The President's Council on Bioethics

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Session 3: Conscience in the Practice of the Health Professions

Panelists:

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Transcript

CHAIRMAN PELLEGRINO: Thank you. Thank you members of the Council. You're here on time, and we'll begin on time. This afternoon we turn our attention to the question of conscience in the practice of the health professions, moving from the somewhat more conceptual and theoretical aspect to the actual difficulty and problem of conflict between conscience and the requirements of patients, society, et cetera, et cetera.

We're going to function as a modified panel, and I will introduce the members of the panel, and they will get an opportunity to speak in succession, and then following that members of the Council will participate in a discussion.

The members of the group are — beginning on my right, Dr. Farr Curlin , Assistant Professor of Medicine, Associate at the MacLean Center for Clinical Medical Ethics at the University of Chicago .

Next is Dr. Howard Brody , John P. McGovern Centennial Chair in Family Medicine and Director of the Institute for the Medical Humanities at the University of Texas Medical branch, and Dr. Anne Drapkin Lyerly , Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine, and Chair of the Ethics Committee at the American College of Obstetrics and Gynecology. And Dr. Lyerly has asked us to point out that she is presenting on her own behalf and she is not representing the American College of Obstetrics and Gynecology or its ethics committee.

I think we'll immediately move into the program by asking Dr. Lyerly if she would kick off the panel.

DR. LYERLY: Well, thank you very much, Dr. Pellegrino , and thank you for inviting me to speak today. I'm absolutely honored to have the opportunity to speak to such a distinguished group and on such an important topic. I've been asked by Drs. Pellegrino and Davis to, in their words, map the contemporary domain regarding issues of conscience in the health professions. As Dr. Pellegrino noted, I should clarify that I'm speaking for myself.

In the last several years I've had the opportunity to think seriously about the question of conscience in the practice of medicine, both in my role as an obstetrician/gynecologist caring for patients, working with colleagues, training residents, and as someone who spends most of her time thinking about ethical issues in reproductive medicine.

I chaired and I currently chair the ethics committee of the American College of Obstetricians and Gynecologists, and I learned quite a bit about the topic of conscience during our deliberations. But as Dr. Pellegrino noted, the views I express today are my own.

Patients and their care providers do not always agree about health care decisions. Such differences are expected and usually, if uncomfortable or frustrating, are not morally — or not deeply morally — problematic. Yet occasionally a situation arises when a physician may find requested or indicated care to be morally objectionable and decline to provide such care on the basis of conscience. That is, of course, at the heart of our discussion today.

Such situations create challenges for professional ethics and social policy. What are the obligations of providers to their patients to provide information, referral, or care? To what degree should public policies be restrictive or protective of provider referrals, and what are the moral considerations that shape the answers to these questions?

So a quick overview. I'll begin with just a brief background, touch on current laws, policies, and the published views of professional organizations, again just to orient, since the question is how we ought to be managing issues of conscience going forward. I'll then turn to the contemporary ethical debate and highlight just a few themes that have emerged with some consensus as

relevant to determining how restrictive or protective we should be of conscientious refusals. Finally, I'll end by looking squarely — or at least naming — some of the fundamental distinctions that may be helpful in framing a discussion.

Another disclaimer: I'm not a legal scholar, so I'm just going to stick to the basics here. Since the early 1970s laws have accumulated that are protective of providers' rights of conscience. Operative federal regulations include the Church Amendment, the Coats Amendment, and the Weldon Amendment. The force of these regulations is to protect individuals, institutions' training programs, insurance companies, and others from requirements to participate, or discrimination for not participating, in abortion and sterilization.

As noted in your briefing book, state laws also protect practitioners and institutions from participating not only in abortion and sterilization, but in the provision of contraception, and in some cases protections have extended to any health care task that is against a provider's conscience.

In response to concerns about access to needed reproductive services, a number of state laws have been passed which press in the other direction which are suggestive of a need to limit refusals in the interests of patient well-being. Twenty-seven states have passed contraceptive equity laws which require insurers who cover prescription drugs to offer a full range of contraceptives approved by the FDA.

Sixteen states have passed emergency contraceptive laws, such as the "Compassionate Care for Rape Victims" law, which requires that emergency departments provide information about emergency contraception to special assault victims, dispense EC on demand, or both.

Finally, a handful of states and pharmacy boards have passed laws or policies that say pharmacies must fulfill all valid prescriptions. And so you see the tension reflected in the state and federal laws on the one hand pressing for the protection of providers' conscientious refusals and on the other hand protecting the rights of access for patients.

I think it is important at the outset to note that while the bulk of these conversations have taken as their central concern the provision of elective abortion or abortion on demand, as some call it, there are a breadth of services that some consider morally objectionable. These range from the provision of oral contraception to blood transfusion to the provision of vaccines whose development depended on the use of fetal tissue.

Most of the examples I use today will be situated in the realm of reproductive medicine, but it is important to remember the breadth when we look toward policy, and as we do, to be careful that our policies about conscience in general are not dominated by the question of restrictions on abortion.

While the ACOG document on conscience has garnered considerable attention in the last several months... issues of conscience have been addressed by a number of both national and international professional organizations. And I've listed just a few of them here. I'll concentrate on statements from the AMA's Council on Ethical and Judicial Affairs, the UK 's General Medical Council, and the International Federation of Gynecology and Obstetrics or FIGO.

Most of these documents begin, or at least at some point in the document there is a statement about the primacy of patient welfare. You must make the care of your patient your first concern. The primary commitment of obstetrician/gynecologists is to serve women's reproductive health

and well-being. A physician while caring for a patient must regard responsibility to the patient as paramount.

The second thing is that most of these organizations have advocated finding a middle ground, a middle ground between categorical views on either side, either that there's an absolute right to the expression of conscience or there's no right to object. These organizations suggest instead that rights to object should be protected but limited.

The AMA put it this way: "Physician's conscientious objection must be counterbalanced with obligations that will respect patients' autonomy and ability to access medical services." The UK General Medical Council says that their guidelines were meant to balance doctors' and patients' rights, including the right to freedom of thought, conscience, and religion and entitlement to care and the treatments to meet clinical needs and advise us on what to do when these rights conflict.

In striking the balance, professional organizations tend to comment on three areas of particular controversy with respect to individual providers: obligations of providers to give information about treatment options, obligations to refer patients to another physician if the service cannot be provided in good conscience, and obligations to provide the service itself when referral is not possible or practicable in emergency situations.

Of course, all of these issues raise the important concerns that Father Paris raised this morning about cooperation. So let's take a closer look. The General Medical Council with regard to information says, "Patients have a right to information about their condition and the options available to them. You must not withhold information about the existence of a procedure or a treatment because carrying it out or giving advice about it conflicts with your religious or moral beliefs."

The AMA says, "The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives." FIGO says that "Practitioners have duties to inform their patients of all medically indicated options for their care, including options in which the practitioners decline to participate."

A referral is also addressed by most of these organizations. Again, referral has been an even more contentious matter than the provision of information as it brings up the concerns of cooperation and moral complicity. The AMA says, "A physician who refuses to provide a treatment still owes an ethical responsibility toward the patient. In most circumstances physicians who refuse to provide treatments on the basis of religious or moral objections should refer patients to other physicians or health care facility."

Referral actually brings up practical questions among practitioners about what exactly is meant by referral. Must you identify a specific physician? How sure must you be that that provider in question provides the service in question? The UK developed a description that captures a spirit that some have found helpful. "You must tell patients of their right to see another doctor with whom they can discuss their situation and ensure that they have sufficient information to exercise that right. In deciding whether the patient has sufficient information, you must explore with the patient what information they might already have or need. If the patient cannot readily make their own arrangements to see another doctor, you must ensure that arrangements are made without delay for another doctor to take over their care."

And, finally, while almost all organizations affirm that providers are justified in refusing to participate in procedures that they find objectionable on moral grounds, they uphold the

obligation to provide care in emergency situations. Patients are entitled to be referred — well, this is another referral one, but it essentially says the same thing.

So provision of care. "In emergency situations to preserve life or physical or mental health practitioners must provide medically indicated care of their patient's choice regardless of the practitioner's moral objections."

Similarly the American Academy of Physician Assistants says something along those lines: "Physician's assistants are obligated to care for patients in emergency situations and to responsibly transfer established patients if they cannot care for them."

So what are some of the ethical considerations that have emerged with some consensus as salient to moral deliberation and policy making around conscientious refusals? Many conversations will begin with the importance of conscience in the profession, the idea that it is critical to good medicine and bioethics that physicians exercise independent judgment, that they should not forsake moral integrity when they enter the practice of medicine, and that conscience is critical to democracy, bioethics, humanity. I suspect that we will hear — we've heard some on this already, and I suspect that we'll hear more from the other panelists with regard to this.

When we hear these arguments, it's easy at first blush to say no when asked about whether a physician should ever act in opposition to her conscience. But I'm going to take a few minutes to discuss a sampling of moral considerations that press against the starker, simpler way of thinking about these topics.

Many of these considerations focus, as I have focused in my career, on the patient who is often in the position of vulnerability in the context of the asymmetrical patient/physician relationship as a need that must be met and who is unable to walk away from the situation.

So what considerations are relevant to her? Three areas tend to emerge. The first are questions of health or welfare and the harms that might derive from non-provision of information, referral, or care. Second are questions of fairness, and third are questions of respect. So I'm going to take these one at a time.

Let's talk about health. Consider a case in 2000 known as Shelton versus the University of Medicine and Dentistry [Shelton v. University of Medicine & Dentistry, 223 F.3d 220, 224 (3d Cir. 2000)]. This was in the year 2000. In this case a woman presented to a New Jersey hospital 18 weeks pregnant with a condition known as placental previa. She was bleeding significantly. She had had a couple of other episodes of bleeding in the previous days, and this was a significant hemorrhage.

Now, you have to understand that placental hemorrhage associated with previa is not like bleeding from a cut on your arm or even on your head. As some of you who may have had children know, those can be significant, but it's more than that. In fact, the volume of blood that can be lost in minutes is tremendous, like a garden hose turned on full blast.

The attending physician called for an emergency C-section, but the nurse on duty declined to scrub in since the surgery would result in fetal death due to the delivery prior to viability. The surgery was delayed for 30 minutes. Fortunately in this case that was not too long. The patient was able to be supported while another nurse was identified to take the objecting nurse's place,

but it may just as easily have gone the other way. So there was the potential for harm associated with refusal, even mortal harm.

The expression of conscience here kept the life and health of a pregnant woman in harm's way. This case is famous actually — or known — for the fact that this nurse was offered a position elsewhere in the hospital but declined and was eventually fired and sued the hospital for discrimination, but she lost because the hospital had tried to accommodate her.

In other cases the welfare setbacks may be less obvious, but they are there. The woman who requests sterilization at the time of Caesarian section, for example, when her abdomen is open, her fallopian tubes are in reach, a couple of minutes and the operation is over, but due to her physician's objections to the sterilization procedure she's required to undergo a second operation weeks later and take on the risks of anesthesia and entry into her abdomen. So the patient incurs risk, and there's potentially harm to herself due to these objections.

Other harms can be described. I myself have accompanied a patient who, following a rape, was declined access to EC in an emergency room. I witnessed the harm associated with a traumatic decision she had to face between pregnancy termination and gestation, birth, and parenthood of a child conceived as a result of a profound bodily violation.

The second are concerns about fairness. How do we think about conscientious refusals when they differently affect different groups? Dr. Paris noted that he hesitated about mentioning the case of Guadalupe Benitez , but I will mention it, a woman who was denied intrauterine insemination for the treatment of infertility.

And while the terms of refusal have been a point of contention, the refusal seems to have been based on the provider's objection to fertility treatment for lesbians. In broader brush strokes, many have highlighted the fact that conscientious refusals to dispense contraception may place a disproportionate burden on disenfranchised women, reinforcing an unfair distribution of benefits and burdens. And while the scope of conscientious refusal, of course, stretches beyond areas of reproductive medicine, when reproductive issues are at stake, women are disproportionately affected.

Third and perhaps most importantly are questions about respect. Some will call this respect for autonomy, about how refusals affect women's bodily and others' bodily dominion. In many ways this brings up the stark question of choice and the divisive topic of abortion on demand, but let me bring up a subtler case.

As many of you know, for some women pregnancy is life-threatening. For women with pulmonary hypertension, for instance, mortality associated with pregnancy can approach 50 percent. Consider the case of a young woman with just such a cardiopulmonary condition. Imagine her pregnancy is desired. Imagine that politically she is pro-life, perhaps conscientiously she's pro-life, and her provider shares her view. So despite the morbidity associated with her anticipated gestation, the topic of abortion is not raised, she's not counseled about termination of a pregnancy that may threaten her life.

The fact of the matter is that pregnancy in the setting of a life-threatening medical condition is a difficult situation and a situation that entails the critical human question, what am I willing to die for? By not raising the question of abortion, the provider fails to respect in a very deep way the patient's right to consider that question for herself.

Another set of considerations derives specifically from the fact that we're talking about the practice of medicine, which carries role-specific responsibilities, and these considerations actually press in both directions. As legal scholar Alta Charo has famously noted, an absolute right to refusal cannot be supported since medicine has duties that derive from its status as a monopoly.

She states, "States give these professionals the exclusive right to offer such services. By granting a monopoly, states 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."

Others have argued that individuals enter the practice of medicine cognizant of the fiduciary duties it entails. Again, provocatively, Savulescu noted in the British Medical Journal, "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."

In the other direction, proponents of conscience protections look to the nature of the medicine itself as a healing profession in justifying refusals to perform services they see as non-beneficial, harmful, or deeply, morally wrong. And then, of course, there's the question of scientific integrity, and this speaks both to the question of the validity of the claim based on the idea that the practice of medicine should be evidence-based and that refusals based on inaccurate or incomplete understanding of science should be questioned.

