Special Section: Open Forum

# *Conscience-Based Exemptions for Medical Students*

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Just as physicians can object to providing services due to their ethical and/or religious beliefs, medical students can have conscience-based objections to participating in educational activities.[1] In 1996, the Medical Student Section of the American Medical Association (AMA) introduced a resolution calling on the AMA to adopt a policy in support of exemptions for students with ethical or religious objections.[2] In that report, students identified abortion, sterilization, and procedures performed on animals as examples of activities that might prompt requests for conscience-based exemptions (CBEs). In response to the student initiative, the Council on Medical Education recommended the adoption of seven "principles to guide exemption of medical students from activities based on conscience."[3] The House of Delegates adopted these principles in their entirety.[4]

## Reasons for Granting CBEs

Why should medical schools grant, or at least seriously consider, students' requests for CBEs? Why, it might be asked, isn't it justified to respond by dismissing such requests, reminding students that they are, after all, *students*, and pointing out that all students must complete the applicable curricular requirements? There are several reasons for rejecting this response.

First, a policy of categorically denying medical students' requests for CBEs may have the unintended consequence of diminishing their ethical sensitivity. To be sure, ethics education requires familiarizing students with the accepted standards of the profession. However, if faculty and administrators discount students' ethical and religious beliefs, they may inadvertently communicate the message that ethics does not matter. That is, students might come to believe that success requires unquestioning accommodation to the established culture and suspension of ethical judgment. Accordingly, summarily dismissing students' conscience-based objections might discourage ethical analysis and desensitize them to ethical concerns.

Studies of medical students suggest that a concern about ethical desensitization is not unfounded. A survey of clinical medical students at the University of Toronto reported that 47% of respondents (48 of 103) replied that they felt pressured to act unethically very frequently, frequently, or occasionally.[5] The authors suggest that an inattention to students' ethical perceptions and concerns is one of the "deleterious aspects of the 'hidden curriculum' which currently hinder the ethical growth of medical students."[6] Another study reported that medical students experience "ethical degradation" during their clinical clerkships.[7] Sixty-seven percent felt bad or guilty about something they did during



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a clinical clerkship, 62% believed they had experienced an erosion or loss of some of their ethical principles, and 38% were displeased with their ethical development. Sixty-five percent of the student respondents reported feeling either very or somewhat uncomfortable challenging other members of the healthcare team. Accordingly, one possible explanation for the students' reported ethical deterioration may be their perception that an exploration of their ethical concerns would not have been welcomed by other members of the healthcare team.

Second, because students may have valuable ethical insights, sometimes granting CBEs can serve as a catalyst for improving the ethical environment within a school and possibly even within the medical profession. Initially, only a few ethical outliers might seek exemptions for reasons of conscience. However, taking their conscience-based objections seriously and granting them exemptions may initiate a process of reexamination that eventually results in an ethically improved environment for all students.

This point is illustrated by medical student opposition to the use of animals, one of the issues identified in the 1996 AMA Medical Student Section resolution. Prior to that year, a growing number of medical students objected to the use of animals for instruction, and some medical schools granted exemptions to individual students.[8] Prompted in part by student protests, medical schools found alternative instructional aids, such as videos and computer simulations, some of which were also more cost-effective. According to the Physicians Committee for Responsible Medicine, as of June 2009 only eight U.S. medical schools use animal laboratories for student training.[9] It would be difficult to justify continuing to require students to dissect and perform procedures on live animals who are eventually killed if there are alternatives that are more cost-effective and no less sound educationally. In this case, then, student objections appear to have acted as a catalyst of ethical improvement—a process that began by granting CBEs to individual students.

Third, a policy of categorically refusing all requests for CBEs can undermine the goal of maintaining a diverse student population and, thereby, present a barrier to achieving diversity in the medical profession. For example, a policy of categorically dismissing Muslim students' requests for exemptions from a curricular requirement that is contrary to their religious beliefs will tend to discourage observant Muslims from attending a medical school. As a result, observant Muslims are unlikely to be included in the populations of schools with such a policy, which also will present an obstacle to observant Muslims who aspire to enter the medical profession.

