

The Celestial Fire of Conscience

Editor's note: We received many letters on the Perspective article by Charo (June 16 issue).¹ We publish two from each end of the spectrum.

1. Charo RA. The celestial fire of conscience — refusing to deliver medical care. *N Engl J Med* 2005;352:2471-3.

TO THE EDITOR: With regard to the Perspective article by Charo on conscience clauses, I am disappointed by the treatment of a very serious topic in medicine. The debate over conscience is an important one for both providers and patients. Charo offers distortions of the proposed Wisconsin law, as well as a very biased approach. Even the title frames the discussion in terms of the refusal of care. I urge readers to read the proposed law for themselves.¹ In the included legislative analysis, it is plain that the law would leave in place current law that deems it unprofessional to fail to make a good-faith effort to refer a patient.

It is also surprising that Charo does not mention the protection in the bill for nurses, medical students, and others in employee relationships who are being fired, harassed, and coerced into actions that they find morally troubling. It seems to me that she would be the “moral busybody” in forcing a medical student or nurse to violate his or her own conscience. That would be the worst “tyranny.” I hope that in the future the *Journal* will deal with this topic in an honest and balanced manner.

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1. History of Assembly Bill 207. Madison: Wisconsin State Legislature (updated June 14, 2005). (Accessed September 1, 2005, at <http://www.legis.state.wi.us/2005/data/AB207hst.html>.)

TO THE EDITOR: Charo links the “abortion wars” to the refusal by medical personnel to collaborate in certain acts. It is not accurate, however, to assert that medical care or services are being refused. Real medical care and services always respect human life. No one should be forced to collaborate in abortion (even when it is achieved through the prevention of implantation), lethal research on embryos, euthanasia, or assisted suicide. Regardless of their legal status, all these acts involve the deliberate destruction of innocent human beings. Conscience is indispensable in preventing even remote

collaboration in these and in other wrong actions,¹ particularly when the law fails to promote self-evident ethical principles. Our government may one day legalize the persecution of doctors, nurses, and pharmacists who refuse to act unethically. Until that time, these health care professionals have the right and obligation of conscientious refusal.

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1. Wiesel E. Without conscience. *N Engl J Med* 2005;352:1511-3.

TO THE EDITOR: Kudos to Charo for reminding us that doctors, hospitals, pharmacists, and pharmacies enjoy monopolies much like those of public utilities — and have commensurate service obligations. Imagine if electric utilities refused service to anyone conducting stem-cell research. At least the victims would know that they had been cut off. Patients who are refused all care and information, however — such as the rape victim who can find no one to tell her where to obtain emergency contraception — are left in a more sinister darkness. A patient justifiably expects care providers to use medicine's full powers to relieve her suffering. If doing so makes a doctor or pharmacist uncomfortable, he or she should say so and refer the patient elsewhere. Failing that, such professionals should post a sign with this language: “To express our religious or personal beliefs, or both, we may intentionally fail or even refuse to inform you of the existence of safe, legal therapies meeting your needs.” That might restore some semblance of informed consent. Until then, patient, beware.

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TO THE EDITOR: It is curious that pharmacists might refuse to fill a prescription. Must all the prescriptions they fill result from morally acceptable diag-

noses? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not allow breaches in confidentiality about diagnoses and therapies so that strangers can make individual judgments about whether to cooperate in treating a patient. A prescription may be written for a diagnosis of which the pharmacist is unaware (e.g., oral contraceptives to treat ovarian dysfunction). There are many other people involved in every patient's care. What if receptionists refused to make an appointment or refused to give the physician a telephone message because they did not approve of something? The pharmacist might refuse to fill a prescription, the cashier might refuse to sell the prescribed item, or the driver of the distributor's delivery truck might refuse to transport it. Why is the pharmacist's moral judgment dominant? Ethically, there should be open disclosure that some prescribed drugs, products, or services will not be provided. Disclosure is also ethically required for diagnoses, symptoms, or clinical issues about which the pharmacist, health care worker, or others in the chain of health care delivery have such feelings that their cooperation in the care of patients is compromised. Will this trend inevitably lead to a balkanization of medicine, whereby pa-

tients will go only to doctors of their own sect, who prescribe only for pharmacists of that sect, and refer only to specialists of that sect? Shouldn't patients be warned?

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PROFESSOR CHARO REPLIES: With regard to Dr. Lee's comment that the proposed Wisconsin legislation does not eliminate a health care provider's duty to provide a referral after refusing to perform a service, I would note that Assembly Bill 207 (passed June 14, 2005, and now pending in the state senate) specifically permits health care providers' refusals to "participate in" services they find personally objectionable, with "participate in" specifically defined in section 2(c) as "to perform; practice; engage in; assist in; recommend; counsel in favor of; *make referrals for*; prescribe, dispense or administer drugs" (emphasis added).

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The VA and Medicare HMOs — Complementary or Redundant?

TO THE EDITOR: U.S. veterans over the age of 65 years may be eligible to enroll in both the Veterans Affairs (VA) health care system and Medicare health maintenance organizations (HMOs).¹⁻³ Although dual use of the systems has been described,⁴ use of health care services by these veterans has not been reported.

Using a cross-sectional survey design, we serially interviewed veterans over the age of 65 years who were receiving primary care from the Denver VA and who had been enrolled in a Medicare HMO for more than six months. We assessed the reasons why veterans joined Medicare HMOs and their self-reported use of health care services. Of the 113 eligible patients screened, 105 consented to participate in the survey (93 percent). On average, subjects were 74 years old; 93 percent of them were male, 76 percent were married, 83 percent were white, and 63 percent had service-connected eligibility for

the health plans. The most commonly cited reasons for HMO enrollment were lower out-of-pocket expenses (e.g., deductibles for emergency transportation) (39 percent), enrollment with a spouse (e.g., "spouse needed insurance") (18 percent), and provision of services not available at the VA (e.g., dental services) (13 percent); 15 percent did not specify why they had joined the HMO.

Assessment of self-reported use of services the previous year revealed that 41 percent had received primary care from both the VA and the Medicare HMO. Although most patients received medications exclusively from the VA (78 percent), 18 percent received medications from both the VA and the HMO. One third reported complementary use of services from the VA and the HMO (e.g., primary care from the VA and subspecialty care from the HMO). Twenty-five percent had not received any care from the HMO in the previous year, and no pa-