

Summary points

Smoking prevalence remains unacceptably high among Muslim communities globally

Numerous religious scholars and institutions in Middle Eastern and North African countries have recently declared smoking to be *haram* (prohibited)

South Asian religious authorities need to follow the leadership shown by their Arab speaking counterparts

Antismoking legislation is often poorly enforced in Muslim countries

Religious rulings need to be backed up by advertising bans and support to stop smoking

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Competing interests: AS chairs the research committees of the Muslim Council of Britain and the British Thoracic Society.

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Ethics

Conscientious objection in medicine

Julian Savulescu

Deeply held religious beliefs may conflict with some aspects of medical practice. But doctors cannot make moral judgments on behalf of patients

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Shakespeare wrote that "Conscience is but a word cowards use, devised at first to keep the strong in awe" (*Richard III* V.iv.1.7). Conscience, indeed, can be an excuse for vice or invoked to avoid doing one's duty. When the duty is a true duty, conscientious objection is wrong and immoral. When there is a grave duty, it should be illegal. A doctors' conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's good and the patient's informed desires (box). 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. Doctors should not offer partial medical services or partially discharge their obligations to care for their patients.

Problem of conscientious objection

Doctors have always given a special place to their own values in the delivery of health care. They have always had greater knowledge of the effects of medical treatment, and this fostered a belief that they should decide which treatments are appropriate for patients—



Conscience, for Shakespeare's Richard III, was "but a word cowards use"

that is, paternalism. Their values crept into clinical decisions.^{1,2} This has been squarely overturned by greater patient participation in decision making and the importance given to respecting patients' autonomy.³ More recently, doctors' values have reappeared as a right to conscientiously object to offering certain medical services. Examples include, refusal to offer termination of pregnancy, especially late term termination, to women who are legally entitled to it and refusal to provide reproductive advice and help to gay couples, single women, or others deemed socially unacceptable.

In the United States pressure has been put on Catholic hospitals to allow obstetricians to sterilise women immediately after giving birth.⁴ Alto Charo notes that a recently proposed Wisconsin bill would allow doctors to refrain from a broad range of activities, including counselling patients:

The privilege of abstaining from counseling or referring would extend to such situations as emergency contraception for rape victims, in vitro fertilization for infertile couples, patients' requests that painful and futile treatments be withheld or withdrawn, and therapies developed with the use of fetal tissue or embryonic stem cells. This last provision could mean, for example, that pediatricians ... could refuse to tell parents about the availability of varicella vaccine for their children, because it was developed with the use of tissue from aborted fetuses.⁵

Indeed, one Wisconsin pharmacist refused to fill an emergency contraception prescription for a rape victim. She became pregnant and had an abortion.⁵

Determinants of medical care

Law
Just distribution of finite resources
Patient's informed desires
Not doctors' values

Arguments against conscientious objection

Inefficiency and inequity

In public medicine, conscientious objection introduces inequity and inefficiency. In a survey I conducted several years ago,⁶ around 80% of clinical geneticists and obstetricians specialising in ultrasonography believed termination of pregnancy should be available for a normal 13 week pregnancy if the woman wants it for career reasons. However, only about 40% were prepared to facilitate it. This implied that less than half of doctors whose primary job is to deal with termination of pregnancy would facilitate a termination at 13 weeks if the woman wanted it for career reasons. The service that patients receive depends on the values of the treating doctor. Not only does this imply that patients must shop among doctors to receive the service to which they are entitled, introducing inefficiency and wasting resources, it also means some patients, less informed of their entitlements, will fail to receive a service they should have received. This inequity is unjustifiable.

Inconsistency

Imagine an intensive care doctor refusing to treat people over the age of 70 because he believes such patients have had a fair innings. This is a plausible moral view,⁷ but it would be inappropriate for him to conscientiously object to delivering such services if society has deemed patients are entitled to treatment.

Or imagine in an epidemic of bird flu or other infectious disease that a specialist decided she valued her own life more than her duty to treat her patients. Such a set of values would be incompatible with being a doctor.

If there is any justification for compromising the care of patients, it must be a grave risk to a doctor's physical welfare. But if self interest and self preservation are not generally deemed sufficient grounds for conscientious objection, how can religious or other values be?

