Chapter 8
Conscientious Objection

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Abstract The phrase "*conscientious objection*" appears to have originated from the military service, but today it can be applied in other fields including education, child immunization, and healthcare. In medicine, conscientious objection refers to the right of providers to refuse to participate in certain types of medical care that they object to on religious or moral grounds. Most commonly, conscientious objection in medicine occurs when providers refuse to participate in abortion. However, conscientious objection is a much broader issue and may also apply to a number of medical and quasi-medical interventions including lethal injection, work with prisoners, futile care, and medical research. Conscientious objection is an issue worthy of consideration by every physician because invoking conscientious objection carries professional responsibilities as well as social, professional, and legal risks. In general, a physician will be better positioned to fulfill their professional responsibilities and minimize their professional risks if they prepare in advance.

Keywords Conscientious Objection • Abortion • Right to Privacy • Lethal Injection • Physician-Assisted Suicide • Prisoners • Roe v. Wade

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B.G. Jericho (ed.), *Ethical Issues in Anesthesiology and Surgery*,
DOI 10.1007/978-3-319-15949-2_8

Case Presentation
You are a young anesthesiologist practicing at a community hospital in Oregon and you are consulted to provide better pain management to a terminally ill patient. The patient is a 67-year-old retired nurse with metastatic lung cancer to his brain. His prognosis is very poor and he has, at most, 6 months to live. While interviewing him, he tells you that he is constantly in agony and cannot bear it anymore. He knows that physician-assisted suicide is legal in Oregon and he asks you to help him end his life. What will you do? If you do not believe in suicide, is it appropriate to decline his request? Do you have an ethical obligation to decline his request? If you decide you cannot in good conscience assist in his suicide, what are your professional obligations to him?

Introduction

Conscientious objection in medicine refers to the right of providers to refuse to participate in certain types of medical care that they object to on religious or moral grounds [1]. Most commonly, conscientious objection in medicine occurs when providers refuse to participate in abortion. Not surprisingly, therefore, the invocation of conscientious objection for legal abortion is controversial and a discussion of conscientious objection is often colored by one's views on abortion [2]. However, conscientious objection is a much broader issue that may apply to a number of medical and quasi-medical interventions including lethal injection, care of prisoners, futile care, and medical research. Moreover, conscientious objection has long held a place in history and applies far beyond medicine to many aspects of society and human interaction. Accordingly, thoughtful discourse about conscientious objection requires consideration of not only its application in the context of abortion but also in many other contexts in which it has been invoked.

The History of Conscientious Objection

The phrase "*conscientious objection*" appears to have originated from the military service and in the modern military refers to a "firm, fixed, and sincere objection to participation in a war in any form or to the bearing of arms, by reason of religious training and or belief" [3].

The oldest known conscientious objector to military service was Saint Maximilian of Tebessa who earned his sainthood for his refusal to serve in the Roman Legions on the basis of his Christian beliefs. He was executed on March 12th, 295 AD, and became a martyr for Christianity [4]. In America, the earliest known conscientious objectors were members of religious sects who refused to bear arms or take part in combat during the American Civil War. During World War I, conscientious objectors

were allowed to take non-combatant military roles, but those who refused to serve in *any* position in the military were subjected to imprisonment and even physical abuse [1, 5]. The honorable service received by conscientious objectors, especially during the world wars, has helped to ensure the commitment of the military to the concept of conscientious objection. In fact, the first non-combat conscientious objector to be awarded the Congressional Medal of Honor was Desmond T. Doss, a Seventh Day Adventist who distinguished himself by heroic service as a medic in World War II [6]. Today, the Department of Defense criteria for conscientious objection states that "the belief upon which conscientious objection is based must be the primary controlling force in the applicant's life" [3].

