

## PAPER

# Is there no alternative? Conscientious objection by medical students

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**ABSTRACT**

Recent survey data gathered from British medical students reveal widespread acceptance of conscientious objection in medicine, despite the existence of strict policies in the UK that discourage conscientious refusals by students to aspects of their medical training. This disconnect demonstrates a pressing need to thoughtfully examine policies that allow conscience objections by medical students; as it so happens, the USA is one country that has examples of such policies. After presenting some background on promulgated US conscience protections and reflecting on their significance for conscience objections by medical students, this paper observes that the dominant approach (following the American Medical Association's conscience clause) is to allow exempted students to instead be evaluated on the basis of alternative curricular activities to learn the associated underlying content. This paper then introduces and discusses an example in which male Muslim students who believe it is wrong to touch members of the opposite sex object to performing physical examinations on female subjects in their medical training. This sort of case, it is argued, causes difficulty for a conscience clause that resolves the dilemma by granting reasonable exemptions in the form of participation in alternative curricular activities: there are cases where one must perform the 'objectionable' activity itself in order to learn the necessary content and underlying principles.

**INTRODUCTION**

Consideration of the proper scope of conscientious objection by medical practitioners has gained renewed interest in biomedicine, in part due to the controversy regarding refusals to dispense emergency contraception.<sup>1</sup> Yet in this debate there has been far less discussion of conscientious refusals by medical students regarding aspects of their training. In a recent survey of British medical students, nearly half reported the belief that providers could conscientiously refuse *any* procedure, and Muslim medical students were stronger believers in a right to conscientious objection than other groups of religious medical students.<sup>2</sup> These data reveal the permissive attitudes of current British medical students towards conscience objections, despite the fact that in the UK such students are prohibited in most cases from conscientiously objecting to learning medical procedures. This study reveals a gap which, if left unattended, may lead to an unworkable state of affairs once these students matriculate and become licensed physicians. Since such strict prohibitions on conscience objections by medical students may simply serve to exacerbate an

already problematic situation, there is a genuine need to critically examine policies that would allow conscientious refusals by students. The American Medical Association has promulgated the most salient policy in the USA addressing students' conscientious refusals, yet discussion of cases such as the one encountered in a major medical centre in which several students objected on religious grounds to performing physical examinations on members of the opposite sex raises questions about the soundness of this solution to the ethical dilemmas raised by such refusals.

**CURRENT PROTECTIONS FOR CONSCIENTIOUS OBJECTION: PRACTITIONERS VERSUS STUDENTS**

I will understand conscientious objection as a refusal to comply with a request based on secular, moral or religiously-inspired ethical reasons.<sup>3</sup> Historically, protections have been extended to medical practitioners' conscience objections at both the federal and state levels in the USA. The Church Amendments are federal laws that were put into place in the early 1970s to prevent discrimination against medical professionals who refused to participate in abortions or sterilisations within healthcare facilities that received federal funding. These laws make clear that individual providers or healthcare institutions have no obligation to perform abortions or sterilisations as a condition of receiving government monies. In addition, almost all individual states have enacted laws allowing practitioners to refuse to provide health services in the USA.<sup>4</sup> These laws vary in their scope; for example, a relevant law in Arkansas states that 'No private institution or physician...shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious objection.'<sup>5</sup> This law is somewhat narrow since it focuses specifically on conscience-based objections to contraception. Yet, while it is focused on a particular locus of disagreement, it is wide-ranging in its effects since it would even allow refusing to discuss any *information* about forms of contraception, thereby providing an exemption from securing informed consent by patients. By contrast, in Mississippi a more recent law states that 'A health-care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.'<sup>6</sup> This law has a much broader scope, since it would presumptively support exemptions for objections to dispensing contraception as well as scruples-based refusals regarding, for example, withdrawing care at the end

of life, participating in prenatal diagnosis or providing infertility services to a same-sex couple. The latter law is similar to very open-ended US federal conscience protections finalised in 2008,<sup>7</sup> though these conscience provisions have recently been revised by the Obama administration.