Of particular concern have been claims about the mechanism of action of emergency contraception. Despite a broad misconception that this medication works to prevent implantation, the literature indicates that it prevents fertilization, like other forms of oral contraception. A

review in the Journal of the American Medical Association in 2006 indicated that the ability of Plan B to interfere with implantation remains speculative since virtually no evidence supports that mechanism and some evidence contradicts it. The best available evidence indicates that Plan B's ability to prevent pregnancy can be fully accounted for by mechanisms that do not involve interference with post-fertilization events. The authors of this article advocated at the very least women should be apprised of such. This can obviously play out in other arenas — refusal to withdraw nutrition and hydration based on the view that it's cruel to starve a person a death, et cetera.

So moving forward, how might we think about these considerations? How should we think about balancing patients' needs and providers' critical interests in maintaining their personal integrity? Public policy is at best a blunt instrument. What it can't be is subtle and expansive enough to be responsive to the breadth of provider convictions or the nature of meaning and the consequence for the patient.

What it can do is provide rough guidance that sets a presumption about how we should reason. There is an ongoing debate about what that presumption should be. There are those that advocate that the rights of conscience should prevail in all cases, but there is a strong case for an approach that balances the immediate needs of patients with the interests of doctors. The question is how to balance.

Some considerations in terms of balancing might be fairly straightforward. So we know in situations outside of medicine that the validity or authenticity of a claim can determine whether we allow conscientious refusals to guide decision-making. In medicine those things might also

be important considerations. Professor Dresser has written eloquently about the ways that distaste for certain procedures or discriminatory factors may be masked by claims of conscience.

But then there are harder questions. It seems to me that there may be a qualitative difference in the way that we balance claims of conscience with patients' interests depending on what is at stake, depending on whether the question is one of welfare, differential access, and, perhaps the most challenging, questions about bodily dominion.

The economies of how we balance may be different depending on what is at stake. If we want to talk about the conditions that must be met to conscientiously refuse to inform, refer, or provide care, how we balance may be different depending on what morally is at stake.

Moving forward, just a few things to consider. At the level of the individual provider, ongoing debate centers around obligations — how should we think specifically about the responsibilities of prior notice, the provision of information and referral.

Of considerable interest — and Dr. Curlin and I spoke about this over lunch — is the role that conversations might have in the process. Might there be a role for respectful conversations involving disclosure of a physician's moral views? Could that soften the sense of complicity?

At the level of institutions some have considered establishment of systems to provide information and referral and staffing that maximizes protection of patient interests and providers' rights of conscience.

Finally, some have advocated shared responsibilities so that the responsibility to uphold the interests of patients does not lie with the individual provider, but it's shared with the institution in which that provider works. But it is in part a responsibility of the individual.

In Portugal , for example, physicians are required to register refusals and then are prohibited from counseling patients seeking elective abortion. The law there states that the health system is obligated to ensure that patients receive care within a time frame responsive to patients' needs.

In the end the question of conscience presents important challenges for professional ethics and public policy. As the Council moves forward, I encourage you to do so acknowledging the nuance of balancing and with an eye not just on the integrity of health professionals but on the asymmetry of the patient/physician relationship and the vulnerability and fragility of patients who request our help.

Thank you very much.

CHAIRMAN PELLEGRINO: Thank you very much. Our next speaker is Dr. Howard Brody .

DR. BRODY: I would like to echo Dr. Lyerly 's comments of gratitude for the opportunity to speak with you this afternoon and be part of this very important process. Dr. Pellegrino has already scolded me with regard to the quantity of slides that I brought with me, so I promised that I would move expeditiously. And I've also, at least by e-mail attachment, made available to the Council a manuscript, which is a somewhat fuller elaboration of what I have in the slides, and if any of you are seriously bothered with insomnia, I trust that you'll be able to get copies of that for your perusal.

What I wish to do with you this afternoon is to start with a very brief case study to simply give us a concrete example of what we're talking about, and then I want to spend most of my time offering an account of how to think about conscience and why its dictates may differ from professional obligations and basically present to you what I'll call a two-promises model. And then I will try to suggest at the end, perhaps rather briefly, that there are helpful ways that this two-promises model gives us suggestions that may possibly help in resolving conflicts.

So the case study I'm going to focus on is the case that appeared initially in the American Journal of Bioethics that a colleague and I responded to in a paper that I suspect may have had something to do with my having been invited to speak to you. And basically this is a situation of the prescription of the morning-after pill or emergency contraception where the prescription is presented to a pharmacist, and the pharmacist objects to filling the prescription based on religious or philosophical grounds, perhaps any use of this medication or perhaps for this particular patient.

And the key assumptions here are that the pharmacist here is a health professional so that in important ways is analogous to a physician or nurse or other health professionals, and the debate we're having — although we need to talk about this some more — is not primarily a scientific one. It's not that the pharmacist says the risks are much greater than what the physician thinks or that the efficacy is much less than what the physician thinks who wrote the prescription.

And I was not aware at the time that I started working on this the extent to which apparently you wish to talk about end-of-life issues as part of this general session, but I would suggest that this case is in important ways analogous to end-of-life issues as well, because if you think about end-of-life issues, either to provide aggressive life-sustaining treatment or to provide palliative

comfort oriented treatment that's providing a sort of package of care to the patients, then, again, you have the situation where the provider is being asked to provide a treatment of some sort to the patient and the provider has a conscientious objection to offering that package of care. So I think we can use this case as a jumping-off point for the more general discussion.

So I want to talk about how we should construe a conscientious objection, and all through I'm going to assume a good-faith, honest appeal to conscience, not an insincere appeal to conscience. What is the relationship between a conscientious objection and acting with professional integrity, and do the requirements of personal and professional integrity differ?

So I think it's a little easier, actually, to start with professional integrity, and I'll start with citing the work of Dr. Pellegrino here in which he highlights the notion in some of his seminal papers on this the act of profession or the verb "to profess" as being critical in understanding professional integrity.

And I'm going to argue that to profess is to promise, and it has two elements that are very important. It's a public promise, and it's a collective promise. So the medical profession — in my case, we all stand up together when we graduate and we all say the oath and we all say it publicly. So the fact that we all do it together and we become a part of a medical collective via the saying of the oath and that we do it in public and the public is supposed to hold us accountable are both important elements of what it means to act with professional integrity.

There's a lot of different accounts as to exactly what we promise, what is the content of the promise, but virtually every account that I know of in one way or other says that we elevate the patients' interests in some way, shape, or form above our own personal interests.

Now, the question that might be asked is, does one own interest include one's personal integrity? Now, the first answer to that question is, well, it can't possibly because my personal integrity is my deepest moral possession, if you will. So how could I give that up in the name of professional integrity?

But I would remind you that that may be — we could raise at least a prima facie question about that because many of us believe — I certainly believe — that one of the things that we promise when we make this collective, public promise is — as my infectious disease friends tell me when the H5N1 virus mutates and we have a flu pandemic of an avian flu variant that's transmissible person to person — that I have made a promise as a physician to potentially risk my life to serve the patient.

So it could be asked, are you saying that health professionals made a promise that they're willing to risk their lives but that they're not willing to risk their personal moral views? So at least that question can be raised. It doesn't answer the question, but I think it legitimizes raising the question.

So now let's turn to personal integrity, and I'm going to use conscience and personal integrity largely as synonymous terms. Now, a very popular account of this is that conscience is an inner moral sense which is attuned to an external source of moral truth, such as divine law. And this has been very popular, and I believe if you did a public opinion poll it would get a lot of assents, but my colleague, Martin Benjamin, I believe very thoughtfully in the analysis of conscience that

he did for the Encyclopedia of Bioethics showed that there are serious concerns with this popular account.

First of all, some of us, at least on occasion, experience conflicts of conscience internally. Our conscience seems to be telling us two different things at the same time. And this account of conscience could not possibly account for that.

And then there's a question ultimately of whether this creates a viciously circular argument. Is our conscience right because the external source is true? Do we know the external source is true because our conscience is always right? And what comes first? So there are some serious conceptual problems with this particular view of conscience.

So another account, then, says, well, let's forget about the external source of moral truth and let's say that conscience is an internal standard. And I think that's an appealing account in one very important sense, that if you've honestly and earnestly consulted your own conscience, I don't think we can imagine an effective appeals process.

It's incoherent at a certain level to say even though your conscience tells you that you must do X, I'm telling you that you really ought to do Y instead. It's very important to see that that assumes a level of appeal which I think the whole concept of conscience disagrees that that level of appeal exists. But a strictly internal account may fail to capture important developmental and social features of conscience. And I didn't have the opportunity to be here this morning for Father Paris , but I believe that he may have alluded a little bit to that idea.

So I'm going to play philosopher here for a minute and go on a little tangent, because I think there's an interesting idea that we can bring back into the idea of conscience from John Rawls ' Theory of Justice.

Now, John Rawls ' Theory of Justice says that one of the most important primary goods is this thing called self-respect. And what does it mean to respect yourself? It's very, very important if you're going to have a life worth living that you respect yourself, says Rawls, and a critical element, as he gives an account of this, is having one's plan of life approved of, affirmed, by a special group of people.

And he doesn't give a name to this group, so the only thing I can come up is this unpronounceable acronym of the Rawlsian Life Plan Review Group. Well, who are these people? Okay, so these are people you respect. You get self-respect because people you respect respect you back again. These are people who you think have special insights into who you are uniquely and what would be a rational life plan for you, and these are people whom you freely choose to occupy this role.

So we can imagine your parents, if you agree with the basic values of your parents; special mentors that you had when you were growing up; and perhaps some close friends are candidates for this life plan review group. So the idea is, if this group of people affirms what you're making of your life and show that they respect you because this is what you're doing with your life, you are then entitled to have self-respect, and this sense of self-respect is a very important good.

So I want to then say, can we play with this a bit. And in order to play with this, I want to go off into an area that some would call a narrative approach to ethics, but I think when people are asked to give a narrative account to justify a moral choice, one thing that crops up in discussion

commonly is this idea of keeping faith. And it is sometimes expressed as "my grandmother would turn over in her grave if I did that" or something along those lines.

And what I'm going to suggest is the people who we feel a moral need to keep faith with when we give this kind of justification for why we did something that seems very deeply rooted in our core identity as a moral individual suggests that those same kind of people who would be on the life plan review group in the account given by Rawls might be the candidates to be the ones with whom we have to keep faith in order to be people with integrity.

The speculation I want to now bring to fruition with this is that the idea that keeping faith in this sense seems to resemble an act of promise keeping. It's as if I promised my grandmother or my mother or my father or my favorite teacher when I was in grade school that I would never behave that way, and I need now today to keep my promise. And my motive today, to be sure that I do this behavior, is the felt need to keep my promise to these very important figures that had this formative role in making me the person today that I am as a moral being.

Now, this is not a good reason from a philosophical point of view, but I think sort of indirectly supporting this is that it gives some credence to popular culture depictions of conscience. The Jiminy Cricket idea, the voice in one's ear, the miniature person sitting on one's shoulder that I used to see in the Saturday morning cartoon shows suggest the idea of this person or this group of people to whom I have made prior in my life this important promise and now they're holding me to live up to that promise.

So basically what I'm suggesting here, to try to pull these threads together, is that conscience is what my internalized group of special moral mentors or guides from my early moral development tell me that I ought to do as if I have promised them to behave in that way, again

emphasizing they're certainly not here now. I don't pick up the phone to call them. They may, in fact, not even be alive anymore.

Now, does this mean that conscience is nothing but an internalized set of social norms from early child development? And Benjamin again says that would be a totally flawed and insufficient account. You could never defend a serious moral weight being placed on the dictates of conscience if it was nothing other than "Well, that was the way I was raised." So if I was raised in a terribly bigoted and prejudiced society and that somehow justifies my being a bigoted and prejudiced person. Absolutely not.

So it's important, I think, then, to see what's going on here, that this Rawlsian narrative account of conscience's promise is different from merely invoking social norms. It presumes a conscious and reflective act of choosing certain individuals to be part of one's life plan review group or promise-to-mentor group. And so, for example, it's interesting when people exclude their parents, when people say, "My father was a bigot, and he brought me up to be a bigot, and I'm not going to be a bigot. So I will not allow my father to play this role in mentoring me for my moral behavior as an adult. I reject my father's candidacy for membership in this mentor group, and I didn't promise my father that I would be like him, and I won't," so that there's a reflective processing of this input. It's not a blind acceptance of the social environment in which one was brought up.

So I'm suggesting in summary that personal integrity or conscience represents a private promise to behave in certain ways to this special group of people who I feel I owe this role in my life to who helped guide me to become the person that I am. Professional integrity grounded in the act of the profession represents a public collective promise to act in certain ways, specifically to be

faithful to the interests of the patients, and therefore it would not be a surprise if the content of the two promises conflicted with each other. So we have two promises which could easily come into conflict, and there we have the so-called conflicts of conscience in the clinician.

Now, how do you resolve this? Well, the first important thing that follows from this account is, you do not resolve this by denying the moral weight of either personal integrity or professionalism. Each is an important way to a considerable extent to the good professional identity constituting. Certainly my personal integrity is identity constituting. Who I have selected to be my special moral mentors and I feel obliged to act as if I promised them to keep faith with them — I would behave in those ways— that is at the very core of my moral identify.

And one of the things it means to say that I'm a professional and that medicine is not a mere occupation, for example, is that that becomes a part of one's identify, and my moral commitment to my field, my service commitment to my patient, is part of who I am. So both of these are to some extent, at least, identity constituting promises. Neither can be taken lightly. Neither can be simply dispensed with.

Now, the rational conversation idea, the counseling idea that Dr. Lyerly alluded to, highlights something that is complicated about the idea of conscience. It may be that there is no higher court of appeal than my own conscience. That does not mean my conscience cannot be mistaken. Conscience is corrigible. So how can conscience be mistaken? I think it's very important that we list these ways.

First of all, as was already pointed out, you could have the incorrect facts. You could not know how certain drugs work, at least in the minds of certain investigators who have elucidated the mechanism. You could certainly adhere to moral principles or rules at one time in your life so

that at that time in your life that rule is the highest moral court of appeal, but at a later time in your life on reinvestigating those moral rules you could find they were flawed and you could come to what you hope is a higher level of understanding of morality such that you no longer adhere in the same way or to the same extent to those moral principles that guided you.