Outside of the military, conscientious objection can be witnessed in education, child immunization, and healthcare. In the United States, compulsory education varies slightly from state to state, but typically begins around the ages of 5–7 and ends between the ages of 16–18 [7]. Home schooling serves as a form of conscientious objection for many parents who would like their children's education to have a certain religious or moral background or who object to some of the classes (e.g. sex education) or topics (e.g. evolution) offered in public schools. Similarly, school immunization laws require parents to vaccinate their children against certain contagious and fatal diseases prior to starting school. However, there are 48 states that allow for religious exemptions and 18 states that allow personal belief exemptions to these immunizations for daycare and school [8]. Many parents elect not to vaccinate their children because of a believed link to autism, although scientific evidence does not support this belief [9]. However, in 2014, an outbreak of measles occurred in the western United States leading to calls for the elimination of conscientious objection exemptions to immunization [10, 11].

The History of Conscientious Objection in Medicine

The history of conscientious objection in medicine is nearly as long as its history in the military. Ironically, given the modern association of conscientious objection to abortion, the original Hippocratic Oath (written in Ionic Greek around the fifth century BC) contained the promise that "I will give no sort of medicine to any pregnant woman, with a view to destroy the child" [12]. Since the Oath was not and is not legally binding, the promise amounted to an assurance that the practitioner would exercise conscientious objection against participation in abortion. But the Oath also called upon physicians to refrain from a number of other interventions: poison, surgery (reserved for surgeons), and broadly to "refrain from injury or wrong from falsehood" [12].

In the United States, the issue of conscientious objection to abortion became acute after the *Roe v. Wade* decision in 1973, in which the Supreme Court found that laws banning abortion were unconstitutional [13]. Congress reacted to *Roe* by passing the Church Amendments that same year, which provide that "receipt of certain federal funds by any individual or entity does not authorize a public authority to

require the recipient to perform or assist in the performance of an abortion or sterilization, make its facilities available for an abortion, or provide personnel to perform or assist in the performance of an abortion or sterilization" [14–16]. In 1996, the Public Health Service Act gave more specific guidelines regarding reproductive rights. These guidelines prohibit the "federal government and any state or local agencies receiving federal financial assistance from discriminating against any health care entity on the basis that: the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions" [15, 17]. More recently, the Affordable Care Act under Section 1303(b)(4) offers health care providers the right to conscientious objection by stating that "No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions" [18].

At the state level, 49 states provide for at least a limited right of conscientious objection for health care providers [19]. In Michigan, for example, the Conscientious Objector Policy Act allows providers to "decline care if that care compromises the provider's beliefs, except in the event of an emergency" [20]. In Mississippi, the Uniform Health-Care Decisions Act provides that "healthcare providers may decline to comply with healthcare decisions for reasons of conscience" [21]. Vermont is the only state that offers no right of conscientious objection to health care providers [19].

Philosophical Underpinnings of Conscientious Objection in Medicine

Conscientious objection has philosophical support from multiple sources both in the United States and internationally. The Constitution of the United States references both a philosophical and legal basis for conscientious objection in the First Amendment [22].

The First Amendment states "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances" [22]. The inclusion of religious freedom in the First Amendment was not an arbitrary choice by the founders. Rather, religious freedom was considered essential to American society and distinguished America (at that time) from most other countries reflecting the strong liberal (in the modern vernacular, "libertarian") philosophical beliefs of the founders. Even in modern times, these protections retain a special place in American society and are treated with the greatest respect by American courts and governmental institutions.

Conscientious objection in the United States is supported primarily by the First Amendment. Certainly, it is argued, one cannot be forced to perform acts contrary

to one's religious or ethical beliefs any more than one can be forced to, for example, pray to a god one does not believe in. Indeed, with respect to religious freedom, the Supreme Court has been particularly sensitive, applying a "strict scrutiny" test to any failure by the government to accommodate religious beliefs and requiring states to show a "compelling interest" for such failures of accommodation [23].

Outside of the United States, a right of conscientious objection is supported by a number of other countries and international organizations. Article 9 of the European Convention on Human Rights provides an explicit right to freedom of thought, conscience, and religion [24]. Though not absolute, Article 9 does provide support for European physicians to conscientiously object to participation in certain care [24]. The British Medical Association supports a conditional right to conscientious objection, and by statute, British physicians may conscientiously object to participate in abortion and fertility treatments [25].