Finally, denying students' requests for CBEs fails to respect, and threatens to undermine, their moral integrity. There are several reasons for respecting and not undermining a student's moral integrity. First, moral integrity is a generally recognized value. People tend to value moral integrity, and medical students are no exception. For students with conscience-based objections, maintaining their moral integrity can be of utmost importance to them. Second, respect for persons requires respect for moral integrity. Third, insofar as maintaining moral integrity requires adherence to a person's core ethical beliefs—beliefs that in part define one's identity or self-conception—its loss can be experienced as "self-betrayal" and diminished self-respect. Fourth, even when students' ethical and/or religious concerns are given a sympathetic hearing, insofar as denying their requests undermines their moral integrity, it can also promote moral desensitization.



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## Reasons for Denying CBEs

Even if it would be mistaken to categorically deny medical students' requests for CBEs, it would be no less mistaken to automatically grant them. There are competing values and interests that need to be considered when determining whether or not to grant such exemptions. The following are the primary considerations that can justify denying CBEs: established core educational requirements, "local" core curricula, nondiscrimination, impact on patients, and impact on substitutes and supervisors.

### *Established Core Educational Requirements*

Because core educational requirements for a particular profession purport to identify the essential components of a curriculum for that profession, it generally is justified to deny CBEs from those requirements. Accreditation standards for schools of medicine express the profession's conception of core educational requirements. Because professions have considerable discretion in setting entry requirements and standards of competence, accreditation standards generally provide an authoritative basis for identifying core educational requirements for medical schools.[10]

The Liaison Committee on Medical Education (LCME) is the accrediting authority for medical education programs leading to the M.D. degree in the United States and Canada. The LCME stipulates that each medical school's curriculum "must include the contemporary content of those disciplines that have been traditionally titled anatomy, biochemistry, genetics, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine."[11] LCME standards also state that if medical schools do not require students to complete clerkships offering clinical experience in family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery, they "must ensure that their students possess the knowledge and clinical abilities to enter any field of graduate medical education."[12]

The American Association of Medical Colleges (AAMC) offers another set of curricular guidelines for medical students in a 1998 report by the Medical School Objectives Project (MSOP).[13] All accredited medical schools in the United States and Canada are members of the AAMC, which has the recognized authority to establish curricular guidelines. The stated aim of the MSOP was "to develop a consensus within the medical education community on the attributes that medical students should possess at the time of graduation, and to set forth learning objectives that can guide each medical school as it establishes objectives for its own program."[14] The MSOP report includes a list of knowledge, skills, and abilities that each student must acquire and demonstrate prior to graduation, including the following:

Knowledge of/about:

- the normal structure and function of the body and of each of its major organ systems
- the various causes of maladies and the ways in which they operate on the body



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- the altered structure and function (pathology and pathophysiology) of the body and its major organ systems that are seen in various diseases and conditions
- the most frequent clinical, laboratory, roentgenologic, and pathologic manifestations of common maladies
- relieving pain and ameliorating the suffering of patients

The ability to:

- perform both a complete and an organ system specific examination, including a mental status examination
- construct appropriate management strategies (both diagnostic and therapeutic) for patients with common conditions, both acute and chronic, including medical, psychiatric, and surgical conditions, and those requiring short- and long-term rehabilitation
- recognize and outline an initial course of management for patients with serious conditions requiring critical care.

If granting a CBE will result in a student's failure to satisfy a component of such established core requirements, a medical school *may* justifiably deny the exemption. However, when core curriculum requirements are not *fully* satisfied, a medical school might nevertheless determine that *partial* satisfaction in special cases can be *sufficient*. For example, medical schools might grant exemptions to accommodate students with disabilities. Similar accommodations might be made for students with conscience-based objections to participating in an activity without which a core requirement will not be fully satisfied. It seems appropriate for medical schools to at least retain limited discretion in relation to such judgments in individual cases. Ultimately, however, the LCME has the authority to determine whether a medical school's criterion of sufficiency is within an acceptable range.