And then I think there's an under-appreciated way the conscience can be mistaken, and that's what I would call single-issue conscience like single-issue voting. That is when you allow one dictate of conscience to assume such prominence in your thinking that you ignore other dictates of conscience. And I'll come back with some examples.

Now, an important distinction that I think guides us into how easy or how hard it's going to be to resolve conflicts of conscience in practical health care settings is — I'll offer a distinction between a mild and a strong interpretation of the dictates of conscience. A mild interpretation of the dictates of conscience essentially requires that one stand aside: "I should not participate in this procedure or this treatment that I morally object to."

A strong interpretation of the dictates of conscience requires acts that start to amount or actually amount to interfering with the patient's access to those services. So refusal to refer is a common one, and I have heard at least anecdotally of one instance where not only did the pharmacist not fill the prescription, but the pharmacist confiscated the prescription, would not give it back to the patient, so the patient was prevented from going to another pharmacy even if there was one just up the road where they could have gotten the prescription.

So those are strong interpretations of what conscience requires of you. And there is where I think that we start to see what I mean by the single-issue conscience, because let us take for a minute the pharmacist who basically stole the prescription from the patient. That pharmacist would say,

"Well, my conscience told me I had to do this," but did this pharmacist promise his mother and his grandmother in those moral guides that he grew up with that he would become a thief? Probably not.

So this pharmacist, I would argue, was allowing one moral commitment, which is a part of his conscience, to cause him to forget that he had made other moral commitments also in his conscience, that none of our consciences, if we're like most people, are single-issue voters. And if we want to follow the dictates of conscience, we are duty bound to buy the whole package. We have to remember what other commitments of conscience we may have and not allow one single one which is particularly in focus at one particular moment in time to cause us to lose sight of the other dictates of conscience.

So the kind of balancing act I think we're struggling with here in many cases is the more that the strong interpretation is favored over the mild interpretation, the more difficult it's going to be to reconcile the individual professional's objection with basic duties owed to the patient. And this is going to lead to cases like the one — the court case that Dr. Lyerly mentioned, where we're going to have to say in some cases that a professional with such stringent dictates of conscience ought not choose that particular career, that they cannot at the same time promise they're going to serve the interests of the patients if their individual personal integrity requires them to say no to so many things that could possibly be a part of the needs of the patient.

An extreme case that I was made aware — and I'll talk a little bit more about that hearing later — in the State of Michigan a state senator, who also happened to be a physician, remembered when he was in residency at the University of Michigan that one of the anesthesiology residents was a

Jehovah's Witness and would not give a blood transfusion to a patient who was bleeding out in surgery. And eventually they had to fire this resident.

So you could argue that you could be a Jehovah's Witness, but you can't be a Jehovah's Witness and be an anesthesiologist. You've got to choose at some point if it's that important a commitment for you.

Now, fortunately most of the time it's nowhere near as bad as the case of the Jehovah's Witness anesthesiologist, and the more that a mild interpretation prevails, the easier it seems to relocate responsibility for handling conflicts at the system's level where we can replace the professional temporarily who has objections with one who is willing to provide the services and that these conflicts can be anticipated and allowed for as you look at the scheduling issues and the way that you staff and deal with your personnel in your particular pharmacy or your hospital or your L&D unit or wherever you may be the manager of.

Obviously this is going to have problems in particular instances. It's particularly going to be a problem in a rural health setting where there may not be that many alternatives available, where the other facility may be many miles away. This may, in turn, argue for limits on where a professional with stringent dictates of conscience may elect to work. Alternatively, it may require a greater personal willingness to participate in arranging referrals and other alternatives if the person with the strong dictates of conscience does elect to work in a more rural setting where they are the only source of care available.

Now, just to give some illustrations of where I think this could cause some problems or where some objections could be raised is the hearing that we had in the State of Michigan before I moved to Texas in 2006, where I was asked to represent the Michigan State Medical Society at a

hearing of the state senate to hear a piece of legislation that had been proposed which was designed to specifically protect the rights of conscience of the health worker.

And we were objecting to it, as were the hospitals and just about every health care facility, frankly, in the State of Michigan was objecting to this law because it seemed totally out of balance. It was all about the right of conscience of the health professional and there was absolutely nothing in the law about service to the patient or the needs of the patient.

So we were very concerned that this was a one-sided piece of legislation. And it struck us as we went to testify against this legislation that when asked what was the need, where were the instances that, for example, a professional had either been fired or had been forced to provide service over their conscientious objections, they in fact could not name a single instance where this happened that created a practical need for this new legislation.

All they could do was hypothetically say, "Well, down the road there might be new drugs derived from stem cell research, and that would offend many people's consciences, so we need a law today to be sure that in the future people didn't have to administer these drugs to which they might have a conscientious objection."

And another example from this hearing was one of the defenders of the legislation said it was very important to extend the right of conscientious objection to the system and not just to the individual. So it's not just a matter of personal integrity, but it extends to the system. "So, for example," said this expert, "the owner of a large business who has a conscientious objection to contraceptives should be able to say that his firm's health insurance policy will not cover contraceptives," because that would violate his own conscience. So in this case it's the firm, the corporation, and not the individual that objects to the treatment.

And I would say that this systems-level refusement makes perfect sense in some settings. So the idea of a network of religious hospitals, for example, saying our religion requires that we do not provide this procedure in any of our hospitals, to me that make perfect sense and I think that's very legitimate.

I would argue that in the case of the owner of the firm that it's mis-described as conscientious objection and it seems to me to be something quite different. I would submit to you that it's abuse of power. It's using one's financial power, in this case, to impose one's own philosophical or religious views on others of differing views, which I think is different from the exercise of one's conscience.

So I would offer some conclusions from this rather hasty set of thoughts. In cases that are reasonably analogous to our case study — the pharmacist with the prescription for the emergency contraceptive — I have tried to suggest to you that the two-promises account explains how conflicts may arise and why both promises deserve moral respect, the public collective promise of the professionals made to the patients to put their interests first, and my personal promise that I made to my special internalized group of moral mentors as to how I would behave in order to be the kind of person that I want to be as a moral being, and that fortunately a system's level attempt to resolve conflicts appears practically workable in many or even most settings.

Now, an implication that comes out of my distinction between the mild and the strong interpretations is a message for leaders of religious faith communities, I believe. And I'm a little on shaky ground talking here because I'm certainly not a theologian and have no expertise in religion, but I'll throw this out for whatever it may be worth.

It may be that your religious tradition allows one interpretation only, that the strong interpretation is the only one consistent with your faith tradition. If that's so, nothing more should be said. That's the way it is. But in many faith traditions interpretation is possible, and it may be that a strong interpretation is correct or it may be that a milder interpretation is correct, and there could be discussion and debate within the faith tradition over which account is correct.

If the leader of the faith community encourages the health professionals who are members of that faith community to lean toward the milder interpretation, it follows as a practical consequence that social conflict will be minimized and that it will be easier for that group of providers, that group of health professionals, to adhere to both those promises that they made, both the promises to their own conscience, to their own inner voice, and the promise to the larger community to serve the patient.

To the extent that the religious leaders insist on the strong interpretation and discount the validity of the mild interpretation, one can predict that social conflict will increase, and it will be harder and harder to engineer social systems or health care systems in such a way as to revolve those conflicts. And I believe that then becomes partly the responsibility of the religious leader if there had been at least the possibility that another interpretation might have had some validity.

So what I personally hope is that in the future we will see more examples of conscientious objection dealt with by a local accommodation in the spirit of mutual respect and fewer instances where the use of political or financial power favors only one promise over the other equally important promise.

Thank you very much.

CHAIRMAN PELLEGRINO: Thank you very much, Howard . Our third speaker is Dr. Farr Curlin . Dr. Curlin.

DR. CURLIN: Thank you, Dr. Pellegrino , and I also would like to say it's a great honor to have a chance to address the Council and to be a part of this panel with my colleagues, although, as you'll see, I will disagree with them on some important levels.

Let me begin with my observations as a physician and as one who has observed the practices of other physicians. Physicians commonly refuse to provide clinical interventions that patients request even when those interventions are legal and permitted by the medical profession. These refusals are neither new nor peripheral to clinical practice.

Physicians of course refuse interventions that they believe are categorically unethical. In taking the Hippocratic Oath, physicians have for centuries sworn to refuse to provide either abortifacients or any drug or information that will be used to help kill patients. Physicians also refuse practices that they believe are ethical in some cases but not in the case at hand. For example, I believe it is ethically permissible to sedate dying patients to the point of unconsciousness if the intended and direct effect of the sedation is to relieve distressful symptoms that are refractory to other treatments. Yet in my own practice of hospice and palliative medicine, I sometimes disagree with patients, their families, or other health care providers about whether we should increase the level of sedation in a particular case.

Sometimes physicians refuse interventions that are the subject of widespread public dispute, such as abortion or emergency contraception. More often their refusals occasion little controversy. For example, surgeons refuse to operate when they believe a surgery is unlikely to be successful whether or not all of their colleagues agree. Physicians refuse requests for antibiotics or other remedies even if the patient's symptoms satisfy some threshold criteria for using these medications. Physicians may refuse requested interventions because of tangible concerns about safety or efficacy, or they may refuse because of concerns that are less tangible if no less real. Some Catholic physicians refuse to provide contraceptive medications because the Roman Catholic Church teaches that such medications illicitly separate the procreative and unitive aspects of human sexuality.

More commonly, physicians' intangible concerns are not explicitly religious. Some pediatricians refuse to provide growth hormone injections to boys who are short because of concern about crossing a line between treatment and enhancement. Internists and family physicians sometimes refuse intensive work-ups and treatment regimens for what they believe are psychosomatic syndromes, because they are concerned about being good stewards of their colleagues' time and other medical resources. Obstetrician-gynecologists who will abort fetuses with lethal congenital anomalies may refuse to abort those with Down's Syndrome or cleft palate out of concern about societal attitudes toward those with disability. Physicians refuse patient requests even when patients are informed, even when threshold medical criteria are met that would generally justify the intervention, and even when physicians are aware that some of their colleagues would disagree with their refusal.

So to say a refusal is conscientious is simply to say that it is based on a physician's best judgment about what he or she ought to do in a given case. In its recent opinion, the ethics committee of

the American College of Obstetricians and Gynecologists wrote that, “An appeal to conscience would express a sentiment such as ‘If I were to do X, I could not live with myself. I would hate myself. I wouldn't be able to sleep at night.'" Professor Brody mentioned a notion that my grandmother would turnover in her grave if I did this.

I would suggest that conscientious refusals need not be so dramatic. Rather, they are merely refusals based on what physicians believe are good reasons. In a morally pluralistic society, such reasons will not be persuasive to all, but they will be intelligible and plausible. And I should note that in virtually every case of which I'm aware, people do give reasons. I have not seen people, at least in public discourse, say "I can't do this just because my conscience says so." Rather, they say "I can't do that in good conscience because" and then what follows as a reason.

Now, critics sometimes suggest that health care professionals' stated reasons for refusing particular interventions are specious and hide unspoken prejudices. I was encouraged to hear Professor Brody note that we should presume good faith about people's objections. In the essay that was in the briefing booklet, Professor Brody and Susan Night say they “suspect that what the conscientious pharmacist" who refuses emergency contraceptive pills — what that pharmacist actually objects to but does not have the nerve to say outright is the possibility that a woman can engage in sexual activity without having to face the moral consequences of her potentially illicit act.

Now, it goes without saying that physicians who act capriciously are not acting conscientiously, yet the scare quotes around the terms conscientious and moral suggest, I think, that the authors do not acknowledge or take sufficiently seriously genuine moral disagreement about postcoital contraception.

To say that conscientious refusals are central to the practice of medicine is not to say that every conscientious refusal is justified. Father Paris talked about that in some detail earlier. A conscience that is malformed or misinformed will err. I'll give you a clinical example. A conscientious physician may fail in his duties to relieve a patient's debilitating pain because he has not been trained to pay close attention to and work hard to address pain. Alternatively, he may fail because he incorrectly interprets the patient's behavior as drug-seeking and malingering. The conscience as a human faculty is both limited and fallible. Yet, however fallible, conscientious refusals are, I think, a logical and necessary consequence of physicians exercising discernment or clinical judgment.

It has long been recognized that medical decisions cannot be reduced to doing what patients want or even to clinical algorithms, rules of thumb, and scientific data. This is in part because the application of medical science always embodies and expresses normative ideas about the body and what it means to be human, to flourish, and to fulfill our obligations to one another. Science can neither provide these ideas nor settle disagreements about them. In addition, even if there were agreement about these underlying moral issues, physicians still must consider and weigh up innumerable different factors, probably many of them unconsciously, in order to discern how best to seek the health of a particular patient in a particular context, all things considered.

This task is almost always attended by ambiguity and uncertainty, and it requires what Aristotle called phronesis or practical wisdom, which in the practice of medicine has been called good clinical judgment. If physicians are to exercise clinical judgment in seeking their patient's health, they will necessarily refuse some patient requests.

So, with respect to the present controversies, it cannot be that conscientious refusals per se are ethically problematic. What we are after are criteria by which to distinguish those refusals that are consistent with physicians' professional obligations from those that contradict those obligations. To find such criteria, we have to figure out what in fact physicians are obligated to do.

We might start with the obligation, as Dr. Pellegrino put it at the end of the morning session, the obligation that has been self-evident to people from virtually every culture and moral tradition throughout the centuries; namely, the obligation to care for the sick so as to preserve and restore their health. The Hippocratic Oath states, “Into whatever houses I enter, I will go into them for the benefit of the sick,” and this universally recognized obligation still provides a powerful criterion by which we can discern that some refusals, however conscientious, are incompatible with good medical practice.

For example, the physician who refuses to care for patients with HIV because of antipathy towards homosexuals or for black patients because of racial prejudice or for criminals because of revulsion at their crimes thereby violates, in my understanding, his or her constitutive professional obligations to seek the health of patients precisely because they are sick without regard to their other characteristics. However, this obligation to seek health does not provide a criterion by which to condemn the sorts of conscientious refusals that have stirred contemporary controversies.