Current Issues Involving Conscientious Objection in Medicine

Abortion

Perhaps more than any other issue, abortion has sharply divided physicians' views on conscientious objection. At one end of the spectrum, Dr. Julian Savulescu, a bioethicist at Oxford, quoted Shakespeare to say that "[c]onscience is but a word cowards use, devised at first to keep the strong in awe." He went on to say that "[i]f people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors" [26]. Dr. Savulescu has brought up a number of concerns regarding conscientious objection by physicians. He notes that conscientious objection in medicine may create barriers and inequality in patient care. For example, if obstetricians refuse to perform abortions, or pediatricians refuse to administer rubella vaccines because the vaccine is developed from aborted fetal cells, then these patients are forced to "shop around" for another doctor who is willing to perform these services. This may create a delay in access to care and be burdensome to the patient. He concludes, therefore, that physicians should set aside their moral objections in deference to the wishes of their patients [26]. Furthermore, since the Supreme Court has found a constitutional right to abortion in the United States, Savulescu's analysis would suggest that American physicians are ethically obligated to participate in abortions when called upon or leave the profession.

However, as noted earlier in our discussion of the philosophical basis of conscientious objection, the Constitution also protects the rights of citizens, including doctors, to be accommodated in their religious beliefs and in their freedom to associate (or not associate) with other citizens. To some extent, the same principles of American freedom that the Supreme Court relied upon to support a right to abortion also lend support to a physician's right to conscientious objection.

In 1973, a single pregnant woman challenged the constitutionality of the Texas abortion laws in a class action suit, *Roe v. Wade*. At that time, it was illegal for women to obtain or even attempt to obtain abortions in Texas, except under circumstances where continuation of the pregnancy would jeopardize the mother's life. Roe eventually won the lawsuit as the district court ruled the Texas abortion laws to be vague and to have abridged her rights under the 9th and 14th amendments [13]. In its reasoning, the court reviewed the protection offered by the Constitution for citizens against governmental intrusion into their beliefs and expressions regarding certain "fundamental" areas including: marriage, procreation, contraception, family relationships, child rearing and education. This right to privacy, nowhere specifically mentioned in the Constitution but implied by the "penumbra" of the Bill of Rights, was found by the Court to mean that a person has the right to follow their conscience in these intensely personal areas of life [13, 27, 28].

The reasoning of the Supreme Court in *Roe* was the culmination of academic theory and legal precedent beginning with a law review article written in 1890 by then lawyer and later to be Supreme Court Justice Louis Brandeis entitled, "The Right to Privacy." In "The Right to Privacy" Louis Brandeis advocated for the "right to be let alone" [27]. This concept was developed further in a series of court decisions to encompass the liberty of personal autonomy, belief, and privacy protected by the 1st, 4th, 5th, 9th, and 14th amendments. In Roe's case, this penumbra of rights was deemed broad enough to protect her "decision whether or not to terminate her pregnancy" based upon her consideration, in consultation with her physician, of the many medical, psychological, social, and other factors involved [13, 27]. Thus, the *Roe* court not only honored her decision but also her right to make her decision based on her own ethical principles and practical reasons.

Certainly, physicians, like other citizens, are entitled to their own sphere of privacy just as the Court found applicable to *Roe*. The question, then, is whether that sphere of privacy extends to physicians' decisions about whether to provide certain services to their patients. Savulescu makes the argument that it does not and that physicians, in effect, should leave their personal beliefs at home [26]. However, just as a law criminalizing abortion represents a heavy interference by government into an area of fundamental belief, a prohibition on conscientious objection to abortion would represent a heavy interference by government upon beliefs that carry what the British Medical Association calls great "moral seriousness" [25]. Moreover, while those considering medicine as a career could conscientiously object by not becoming physicians or by choosing specialties where they would not be asked to participate in abortion, most of the same benefit to the patient could be achieved through simple referral to another provider. Concerns about the need to "shop around" for physicians willing to provide abortion services seem anachronistic in modern America where diversity of opinion is prevalent and transportation is relatively cheap. Moreover, in a country that provides for conscientious objection to armed conflict even in an all-volunteer army (on the rationale that a soldier might have a change of beliefs while in service) [1], the notion that those entering medicine should be required to "fish or cut bait" at an early stage of their careers without any tolerance for change in beliefs is draconian and unrealistic.

