Highlights from this issue

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Conscientious objection

Do doctors have the right to refuse to perform certain procedures on their patients on moral or religious grounds, or does their duty to their patients override their personal moral objections? Several papers in this issue explore this perennial ethical dilemma.

Paediatrician Giles Birchley (***see page 13***) seeks to defend the role of the doctor's conscience in all medical decision-making, not only the cases where treatment is declined by the clinician. He observes that the role of conscience has been systematically reduced in medical practice, with a small number of controversial exceptions involving late-term abortions and stem-cell research. Birchley argues that this trend ought to be reversed, so that the clinician's conscience can serve as a kind of interface between everyday moral values and the peculiar, special-case moral frameworks that are employed in the practice of healthcare. He also suggests that allowing the physician to express her conscience might improve morale and reduce burn-out, among other more pragmatic benefits.

Morten Magelssen (***see page 18***) is also in favour of conscientious objection, but argues the case on rather different grounds. Rather than casting conscientious objection as an opportunity for real-world values to enter the medical arena, he argues that there is an obligation to protect the 'moral integrity' of clinicians, not least because medical treatment is, in his view, an intrinsically moral practice requiring clinicians with morally virtuous characters. Magelssen allows, however, that this obligation only applies in a narrow range of cases, and it can be overridden in cases where the patient is in urgent need of a procedure, and when the burden of care is not simply passed to the doctor's colleagues.

These philosophical defenses of the role of conscience in medicine are cast into an more practical light by the empirical study of Sophie Strickland, (***see page 22***, Editor's choice) whose survey finds that the demands of medical students' conscience often go much further than the refusal to perform late-term abortions, extending to religious refusals to prescribe birth control or even to examine a member of the opposite sex. An increasing number of medical students in the UK are Muslims, and among these students Strickland found that three-quarters felt that doctors should have the right to refuse to perform any kind of treatment. It is clear that these issues will only become more pronounced with the passage of time, as the demographics of clinicians shift.

Rimon-Zarfaty and Jotkowitz offer a further glimpse into the kind of religious difficulty that may arise in the future of Western medical systems, looking at that Israel's delegation of abortion decisions to committee (***see page 26***). They note that while it represents a violation of parental autonomy to involve a committee in the abortion decision, the committees only rarely refuse the procedure to parents, and so they may paradoxically represent a means of insulating the decision-making process against even more intrusive external pressures, such as the strong legal and religious constraints that Israel imposes on the provision of abortion.

Sparrow versus Harris: round two

John Harris has frequently called for a conception of medical benefit that does not appeal to restoring the 'normal function' of patients, pointing out that there are those 'for whom normal functioning is a disaster', and who would be better served by treatment that moves them to a better-than-normal state.[1] In *JME* 37(5), Rob Sparrow challenged this view, arguing that any attempt to define medical benefit without making reference to what is normal would produce very odd results.[2] He took the example of a womb replacement procedure, offered to a girl who was born without a uterus, and to a boy, who was also (unsurprisingly) born without a uterus. Without taking it into account that it is not normal for boys to have wombs, Sparrow argued, we would have to consider the procedure to be of equal benefit to both the boy and the girl. Pointing out that it is also normal for women to live longer than men, Sparrow mounted the case that Harris' view would commit us to producing only female babies so as to create babies with the best lives.

Harris' response, printed in that issue, has not left Sparrow satisfied, and the debate rages on in these pages. In this issue, Sparrow ups the ante by claiming to have identified 'strong eugenic tendencies' in Harris' work on human enhancement, (***see page 4***). Harris replies that he has indeed always supported eugenics, at least understood as 'the attempt to produce fine healthy children', but that he thinks the difference in life expectancy between males and females is not enough to make it worth living on a female planet (***see page 8***).

REFERENCES

1. **Harris J.** Sparrows, hedgehogs and castrati: reflections on gender and enhancement. *J Med Ethics* 2011;**37**:262–6.
2. **Sparrow R.** Harris, harmed states, and sexed bodies. *J Med Ethics* 2011;**37**:276–9.