Both the LCME standards and the AAMC curricular guidelines provide a basis for denying a CBE to a student who refuses to participate in any activities that involve observing and touching bodies and body parts or even viewing images of them. But, what about more realistic cases in which a student refuses only to touch cadavers or perform examinations on members of the opposite sex?[15] The answer in both cases requires a determination of the extent to which the refusal at issue will result in a student's failure to satisfy established curricular standards. For example, if required knowledge and skills are usually acquired from dissecting human cadavers and there are no effective alternative means for students to satisfy those requirements, established curricular standards would support denying an exemption to students with conscience-based objections to dissecting human cadavers. Similarly, if required knowledge and skills are usually acquired from examining members of the opposite sex, and if there are no effective alternative means for students to satisfy those requirements, established curricular standards would support denying an exemption.[16]

Neither the LCME nor the AAMC standards provide a basis for denying CBEs from participating in abortions. However, when determining whether granting a CBE is compatible with established curricular standards, it can be important to distinguish between two kinds of exemptions: (1) exemptions from observing or



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assisting in the provision of a health service and (2) exemptions from learning about indications, contraindications, benefits, risks, complications, and so forth. Even if it is compatible with established curricular standards to grant students exemptions from *observing* or *participating* in the provision of a service that violates their ethical and/or religious beliefs, to satisfy those standards it may still be necessary for students to *understand* relevant basic science and clinical information. Such cognitive knowledge is essential for identifying the appropriate standard of care and is needed to inform, counsel, and refer patients. Moreover, it is required for proper follow-up care, treatment of complications, and so forth. In relation to abortion, a medical school curriculum committee might interpret established standards to require an understanding of the relevant basic science, clinical indications, methods, complications, and postabortion care. This appears to be a reasonable interpretation of established curricular standards and therefore does not exceed a school's legitimate interpretive discretion. Accordingly, a medical school might justifiably deny CBEs from activities designed to achieve the specified cognitive goals related to abortion.

Generally, it is warranted to deny CBEs from course or clerkship requirements that aim to increase cognitive knowledge and understanding and do not require students to perform actions (excluding reading and attending lectures and seminars) that violate their ethical and/or religious beliefs. Without such cognitive knowledge conditions cannot be properly diagnosed and the appropriate standard of care cannot be identified. For example, some Muslim students in the United Kingdom reportedly have refused to learn about alcohol-related or sexually transmitted diseases because it offends their religious beliefs.[17] Without such knowledge, however, they will not be able to perform satisfactory differential diagnoses because they will not recognize the specific symptoms of alcohol-related or sexually transmitted diseases. In addition, without comprehensive cognitive knowledge and understanding, students and physicians may not be able to accurately determine which, if any, services and medications are incompatible with their ethical and/or religious beliefs. For example, without an understanding of the mechanisms of Plan B (emergency contraception), no informed decision can be made about whether a conscience-based objection to contraceptives with postfertilization effects applies to it.

### *Local Core Curricula*

Established core educational requirements serve as general minimal standards. Accordingly, it generally is justified to deny CBEs from satisfying core educational requirements. Medical schools have limited discretion to grant exemptions from activities that are needed to *fully* satisfy core requirements. They also can *add* requirements to create a "local" core curriculum that is more extensive than the established core. Additional local requirements can be based on the judgment that certain areas not included within the established core should nevertheless be part of each student's medical education. For example, a curriculum committee might decide to require all students to complete an extensive scholarly research project. This decision might stem from a belief that, despite its exclusion from the established core, an ability to conduct scholarly research is properly part of a core curriculum. Alternatively, it might reflect only a commitment to a curricular profile for that school. For example, a particular school might aim to distinguish



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itself for its commitment to training clinician–scientists with an ability to conduct scholarly research. Decisions to add curricular requirements beyond established core requirements also can be based on a school's social mission. For example, a medical school in a mostly rural state might require all students to receive instruction oriented to practicing in rural areas. This requirement might be based on the goal of producing graduates who will have specialized training to enable them to better serve rural populations.

