ It is odd that Stahl and Emanuel should appeal to professional standards to adjudicate conflicts between a patient’s interests in getting an abortion and a health care professional’s interests in not providing one, since the standard set by the American Medical Association contradicts the view they advocate. If the profession elucidates the interpretation and limits of the patient’s interests, then health care professionals should be permitted to decline to perform abortions, since the AMA allows them to do so.

Stahl and Emanuel go on to argue that it is inconsistent for the AMA to both assert “fidelity to patients and respect for patient self-determination” and protect health care professionals who conscientiously object to performing abortions. On one hand, the AMA urges doctors to place patient well-being above self-interest and forbids doctors from rejecting patients on the basis of “race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual’s care.”¹⁰ On the other hand, according to Stahl and Emanuel, the AMA contradicts itself, because “it permits physicians to refuse to

7. Stahl and Emanuel, “Physicians, Not Conscripts,” 1381.

8. Ibid. The authors cite American Medical Association (AMA), “Patient–Physician Relationships,” opinion 1.1.1, in *Code of Medical Ethics* (Chicago: AMA, 2016).

9. Ibid., 1382. The authors are referring to AMA, “Patient–Physician Relationships.”

10. AMA, “Prospective Patients,” opinion 1.1.2, in *Code of Medical Ethics*.

treat patients who are seeking care that is ‘incompatible with the physician’s deeply held personal, religious, or moral beliefs.’”¹¹ Is there really a contradiction?

In fact, Stahl and Emanuel create an apparent contraction in the AMA opinion by misconstruing the text. They conflate declining to provide a *treatment* with refusing to treat a *patient*. However, a doctor might decline to provide abortion but continue to treat the patient and care for her in a variety of ways. Stahl and Emanuel claim that the AMA “permits physicians to refuse to treat patients who are seeking care.” But this assertion is not found in the AMA opinion, which addresses physicians’ right to refuse particular *treatments*, not particular *patients*. The legal and professional protection of conscience rights has nothing to do with refusing to accept women or anyone else as patients. Stahl and Emanuel construct a contradiction only by misconstruing the AMA opinion.

Even they concede that the professional obligations of physicians do not always trump their self-interest: “This obligation is not unlimited, but exceptions are reserved for cases in which there are substantial risks of permanent injury or death.”¹² Stahl and Emanuel mistakenly claim that professional codes reserve exceptions only for cases in which a patient risks death or permanent injury.

Moreover, the exceptions in these cases lend support to conscience protections. Socrates taught that it is better to suffer harm than to do it.¹³ Moral heroes throughout the centuries have lived according to this principle. St. Thomas More, Dietrich Bonhoeffer, Gandhi, Martin Luther King Jr., and Nelson Mandela were willing to suffer and even die rather than violate their consciences. Like them, many people of good will would rather die than intentionally kill an innocent human being. If Immanuel Kant is right that conscience is an unconditional command, then there can never be any interest whatsoever that trumps the demands of conscience. If it is worse to do harm than to suffer harm, health care workers’ interests in not violating their consciences are maximally strong, indeed stronger even than their interests in avoiding death. Thus, even given Stahl and Emanuel’s stringent interpretation of the primacy of patients’ interests, health care workers should be protected from being forced to violate their consciences. If the mere risk of permanent injury justifies putting the interests of a physician ahead of the interests of a patient, how much more does the certain harm to ethical integrity justify protecting health care professionals?

A final trouble with Stahl and Emanuel’s case against conscience is that many justifications of conscience protections for health care workers do not depend on an appeal to conscience protections for those serving in the military. The authors neither reference these arguments nor even try to show that the analogy to conscience protections in the military is the only grounds for justifying conscience protections in

11. Stahl and Emanuel, “Physicians, Not Conscripts,” 1381.

12. AMA, “Prospective Patients,” opinion 1.1.2(a), quoted in Stahl and Emanuel, “Physicians, Not Conscripts,” 1382.

13. “Any wrong whatsoever done to me or mine [is] both worse and more shameful to the wrongdoer than to me the wronged.” Plato, *Gorgias*, 508e, in *Plato in Twelve Volumes*, vol. 3, trans. W. R. M. Lamb (Cambridge, MA: Cambridge University Press, 1967).

health care. So even if they successfully had proven the disanalogy between military service and medical service, their case leaves these other justifications untouched.¹⁴

Precisely speaking, what is at issue in this debate is not the conflict of interest between a patient who wants an abortion and a doctor who does not want to provide it. Rather, the question is, should a patient be able to force a doctor to perform an abortion? The right to get an abortion (from someone) is not at issue. In the United States, millions of abortions have taken place since *Roe*. Even with the current conscience protections, abortion is a common surgery.

What are the practical implications of the Stahl–Emanuel rejection of conscience rights? Imagine a fifty-year-old Muslim gynecologist named Okina Makenzua who emigrated from Nigeria and now works in Los Angeles. She is the mother of three children whom she supports on her income alone. Despite living in a large metropolitan city, she is, as far as she knows, the only female Nigerian Muslim gynecologist in the area. She makes special efforts to serve the immigrant Muslim community. Likewise, Nigerian Muslim women make special efforts to come to her, because she shares their language, culture, and faith. They trust her, and she establishes a superb mutual understanding because of her shared background with them. Suddenly, the Stahl–Emanuel constraint is imposed on her: provide abortions or get out of medicine. She feels that she is too old and does not have the time and money to learn another medical specialty, such as radiology. Her children and ethnic community depend on her in unique ways. In Los Angeles, there are dozens of abortion providers, but because Dr. Makenzua does not provide abortions, she is suddenly forced out of her profession.

Whom does the Stahl–Emanuel rule benefit? It directly and gravely harms Dr. Makenzua and her children. It harms the local Muslim community, which is deprived of a physician who has a wonderful rapport with the recent immigrants. The Stahl–Emanuel restriction does not even benefit women seeking abortions, since there already are dozens of abortion providers in the area, and they lose the services of Dr. Makenzua, who is no longer available to provide gynecological exams, Pap smears, or anything else. The Stahl–Emanuel rule imposes severe and certain costs without proportional benefit.

If the US military had forced Private Doss out of military service, many men would have lost their lives on Hacksaw Ridge. If the Stahl–Emanuel rule forces Dr. Makenzua and health care professionals like her out of medical service, she will suffer and we all will directly or indirectly suffer. Banning Private Doss and banning Dr. Makenzua are wrong for the same reason. Conscientious objection in military service and in medical service benefits not only conscientious objectors but all whom they serve.

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14. See, for example, chapters 12 and 13 in Christopher Kaczor, *A Defense of Dignity: Creating Life, Destroying Life, and Protecting the Rights of Conscience* (Notre Dame, IN: University of Notre Dame Press, 2013).