Rather, as biomedical science has expanded, it has made possible many uses of medical technology that are not so obviously directed to preserving and restoring health. Examples include terminal sedation, growth hormone for short children — or, as we have learned, for

professional athletes — cosmetic surgery, most assisted reproductive technologies, elective abortion, and others. Yet the paradigmatic example of such interventions and the one that continues, not surprisingly, to animate disputes about conscientious refusals, is contraception.

In 1979, twenty years after the FDA approved the first oral contraceptive, Mark Siegler and Anne Dudley Goldblatt wrote the following: "The oral contraceptive medication was the first prescription drug that was and is, in effect, a self-prescribed treatment. Patients — i.e., medical consumers desiring elective medication — demanded that physicians prescribe the contraceptive pill. Other popularly self-prescribed medications soon followed and came to be seen as appropriate solutions for treatments for problems previously considered individual or social concerns, but in any case not biological abnormalities or specific diseases."

It is not surprising that physicians became the purveyors of these technologies. They had the scientific expertise and the legal authority to manipulate the body. However, from the beginning many within the profession have argued that physicians have no business pursuing ends other than health, and despite the widespread use of these technologies some have always refused to provide them. For a long time such refusals were uncontroversial. The medical profession has traditionally given wide latitude to physician discretion in areas of disagreement. Professional codes have consistently stated that physicians are not obligated to satisfy patients' requests for interventions that the physician does not believe are in the interest of the patient's health. In this respect, and notwithstanding claims to the contrary, physicians who refuse to provide such technologies today are not claiming new freedom from old professional obligations.

Physician refusals have become newly controversial, I would argue, because the emergence of a new technology — in this case postcoital contraceptives — has intensified an old concern about

patients having access to reproductive services. For better and worse, physicians do have exclusive license to administer technologies by which millions of Americans have come to order their lives — and, in all fairness, have come to order their lives in a conscientious fashion. With respect to most of these technologies, if one physician will not provide what a patient seeks, the patient can go to another physician who will. The patient incurs relatively modest costs as a result of the physician's refusal.

Postcoital contraception is different. It works only if administered within a brief window of time. If a woman seeks emergency contraception after intercourse and her physician refuses to prescribe it or her pharmacist refuses to dispense it, she may get pregnant when she would not have otherwise. In response to reports of such refusals, a chorus of different writers has argued that doctors and pharmacists must provide or facilitate access to all legal and professionally accepted medical technologies, notwithstanding their moral objections.

Now, here I'm going to part ways with my colleagues here in that these arguments lean heavily on a moral distinction and tension between the personal and the professional. That's right in the title, for example, with Professor Brody 's talk. Whether this tension is posed as personal moral values versus professional ethical obligations or personal conscience versus professional conscience or, in the case Professor Brody described, duties related to personal versus professional integrity.

Health care professionals who refuse to provide what patients request, the arguments go — or, to be fair, refer for or facilitate access to those things at patients' request — thereby allow their personal considerations to trump their professional obligations.

Unfortunately, this pitting of personal versus professional tends to beg the relevant moral question, because unless and until we can specify our professional obligations, we cannot know whether they are being violated, nor can we know which obligations are merely personal.

In these debates, it seems to me, everything turns on how we define the substance of our professional obligations, because at the heart of every controversy about physician refusals lies a debate about what medicine is for. As biomedical science generates technologies that people desire to use that they highly value, questions are raised as to whether those uses are really directed at health objectively defined. If not, then some argue for a broadening of the concept of health to justify the use of the new technology or they argue that physicians are obligated to pursue other goals in addition to health.

In his 1975 essay “Regarding the End of Medicine and the Pursuit of Health,” Leon Kass noted, “It is ironic, but not accidental, that medicine's great technical power should arrive in tandem with great confusion about the standards and goals for guiding its use. When its powers were fewer, its purpose was clearer.” Several years later, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research — quite a mouthful; I'm glad that's been revised — echoed this observation. Citing Siegler, the Commission wrote in 1982:

"Judgments of conscientious persons have become divergent and perplexed and societal consensus does not exist. No longer are the proper ends and limits of health care commonly understood and broadly accepted; a new concept of health care, characterized by changing expectations and uncertain understanding between patient and practitioner, is evolving. The need to find an appropriate balance of the rights and responsibilities of patients and health care

professionals in this time of change has been called the critical challenge facing medicine in the coming decades." And if today's forum is any indication, it seems the challenge remains.

Those who frame conscientious refusals, I would argue, as a conflict between personal values and professional obligations thereby take one side in a debate they rarely acknowledge. For example, Chervenak and McCullough, two very prominent ethicists in the area of obstetrics and gynecology, claim that conscientious refusals violate physicians' duty to protect and promote the health-related interests of patients. Professor Brody and Susan Night in their essay in the booklet claim that pharmacists who refuse to make arrangements for patients to receive emergency contraception violate their professional duty to dispense medications that are, in the authors' terms, medically indicated for the patients' condition. The ethics committee of the American College of Obstetricians and Gynecologists also criticizes those who fail to provide medically indicated treatments. Unfortunately, these claims beg the question they propose to answer, because they do not address disagreements about whether the interventions in question are really health-related. To put it another way, we cannot know whether something is medically indicated unless we know what medicine is for, whether, for example, the patients' condition is one which medicine properly treats.

In these critiques, if authors do not beg physicians' obligations, they often assert obligations that are themselves highly disputed. For example, Chervenak and McCullough criticize physicians who disclose the reasons for their conscientious refusals to patients. They argue that such disclosures violate an ethical consensus that physicians should be nondirective in their counsel to patients. Yet, we can see that no such consensus exists by turning to the paper on enhanced autonomy by Professor Brody and Timothy Quill who there argue that physicians fail to use their

power appropriately when they withhold their guidance and that this failure reflects a misunderstanding about the moral requirements of respecting patient autonomy.

Now, the ACOG Ethics Committee opinion also interprets uncontroversial physician commitments, I would argue, in novel and controversial ways. For example, the Committee invokes respect for patient autonomy but without explanation amplifies it to imply respect for the choices patients make and a “fundamental duty to enable patients to make decisions for themselves.” Moreover, the Committee replaces the objective references for the concepts of health and harm. It asserts that harm cannot merely be measured with reference to bodily health but also with reference to “well-being as the patient perceives it.” It does not attempt to demonstrate that physicians must provide particular interventions if they are to preserve and restore patients' health. Rather, and in a telling use of language, the Committee asserts that physicians are obligated to provide — and here again I'll quote several of these phrases: "to provide reproductive technology..., health resources..., professional services..., standard reproductive services that patients request..., and safe and legal reproductive services..."

A comprehensive treatment of the merits and weaknesses of each of these claims is beyond the scope of my comments. It's perhaps enough to point out that there is even less consensus about these purported physician obligations than there is about the controversial practices which the physicians are refusing to provide. Moreover, and I think more problematically, these purported obligations depend on a provider-consumer ideal for the doctor-patient relationship that has been widely criticized as being insufficient for, and even corrosive of, the practice of medicine. Siegler and Goldblatt drew the connection in 1979, warning that the demanding patient presents a serious danger to clinical medicine. They continued: "The demanding patient denies that the physician's responsibilities and expertise have any relevance except insofar as this coincides with

the patient's desires. The demanding patient inverts the traditional model and makes the physician a passive agent. The patient proposes; the physician provides. The physician becomes a technician practicing under the direction and control of his or her client."

In 1982, the President's Commission report titled Making Health Care Decisions echoed Siegler and Goldblatt's concern, and over the ensuing three decades a series of influential clinicians and ethicists who disagree on a great many other substantive moral questions have agreed that the pendulum has swung too far away from physician paternalism toward an emphasis on patient autonomy that amounts to what the President's Commission called "patient sovereignty."

In the paternalism model, the physician ordered, the patient obeyed. After the patients' rights movement, the physician proposed, the patient chose or gave consent. In the patient sovereignty model, or what Quill and Professor Brody called the independent choice model, the patient proposes, the physician provides. The physician has effectively lost both moral agency and responsibility.

Arguments for reining in conscientious refusal depend on this latter model being the right one. Only if the physician-patient relationship is one of provider-consumer or technician-client can patients' legal right to seek biomedical interventions imply that physicians have a professional obligation to provide what patients seek. Only then can respect for autonomy imply nondirective counseling and a fundamental duty to enable patients to make decisions for themselves. Only then can informed consent be redefined as informed choice. Only then can physicians' obligation to care for the sick be exchanged for an obligation to provide health care services toward the goal of maximizing well being as the patient perceives it.

Some would welcome the prospect of physicians answering to their patients regarding what is good for them. After all, if these controversial technologies are not directly related to restoring health, they are at least medical commodities — health care services, to use the prevalent language — and physicians have no particular expertise or standing to determine how autonomous individuals put non health-related commodities use. An independent choice model for the doctor-patient relationship would improve access to these services while reducing patients' risk of surprise and embarrassment. The model would bring simplicity, efficiency, choice and control. If some physicians do not like providing these services, they can quit or find another clinical specialty.

That is one option. We have a choice which will be made through all of the instruments of politics.

My point here is that it is a consequential choice. The profession can continue to ask its members to commit themselves to an objective goal, namely health, that is not subject to wholesale revision. If this route is taken, the profession must allow, from my understanding, conscientious refusals where there is reasoned dispute about whether an intervention is consistent with that goal. Or the profession may constrain the scope of conscientious refusals and move toward a provider-consumer model in which physicians' moral and clinical judgment is irrelevant to their task of providing what patients lawfully seek. We cannot have it both ways.

And to close I'll describe three logical — I think logical, if unintended — consequences of taking the latter route to argue that if we choose it we may lose more than we gain. First, any policy that constrains the scope of conscientious refusals thereby erodes the possibility of conscientious practice. It seems obvious that patients want their physicians to be conscientious insofar as

possible. Few would respect or desire the care of physicians who are in the habit of doing things they know to be unethical. Fortunately, individuals from virtually all moral traditions and communities can conscientiously and enthusiastically commit themselves to caring for the sick. That is one reason why the profession of medicine has been able to maintain both prestige and a semblance of unity in a society made up of many different moral communities. Yet if physicians must be willing also to participate in contraception and sterilization, those who believe what the Roman Catholic Church has taught for centuries about the human body and sexuality, and those who believe that physicians should aim at health and nothing else, will no longer be able to practice conscientiously.

If physicians are required to refer patients to abortionists — to those who provide abortions — when requested, those who believe that such referral makes them complicit in a gravely immoral action will have to quit. And so the process goes.

Every time the scope of conscientious refusal is narrowed, the pool of people who can be conscientious physicians is reduced. Eventually, the only ones left will be those who are willing to make all legal medical technology available to be used by patients according to their own judgment.

Second, by requiring physicians to do what patients request, we set physicians and patients at odds with one another. Professor Brody and Timothy Quill argue that in the independent choice model, the physician as a person with values and experience has become an impediment to rather than a resource for decision making. I would add that the patient also becomes a moral threat to the physician, particularly if restrictions on conscientious refusals take on the force of professional or legislative policy. Physicians will then wonder when their patients might, with

the backing of legal sanction, ask them to act against their own understanding and do that which they believe is unethical.

Third, patients will lose the basis for trusting that their physicians are committed to their good. Benjamin Franklin once said, “If we restrict liberty to attain security we will lose them both.” A similar dynamic is at work with respect to the practice of medicine. If we restrict professional autonomy and physician discretion to preserve patients' interests, we will lose both. Why would that be?

Well, under the old model of paternalism, patients could trust that physicians had committed themselves to the patients' best interests, albeit in a limited way — only insofar as those interests included restoring and preserving health. The patients' rights movement and the rise of the doctrine of informed consent qualified and delimited physicians' commitment to pursue health. Out of respect for persons, it was decided — I think rightly — that physicians are to act only with the permission of the patient. Because health is a relative and not an absolute good, patients are authorized to relativize that good to other concerns such as not being overburdened by medical technology. Yet within these limits, physicians remain committed to health. In the enhanced autonomy model of Quill and Brody, the deliberative model of Emanuel and Emanuel, and the physicians' conscience model of David Thomasma , physicians are responsible for thinking, using discernment, making judgments, providing counsel, and even seeking to persuade patients to make the choice the physician believes is best.

Models that support constraining conscientious refusals differ in a fundamental way. In them patients not only relativize the good of health to other concerns but also define which goods physicians will seek. Patients gain technicians, it seems to me — technicians who are committed

to cooperation, and they lose healers committed to health. They gain control over physicians, but thereby divest physicians of responsibility. As a result, physicians can wash their hands of patients' decisions so long as the physician gives accurate information and provides technically proficient health care services.

So one cannot merely constrain the scope of conscientious refusals and leave all else the same. Policies that devalue conscientious practice and/or make it more difficult reduce that which makes the practice of medicine its own reward: the confidence and conviction that what one is doing is very good. This morning Dr. McHugh described working long hours for little pay and yet being very happy at it. Dr. Hurlbut described watching his father spend a portion of each week caring for patients who could not pay for that care and finding that work immensely rewarding and satisfying. If I remember his comments correctly, Dr. Hurlbut you said it stirred in you a sense of the nobility of the practice of medicine.

It seems to me that if physicians surrender their commitment to do only that which they believe is good for their patients' health, they will also surrender the nobility, joy, and other intrinsic rewards of medical practice. Their morale will decline, and I would argue has already declined precisely because the practice of medicine has been literally demoralized.

There is a better way, I think, that has been iterated again and again by the clinicians and ethicists that I have already mentioned. That way involves conscientiousness and candor on the part of physicians. Where there is ambiguity or dispute about whether a particular practice belongs in medicine, physicians and patients have a respectful and candid discussion so that they can negotiate an accommodation that does not require either to do what they believe is unethical. In this model, physicians would not feign moral neutrality but instead would tell their patients

frankly what the options are, which ones the physician is willing to provide, and why the physician recommends one over another.

The scope of permissible accommodations will have to be set through the political process. But I would echo the conclusion reached by the President's Commission in 1982, which is that considerable flexibility should be accorded to patients and professionals to define the terms of their own relationships. This model would encourage policy accommodations that provide reasonable access to controversial technologies without asking physicians to provide interventions to which they object. For example, before the FDA approved over-the-counter sales of postcoital contraceptives, some states had bypassed the need for a cooperating physician by allowing pharmacists to dispense the drug without a prescription. In a forthcoming essay in Theoretical Medicine and Bioethics, Armand Antommaria argues for and provides numerous other examples of policy accommodations that promote patients' interests and access to medical technologies without diminishing physicians' interests in maintaining moral integrity.