Requirements that students complete an extensive scholarly research project or receive instruction that will enable them to better serve rural populations are hardly controversial. As long as the school's particular profile is clearly communicated to prospective applicants, anyone who is not interested in the distinctive areas of a school's local core curriculum can apply to schools that do not have these additional core requirements. Conversely, schools with distinctive local core curricula are likely to attract applicants with corresponding interests. For example, a medical school with a local core requirement that all students complete an extensive scholarly research project is likely to attract applicants with corresponding interests.

It might be objected that because financial considerations can limit applicants to their own state's public medical school(s), a resident of a state in which all public medical schools have curricular requirements beyond the established core would have no real options. However, even if some applicants are left with little, if any, choice, as long as the curricular requirements are not arbitrary and are reasonably related to a legitimate objective, such as maintaining rural residents' access to important health services, generally it is ethically acceptable for medical schools to add local requirements to the established core.

Although students may want to opt out of research and rural training requirements for a variety of reasons, such requirements are unlikely to occasion requests for CBEs. By contrast, a local family planning instruction requirement may well occasion conscience-based refusals by medical students. As in the case of a research requirement, this requirement might derive from a local conception of a core education. Alternatively, it might derive from an institution's social mission. For example, the family planning instruction requirement might be based on the goal of sustaining patients' access to family planning services.

May a medical school with a family planning instruction requirement justifiably deny exemptions to students with conscience-based objections to family planning? Recalling a distinction introduced earlier, there are two types of requirements in relation to family planning instruction: (1) a requirement to learn about the various options, their relative effectiveness, and their respective benefits and risks and (2) a requirement to provide or assist in providing information and contraceptives to patients. Insofar as it is generally justified to refuse to exempt students from cognitive requirements, a school may justifiably refuse to grant CBEs from the first set of requirements. However, it remains to be considered whether a local requirement to *participate* in family planning activities can justify denying students an exemption from participating in those activities.

It might be argued that the reason for objecting to a local requirement does not matter. Suppose students are unwilling to receive instruction in rural medicine or family planning because they have no interest in practicing in a field in which the corresponding skills would be relevant. If medical schools may justifiably refuse to exempt such unwilling students from a requirement to receive instruction in



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rural medicine or family planning, why may they not also justifiably refuse to exempt students whose unwillingness is based on their ethical and/or religious beliefs?

One obvious answer is that, for the reasons previously identified, refusals based on ethical and/or religious beliefs merit special consideration. But does this special consideration preclude justifiably denying CBEs from local requirements that are reasonably related to a legitimate objective? Suppose medical school $MS_1$ clearly communicates to applicants the expectation that all students must satisfy a requirement to receive family planning instruction. $MS_1$ also explains the basis for this requirement: a commitment to provide instruction that will contribute to maintaining a sufficient supply of physicians to meet the demand for this crucial health service. Ms. A wants to attend $MS_1$ but is unwilling to receive family planning instruction due to her religious beliefs. There are two other schools, $MS_2$ and $MS_3$, comparable to $MS_1$, that have admitted Ms. A. Under these conditions, Ms. A would not be faced with a decision between pursuing a career in medicine and the dictates of her conscience. At most, it might be said that, as a result of the policy of $MS_1$, Ms. A is presented with a choice between attending $MS_1$ and violating her religious beliefs or attending $MS_2$ or $MS_3$ and not violating them.