The degree of applicability of these laws to medical students is quite unclear. As federal laws, the Church Amendments have the most potential relevance to mediating conscience objections in an educational setting; the most explicit statement in these laws relating to medical students is the following:

'No entity which receives...any grant, contract, loan, loan guarantee, or interest subsidy...may deny admission or otherwise discriminate against any applicant (including applicants for internships and residencies) for training or study because of the applicant's reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions.'<sup>8</sup>

Since the Church Amendments focus upon abortion and sterilisation, the clear message is that the same protections afforded to practitioners are being extended to students by this provision. Yet from a moral point of view, this is striking: after a successful application, why should a student be treated no differently than a licensed medical professional? After all, there is an important distinction between *learning* a trade and *practicing* a trade. It is reasonable to think that medical students possess a *prima facie* right to conscientious objection; this position is rooted in the salience of this distinction and in the fact that the circumstances in which students 'practice' medicine make them morally separable from licensed physicians. Just as medicine has recognised that children are not 'little adults' for the purposes of medical treatment, medical students are not 'little doctors' for the purposes of ethical assessment. This implies that licensed practitioners have relatively greater responsibilities for patient well-being, which in turn lessens their latitude for conscientious objection (when compared with medical students).

There are several strong reasons supporting the position that physicians have less room for conscientious objection than medical students. First, physicians have greater moral responsibilities to satisfy their patients' requests because they have been granted monopolistic rights over most medical care. Having earned the right to legally care for patients and to enjoy significant social and economic benefits implies that physicians have special responsibilities to their patients. In this way, medical professionals are similar to police officers: they are granted special privileges, and these rights are conditioned upon upholding the responsibilities in the associated social contract. By contrast, medical students have been granted no such rights and are not licensed professionals; they are instead apprentices engaged in training and are not subject to the same sorts of regulations and responsibilities. Further, patients' needs can be pressing and may constitute a medical emergency. Emergencies emphasise the strength of the duty to care and the fact that the commitment to patient well-being (eg, providing life-saving and stabilising care) outweighs even valid moral objections to participation in 'objectionable' medical procedures. Since students are not placed in a position where patients solely rely upon them for emergency medical care, physicians and students occupy distinct ethical spaces with respect to their latitude for justified conscience objections. These sorts of considerations support the view that conscience protections promulgated for practitioners have little to say about the sort of exemptions that should be extended to medical students.

The most pertinent delineation of student protections comes from the American Medical Association's Conscience Clause; this document outlines guiding principles to exempt medical students from curricular activities. In essence, this conscience clause proposes that medical schools should have formal written policies governing such exemptions that are consistently applied and made known to students before matriculation. The crucial part of the policy states that if students are excused based on ethical or religious beliefs, the '...Students should be required to learn the basic content or principles underlying procedures or activities that they exempt.'<sup>9</sup> The exemption is acceptable only if a student can learn the underlying principles by participating in an alternative curricular activity. By contrast, medical students in Britain are prohibited from objecting to participation in medical procedures on moral or religious grounds.<sup>2</sup> According to the UK's General Medical Council guidelines regarding conscience, medical students should not be able to exempt themselves from learning procedures that are part of a core curriculum even if they have a related conscience objection.<sup>10 11</sup> Yet, 76.2% of Muslim students in a recent study stated that doctors should be able to object to any procedure,<sup>2</sup> which demonstrates widespread disagreement regarding the scope of conscience rights as stated in the General Medical Council guidelines. Clearly, the issue of conscientious objection must be addressed given the dissonant attitudes held by current medical students—those who will be future practitioners with the expectation that conscientious refusals are a professional privilege.