In conclusion, unless and until consensus is forged regarding the ends of medicine, refusals of controversial practices cannot be shown to violate physicians' professional obligations. In the meantime, the practice of medicine should be open, I think, to anyone who is willing to unreservedly commit herself to caring for the sick so as to preserve and restore their health. In light of deep moral disagreements in our society about the scope and limits of medicine, the profession should invite differences in practice so long as physicians are candid about their practices so that patients can effectively participate in medical decisions. Conscientiousness, when accompanied by candor and respect, gives a limited ground for patients to trust physicians as they work out accommodations in the face of genuine disagreement about how to apply medical science toward the patient's good.

Thank you.

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Curlin, and thank you also to the other panelists for being so very, very punctual and bringing us to the point of our break. We're going to break now and then on return at 3:45 we will hear from Dr. Robby George, who will open the discussion for the rest of the Council members.

(Session 3 continued)

CHAIRMAN PELLEGRINO: I think we'll move ahead. Robby, would you introduce the discussion?

PROF. GEORGE: Thank you very much, Dr. Pellegrino , and thanks very much for the opportunity to offer an opening comment and lead the discussion. My comment will focus mainly on the ACOG Committee Opinion No. 385 of November 2007 on "The Limits of Conscientious Refusal in Reproductive Medicine."

The critical things — and I'm very critical of this opinion -but I have to say were reinforced in my saying them by Dr. Lyerly 's presentation this morning. And so I do hope that Dr. Lyerly will be given an opportunity as the other panelists will be to challenge what I have to say because it is highly critical.

DR. ROWLEY: Well, she's not here to hear them, so I think that you have to wait until she comes.

PROF. GEORGE: Absolutely fine with me.

CHAIRMAN PELLEGRINO: She's here. Dr. Lyerly is here. She's just been in the wings.

PROF. GEORGE: Dr. Lyerly, while you were out I said that my comments are going to be focused on the ACOG report of November 2007, "The Limits of Conscientious Refusal in Reproductive Medicine," and my comments are going to be highly critical. So I expressed a hope that you'd be given an opportunity to respond to them and to challenge me if you'd like. The same for, of course, the other panelists.

The first thing to notice about the ACOG Committee report is that it is an exercise in moral philosophy. It proposes a definition of conscience, something that cannot be supplied by science or medicine. It then proposes to instruct its readers on, "...the limits of conscientious refusals describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care."

Again, knowledge of these limits and values, as well as knowledge of what should count as the ethical provision of health care, are not and cannot possibly be the product of scientific inquiry

for medicine as such. The proposed instruction offered here by those responsible for the ACOG Committee report represents a philosophical and ethical opinion — their philosophical and ethical opinion.

The report goes on to, "outline options for public policy," and propose, "recommendations that maximize accommodation of the individual's religious and moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve."

Yet again notice that every concept in play here — the punitive balancing, the judgment as to what constitutes an imposition of personal beliefs on others, the view of what constitutes health care or reproductive health care, the judgment about what is deserved is philosophical, not scientific or, strictly speaking, medical.

To the extent that they are medical judgments even loosely speaking they reflect a concept of medicine informed and structured, shaped by philosophical and ethical judgments. Those responsible for the report purport to be speaking as physicians and medical professionals.

The special authority the report is supposed to have derives from their standing and expertise as physicians and medical professionals, yet at every point that matters, the judgments offered reflect their philosophical, ethical, and political judgments, not any expertise they have by virtue of their training and experience in science and medicine.

At every key point in the report their judgments are contestable and contested. Indeed they are contested by the very people on who consciences they seek to impose, the people whom they would, if their report were adopted and made binding, force into line with their philosophical and

ethical judgments or drive out of their fields of medical practice. And they are contested, of course, by many others. And in each of these contests a resolution one way or the other cannot be determined by scientific methods, rather the debate is philosophical, ethical, or political.

Lay aside for the moment the question of whose philosophical judgments are right and whose are wrong. My point so far has only been that the report is laced and dependent upon at every turn philosophical judgments. I've not offered a critique of those judgments, although anyone who cares to can find plenty of criticisms in my work of those judgments. But lay that aside for now.

The key thing to see is that the issues in dispute are philosophical and can only be resolved by philosophical reflection and debate. They cannot be resolved by science or methods of scientific inquiry. The committee report reflects and promotes a particular moral view and vision and understandings of health and medicine shaped in every contested dimension and in every dimension relevant to the report's subject matter, namely the limits of conscientious refusal, by that moral view and vision.

The report, in other words, in its driving assumptions, reasoning, and conclusions is not morally neutral. Its analysis and recommendations for action do not proceed from a basis of moral neutrality. It represents a partisan position among the family of possible positions debated or adopted by people of reason and goodwill in the medical profession and beyond. Indeed, for me, the partisanship of the report is its most striking feature.

Its greatest irony is the report's concern for physicians' allegedly imposing their beliefs on patients by, for example, declining to perform or refer for abortions — or at least declining to perform abortions or provide other services in emergency situations and certainly to refer for

these procedures. The assumption here, of course, is the philosophical one that deliberate feticide is morally acceptable and even a woman's right.

But lay that aside for now. Of course, the physician or the pharmacist who declines to dispense coerces no one, though I think that Prof. Brody and I would have a debate about that. He or she, that physician or pharmacist, simply refuses to participate in the destruction of human life or human life in utero.

By contrast, those responsible for the report and its recommendations evidently would use coercion to force physicians and pharmacists who have the temerity to dissent from their philosophical and ethical views to either get in line or go out of business.

If their advice were followed, they had their way, their fields of medical practice would be cleansed of pro-life physicians whose convictions required them to refrain from performing or referring for abortions. The entire field would be composed of people who could be relied on either to agree with or at a minimum go along with their convictions, those of the report's authors, on this most profound of moral questions upon which reasonable people of goodwill disagree, yet must somehow find a way to live together in peace and discuss their differences with civility and mutual respect.

And, of course, abortion here is simply the most profound of the examples. I do agree with Dr. Lyerly that there are many other issues that are at stake besides abortion, though less profound in most cases than that issue.

Now, I'm on the pro-life side of the question, but one need not share my view to see that the report proposes to impose its morality, the morality of those responsible for the report, on others if these were accepted as binding norms of ethics in the field.

It won't do, in my opinion, to say that what is being imposed for imposition on dissenters here is not a morality, but merely good medical practice for it is not science or medicine itself that is shaping the report's understanding of what is to count as good medical practice. It is philosophical and ethical judgments, judgments brought to medicine, not judgments derived from it.

Whether an elective abortion or an in vitro procedure or what have you counts as health care as opposed to a decision about what one desires or what lifestyle choices one wishes to make cannot be established or resolved by the methods of science or by any morally or ethically neutral form of inquiry or reasoning. One's view of the matter will reflect one's moral and ethical convictions either way — either way.

So the report's constant use of the language of health and reproductive health in describing or referring to the key issues giving rise to conflicts of conscience is at best — at best — question begging.

Let me close these remarks with yet another irony as I see it. The report in defending its proposal to compel physicians in the relevant fields to at least refer for procedures that physicians may believe are immoral, unjust, and even homicidal said that such referrals — and I quote — "need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgement of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees."

So suddenly it's the case that the underlying issues at stake, such as abortion, are matters of widespread and thoughtful disagreement, and I agree with that. And it becomes clear from the report that we should show respect for the moral sincerity of those with whom we disagree. But it seems to me that it follows from these counsels that thoughtful and sincere people need not agree that abortion, for example, is morally innocent or acceptable or that there is a right to abortion or that the provisions of abortion is part of good health care or is health care at all, at least in the case of elective abortions.

But then what could possibly justify — what justification could there possibly be for the exercise of coercion to require thoughtful, morally sincere physicians who believe that abortion is a homicidal injustice that they either make a referral for it, a procedure that they reasonably regard as the killing of a child in utero, or leave the practice of medicine as the other alternative.

The report's "my way or the highway" view of the thing is anything but an acknowledgement of the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of those with whom one disagrees. Indeed, it is a repudiation of it.

Thank you.

CHAIRMAN PELLEGRINO: Thank you, Robby. We'll now give an opportunity for the panelists to respond in any way they wish. Dr. Lyerly , would you like to go first?

DR. LYERLY: Well, thank you very much for your thoughtful comments, for reading the position statement so carefully. I neglect that in my deciding that I'm not going to be able to respond point by point and particularly to your concerns because in my agreement to attend and speak at this meeting, I have been — I've agreed also not to discuss the opinion 385 specifically. So I can only speak on my own behalf.

But I will say, though, as a matter of fact is that ACOG's Committee on Ethics is not just a group of physicians who get together and make moral judgments. We have people trained in philosophy on our committee, we have people trained in public health, and we have physicians with a great deal of moral wisdom. So I think the concern about whether this is a scientific judgment or a moral judgment should be considered in light of the fact that the committee is a diverse committee both in terms of expertise and in terms of views about the sorts of issues that you brought up. Thanks.

CHAIRMAN PELLEGRINO: Dr. Brody .

PROF. BRODY: I guess I would prefer to pass at this time, if I may, and actually try to hold any comments to questions directed more at what I said specifically here.

CHAIRMAN PELLEGRINO: Dr. Curlin.

DR. CURLIN: Well, I'll maybe just raise one issue that might be the first question to Prof. Brody , which is why — you drew a distinction between mild and strong interpretations of judgments of conscience or conscientious refusals. You said a mild one would imply something like standing aside and that a strong would imply some sort of — I forget the terms you used, but active resistance to or incumbering patients' choices, and I was curious why you put the refusal to refer — this relates somewhat to Prof. George's comments — why you put the refusal to refer in the strong category. How does it constitute an active prevention of someone else obtaining what they seek?

PROF. GEORGE: Okay. Thank you. I'm not happy with those terms. I grasped at something to call it, and if somebody could come up with some better terms, I would be grateful. There's a spectrum here, and I think it's a spectrum that — I think I saw a slide in Dr. Lyerly's presentation that had an arrow with a thing at both ends of the arrow I think that got at somewhat the same idea. But there's clearly a spectrum. It's not an either/or.

And at one end of the spectrum I was thinking of actions that primarily involved the individual health professional standing aside, but that was the least amount of interference with the patient getting the service that the patient sought, and at the other end of the spectrum the patient was most inconvenienced or prevented or coerced from having that service provided by the action of the health professional.

So the referral was more in the middle of the spectrum. It was not at the far end of the spectrum, but it clearly put an impediment in the way of the patient getting the service. If the patient was not as familiar with other sources of care or other sources of service then the patient would be

relatively more dependent on this provider letting the patient know that these things existed or that they could help the patient get there.

To the extent that the patient is very well informed and is very knowledgeable and has the means to go around and to find out other things, it would be the least amount of impediment. So it might be patient specific or even social class specific in terms of how much or how little of an interference that was with the patient's ability to obtain the service.

CHAIRMAN PELLEGRINO: Dr. Meilaender and Dr. Elshtain .

PROF. MEILAENDER: I want to try to just think about a couple of theoretical questions. I'm more interested in them for the moment than in the particular issues that get debated here. And I have a question for Dr. Lyerly and one for Dr. Brody . But first I have a friendly suggestion, and that is that the use of the language of imposition in these contexts is always misleading. It suggests the need for complicated arguments about entitlements that haven't been made.

And if I'm a person who declines ever to use force against anyone else and you need me to do it in order to protect you and I say, "I'm sorry, that's something I never do," it would be very peculiar to describe me as having imposed my values on you. It might be too bad from your perspective, but I haven't imposed them on you anymore than you would be imposing on me if you tried to persuade me to do it. So I just think the language of "imposition" should be gotten rid of.

But my theoretical interest — it's really a very old question. It's just a form of the "Can a good man be a good citizen" question that philosophers have been thinking about for a long time. And I have a particular question for Dr. Lyerly and one for Dr. Brody .

For Dr. Lyerly , you gave us a slide about different ethical considerations. One of them was conscience, but then there are others — health, fairness, and respect. And these are all the values in play in the situation, and they are somehow to be balanced or we're to decide relative weights or something, and I would like to hear you say more about how one does that, how this procedure of balancing or weighing takes place. That's my question for you.

And for Dr. Brody, you had — the fascinating question you raised under your slide on professional integrity about a professional elevating the — in this case the patient's needs above his own interests, and then you said does one's own interest include one's personal integrity. But then you confused — and I think that's — it's like, you know, "Should I be prepared to go to hell in order to help somebody," a question which theologians have actually discussed.

But you gave the, to me, puzzling example of physicians who should be willing to risk their own lives in an epidemic, for instance, to do it, and then you said, you know, if you'd risk your life, why wouldn't you risk your integrity.

But I thought the reason for a physician being willing to risk his life in an epidemic was precisely that he didn't think staying alive was the most important thing, that there was something else that was morally more compelling and obligatory even than preserving his existence. And that would have something to do with the personal integrity that you seem willing to think may be — one should be willing to set aside in embracing what one thinks is evil. And so I'd like you to just sort that one out for me a little bit more.

DR. LYERLY: Thank you for your question. I wish had a truly formulated answer to it because the framework that I presented really came to me as I was thinking through considerations from the perspective of the patient, which is I think a perspective that is often not represented in fine grains to the degree that considerations about conscience itself in the profession are.

So as I was thinking about the patient-centered considerations, they really fell into three categories. Again, one was questions about welfare. So the harms that might result from the decisions of providers not to inform, refer, or provide services they find morally objectionable, and I gave some examples of those potential harms. Some may be palpable, measurable harms that we as physicians can see. Some may be express harm. So that's one category that ought to be considered when we're thinking broadly about the category of patients, the effect of conscientious refusals on patients.

The second is questions about justice and how the decisions that providers make that lead to differential access to different — to goods and services. So the degree to which the decisions of providers lead to differential access — how do we measure that.