In the real world, however, applicants' choices can be limited by financial and other factors, such as test scores, grades, recommendations, income, and family circumstances. Moreover, $MS_1$ may be able to satisfy its commitment to producing physicians who can provide family planning services without requiring *all* students to receive such instruction. Thus, some flexibility may be warranted. For example, $MS_1$ might communicate to applicants that exemptions to its family planning instruction requirement can be granted—but only at the school's discretion and only in special circumstances. Applicants might be invited to submit in writing reasons why they should be granted an exemption, and some or all might be invited for a follow-up personal interview. Alternatively, applicants might be asked to present their reasons in person. No one has a right to attend medical school, let alone to be accepted by a particular school. Nevertheless, in view of the reasons for accommodating conscience-based objections, it would be regrettable if admissions committees did not at least make a reasonable effort to avoid placing otherwise qualified applicants in a situation of having to choose between the dictates of their conscience and a career in medicine. Ultimately, however, it is within the discretion of $MS_1$ to decide on the basis of its mission to deny exemptions to its family planning instruction requirement.[18]

A school of medicine that has as part of its mission producing physicians who will sustain women's access to abortion might cite that mission in an attempt to justify requiring all students to receive abortion training. However, there are several reasons to treat abortion as a special case and for all schools of medicine, notwithstanding their specific missions, to grant exemptions to students with conscience-based objections to performing and/or assisting in performing abortions.

First, two U.S. federal laws protect students and applicants with conscience-based objections to abortion. The Coats Amendment prohibits the federal government as well as state and local governments that receive federal funds from discriminating against any "participant in a program of training in the health professions" who refuses abortion training.[19] A section of the Church



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Amendment states that no "entity" that receives certain federal funds "may deny admission or otherwise discriminate against any applicant . . . 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."[20] Although neither law explicitly prohibits medical schools from requiring abortion training, they offer special protection for students and applicants with conscience-based objections to abortion.

Second, as evidenced by the Coats and Church Amendments, of all legal and professionally accepted medical procedures, abortion is undoubtedly the most divisive and controversial. Disagreements about abortion reflect differences in core beliefs about moral standing, the value and meaning of human life, personhood, autonomy, and sex. Accordingly, it would seem especially important to make reasonable efforts to avoid confronting individuals with a choice between receiving medical education or not violating their conscience-based objections to abortion.

Third, CBEs in relation to abortion are firmly established and entrenched in law as well as practice. As a result, there may well be a legitimate expectation that exemptions will be granted for students who cannot in good conscience participate in performing abortions. Because medical schools routinely grant exemptions for students with a conscience-based objection to participating in abortions, granting such exemptions will only minimally burden faculty and administrators. Moreover, compared to less routinely granted exemptions, students who do not seek to be excused from abortion-related activities are more likely to accept CBEs for those who do and also are less likely to experience associated additional work assignments as an undue burden.

For all these reasons, then, and notwithstanding their special missions, it is appropriate for medical schools to treat conscience-based refusals to participate in abortion as a special case. However, the cumulative effect of granting CBEs in relation to abortion training can be a legitimate overriding consideration. Accordingly, a school of medicine might justify denying such exemptions by citing evidence that the cumulative effect over time of granting them is likely to be an insufficient supply of physicians to meet the demand for abortion.

### *Nondiscrimination*

A prohibition of invidious discrimination is the basis of another justification for denying medical students' requests for CBEs. Insofar as it is wrong to discriminate on the basis of race, ethnicity, national origin, age, religion, sex, sexual orientation, and gender identity, it is justified to deny students' requests for CBEs if they have a discriminatory basis. Arguably, when requests for CBEs are based on invidious discrimination, it is wrong to grant them.

The wrongness of invidious discrimination is recognized by LCME accreditation standards. Standard MS-31, states: "In the admissions process and *throughout medical school*, there should be no discrimination on the basis of gender, sexual orientation, age, race, creed, or national origin."[21] Standard MS-31-A, which first took effect on July 1, 2008, states: "Medical schools must ensure that the learning environment for medical students promotes the development of explicit and appropriate professional attributes (attitudes, behaviors, and identity) in their medical students."[22] Because invidious discrimination is ethically unacceptable



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when physicians decide whom to accept as patients,[23] medical schools would fail to satisfy this standard if they were to grant CBEs that enabled students to practice invidious discrimination.