Commitments of a doctor

These examples show that people have to take on certain commitments in order to become a doctor. They are a part of being a doctor. Someone not prepared on religious grounds to do internal examinations of women should not become a gynaecologist. To be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system.

If we do not allow moral values or self interest to corrupt the delivery of the just and legal delivery of health services, we should not let other values, such as religious values, corrupt them either.

Discrimination

Sometimes religious values are considered special. However, to treat religious values differently from secular moral values is to discriminate unfairly against the secular, a practice not uncommon in medical ethics.⁸ Other values can be as closely held and as central to conceptions of the good life as religious values.

Place for conscientious objection

The argument in favour of allowing conscientious objection is that to fail to do so harms the doctor and

constrains liberty. This is true. When a doctor's values can be accommodated without compromising the quality and efficiency of public medicine they should, of course, be accommodated. If many doctors are prepared to perform a procedure and known to be so, there is an argument for allowing a few to object out. A few obstetricians refusing to perform abortions may be tolerable if many others are prepared to perform these, just as a few self-interested infectious disease doctors refusing to treat patients in a flu epidemic, on the grounds of self interest, might be tolerable if there were enough altruistic physicians willing to risk their health. But when conscientious objection compromises the quality, efficiency, or equitable delivery of a service, it should not be tolerated. The primary goal of a health service is to protect the health of its recipients.

Certain constraints are necessary to ensure the legal, equitable, and efficient delivery of health care:

- Medical students and trainees must be aware of the commitments of the profession and be prepared to undertake these or not become doctors
- The medical profession has an obligation to ensure that all patients are aware of the full range of services to which they are entitled
- Any would-be conscientious objector must ensure that patients know about and receive care that they are entitled to from another professional in a timely manner that does not compromise their access to care
- Doctors who compromise the delivery of medical services to patients on conscience grounds must be punished through removal of licence to practise and other legal mechanisms
- The place for expression and consideration of different values is at the level of policy relating to public medicine.

Legal uncertainty

In some areas of medicine, such as the hastening of death and late termination of pregnancy, doctors may in good faith be uncertain as to whether an intervention is legal. In 1990, the Human Fertilisation and Embryology Act in the United Kingdom reduced the limit for "social termination" to 24 weeks, but placed no upper gestational limit on termination when there is "substantial risk of serious handicap" or if it is necessary to prevent "grave permanent injury to the physical or mental health of the pregnant woman." Concern has been expressed about what constitutes a substantial risk and a serious handicap. Lilford and Thornton claimed that the issue might cause significant public controversy and expressed their "deep personal uncertainty."⁹ In 1993, Green asked 391 obstetric consultants in the United Kingdom how late they would be prepared to offer termination of pregnancy for anencephaly, spina bifida, and Down's syndrome.¹⁰ She found that 89% of consultants would offer termination for anencephaly at 24 weeks, falling to 64% beyond 24 weeks. For Down's syndrome, 60% would offer termination at 24 weeks but only 13% after this time. For open spina bifida, 53% would offer termination at 24 weeks and 21% after 24 weeks.

In Australia, laws relating to late termination are even more unclear and vary from state to state.^{6 11} My survey of clinical geneticists and obstetricians with specialist training in obstetric ultrasonography showed

Summary points

A doctor's conscience should not be allowed to interfere with medical care

All doctors and medical students should be aware of their responsibility to provide all legal and beneficial care

Conscientious objection may be permissible if sufficient doctors are willing to provide the service

Conscientious objectors must ensure that their patients are aware of the care they are entitled to and refer them to another professional

Conscientious objectors who compromise the care of their patients must be disciplined

similar variation in practice to that found by Green.⁶ I asked respondents to imagine that a pregnant woman presents after prenatal testing with one of several diagnoses at 13 and 24 weeks. These included anencephaly, trisomy 18, hypoplastic left heart, spina bifida with hydrocephalus, fragile X syndrome, Down's syndrome, achondroplasia, and cleft palate. I also asked respondents about pregnancies in which the fetus was normal. Some practitioners would not facilitate termination at 24 weeks even for lethal abnormalities. Fewer practitioners supported termination or would facilitate it at 24 weeks than at 13 weeks for all conditions. The difference in opinion between 24 and 13 weeks was greatest for pregnancies in which the fetus was normal or had a relatively mild disorder. There was a lack of consensus about which abnormalities were severe enough to warrant termination and up to what gestation termination is acceptable. For example, around 75% of respondents believed termination should be available for dwarfism at 24 weeks.