And the third is questions — and I think it's really — as you said it's difficult to find the correct word, and I have been searching for one and trying different ones on. You know, some might call it respect for autonomy. Some might think more narrowly, especially when we consider questions of reproduction about bodily dominion, so deciding whether you can control what happens to your body, what to die for, et cetera.

So those are sort of three areas that I think there may be different economies with which to measure them. So, again, theories of justice can help us with the differential access questions. Other theories about utility measurement or welfare can help us with the questions about harm to patient health.

But I think the third question, questions about bodily dominion, are really, really difficult ones. They'll probably need a theory unto themselves. But I think it may be helpful to think about them separately as we're balancing. You know, balancing acts are always difficult.

Beauchamp and Childress worked for years to talk about how you might balance principles. So that's not something I personally have worked out, but my hope that as the committee thinks through these problems that those categories would be helpful distinctions for the applications of theory.

PROF. MEILAENDER: I don't want to prolong, but I guess I'll go on record as saying I think that the image or metaphor or whatever we want to call it, the balance, is entirely uninformative. It doesn't actually tell us anything about what we're being asked to do in thinking about these things, and it's not surprising, therefore, that the way we balance them turns out to be drastically different from one person to the next. It's sounds scientific, but it's not.

PROF. BRODY: I actually totally agree with you that the example of the risking of one's life in the face of an epidemic threat may be more misleading than informative in that case. I raised it

purely to pique the person's interest to go further into it and not with the idea that I thought it was any sort of conclusive argument.

And I think that if we were to plumb this sort of toward the bottom, we would need — in addition to our theoretical account of professional integrity, we would need a theoretical account of the physician's self-interest.

And I have looked at the literature to try to find that account of the physician's self-interest because I believe that ultimately if we're going to teach our medical students that in order to serve the patient you have to put the patient's interests — which Dr. Pellegrino reminded me needs careful definition — just what are those interests — above to some extent the interests — to some degree, at least, the interests of the physician or the health provider, what does that mean. And until you can define both sets of terms, I don't think you've gone very far theoretically.

I have been struck by how often the appeal to professionalism and altruism is completely uninformed by that account of what are the legitimate interests of the provider against which — which are to be put in second place. So I've tried to inform myself on this issue and, frankly, had a hard time with it. I don't know where that theoretical account lives.

So if somebody knows that, please tell me. Like, for example, how much money is a reasonable amount of money for physicians to make so that if they make more than that, they're greedy and they're putting their interests ahead of their patients' and if they make less than that, they have a legitimate grievance? How do we draw that line? How do we even think about that? I don't know of any ethical literature on that subject.

Please come to Galveston in November 5th to 7th — not now, because November, I hasten to say, is after the hurricane season — and we'll be doing a conference on the physician's duty to treat in the face of epidemic threats, and I hope we'll talk about that, because I think it's a very, very deep and troubling question and I don't believe the existing literature has as yet put the lid on it.

But certainly it's the case that we could — one reason to give up your life or to risk giving up your life is because your professional integrity seems to require it in order to serve the patient. Another reason to give up your life or risk giving up your life is because your personal conscience requires it or your faith commitments require it. That's certainly . So you could have different reasons why you might be obligated to risk your life. And so, yes, I absolutely did not prove anything by throwing that example out, other than to just, as I hoped to say, "This needs to be explored more."

CHAIRMAN PELLEGRINO: Dr. Elshtain .

PROF. ELSHTAIN: Well, I want to begin by thanking the three of you for your very challenging presentations and also for your very obvious concern for the people that you treat and that you teach. I want to raise a question or develop an issue that Prof. George raised in his commentary, and that has to do with whether we are not often faced with a particular rather comprehensive morality that refuses to name itself and that is often presented in the guise of a kind of neutral look at the question, because I think that's often what's going on when we get a positioning sort

of from the point of view of those who, in a rather neutral way, want to look at medical and scientific questions without the sort of taint of extraneous moralities is often presented as, again, a scientific view or a kind of neutral view as between competing possibilities, morally speaking, when, in fact, it is not that at all.

Now, there's a mass of literature by now. It's been accumulating over 20 years criticizing this neutrality argument, most of it written by liberal political philosophers, not conservative political philosophers. I'm thinking of people like Michael Sandel , people like Charles Taylor , William Galston , and a number of others.

And I think what these folks would say is that it's much better to have these moralities unpacked and laid out than to assume we have a sort of neutral view and then we've got a partisan view of some kind and that the neutral view somehow, the sort of scientific view, has to constantly take care that the partial or sectarian view doesn't insinuate itself.

And let me give you, Dr. Lyerly , some examples from your presentation that I think are illustrative of what I'm saying, that there's a morality involved here. I'm not saying that's wrong. I'm saying that it needs to be unpacked, understood, and named.

In your discussion of the pro-life woman with, I believe, pulmonary hypertension — was that the issue, the health issue? And you indicated that her physician, being himself or herself pro-life, might not raise for her the possibilities of or explain to her the possibilities of abortion given the health conflict that she has.

And, again, it occurred to me that in calling her pro-life, you already presuppose a pro-choice position. The pro-life position came into being in response to the pro-choice position. So we cannot assume this woman knows nothing about the alternatives.

So it seemed to me that what was, again, sort of percolating in here was, again, a particular view of the physician, of the patient, of morality that wasn't being put forward and instead it was seen as a kind of clear-cut case, which it clearly is not, of a patient not being well-informed. But, again, to call herself pro-life, as you describe her, means that she certainly is aware of an alternative.

In the example of — I believe it was the lesbian woman who came in for — was it an IUD? It was for some kind of reproductive — yes. And there again it seems to me that what we have is a situation — with everyone's views on those sorts of issues, we have a situation where a patient is coming in with an expressed desire that so far as I can tell has very little to do with what we ordinarily consider medicine or health.

It's a desire that turns on a particular understanding of the self, a particular understanding of ethical and social relations, a particular understanding of where physicians should be in relation to patients' articulation of what it is they want.

So, again, an example, but lifted out of this whole world view, and I don't think it helps us very much. It's better to articulate the cluster of presuppositions that lead to this kind of instance, this kind of example. So more clarification on that I think would be extraordinarily helpful — you know, what kinds of moralities are we talking about here, who's imposing what on whom?

Although I agree with my colleague, Dr. Meilaender, that the language of imposition is tremendously misleading, because no society has ever existed anywhere at any time that didn't mandate certain things and that was not coercive in the implication of those things. Every time we enforce a law, there's an element of coercion. So I think we have to be clear about that.

There are all kinds of things that you and I are prohibited from doing every single day, and we're glad that society imposes for the most part. I've got to stop at a red light. It's an imposition. So I think the language of imposition isn't tremendously helpful. We need to think of another way of talking about this because we cannot live with the issue of some kinds of mandates and certain forms of coercion. Liberal societies try to reduce the coercion as much as they can, but it's there, although we often don't like to talk about it very much.

Dr. Brody , in your case, I wanted to just — a couple of questions. They tie into the issue of conscience and the kind of Rawlsian position that you adopt. And I'll try to make this as quick as possible.

In your discussion of conscience you argue that the popular account of conscience, inner moral sense, et cetera, cannot accommodate inner conflicts of conscience. I think that's true only if you are approaching conscience from a strictly deontological point of view. It seems to me that within other alternative understandings of conscience, there is indeed the recognition that conflicts of conscience are going to occur, both within the individual, between the individual and what society mandates, and so forth.

If you look at the whole great tradition of casuistry that we heard something about this morning, the presupposition is that there are going to be some mandates of conscience, if you will, that may at times be overridden because other mandates of conscience trump at a particular point in

time. So, again, it's the adoption of a particular moral philosophy that leads to that particular view about conscience and doesn't cover the whole at all.

On the issue of Prof. Rawls and the RLPRG — I have no idea how you would say that — RLPRG, something like that — the group of people that you freely choose. I certainly didn't freely choose Ms. McCarthy in the seventh grade, but she's in my head. I mean, the notion that you could simply at one point sort of say, "I choose you special five people. You're going to be my reference here," that could become entirely narcissistic.

You know what you would wind up with is a nice group of people validating you and some of that horrible language. And I want my parents out of it because they don't like the fact that I've chosen to be a happy-go-lucky beach bum. So, you know, I don't want them saying anything to me. I want other happy-go-lucky beach bums who are going to second my motion.

So I'm not sure that this is again a tremendously helpful way to think about especially moral formation, because most of our — and I'm sure you won't disagree with that. Most of moral formation takes place before we start picking who we want to be with in the world.

So I'm afraid these are more comments than questions, but I thought they might be worth putting on the table for your consideration. Thank you.

CHAIRMAN PELLEGRINO: Next is Peter Lawler .

PROF. LAWLER: Right. And thanks to you all for some wonderful presentations. They're very thought-provoking. I thought the most challenging thing Dr. Curlin talked about was this challenge to the distinction between personal ethics and professional ethics, which you are to assume, that personal ethics is somehow religious or comes from the group which affirms your rational life plan. And we have this. We have to take it seriously; nonetheless, it often conflicts with professional ethics, which is more objective, rooted more in health.

So you knock yourself out to not want to privilege professional ethics over personal ethics, but you still did finally, because one seems rather subjective and arbitrary — you know, who knows where this group comes from — and the other seems more real and scientific. Prof. Curlin said it. I just don't see that going on.

When I see conscientious objection, I see doctors giving reasons and they're giving reasons about health. When doctors conscientiously object to performing an abortion, because they don't see how abortion contributes to health. And the same with contraception and the same when they refuse to prescribe Prozac for ordinary unhappiness and so forth.

And so Robby's objection to abortion is not religious. It may conform with his religious belief, but he writes book after book showing how it's rooted in science, the facts about health. This is a matter of legitimate controversy. And Dr. Curlin had this great quote from Leon Kass where he says, "As medicine gets more powerful, we become more unclear about the ends of medicine because it becomes more unclear what health is," and when we enter the era of enhancement where we'll be able to satisfy people's desires and call that medicine, when we enter the era of biotechnology, it's going to become more and more unclear what health is.

So let's give our — Dr. Curlin gives our doctors more credit. They give reasons. Their objections are rooted in the legitimate controversy — to the legitimate scientific controversy over what health is. So the more powerful medicine becomes, the more the domain of conscientious objection should be allowed to expand because the domain of reasonable controversy over what health is is going to expand. So I wonder if you diminish unreasonably these conscientious objectors by calling them merely religious or merely — you know, referring to whatever that initial group is.

PROF. BRODY: To whom was that question asked?

PROF. LAWLER: I wondered whether you now agreed totally that Dr. Curlin was right in his criticism of you on that.

PROF. BRODY: I will elect to respond, then, if I may. I disagree with Dr. Curlin in one way, and I would want to just add a qualification to what Dr. Curlin said in another way.

The way I disagree with Dr. Curlin is I believe Dr. Curlin has confused two very different concepts. He's confused conscientiousness with appeals to conscience. And there are many, many things in life that I could do conscientiously, and one thing I can do conscientiously is give you moral reasons in defense of my judgments.

That does not necessarily mean that I have appealed to conscience in the way I would define — or I take it Prof. Paris would define conscience. So I would want to have a very clear distinction between simple conscientiousness and an appeal to conscience. So that would be my main disagreement.

My qualification I would add to what Dr. Curlin said is that I understood the primary focus of the discussion and came essentially prepared to talk about, when a professional says, "I don't want to do something," and the main reason they give for not wanting to do it is, "It offends my personal conscience," which doesn't have to be religious, but may be religious.

Now, another reason you could give — which I agree is totally legitimate and should be investigated deeply — is, "I object to this because it's not professional. It's outside the bounds of the goals of medicine" or the goals of nursing or pharmacy or whatever. That's a perfectly legitimate line of argument. It deserves very careful scrutiny.

If I take the first line of argument, "It offends my personal conscience," I don't believe logically I'm saying anything that necessarily impacts on any other professional, except those who happen to come from the same philosophical, moral, perhaps religious tradition that I come from.

On the other hand, if I say it in terms of "This violates my professional integrity because it's outside the bounds of dealing with health, it's not a health issue," then I'm implying that no physician of integrity, no nurse of integrity, no pharmacist of integrity really ought to do that either. They're misguided if they think that they should be doing that.

So those are very different kinds of arguments and they deserve — each one could be a very serious argument and each one could be accompanied by a lot of reasons in addition to the

appeal to conscience or the appeal to professional integrity, all of which would then need to be carefully sorted out. Some might be empirical claims; some might be moral claims. Most in one way or another, I agree, are going to be value laden, and we deserve to sort out the value laden features.

So had we wished to, we could have gone in that other direction. We could have said, "Let's look at what do you mean by professional integrity, what do we mean by the goals of medicine, the goals of pharmacy, et cetera." And those are heavily, heavily value laden ethical concepts — what is health. And we could have gone that way had we elected to do so.

CHAIRMAN PELLEGRINO: Dr. Curlin , did you want to comment?

DR. CURLIN: I think that what Prof. Brody is doing is defining an appeal to conscience, in my judgment, too narrowly as an appeal that will not give a further reason and then defining as conscientious reasoning those appeals that give a reason. And I guess I would say that certainly I would agree that a physician who says I am not going to provide this thing that other people think I should provide by virtue of being a physician or because of my position as a physician needs to give some account as to why they don't think being a physician implies providing that thing.

Again, in my understanding with respect to all these areas of controversy those reasons are given. Some people are not as articulate about it, but reasons are given. These are not arbitrary refusals.

And I think I do agree with Prof. Elshtain that there's a lot that's hidden — and Prof. George — a lot that's hidden under the language of standard versus not standard or personal versus professional or private versus public or objective versus subjective or all that language — are hidden in this debate about what, in fact, we're obligated to do as physicians.

And my last thought on that would be just that medicine would not be a profession of such prestige historically if people were having to — if the profession we make implied putting aside things that we think are very good, but rather the reason it's been seen as a noble profession as it's always been understood as a professing upward — in effect, taking on new commitments that are higher, not lower than the ones you had before.

And so the notion that you have a professional integrity and a personal integrity seems to me wrong-headed in the sense that of course you have commitments that are specific to your professional role and those that are not, but having integrity is to know how to act in light of both of those, it seems to me, not to give up one form of integrity for another.