A medical student's refusal to examine members of the opposite sex can, but need not be, an instance of invidious discrimination. For example, if it is based on a general religious proscription against viewing uncovered bodies of members of the opposite sex, absent disdain, contempt, disrespect, and the like, the refusal cannot be characterized as an instance of invidious discrimination. By contrast, there is invidious discrimination if a male medical student's objection to performing examinations on women is based on beliefs about the inherent inferiority and/or uncleanliness of women and/or their bodies. However, if there is a benign basis for the objection, the charge of invidious discrimination may be unwarranted. In such cases, the best response to requests for exemptions may be to attempt to strike a reasonable balance between tolerance of religious and cultural diversity and intolerance of invidious discrimination.

### *Impact on Patients*

An expected negative impact on patients' well-being can provide another justification for denying medical students' requests for CBEs from clinical activities. Denying an exemption is justified if patient harm is a foreseeable result of granting it. For example, if an induced abortion is performed on an emergent basis, and a student's assistance is essential during or after the procedure, it is justified to deny a request for an exemption. In nonemergent situations, it is justified to deny a student's request for an exemption if no substitute is available and it is expected that the patient will not receive an acceptable standard of care if an exemption is granted.

In both emergent and nonemergent situations, the timing of requests for CBEs can be crucial. Granting unanticipated last minute requests runs the highest risk of negatively impacting patients. By contrast, if requests for exemptions are made well in advance, more time is available to make arrangements for substitutes so that patients are not harmed. Accordingly, a concern for patient well-being might justify denying last-minute requests for exemptions even if similar requests could have been granted without jeopardizing patient well-being if they had been presented earlier. However, when suitable substitutes are not available, an overriding concern for patient well-being can justify not granting even timely requests for CBEs.

When considering the potential impact on patient care and well-being, it is appropriate to consider the cumulative impact of granting similar exemptions. For example, depending on the composition of the student body and the corresponding patient population, whereas exempting one medical student from providing information about family planning may not have any negative impact on patient care, granting a similar CBE to all students who request it might.

### *Impact on Substitutes and Supervisors*

Beyond the potential negative impact on patient well-being, CBEs from clinical activities can have additional disruptive effects that provide reasons for denying them. When medical students are exempted from participating in clinical activities,



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other members of the healthcare team (e.g., students, interns, or residents) may have to fill in. When replacements or substitutes are required, depending on the circumstances, there can be three reasons for not granting CBEs from clinical activities: (1) No suitable substitutes are available, (2) an undue burden will be placed on substitutes, and (3) the process of securing substitutes gives rise to excessive administrative burdens or inconvenience.

With respect to the first reason, if providing an acceptable standard of care requires substitutes and no substitutes are available, requests for CBEs justifiably may be denied. As the second reason suggests, when someone (e.g., another student) has to take over the responsibilities of a medical student who is granted a CBE, the workload of the replacement may increase. To be sure, it may be possible to reassign responsibilities among exempted students and their replacements in such a way that there are no significant changes in workloads. However, if an exemption results in a significantly decreased workload for an exempted student and/or a significantly increased workload for someone else, the latter may be in a position to justifiably object that the reassignment is unfair. Although a willingness to accommodate students with conscience-based objections is desirable, there are limits to what can be expected of others to facilitate such accommodations. There may be no clear line separating reasonable and excessive burdens, but wherever the line is drawn, CBEs justifiably may be denied if granting them is expected to impose excessive burdens on other students.

To turn to the third reason, reassigning responsibilities in order to accommodate medical students who request CBEs from clinical activities can increase the workload of supervisors (e.g., residents or faculty). One means to minimize such additional burdens is to require students who request CBEs to find substitutes. However, even if students have to identify willing substitutes, supervisors still bear the ultimate responsibility for oversight and assuring that there will be no gaps in providing services to patients. Once again, there may be no clear line separating reasonable and excessive burdens, but wherever the line is drawn, CBEs justifiably may be denied if granting them is expected to impose excessive burdens on supervisors.

When considering potential impact on substitutes and supervisors, it is appropriate to consider the cumulative impact of granting similar exemptions. Whereas granting a one-time exemption to one student may not be unduly burdensome, depending on the composition of the student body and the corresponding patient population, granting all students with conscience-based objections a standing exemption from participating in a clinical activity might be excessively burdensome.