Prisoners

On December 9, 1946, an "American military tribunal opened criminal proceedings against 23 leading German physicians" [29]. Although formally titled *United States of America v. Karl Brandt, et al.*, the trial became known as the "Doctor's Trial." The doctors were all involved in planning or participating in the "Euthanasia" program in Nazi Germany. In this program, those deemed "unworthy of life" including the mentally retarded, institutionalized mentally ill, and physically impaired were killed. In addition, some of the physicians conducted medical experiments on concentration camp prisoners without the prisoners' consent. The criminal allegations against them included murder and torture [29].

At Guantanamo Bay, the United States has and continues to imprison people designated as "enemy combatants" [30]. It is estimated that at least 780 people have been imprisoned at Guantanamo since 2002 [30]. As of June 2014, 7 prisoners had been convicted of crimes or accepted guilty pleas, approximately 600 had been released without charges, and 149 remained in custody, of whom only 6 had charges of any kind pending [31]. According to the President of the United States, in the course of some Central Intelligence Agency interrogations, "we tortured some folks" [32]. Some of the Guantanamo Bay prisoners were subject to "enhanced interrogations" in which they were exposed to "some beatings", restrained for extended periods in "forced positions", and exposed to "temperature extremes" [33]. Furthermore, some prisoners were subjected to "*waterboarding*", a technique designed to simulate drowning [34]. By report, the basic method of interrogation used was devised by psychologists under contract to the United States government [35]. Also by report, a number of physicians were involved in various aspects of the prisoners' treatment including providing interrogators the medical information of the prisoners which was used to help "break" the prisoner [36]. A number of prisoners participated in hunger strikes, which were broken by placing the prisoners in restraint chairs and force-feeding them via nasogastric tubes [37]. Both the use of confidential medical information to assist interrogators and force-feeding have been criticized as violating medical ethics [36, 37].

One can then imagine the position of military physicians both in Nazi Germany and in Guantanamo Bay. Did these physicians participate in these acts of their own free will, or were they pressured or even forced, into doing so? At what point should the physicians at Guantanamo Bay have conscientiously objected, if at all? Furthermore, while conscientious objection is often viewed as a right held by physicians, in a setting like Guantanamo Bay, where physicians were involved to some extent in activities both harmful to patients and possibly illegal, was conscientious objection in fact an obligation? If so, should that obligation be enforced? Is it the case, for example, that specialty boards, state medical boards, and medical societies have an obligation to investigate questionable actions relating to prisoners by their members? Should they discipline members for failing to conscientiously object to unethical activities?

Lethal Injection

In February 2006, a federal judge in California issued an order requiring an anesthesiologist to be present during all scheduled lethal injections to ensure that the prisoners are adequately anesthetized prior to receiving the lethal injection [38]. The president of the American Society of Anesthesiologists (ASA), Dr. Guidry, reacted and quoted from the American Medical Association's (AMA) Code of Ethics that "an individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution" [38]. What constitutes involvement in lethal injection is defined as "selecting injection sites; starting intravenous lines as a port for lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their dose or type; testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel" [38]. Dr. Guidry noted that while "ASA does not have a detailed position on anesthesiologist participation in lethal injection," it does support the AMA's "position regarding physician nonparticipation in execution" [38]. Dr. Guidry advised the members to "be well informed on the subject and steer clear" [38]. While the surgical literature is more sparse regarding lethal injection, there are examples of surgeons having participated in the past (for instance, Dr. Alan Doerhoff, a surgeon, supervised 54 executions in Missouri) [39].

