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Commentary on "Of More than One Mind"

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In modern pluralistic societies conflicts in moral belief and practice are becoming more commonplace. Often they can be peacefully negotiated by avoidance of certain relationships, compromise, or mutual respect. At other times, the nature of the human relationship is such that the mechanisms for resolving conflicts become themselves ethically problematic.

This is the case in the physician-patient relationship when patients demand a treatment or procedure that physicians judge to be morally damaging to their personal or professional integrity. Curlin and colleagues' article in this issue of *JCE* surveys the ways a small sample of physicians of varying moral and religious persuasions confront this conflict.[1] Curlin sampled obstetrician-gynecologists. Surveys of other specialties describe similar ethical conflicts.[2]

Physician-patient moral conflicts are especially significant in obstetrics and gynecology. Here sociocultural conflicts surrounding abortion, *in vitro* fertilization, and a variety of techniques of assisted reproduction, et cetera, are of the most morally divisive.[3] Recently these conflicts were exacerbated by publication of an opinion of the ethics committee of the American College of Obstetrics and Gynecology, which stated that physicians who cannot in conscience provide reproductive services that patients request must refer patients to another physician who will.[4] That the U.S. Secretary of Health and Human Services later challenged this policy is significant, but not entirely reassuring.

The ACOG committee's recommendation must be seen against the background of a more general trend to demand moral neutrality of physicians, that is, a separation of personal from professional ethics. This is part of a trend toward erosion of conscientious objection as a right of physicians who refuse to compromise their personal moral integrity.[5] The questions Curlin's and other surveys raise are more than questions of procedures physicians should follow to confront conflict with patients. They are moral questions of the gravest significance.

Is the right of conscientious objection a natural right, that is, a right based in human dignity? Or is it a *prima facie* right that can be overridden by the autonomy owed to patients? Are not physicians persons worthy of equal respect? Do they not also have a claim to autonomy? Is it not more consistent with human rights to protect the autonomy of both patients and physicians? Autonomy is a reciprocal, not a unilateral, principle. Can the principle of autonomy be used to violate autonomy? If physicians are entitled to respect for their moral and professional integrity, can they be compelled to act against conscience and refer patients to someone who will provide an abortion? Is this not an act of complicity with what many physicians consider a seriously offensive moral act?

Curlin's article and other surveys are important sources of data about what *is* done, but not about what *ought* to be done. Surveys cannot answer normative questions. They provide valuable data about the kinds and prevalence of ethical issues that arise in clinical practice. Agreement on a "mainstream" set of proce-

dures does not confer moral probity on those procedures, or by itself compel others to participate.

This is not the place to evaluate the statistical questions raised by Curlin's survey. He and his coauthors are aware of some of them. What can be questioned is the conclusion from the practices of 19 physicians of varying moral persuasions that there is a "mainline" approach. Does this imply that the mainline opinion has a certain moral weight? The moral questions raised by the survey cannot be resolved by majority opinion, even in a democracy.

The "mainline" opinion asserts that physicians who oppose abortion, or any other procedure on moral grounds have but one choice: to refer to another physician not opposed. Those who will not refer, on grounds of moral complicity in an intrinsically wrong act, are cited as being "judgmental," preachy, imposing their will on others, or abandoning the patient. Explaining the reasons for one's refusal, saying when asked what he or she would advise, or suggesting alternatives are prohibited.

One can agree with the mainline view that respects the right of ultimate choice to rest with the patient. Prohibition of coercion or derogation of the patient is a moral requisite. But there must be equal regard for the right of physicians to refuse. They must not be coerced by threats of loss of certification, or disciplinary action if they dissent from the mainline course.

Physicians opposed to abortion are morally entitled to refuse and give reasons for doing so clearly and honestly without demeaning the patient. Explanations must be given with respect for the patient. Physicians can answer questions about the reasons for refusal and acknowledge that people may differ without demeaning the person who differs. They must absorb patiently the reproach of patients or "mainstream" colleagues. They are bound to give reasons without sanctimonious self-righteousness. But physicians cannot knowingly assist in abortion by making a referral. Physicians opposed to abortion cannot "abandon" a patient once they have entered a professional relationship with her. They should refer her to an obstetrician known to be competent for needed non-abortion care. It is the patient's responsibility to negotiate her demands freely with other obstetricians.

Physicians who cannot morally perform an abortion must always treat patients compassionately while making their own moral position clear. This is the case also for other procedures of dubious moral probity. Physicians may find a procedure unacceptable but must never treat patients with less than the respect their human dignity demands. Physicians must learn to respect the human person, even while disagreeing with her request or demand for a morally questionable procedure. Indeed, speaking one's mind to another without castigation is more respectful of the other than a refusal to do so.

Early disclosure of a physician's objection to abortion or other procedure usually subsumed under the rubric "reproductive technology" is mandatory. Indeed, obstetricians who have objections should make them known before entering a professional relationship with a patient. A brochure stating what treatments and procedures a physician will not do should be available to patients and posted in a visible place. As in any other potential conflict, prevention is the best course. It is recommended even by those arguing physicians should be morally neutral.[6]

Dissenting physicians should offer to continue seeing a patient if needed. They should treat the complications of procedures they find objectionable. Elective or selective abortions are not true medical emergencies. In true medical emergencies, physicians have the duty to provide medically indicated care guided by their conscientious assessment of what is in the patient's best interest.

NOTES

1. F. Curlin, S. Dinner, and S. Tessler Lindau, "Of More than One Mind," in this issue of *JCE*.

2. F. Curlin et al., "Religion, Conscience and Controversial Clinical Practices," *New England Journal of Medicine* 256 (2007): 593-600; R.A. Burt, "The Medical Futility Debate: Patient Choice, Physician Obligation, and End of Life Care," *Journal of Palliative Medicine* 5 (2002): 249-54.

3. M. Oberman, "Mothers and Doctor's Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts," *Northwestern University Law Review* (Winter 2000): 497-501.

4. "The Limits of Conscientious Refusal in Reproductive Medicine," *ACOG Committee Opinion* no. 385 (2007), *http://www. acog.org/from_home/publications/ethics/co385.pdf*.

5. E.D. Pellegrino, "The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective," *Fordham Urban Law Journal* 30, no. 1 (November 2002): 221-44.

6. Oberman, see note 3 above.