## Policies and Procedures

By enacting a CBE policy and clearly communicating it to applicants as well as students, medical schools can facilitate informed choices and consistency and minimize contention and disagreement due to ambiguity, confusion, and unrealistic expectations. Enacting such a policy also complies with AMA guidelines that state: "There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies."[24]



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There are several possible options for CBE policies. They can include a list of specific activities that qualify for CBEs. For example, a policy might identify clinical activities related to abortion and sterilization as activities that qualify for CBEs. Policies also might identify areas that do not qualify for exemptions, such as learning the relevant basic science and clinical facts and acquiring the knowledge needed to inform, counsel, and refer patients. Instead of listing specific activities, policies can present general substantive criteria that determine whether or not an exemption will be granted in specific cases. For example, a policy might provide a list of factors that will be considered, such as core educational requirements, nondiscrimination, impact on patients, and impact on other students and supervisors. Policies can also combine both of the foregoing features, providing general guidelines as well as a noninclusive list of activities that normally do and do not qualify for exemptions. Yet another option is to forgo both specific and general substantive criteria and provide instead a process for determining whether requests for CBEs are granted or denied. Policies of this type might require students to explain in writing their reasons for requesting CBEs and/or to explain their views in person to a dean, director, or committee. The policy might also specify an appeals process. Finally, policies can provide specific and/or general substantive criteria as well as procedural rules.

It may well be impossible to anticipate all requests for CBEs. This point is especially pertinent in a country such as the United States that is steadily becoming more and more multicultural. Hence, it may be short-sighted to formulate a policy that provides an inclusive list of activities for which CBEs will be granted. However, a partial list may be appropriate if there are certain activities, such as assisting in performing abortions, for which exemptions will be more or less automatically granted. In the absence of any substantive guidelines, applicants who expect to request CBEs are not given a basis for making informed choices about medical schools.

Requiring students to provide written and/or oral explanations provides an opportunity to assess their reasons as well as their sincerity. It also may discourage attempts to ''game the system.'' If students could automatically receive an exemption by checking a box on a form, some who do not have a conscience-based objection might be tempted to request an exemption to avoid onerous, higher risk, and/or unpleasant tasks. An in-person meeting with an opportunity to question students who request CBEs can enhance understanding of their reasons. An opportunity to engage in dialogue with students also can help to determine if invidious discrimination is a factor. It is justified to deny requests for CBEs on grounds of invidious discrimination or insincerity. However, to deny requests merely because they are deemed to be based on ''unsound values'' would thwart the goals of CBEs.

Whether or not a policy provides specific and/or general substantive criteria, the full advantages of having a policy will be realized only if it includes procedural guidelines that describe the application and decision process. If appeals are allowed, the policy should also include a description of the appeals process. Whatever format is selected, a policy will be effective only if applicants and students are familiar with it or, at the very least, know how to access it. Optimally, the policy should be clearly posted on the school's web site. It should also be available in written material (e.g., student handbooks), and it should be one of the topics discussed during orientation sessions for new students.



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## Conclusion

When deciding whether to grant requests for CBEs, relevant considerations include (1) established core educational requirements, (2) local core curricula, (3) nondiscrimination, (4) impact on patients, and (5) impact on other students and supervisors. By enacting a CBE policy and clearly communicating it to applicants as well as students, medical schools can facilitate informed choices and consistency and minimize contention and disagreement due to ambiguity, confusion, and unrealistic expectations.

