Conscientious Objection: What's in an Analogy?

To the Editor: In his recent article "The Internal Morality of Conscience," Dominic Mangino raises several important points in the debate over conscientious objection in medicine.[1] Primary in this regard is his criticism of his adversaries' anthropological assumptions. He also responds to Ronit Stahl and Ezekiel Emanuel's statement that conscientious objection should not be tolerated. Mangino claims that a central piece of their argument, the analogy to military conscription, is faulty.[2] I agree. However, I found myself wishing Mangino would have offered more in his examination as to why the analogy is faulty.

In any analysis, an analogy compares two things that are alike in some way and dissimilar in others. The purpose is to better understand the thing under investigation in light of something already understood. This is different from treating things equivocally (wholly different things are exactly the same) or univocally (two things are one and the same). I agree that it is appropriate to speak of conscientious objection as analogous in health care and the military, for the following reasons.

To properly assess the conscientious-objection debate, we must start with a definition of conscience. While space does not permit an exhaustive examination of the underlying anthropology, divergent opinions could agree that, at minimum, the act we call the *judgment of conscience* can be roughly defined as the application of moral norms to a concrete situation. When one does this on behalf of an institution, we call it *institutional conscience*.[3] Once it is clear how such moral norms apply to the situation, the agent, in his freedom, is called to act in accord with said judgment. The integrity of freely acting on applied norms (autonomy) is disrupted if the agent is coerced or compelled by external forces to act against or contrary to his best moral judgment. The response to such coercion or compulsion is what we call conscientious objection. With these definitions in place, it is possible to sketch some areas of similitude and difference to assess the strength and validity of the analogy to military conscription. Because of space, I will highlight only a few.

To begin with, the fields share some distinctive similarities. Both military service and medical practice have, in part, the object of preserving and promoting the common good. Furthermore, at least in the United States, one can freely enter both medicine and the military—so long as one qualifies. That is, only in certain situations is one conscripted. Thus, I would agree that there is a circumstantial difference between freely entering medicine and being conscripted into the military.

Furthermore, I would suggest that in each field members are called to develop and employ specific best practices and skills to accomplish the specific tasks needed to further the common good. Hence soldiers need basic training, self-defense training, arms training, and so on, just as physicians need medical courses, procedure training, and the like. Finally, each field is subject to an overarching moral and legal framework—hence, each group has processes for establishing acceptable conduct and dealing with misbehavior.

The points of divergence are no less striking. As exercised by the state, military conscription exists as a tool to ensure that the common good is defended against proportionate threats. For example, in the United States the draft is instituted only in certain wartime instances. Yet in Israel, a country whose existence is under constant threat, all citizens are bound to two years of military service at minimum.

Moreover, the military as a whole operates on the basis of a clearly delineated and reinforced hierarchy, with each part executing orders to implement strategies and accomplishing objectives through communication and coordinated forces. That is, it is a unified whole with each part, down to the individual, following specific orders. Medicine, on the other hand, operates completely differently. Each physician receives a medical license precisely to affirm his general ability to practice medicine prudently. Board certifications go further to indicate a physician's competence in a specific field of practice. The autonomy and integrity of each physician's practice is nearly sacrosanct—institutions and corporations are explicitly forbidden by law from interfering in the judgment of physicians.

This important distinction emphasizes that the medical profession is structured for a very specific purpose: to foster and support the prudential judgments of the physician. This is the distinguishing mark between the two fields. Conscience is the necessary precondition for prudential medical practice. It is operative when discerning the appropriate intervention to apply for the authentic benefit of the patient. This is not to say that prudence and conscience are not valued in military service—clearly they are. The difference is that the military is designed to operate as a collective whole through a hierarchy of orders from superiors to subordinates, while medicine is designed to emphasize the judgment (see conscience) and practice of the individual physician without hierarchy.

The similarities between conscientious objection in the military and in health care are helpful in some ways. Yet circumstantial differences between the two show where the analogy is strong and helpful and where it is weak and unhelpful.

For instance, one of the values of the analogy to military conscription—indeed, the primary reason it is used—is the process that has developed over time to manage it. Historically in the United States, the draft has been the context for much of our experience with conscientious objection. Consequently, processes and procedures have been developed to adjudicate conflicts in a manner that is consistent with the general principles of the American ethos, for example, with individual liberty.[4] Some commentators have looked to the analogy for just this purpose. For instance, Steve Clarke examines ways to provide alternative service, for example, when someone with an objection to combat serves in a noncombat role.[6] Thus I agree that the analogy to military conscription can provide some insight into how to procedurally manage conscientious objection in health care.

Despite the particularly useful aspects of the analogy to military conscription, however, it has important weakness—namely, the fundamentally distinct organization, structure, and operation of each field means that conscience must be addressed in their respective contexts. In other words, just because conscience is operative in both fields, it does not follow that it should be dealt with in exactly the same way. This is especially true when the practice of medicine is predicated on the prudence of the physician. Compelling a physician to act against what he judges in conscience to be best is to compel him to be imprudent—a perversion of medicine itself. Finally, beyond these significant weaknesses of the analogy to military conscription, it is a leap in logic—I would argue, one driven by ideology—to use the analogy to systematically purge or exclude physicians who would practice on the basis of values that differ from the values of those entrenched in power, as Stahl and Emanuel (and others like Udo Schuklenk, Ricardo Smalling, and Julian Savulescu) propose.[7] The debate over conscience in medicine is an important one, and we should examine every means that can help advance a reasonable solution that preserves conscience protections. The analogy to military conscription

has some value in certain respects, but it is not the end of the debate.

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1. Dominic R. Mangino, "The Internal Morality of Conscience: A Response to Ronit Stahl and Ezekiel Emanuel," *National Catholic Bioethics Quarterly* 17.4 (Winter 2017): 595–603.

2. Ronit Y. Stahl and Ezekiel J. Emanuel, "Physicians, Not Conscripts: Conscientious Objection in Health Care," *New England Journal of Medicine* 376.14 (April 6, 2017): 1380–1385, doi: 10.1056/NEJMsb1612472.

3. See Elliott Louis Bedford, "The Concept of Institutional Conscience," *National Catholic Bioethics Quarterly* 12.3 (Autumn 2012): 409–420; and Elliott Louis Bedford, "The Reality of Institutional Conscience," *National Catholic Bioethics Quarterly* 16.2 (Summer 2016): 255–272.

4. Compare with Robert K. Vischer, *Conscience and the Common Good: Reclaiming the Space between Person and State* (New York: Cambridge University Press, 2010); and Martha Nussbaum, *Liberty of Conscience: In Defense of America's Tradition of Religious Equality* (New York: Basic Books, 2008).

5. Eva LaFollette and Hugh LaFollette, "Private Conscience, Public Acts," *Journal of Medical Ethics* 33.5 (May 2007): 249–254, doi: 10.1136/jme.2007.020727.

6. Steve Clarke, "Conscientious Objection in Healthcare, Referral and the Military Analogy," *Journal of Medical Ethics* 43.4 (April 2017): 218–221, doi: 10.1136/medethics-2016-103777.

7. Udo Schuklenk and Ricardo Smalling, "Why Medical Professionals Have No Moral Claim to Conscientious Objection Accommodation in Liberal Democracies," *Journal of Medical Ethics* 43.4 (April 2017): 234–240, doi: 10.1136/medethics-2016-103560; and Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 332.7536 (Feburary 2, 2006): 294–297, doi: 10.1136/bmj.332.7536.294.