#### **POLICY IMPLEMENTATION: THE NON-EXISTENCE OF ALTERNATIVES**

Are policies that require exempted medical students to instead engage in alternative curricular activities satisfactory? There are cases where it might be reasonable to grant the exemption yet the underlying principles cannot be learned an alternative manner. Several students of the Muslim faith at the University of Rochester Medical Center believed it was wrong to touch or be touched by a member of the opposite sex who was not a member of their family; as a result, they objected to performing physical examinations on members of the opposite sex in the course of their training. These students expressed their discomfort to their advising dean but did not formally pursue an exemption, yet reports of Muslim medical students in the UK opting out for precisely this reason have been confirmed by the British Medical Association.<sup>12</sup> Touching persons of the opposite sex outside the boundaries of family—namely, those not related by blood, by marriage or by the same wet-nurse—is considered wrong and this is a sincerely held belief of many Muslims.<sup>13</sup> In this consideration of the Muslim students' case the focus is on cross-gendered interactions; this discussion should not be understood as an exhaustive treatment of the norms regarding touching from a Muslim perspective (including forms of acceptable touch between members of the same gender). Padela and del Pozo's helpful discussion of gender relations in Islam makes clear that the main principle in an Islamic ethic is modesty.<sup>13</sup> With regard to dress code, seclusion of a man and woman in a closed space alone, as well as physical contact between the sexes, Padela and del Pozo identify prevention of sexual temptation (including accusation and possible commission of illicit sexual relations) as the governing theme in cross-gendered relations in Islam. Therefore, to require participation in these clinical activities requiring touching members of the opposite sex would violate such Muslim students' religious

beliefs and hence an exemption seems reasonable on its face. Yet this case is a difficult one worthy of reflection because it is unclear what curricular alternative should be proposed for students granted such an exemption during the course of their medical schooling.

An obvious resolution would be to simply allow such students to perform examinations only on members of the same sex. But this solution falls short in numerous ways, one of which is very important for our purposes. By refusing to perform examinations on members of the opposite sex, such students are failing to engage the question of what constitutes a touch that is professional and non-sexual—one that exemplifies a ‘cool intimacy’ that is still compatible with closeness to a patient.<sup>14</sup> The matter here is not one of the mechanics of touch; it is instead an emotional and psychological investigation whereby one learns how to cognitively distinguish clinical touching from touch that might otherwise signify erotic or romantic affection. This reasoning suggests that an inherent part of learning how to perform physical examinations involves a deep core competency that is cognitive in nature; this point is in addition to the plausible notion that it would be very difficult to deliver efficient and good care if those who are to become doctors did not learn how to examine and cure members of the opposite gender. Exempting students from performing examinations on members of the opposite sex is one example of a case that causes difficulties for a policy that allows exemptions as long as an alternative curricular activity is in place: verifiable reasons may exist to grant the exemption yet it seems one must perform the ‘objectionable’ activity itself in order to learn the relevant underlying principles. To reinforce an earlier point, simply learning about an activity is morally distinct from participation in the said activity. Therefore, for Muslim students who conscientiously refuse to, for example, learn about alcohol-related or sexually transmitted diseases,<sup>12</sup> their objection appears unsustainable once we emphasise the distinction between knowledge and practice. But in the case at hand, gaining knowledge necessarily involves participation in the objected-to activity.

If thoughtful people have reservations about allowing this particular exemption, perhaps because they simply think the belief is illegitimate (eg, sexist), it is easy to think of cases of reasonable beliefs that would likely exempt an even greater scope of curricular activities. Imagine that students objected to taking histories and performing examinations on standardised patients because they learned (rightly) that the actors received very little pay. If the students felt sincerely that participation violated the principles of justice, then this moral belief could ground a successful conscience-based objection. The reasons in this case are more practical in nature as compared with the philosophical difficulties posed by the Muslim students’ case, and therefore could be more easily accommodated. Only if a sufficiently large number of students in the standardised patient case objected would it become challenging to meet the requirement that the relevant underlying principles be learned by exempted students.

The Muslim students’ objection, by contrast, is deeper and more troubling to resolve. We might hold that a sensible approach to granting exemptions makes an exception for emergency care and core competencies, and requires that petitioners state their reasons for wishing to be excused in order to be granted a limited

kind of conscientious objector status.<sup>15</sup> We might go further and advocate that medical students declare their specialty earlier in their training so that they could more effectively determine what curricular activities are most relevant to their future versus those to which they could choose to conscientiously object.<sup>16</sup> This further suggestion falters, however, given the existence of core competencies; as argued in this paper, performing physical examinations on members of both sexes involves an essential competency to be learned in medical school. This discussion confronts us with the reality that a curricular alternative may not be possible for some aspects of training, if we also require that students learn the associated basic content or underlying principles. Sometimes there is no alternative.

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