## Notes

1. This paper draws on some material that will be published in *Conscientious Objection in Healthcare: An Ethical Analysis* (Cambridge University Press; forthcoming).
2. American Medical Association Student Section Resolution 7-I-96, "Respect for Individual Student's Beliefs" 1996 (in AMA archives).
3. AMA Council on Medical Education Report 4 (A-98), 1998 (in AMA archives). With two exceptions, the recommended principles are procedural. The exceptions are a requirement that patient care not be compromised and a requirement that students "learn the basic content or principles underlying procedures or activities that they exempt." However, even the latter requirement has a procedural escape clause: "Any exceptions to this principle should be explicitly described by the school."
4. AMA Policy H-295.896, "Conscience Clause: Final Report" 1998. Available at http://www.ama-assn.org/ama/no-index/advocacy/8152.shtml.
5. Hicks LK, Lin Y, Robertson DW, Robinson DL, Woodrow SI. Understanding the clinical dilemmas that shape medical students' ethical development: Questionnaire survey and focus group study. *British Medical Journal* 2001;322(24):709–10.
6. See note 5, Hicks et al. 2001:710.
7. Feudtner C, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Academic Medicine* 1994; 69(8):670–9.
8. Dodge S. Under pressure from students, medical schools offer alternatives to use of live animals in experiments. *The Chronical of Higher Education* 1989 Nov 15:A41, A43.
9. Physicians Committee for Responsible Medicine. Medical school curricula with live animal laboratories; available at http://www.pcrm.org/resch/meded/ethics_medlab_list.html (last accessed 30 Jun 2009).
10. There are, of course, external checks and balances that place limits on the discretion of accreditation organizations.
11. Liaison Committee on Medical Education. *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree*. Washington, DC: Liaison Committee on Medical Education; 2008 Jun:8(ED-11); available at http://www.lcme.org/functions2008jun.pdf (last accessed 30 Jun 2009).
12. See note 11, Liaison Committee on Medical Education 2008:8(ED-15).
13. Medical School Objectives Project. *Report I: Learning Objectives for Medical Student Education: Guidelines for Medical Schools*. Washington, DC: American Association of Medical Colleges; 1998 Jan; available at https://services.aamc.org/publications/index.cfm?fuseaction=Product.displayForm&prd_id=198&cfid=1&cftoken=32975D3D-9FEB-7545-A14A9722B4D2FFFD (last accessed 30 June 2009).
14. See note 13, Medical School Objectives Project 1998:13.
15. Some Muslim students in the United Kingdom reportedly have refused to treat patients of the opposite sex. See Foggo D, Taher A. Muslim medical students get picky. *Times Online* 2007 Oct 7; available at http://www.timesonline.co.uk/tol/news/uk/health/article2603966.ece (last accessed 15 Mar 2009).
16. Nondiscrimination might provide another basis for denying requests for CBEs from performing physical examinations on members of the opposite sex. This reason will be considered below.
17. See note 15, Foggo, Taher 2007.
18. This conclusion is consistent with the position of the AMA Council on Medical Education: "It would not be appropriate for an organization other than the medical school attended by the



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student to define, *a priori*, a set of activities for which medical students may be granted an exemption because of conscience or a specific process by which an exemption may be granted. This is because medical schools differ in a variety of ways that could affect the types of exemptions that they grant and the way that exemptions are granted. These differences could include their core mission, religious affiliation, state legal and regulatory requirements, organizational structures, and student body characteristics. Medical schools should be free to develop their own policies related to what activities come under a 'conscience clause,' and how students should go about gaining an exemption from the specified activities"; see note 3, AMA Council on Medical Education Report 4 (A-98) "Conscience Clause."

19. 42 USC § 238n(c)(2) (1996).
20. 42 USC § 300a-7(e) (1973).
21. See note 11, Liaison Committee on Medical Education 2008:20 (emphasis added). The AMA recommended adding gender identity to the list of characteristics that constitute invidious discrimination in relation to admissions (H-295.969, "Nondiscrimination Toward Medical School and Residency Applicants").
22. See note 11, Liaison Committee on Medical Education 2008:20.
23. "Physicians cannot refuse to care for patients based on race, gender, sexual orientation, gender identity, or any other criteria that would constitute invidious discrimination. . ." (*AMA Code of Medical Ethics*, "Potential Patients," E-10.05 [2-b]). Available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1005.shtml (accessed 23 Sept 2009).
24. H-295.896 "Conscience Clause: Final Report."

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