CHAIRMAN PELLEGRINO: I have a problem. We have lots of commentators and questions, so we may at some point ask you to just hold it, and then when you have an opportunity, get it. Prof. Gómez-Lobo .

PROF. GÓMEZ-LOBO: Thank you. I want to go back to the very notion of conscience that underlies part of our discussion. And the reason why I do this — and I'm addressing this to Prof. Brody — is because of that claim that certain dictates of conscience ought to lead certain

individuals not to choose a health career. I was really worried about that, not because I'm about to embark on a health career — it's too late in life for that — but I think that there's a deep misunderstanding there.

And let me start with the ACOG committee opinion where conscience is — first it says it expresses a sentiment, such as, "If I were to do X, I could not live with myself, I would hate myself, I wouldn't be able to sleep at night," and then the opinion piece goes on to say "according to this definition."

Now, I find that incredible. I mean, it's such a misunderstanding of what's going on. It may be a consequence of that conscience that I cannot sleep at night, but conscience is a particular practical judgment as to whether what I'm going to do is morally right or morally wrong, which means whether I'm going to harm a human good or benefit a human good.

And in that regard I totally agree with Dr. Curlin . It is in a very important sense a public judgment. I have to give reasons. I cannot just say my conscience tells me to do this. I have to go on and give reasons.

And in that regard, for instance, it seems to be absolutely natural and even a duty of a doctor who refuses to perform abortions to say why he or she refuses to perform an abortion. I mean, that has to be clear and up front. It's a human good that is going to be harmed.

Now, if we view it in this way, then there's no conflict between integrity of the physician or the care giver and the benefit of the patient. On the contrary, the judgment of conscience is a judgment about the good of the patient. It's not a judgment about my integrity. It's a judgment about what objectively I would be doing if I did it and that's why it is such a crucial thing.

Now, I would want to add this on the balancing question. There's a very serious problem there for the following reason. It ultimately seems to me judgments of conscience can be modified. In other words, I can be led to change my judgment of conscience. For instance, if there's empirical evidence about emergency contraception, for instance. That's seems to me absolutely natural. Again, that shows that judgments of conscience are public in a very important way.

But once I have all of the available evidence, once I have decided that it be wrong for me to do it, I have no further way of judging the truth of my — of passing judgment on the truth of my conscience. Now, what does that entail? It entails that there are no occasions in which it would be rational to force someone to act against their conscience because that person would always be doing something morally wrong if she would act against her conscience. So integrity is a derivative of acting in accordance with one's conscience, but conscience itself stands in a quite different position with regard to the patient and with regard to health and the basics of the medical profession.

So I would plead with Prof. Brody , please don't exclude from a medical or a health career someone who thinks along those lines. On the contrary. Thank you.

PROF. BRODY: Yes. If I thought that by saying that there might come a time when one would be forced to suggest to a person of conscience that because you're a person of conscience you ought not to seek a career in health care — I would be horrified if that was a common sort of thing.

However, I gave one example, which I think typifies the sort of very extreme case I had in mind where that might come up and that was the example of the Jehovah's Witness anesthesia resident who would not give a blood transfusion to a non-Jehovah's Witness patient even if the consequence might be the death of the patient.

Now, I believe that someone — I can't remember where I read this — but someone gave the example of would a Quaker, for example, or a pacifist seek a commission to West Point . At some point, practically speaking, there's such a conflict between what you feel required to do as a matter of conscientious commitment and what you know is a role responsibility normally expected of people who undertake that kind of career that there's a serious question of practical wisdom or prudence of saying that's the field of work I want to go into. So that was the kind of extreme case, exceptional case, that I had in mind.

I also thank you for highlighting the question about how your conscience could be wrong and you'd want to give reasons and why it's a public act of giving reasons to correct the conscience if the conscience is mistaken because I think I just heard a minute ago Dr. Curlin say that I said that when you appeal to personal conscience, then you don't have to give any reasons. So I hope I didn't say that.

I certainly did not intend to say that, and I hope that by saying conscience can be corrected and could be wrong, I specifically made that point, that, yes, you could be called upon to give reasons. And often giving reasons is a part of the exercise of conscience.

CHAIRMAN PELLEGRINO: Paul McHugh .

PROF. MCHUGH: I also join in the chorus of thanks to all of you for your thoughtful presentations, and my comments are really comments that come in part out of ignorance of the philosophy, but out of a lot of experience dealing with patients who say they have needs. I'm very worried about "needs" when a patient comes in and tells me that and so therefore I was a little concerned about this little diagram that overlapped conscience with patients' needs.

Most patients' needs turn to out to be wants, wishes, and sometimes fantasies, and our job is to sort them out. But where I come to want to ask a question and relate to what's been said, Dr. Brody , it begins with you, this very helpful distinction that you are making between what were private commitments and publicly made commitments, and particularly in oaths. You made that point.

I took an oath. I took the old Hippocratic Oath, the plain old straightforward, no abortions, no physician suicide, the old, hard line things like that and stick to to this day. And the point that you were making in drawing that sharp point I thought — and I might be wrong about this — is that you said that usually the public commitments were related to a public — to a given public stance where, at least in our society, things were settled on those public issues.

And I want to remind you that you could make a public statement like the public Hippocratic Oath and be at war with what the public stance became. And I want to remind you — I might make reference to three books that have been written in the last five years on each one of these matters that proved how often the physician publicly committing himself to the views of the Hippocratic Oath that was both private and public in that sense — you get up, say it, and do it —

proved that they had that public commitment, really meant something that was driven by his real private sense.

And the three books — one was the book by Kevles on eugenics, where 35 states in the union sterilized people because they thought they were mentally retarded. And many of those people were not, and many of them weren't even told that they were going to be sterilized and were distressed to learn later in life that their failure to conceive had been done to them. Okay, and that's the first one. [Daniel Kevles, In the Name of Eugenics: Genetics and the Uses of Human Heredity (Cambridge, Mass: Harvard Univ. Press, 1998).]

The second arena that has just been recently was a book by a historian at Columbia — H. Scanlan , I think. The title of the book, the fascinating title of the book, is Fatal Misconception. It's a marvelous book on the imperialism of American contraception imposed upon the people of India and China and other places of this sort where what ultimately has come — because we had no — we were so committed to our view on population and had no reason to — we're not going to be held responsible are now held responsible for having done things like enforced sterilization amongst those people. [Matthew Connelly, Fatal Misconception: The Struggle to Control World Population, Harvard University Press, 2008.]

And then the final book written only a year or so ago is Helen Epstein's book entitled The Invisible Cure [NY: Picador, 2008] where our medical services going into Africa to try to help in HIV totally refused to listen — thinking in mechanical terms refused to listen to the women of Uganda who had demonstrated unquestionably that the partner reduction approach was the correct approach to the ending of it, whereas, we, running our zeal for the condom method, continued to have a huge a death rate for HIV in young women in other African countries.

Again, you made a point that you — this might not have been where you were going to come in, but I want to ask you that question, why you would think that a public commitment that was voiced in terms of care of patients might not sometimes run against the public stance on matters related to services to people.

PROF. BRODY: Thank you for the challenging question, because I think you've — frankly, I think you've wrapped up a number of very, very important issues, and I am going to have a very hard time disentangling them in order to be able to say anything at all wise.

Let me be very simplistic in responding to just one point, which is what is the big deal about the public promise. And what I'm saying is when physicians get up together and say the oath — and what I meant by that was less the content of the oath, but the idea of we all get up and say the oath — is the ability of the public then to trust physicians to have made some kind of promise to them for which we are accountable.

And my willingness — if I am hit by a car on the way across the street to get back to the Metro and I am whisked to an ER here in Washington and I don't know the doctors, I don't know the nurses, on what basis am I going to trust that they will be looking out for my health.

And a very important piece of the reason I'm going to trust them and I'm going to not demand that I see their biographies and did they really get their diploma, et cetera, et cetera, is because I imagine they have engaged collectively in this commitment to the well-being of the patient, that I'm now a patient and I'm going to take advantage of their commitment to my well-being.

So it's really that ability of the public to respond to this public act with the bestowal of trust. And to have that trust be merited, not just, you know, a mistaken trust on the part of the public, but a merited trust in us because we've taken this commitment is what I frankly — was at the root of this appeal to the public.

Now, then, I would just simply add to that — if I go back to my example of should a pacifist seek a commission at West Point, I would imagine that there are folks at West Point who believe, for example, that American military policy today is very misguided and that if they ever were to rise up far enough into the — there may be only a few of them, but if they were ever to rise up high enough in the hierarchy, they would do what they could to change that policy.

And it is good and it shows that we are a vigorous and lively profession if there's this active dissent in our ranks about what do we mean by our commitments, what did we promise the public, what is health. These are all questions that are potentially contested, these are all questions on which some scientific facts are pertinent and moral values are pertinent and social policy is pertinent. As you point out, international relations are even pertinent. And so we should be having a vigorous debate about this

And so whatever I get up and promise the public that I'm going to do — I may have my personal doubts about it. I may carry out internally a dissent within medicine about it, but I have to be careful of when I treat my patients to be sure that I don't confuse my personal take on this contentious issue with the larger commitment made by the whole profession.

So there are some things where we can have a lot — it just so happens that we have a lot of agreement within the profession about what we ought to do, and there are other instances where there's a lot of disagreement about what we ought to do, and I at least ought to be clear on that.

I ought not imagine that if I'm a minority of just a very small number of physicians who believe something that I speak on behalf of all of medicine when I get up and say that thing. That's what I think we need to guard against.

CHAIRMAN PELLEGRINO: I have five members of the Council who wish to comment, and we're checking on seeing whether we need to evacuate this room at 5:00 . I don't know. We'll be finding out shortly. So Dr. Carson .

PROF. CARSON: Just a short comment with perhaps a short rhetorical question associated with it. First of all, I thank the three of you very much. I think most of what was said has general applicability to the medical profession and is very wise; however, when it comes to what I call 50/50 issues, things like euthanasia and abortion where you have very substantial portions of the population that have varying opinions, I wonder if maybe our energies could be better spent looking for ways to be able to accommodate everybody.

I sometimes feel on these kind of discussions that we're in Congress, you know. You can't get anything done. It's my way or the highway. And, in fact, even going to an extreme example, such as the Jehovah's Witness — and, you know, obviously as a surgeon, I give plenty of blood, but let's say someone was a Jehovah's Witness anesthesiologist — you know, I run into a lot of Jehovah's Witness patients who don't want any blood. Maybe we compare those people — the point being that perhaps if we spent a little extra time figuring out ways to accommodate as opposed to exclude, we could get further along in this argument.

CHAIRMAN PELLEGRINO: Next I have Dr. Hurlbut .

DR. HURLBUT: I want to continue in the line of discussion that Alfonso and Paul have initiated and I wanted to ask Dr. Lyerly, is it impossible to put the slide with the quote from Julian Savulescu back up?

DR. LYERLY: I don't know.

DR. HURLBUT: As you try to do that, let me go to where I want to go here. What I want to try to get at here is — first of all, I want to ask you a question and then I want to make a comment on it, depending on what you say, of course. But I want to get at the challenging dimensions of what we're actually doing here, because it's easy to focus on a single issue like abortion or sterilization and miss the larger context of the drift of medicine across time and culture and so forth, and we need to seek a very broad foundation for the future of medicine.

And so I want to just specifically ask you, Dr. Lyerly, in your report what principle of professional obligation did you — where did you draw — more specifically I'm a little troubled by what's already been brought out — the emphasis on conscience being sort of a personally driven thing, and then just a page later you say, "By virtue of entering the profession of

medicine, physicians accept a set of moral values and duties that are central to medical practice." And where do you see those as coming from, I guess is the chief question.

DR. LYERLY: I'm not at liberty to comment on 385.

DR. HURLBUT: Okay, your own opinion, then, on those issues.

DR. LYERLY: I mean, I've been asked not to comment or — I've been asked not to comment on the document, and so I really can't do that. I'm sorry.

DR. HURLBUT: Okay, let's forget about the document. Let's go back. We're talking more broadly about the very crucial issue that Dr. Curlin has raised about professional obligation, and I think he's zeroed in on the key question here. What are the professional obligations? They're clearly not just individually decided on from somewhere or nowhere. What would be our sources for this — for understanding these parameters?

DR. LYERLY: How might we understand the professional obligations of doctors and other health professionals?

DR. HURLBUT: Right. Where do we go?

DR. LYERLY: I mean, I think that's a wonderful question for this group to start thinking about. I mean, what I would add and what I tried to reinforce today is that conversations about health and the aims of health need to engage the perspective of the people who will be benefited or be harmed by its provision.

So it is not just the providers of health care or even theorists about health and its meaning that should be at the table, but it needs to be people that live in these bodies, experience the impact or not of conditions, technologies, living in the world, living in cultures, and we need to incorporate those views as we think forward about what the aims of health are.

DR. HURLBUT: In other words, the good of the patient. I mean, that's what you're saying?

DR. LYERLY: Right. I think that's part of it, but what — for us to understand what health is and what the goals of medicine are, we need to hear how people experience what we do. So that's an important part of the equation that I don't think has been there.

I think in the last ten, fifteen years we've been much better at gathering data about that. We've gathered beautiful empirical data about how people experience end-of-life care and it's transformed the way that we provide it. We're beginning to collect data to listen to people about

how they experience care during the process of birth, and I expect that that is also going to change the way that we think about pain in labor, support, et cetera.

So in crafting what we think is good health care, we cannot do so and we can't think about whether it meets ethical standards unless we listen, unless we take a moment to listen. So I just — I would urge the brilliant people who are deliberating about this to consider the views of people who experience patient —

DR. HURLBUT: Is the quote possible to show or no?

PROF. ROWLEY: Come on, now.

DR. HURLBUT: Can you read it?

PROF. GOMEZ-LOBO: "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."

DR. HURLBUT: So, look, I can certainly agree with you about listening to the patient, but it seems to me there are other things we have to listen to and not — and these are very serious

issues, because we want to transcend time and we want to transcend culture as we deliberate on these issues.