Such wide variation in practice around late termination is due both to practitioners' differing values but also to legitimate uncertainty about the legal status of late termination for "milder" conditions. I have argued elsewhere that we urgently need to clarify the law in this area.¹¹ In the absence of such clarification, practitioners have a legitimate right to refuse to provide a service which they believe to be illegal. However, they should make this reason clear to patients and also the fact that the law is unclear. They should also inform patients of the availability of other practitioners who take a different view of the law.

Private elective medicine

Private elective medicine is different from public medicine. Doctors have more liberty to offer the service of their choice, based on their values. Nevertheless, for patients to give valid consent to treatment, they must be informed of relevant alternatives and their risks and benefits (in a reasonable, complete, and unbiased way).

Conclusion

Values are important parts of our lives. But values and conscience have different roles in public and private life. They should influence discussion on what kind of health system to deliver. But they should not influence the care an individual doctor offers to his or her patient. The door to “value-driven medicine” is a door to a Pandora’s box of idiosyncratic, bigoted, discriminatory medicine. Public servants must act in the public interest, not their own.

Contributors and sources: JS is a professional medical ethicist with experience in practising general and emergency medicine. This article arose from reflections on the literature and his experience

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Ethics

Just a family medical history?

Dagmar Schmitz, Urban Wiesing

If you have a family history of inherited disease, giving details could lead to discrimination

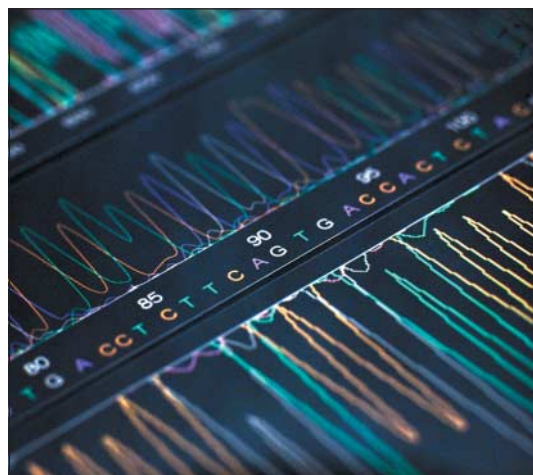
A recent case in Germany has highlighted the use of genetic information obtained from family medical histories in employment decisions. Although laboratory genetic testing is rarely used in occupational health medicine, prospective employees are often asked about family medical history and may be unaware of the potential consequences. We argue that information obtained from family histories is similar to that from genetic testing and consent procedures should be the same.

Case

Teachers in Germany, like all civil servants, have to have a medical examination before getting a permanent job. In this case, a young female teacher was examined by the occupational health doctor and found to be in perfect health. But in response to questions about her family medical history, she indicated that her father had Huntington’s disease. She refused genetic testing. Her risk of inheriting the disease from her father and still being in perfect health is 50% at most. At the same time, her chance of not having inherited the disease from her father is at least 50%. The doctor reported that she had an above average risk of future absenteeism because of her family history. The Hessen educational authorities then refused to give her a permanent job in the German civil service on the grounds of this medical report.^{1 2} The teacher has since successfully contested the decision in the German Administrative Court.

Legal position

Although the German Administrative Court abolished the decision of the Hessen educational authorities because it thought the risk had been wrongly interpreted, it explicitly approved the use of predictive



Family history can sometimes be as revealing as genetic analysis

medical information from a family history. Civil servants in Germany have particular privileges, which the court believes justifies questioning the future ability for performing the job.³ The occupational physician is therefore obliged to consider the future health of the applicant and to give a prognosis based on a physical examination and family history. The court also recommended that genetic testing should be prohibited in pre-employment medical testing because of the related ethical problems and their lack of legal regulation in Germany.³

The approval of family histories and disapproval of laboratory genetic testing in the workplace reflects the current opinion and legal practice in most of Europe. Countries such as Switzerland have implemented restrictions on the use of genetic tests in the workplace, and 22 US states have banned the use of genetic screening in making employment decisions. Bills

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