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JOURNAL DISCUSSION
Conscientious Objection: A Medical Student Perspective
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Frader J, Bosk CL. The personal is political, the professional is not: conscientious objection to obtaining/providing/acting on genetic information. *Am J Med Genet C Semin Med Genet.* 2009;151C(1):62-67.

During the third year of medical school, the question, "Do you know what specialty you're going into?" comes up daily. While some students know what they want to do from the beginning of medical school, others find this question more vexing. Students in the latter group spend tremendous mental and emotional energy comparing and contrasting various aspects of different specialties in an attempt to decide which one is right for them. These students often take months before arriving at a final decision and seek advice from many advisors and faculty mentors along the way.

Medical students and their mentors, however, rarely discuss the potential that the standard of care in certain fields might conflict with the student's personal moral code. Perhaps students with ethical concerns are reluctant to address them with housestaff and attending physicians they hope to impress. Regardless, students who have ethical objections to certain routine medical services should keep their objections in mind when choosing a specialty. For example, it is perfectly legitimate for a person morally opposed to emergency contraception to question whether he or she should pursue a career in pediatrics.

This issue reflects the well-publicized debate currently taking place among health care professionals on the acceptable limits of conscientious objection. The fields of obstetrics and gynecology, pediatrics, medical genetics, and genetic counseling are most often implicated. A number of physicians already established in their chosen specialties object on moral grounds to the medical services delivered by most of their fellow practitioners and claim the prerogative to refuse to provide these services to their own patients. Some take this a step further, refusing to refer patients to others who offer the services or even refusing to inform their patients of the availability of the services. These "conscientious objectors" cite physician autonomy, the immorality of complicity, and the responsibility to act in patients' best interest by preventing them from engaging in morally objectionable behavior as justification for their refusals [1-3].

In "The Personal is Political, the Professional is Not: Conscientious Objection to Obtaining/Providing/Acting on Genetic Information," Frader and Bosk examine

these arguments in the context of genetic screening [4]. In their view, the health care professional is morally obligated to inform patients in advance of any standard services he or she does not offer. When a patient has not been so advised and requests such a service, the health care professional is bound to expeditiously arrange care for him or her elsewhere.

The authors frame their argument in terms of the many privileges enjoyed by physicians. Society offers medical doctors a specialized fund of knowledge to use on their patient's behalf. We grant them high economic and social status to secure their role as their patients' fiduciaries. In return, we expect them to put patients' interests first, even when matters of conscience are involved.

Physicians who object on the basis of conscience often risk undermining their patients' autonomy in asserting their own right. Most patients lack the medical knowledge and resources to learn about and access treatment options on their own. They are unable to exercise autonomy in making health care decisions unassisted and are thus left completely in their physician's power. Physicians who withhold information or treatment from patients fail to meet their obligation to put the patient's best interest before their own.

Frader and Bosk note that conscientious objectors have historically been disenfranchised individuals. In contrast, conscientious objectors in modern medicine are among the most privileged and secure members of society. Their authority, social and economic status, and knowledge far exceed that of most of their patients. This disparity makes their claim to the right to exercise their moral prerogative at their patient's expense seem particularly exploitative and selfish.

Frader and Bosk ask why individuals would choose a specialty in which they find providing routine services to be objectionable. They also urge associations of professional specialists to more forcefully protect patients' right to access these services. This stance implies that, by choosing a given specialty, a medical student is obligated to ensure that his or her future patients have access to services that are considered standard of care by that specialty's professional association. Frader and Bosk do not claim, however, that this obligation binds the physician to providing that care himself or herself. So long as a physician promptly discloses what services are not offered, fully informs patients about the nature of these services, and, when necessary, makes provisions for patients to receive these services elsewhere, it is acceptable for him or her to decline to provide them. In summary, Frader and Bosk's position is that a medical student must be prepared to facilitate access to care that he or she finds morally objectionable, though he or she is not be obligated to provide the care.

Julie Cantor, in critiquing a December 2008 Department of Health and Human Services Regulation that extends protections for conscientious objectors, takes an even stronger stance [5]. In her view, a physician should act in a morally neutral fashion, offering to each patient all legal treatment options. In most cases, it is not

possible for a physician to disclose moral opposition to a particular plan of care and maintain a morally neutral stance. Thus, Cantor provides a warning to medical students that is stronger than the one issued by Frader and Bosk: Do not choose a specialty in which you will object to routine treatments that are considered standard of care; more often than not, professional duty requires you to carry out such treatments, regardless of your moral stance.

Frader, Bosk, and Cantor are united in a conception of medical professionalism that is overlooked in undergraduate medical education. In their eyes, professionalism demands that one concede moral authority for deciding which services should or should not be offered to the legal system, a professional organization, or the informal consensus of one's peers. I believe that this arrangement discourages physicians from restricting patient care based on personal values, maximizes patient autonomy and trust in the medical profession, and keeps misguided paternalism to a minimum. It does not undermine the autonomy of the individual practitioner inasmuch as he or she is free to leave the profession at any time or, more appropriately, to choose a different career path as a medical student. I do not believe that a medical student's ability to practice the specialty that he or she finds most interesting or enjoyable outweighs the right of patients to receive a full range of medical services in a morally open environment that respects the pluralism of our society. A physician who asserts his or her right to conscientiously object on the basis of moral pluralism must extend the same consideration to patients and, in so doing, loses all ground for refusing to facilitate their access to clinically appropriate services they desire.

Medical students considering a specialty where certain standards of care are at odds with their own personal belief systems must seriously question whether that specialty is the right choice. In the United States, obstetrics and gynecology residents with an ethical or religious objection to abortions are not required to perform them [6]. Some residency programs and many medical centers do not provide controversial services for religious reasons. Thus, medical students presented with the possibility of conscientious objection can select practice scenarios in which they are not obligated to perform the services in question. If they do not plan to ensure that their patients have access to these services elsewhere, however, they are committing themselves to a form of medical practice that results in substandard patient care and that has the potential to erode the trust between society and physicians.

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