And the quote that was read seems to — there's something wrong in it, and I can feel it. It's excluding people from the dialogue by saying, "If you don't like it, don't go into this profession." And so what I'd just like to briefly lay out is a couple of parameters that have not been mentioned.

It seems to me that the examples that are given in the paper — sterilization, artificial insemination for a lesbian — one might add issues you didn't bring up like face lifts or growth hormone. How do we decide these kind of issues?

Now, quite apart from whether or not they should be legal or not, there ought to be some reference to — in grounding medicine to the natural standards of health and the immanant powers of the body. And I can't see that some of the issues that you've raised as sort of moral controversies qualify as that.

I mean, whether or not it should be legal for a lesbian to be inseminated is quite different from the question of whether a physician should feel like that's part of his profession obligation. It doesn't seem to me that that's part of the natural immanent powers of the body to be inseminated without the act of sexual intercourse.

Now, maybe I'm wrong. Maybe you could make an argument for that, but it seems to me that by saying in the text that you supplied that she was prompted — this physician was prompted by religious beliefs and some disapproval of lesbians having children — I mean, that doesn't seem

to me necessary to label that a religious belief. There's an attitude there that might say, "Well, that's not a natural phenomenon that I'm trying to heal." Do you see what I'm saying?

DR. LYERLY: Again, I'm not at liberty to comment on the paper, but I will say it sounds like you are making an important contribution to thinking about how we're going to define health. And there is a claim that it has to do with — I don't want to misquote here, but having to do with the body's natural functioning. Is that correct?

DR. HURLBUT: Some reference to natural functioning, yes.

DR. LYERLY: So I think an argument can be made for that, certainly, but I don't think that we can take that as truth anymore than any of the other considerations on the table without a moral argument for it. So I think that would be an important thing to think about, but I don't think we need to presume it is or it's not at this point.

DR. HURLBUT: But just to make a brief conclusion of this, it seems to me that — I mean, we're talking about an issue — say just the abortion issue alone. There's an enormous history on this issue. I mean, here just for example from the physician's oath in the declaration of Geneva in 1948, "I will maintain the utmost respect for human life from the time of conception, even under threat."

I mean, this is very different from the prevailing sentiment that's going on right now, and there seems to be a sort of social pressure that's being imposed on the medical profession as a whole to accept this kind of realm of things as though it has no past. And it seems to me if we're going to enter a profession, as your document says, with moral beliefs and values that echo our profession, we should look more seriously at history.

We've got a very challenging era ahead with biomedical technology. It's knocking us off balance. The new paradigm for medicine seems to be liberation, not a reference to what would be called restoration or healing of the body. This is going to challenge us very deeply, and if we don't have any grounding in this, if we simply say, "If you don't like it, don't join the profession," that seems to me setting us up for some big problems. It's like closing the conversation rather than opening it.

And just to emphasize this, before we had the session I went back — and admittedly this is heavy-weighted and maybe disproportionate — but I went back and I read a couple of papers on medicine under the Nazi dictatorship, and, boy, they're powerful things. I mean, it's hard to believe that some of us in this room were alive when this was going on.

And just to give you two brief quotes, it says, "The chief of the medical institution Hjalmar was responsible for the murder of over a thousand patients. He personally opened the containers of gas and watched through the peephole the death agonies of the patients, including the children."

And then at the Nuremberg trials he stated, "I was of course torn this way and that. It reassured me to learn what eminent scientists partook in the action." And then Leo Alexander , who wrote part of the Nuremberg Code, warned us. He said, "Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small

beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude basic in the euthanasia movement that there is such as thing as a life not worth living."

Just to conclude, let me point out that the guy whose quote you used, Julian Savulescu, who would like to say some people shouldn't join the profession if they just can't get along with the standards, has himself advocated the creation, gestation, and harvesting of cloned human embryos. And this is a quote. He says, "Indeed it is not merely morally permissible, but morally required that we employ cloning to produce embryos or fetuses for the sake of providing cells, tissues, and even organs for therapy followed by abortion of the embryo or fetus."

I think the last thing we need right now is to be telling people that they shouldn't go into medicine. If anything right now, we need some diversity of views and to take this issue of conscience very seriously.

DR. LYERLY: I absolutely agree with you. I think it's wonderful that this committee is taking on this issue. I spoke to one of the committee members earlier and I — in addition to recognizing how important this issue is, I actually think it's a place where there's a potential for good, valuable, deeply rich deliberation.

I was asked by Dr. Pellegrino and Dr. Davis to demonstrate a range of views that's out there right now. They fall on a spectrum. I was asked not to advocate for a single position, but to demonstrate a range of views. I used Savulescu's quote word for word because I think it does show a view on one end of the spectrum, which is a very — a view that is very impermissive of

conscientious refusals, which I agree with you are — the role of conscience has a critically important place in medicine and bioethics.

So as we think forward, I think that dialogue is absolutely important. I think to engage in that dialogue with respect for people that don't hold the same views as you that bring to the table different conceptions of health, that bring to the table different ideas of what matters in how we should set professional standards, how we should treat our patients and the like — I think that conversation is absolutely vital.

Its tenor goes up several notches when we're talking about elective abortion, but it's important to a range of issues that arise in medicine. So I think — just in closing I think — I agree with you this is an important conversation. It's not going to serve anyone to shut people down on either edge, but in order to understand that there's a range of views — I mean, it's helpful to look at the edges.

And there has been some conversation today that we weren't contextualizing conversation, but that was partly what I was attempting to do with my introductory remarks. And I think we all come to the table with certain moral views, some of which we are wearing on our sleeve and some of which are very deeply held and we may not recognize it as starkly. So that being said, I appreciate your view and I think that thoughtful deliberation on this is exactly what we should be doing.

CHAIRMAN PELLEGRINO: I'm going to use the chairman's prerogative. We have three more members of the Council who would like to speak. We'll give them an opportunity to make their

comments and then afford the opportunity of a response on the part of our panelists. I have Dr. Rowley , Dr. Dresser , and Dr. Landry in that order.

DR. ROWLEY: Mine is going to be very short, and it was just somewhat similar to a concern of Dr. Brody's that Dr. Curlin seems to me to have — in his early examples, they were people who — physicians who disagreed with one another on various aspects of the appropriate medical care, and I think that's very different than the matters of conscience that we are discussing in this particular session. And those I would have classified as more differences amongst clinical judgment. And I think that they have to be separated out from matters of conscience.

CHAIRMAN PELLEGRINO: Thank you, Janet . Dr. Dresser .

PROF. DRESSER: Well, we have this pluralistic country and practice of medicine and it's also organic in that it's changing and we — and I'm sure in a hundred years we'll look back on things we approved of today and shake our — people will shake their heads, so on and so forth.

So I guess I would like to second Ben 's statement about — to talk about accommodation, more about what institutions, professional organizations, medical schools, and so forth can do in terms of procedures, systemic approaches to allow people who have objections of conscience to act accordingly and at the same time to meet the standard of care.

I agreed with Howard Brody 's comment about how many of these can be settled within institutions. You just have to plan. People who come in who have objections need to — have a duty to state them and others need to be aware and there needs to be arrangements made. Perhaps in some cases it's not possible, for example the Jehovah's Witness, but it seems to me it's easy to get very polarized and rigid and say, "Oh, patients need them, personal conscience and so forth," but this is a social/professional problem, as well.

And so it's perhaps not as interesting to talk about things like scheduling and so forth, but it seems to me that's where a lot of this will live out and you can minimize the damage on both sides by working on that stuff.

CHAIRMAN PELLEGRINO: Thank you, Rebecca . And Dr. Landry .

PROF. LANDRY: I'd just like to say thank you to the panelists, and just some quick comments about conclusions. Dr. Brody , in yours you look at mild versus strong interpretations, and perhaps that's a way. There's wiggle room to sort of get by. And the idea is that willingness to refer will be mild and unwillingness will be strong.

But then there was an aside about rural areas, and I got the feeling that if you're in a rural area and there was no one else to do it, then willingness to refer might end up being strong because to be mild you really have to perform it. And so maybe these aren't such absolute categories. They're sort of relative.

And the bottom line is you can object to the extent to which it doesn't have an effect. If it doesn't effect, then you're in sort of the other category. If you don't regard that as entirely fair, you can comment.

And, Dr. Curlin , you made an appeal that physicians who have their range of conscientious objection narrowed would be reduced to technicians, but isn't it more likely that they'll just be driven out. Some specialties will soon become hostile work environments and you'll get sort of the equivalent of ethnic cleansing. It will be sort of a ethics cleansing, and you'll get to the homogeneous view with potential on the other side.

I mean, I think a 38-year-old woman in New York or LA who becomes pregnant actually gets a lot of pressure for amniocentesis, and with a Down's diagnosis a lot of pressure for abortion, which would then harken to the issue of this being simply a matter of politics and political views and not really a science driven enterprise. So those are my comments.

CHAIRMAN PELLEGRINO: Thank you very much. Now we'll give an opportunity for each of the panelists to make what comment they would like to make. I'll start with Dr. Curlin .

DR. CURLIN: If I can begin with the last comment, I think that they would be both driven out as well driven being technicians in this sense. And I don't want to make it overdramatic. At this stage most people of a wide range of moral views can effectively practice and are not being driven out, although there seems like there's a growing sense of a threat.

But they would be, of course, driven out if they were required to do things that they could not in good conscience do. They would have to, to live with understanding and live with integrity, leave the profession.

But they would also, I think — the profession is driven toward a provider/consumer model because the impulse that leads — and it comes out in all these essays — that leads to the judgment that we should constrain conscientious refusals is something on the order of "Doctors have no business making judgments about whether that thing is good for patients or they don't have the authority to make that judgment, or if they do make that judgment, that's a threat."

And so to the extent doctors retreat from — and Prof. Brody in that essay about , I don't need — if I'm misinterpreting how it would apply to this situation, I'll let him to speak that, but it said that what you don't want is doctors retreating from making recommendations, retreating from seeing themselves as responsible for your good, responsible for your health. And to the extent you say, well, you're responsible so long as you are willing to do these things that you think are not ethical, then I think that drives in that direction.

And with respect to Prof. Rowley 's comment, I do think there is a difference between disagreements that you described as clinical judgment. You said some are clinical judgments versus appeals to the conscience. They are different, but the difference is in some cases you have an agreement about what the ends of medicine are, about what we're after here, and a disagreement about how best to pursue it.

The difference is not that one is conscientious and one is not. The difference is that some are disagreements about what the ends of medicine are and some are disagreements about how to achieve those ends. And then within the former — about what the ends of medicine are — sometimes these disagreements track onto religious teachings and some don't.

And it seems to me that in our culture, because of these rubrics of private versus public and whatnot, those that can be seen as tracking more directly onto religious disagreements are seen in a kind of prima facie way and I think in an incorrect way as being less valid to be considered in one's making decisions about one's practice.

CHAIRMAN PELLEGRINO: Dr. Brody .

PROF. BRODY: Specifically in response to Dr. Lawler's comment, which was quite helpful, I would ask you that if you wish to consider what I said to see whether it's of some value for your deliberations here, please keep in mind the title "Two promises."

The reason I say that is because — if I may give an analogy — it may be a very, very imperfect analogy — I believe today I made two promises. I made an implicit promise to my wife that if our home were to be threatened, I would be at her side and would not go running away to some academic thing that would take me away from my home responsibilities, and I made a promise to the President's Council on Bioethics to be here at this hearing.

Whether I'm able to keep both promises has a lot to do with how fast a certain hurricane is moving across the Gulf of Mexico and which direction it's going. I may find tonight that I was able to get home in plenty of time and do what I need to do and all will be well. I may discover that I was too late and I'm trapped in Washington and she's trapped in who knows where. And a lot of practical things will get in the way of whether I'm able to keep both promises or whether I find that my commitment to one promise interfered with my ability to keep the other promise.

So it may seem cute or sort of begging the question if I said, well, the rural circumstances may be different, but sadly, I think, if you look at it from the point of view of these are two promises — and I believe — the reason I said two promises is because I happen to share the concern people have with the idea of balance.

I wanted to avoid the idea that we're trying to balance something, and so I was looking for another way to say that, that I hoped would be more enlightening. And I chose the two promises, and maybe it worked, maybe it didn't, but I think your comment gets right to the heart of what might be of value or might not be of value in making that analogy of the two promises.

And just to complete, since we are looking back at slides, I would like to read my last slide, because I believe it very much fits with what Dr. Dresser said and what Dr. Carson said. My last slide was titled "Personal Hope."

"In the future we will see more examples of conscientious objection dealt with by local accommodation in the spirit of mutual respect and few instances of the use of political or financial power to favor only one promise."

CHAIRMAN PELLEGRINO: Thank you, Howard . Dr. Lyerly .

DR. LYERLY: Well, that would have been a beautiful way to end on hope, but I just want to take a minute to address a worry that seems to have surfaced today, which I find interesting and not one that had struck me particularly, and I wonder if it's just the way that we think about things, namely that limitations or potential accommodation of providers' rights of conscientious refusal necessarily are going to translate into a provider/patient relationship in which one is the technician and one is the consumer of goods.

I think what the concern is on the side, too, of individuals that are worried about the expression of conscience is also silence in that relationship between doctor and patient, that not talking about options, not exploring the ways in which those options might have meaning for somebody, but instead refusing to talk about things and refusing to make sure that the patient's needs — and I don't consider the patient's needs frivolous. I consider them deep and concerning and oftentimes not intuitive — you know, how to make sure that those things are met.

And so in some ways it may have to do with the idea of what sorts of things a conversation can do. So if we're only talking about conversations being an exchange of information or the provision of — or attempts to persuade people to do one thing or another, then I can see where that concern comes from. But conversations do a lot more.

Conversations between patients and their physicians establish trust, they help shape options for people, they make people feel cared for, and my sense is that that is and continues to be a goal for people who are concerned both about maintaining providers' rights to conscience and also

about individuals who are concerned about the impact of expression of conscience on patients' well-being.

CHAIRMAN PELLEGRINO: Thank you very much. You three panelists really put on a heavy afternoon, and we really appreciate it. Thank you.

End transcript.

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