While the ethical responsibilities of physicians in regard to lethal injection seem clear at first blush (to "steer clear"), on closer analysis the question is more difficult and good-faith arguments have been advanced supporting participation by anesthesiologists. Savulescu offers a three-part test for what procedures physicians should be prepared to perform: "*(1) legally permitted, (2) efficient, and (3) beneficial care*" [26]. Applying his test demonstrates the challenges presented to physicians by the concept of conscientious objection. By definition, lethal injection is *legal* in much of the United States. Is it *efficient*? Arguments can be advanced on either side. On the one hand, keeping someone prisoner for life is exceedingly expensive, so lethal injection may be less expensive to society. On the other hand, the legal wrangling associated with lethal injection often makes it equally or more expensive than incarceration. It is possible, however, that participation by anesthesiologists would lower the costs of lethal injection by removing many of the legal challenges based on claims of cruelty. Would participation in lethal injection be "*beneficial*"? The obvious answer is no, because participation in the killing of a person can never be beneficial to that person. But what if they are going to die anyway and the anesthesiologist's participation makes their death less painful? Often, physicians treat patients who are dying not to prolong their life, but to make their inevitable death less painful (e.g. hospice). Moreover, some states have made it clear that if they cannot successfully conduct lethal injection due to conscientious objection by physicians or inability to obtain the required drugs, then they will resort to arguably more barbaric methods (e.g., Utah has recently announced a return to the firing squad) [40]. In addition, what if the request for participation of the anesthesiologist

comes from the condemned? Does that make it beneficial to participate? As often happens, so-called obvious issues can become much more difficult to resolve upon closer scrutiny. In the end, individual physicians will have to decide for themselves whether to participate in lethal injection and if so, under what conditions.

Physician-Assisted Suicide

Physician-assisted suicide (PAS) is becoming increasingly common. The phrase, physician-assisted suicide, is often used interchangeably with euthanasia, but the two are very different concepts. In the case of euthanasia, the physician is the one that administers the lethal injection to end the patient's life. In PAS, the physician usually prescribes a lethal drug, and the patient uses the drug to end his or her own life [41]. Euthanasia is legal in Belgium, the Netherlands, and Luxembourg. PAS is legal in the Netherlands, Luxembourg, Switzerland, and a few states in the United States [42]. In the United States, Oregon led the way, followed by Washington, Vermont, and New Mexico. The Montana Supreme Court, in the *Baxter v. Montana* case, ruled "although the Constitution did not guarantee a right to PAS, there was nothing in the Montana Supreme Court precedent or Montana statutes indicating PAS is against public policies" [41, 43]. In Oregon, the Oregon Death with Dignity Act states that "in order for a patient to participate, the patient must be 18 years or older, a resident of Oregon, capable of making and communicating healthcare decisions, and diagnosed with a terminal illness that will lead to death within 6 months" [44]. In Washington and Vermont, the restrictions are similar, except that the patient has to be seen by two physicians and both physicians have to agree upon the patient's prognosis [45, 46]. In New Mexico, during the *Morris v. New Mexico* case, a second Judicial Court Judge, Nan Nash, ruled "This court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying" [47].

So, would you participate in physician-assisted suicide if it is legal in your jurisdiction and your terminally ill cancer patient asks you to help end his misery? If you are not comfortable doing so and cannot find someone else to take your place, what should you do? If you are willing to prescribe a lethal medication to a dying patient, is that different than participating in lethal injection at the request of the condemned prisoner?

Practical Issues Surrounding the Invocation of Conscientious Objection

Conscientious objection is an issue worthy of consideration by every physician because invoking conscientious objection carries with it professional responsibilities as well as social, professional, and legal risk. In general, physicians will be better positioned to fulfill their professional responsibilities and minimize the risks if they prepare in advance [19].

Invocation of conscientious objection does not absolve physicians of responsibilities to their patient nor does it necessarily end the physician-patient relationship. At a minimum, physicians continue to have a responsibility not to abandon or compromise the care of their patients. Failure to fulfill professional responsibilities carries considerable risk. For example, a fertility clinic that would not inseminate a lesbian patient was sued for discrimination, and a religious hospital was found liable for failing to inform a rape victim about the availability of emergency contraception [48, 49]. In addition to civil liability, a physician who compromises the care of a patient on grounds of conscience may face investigation or discipline by the state board, loss of privileges, or dismissal from their medical practice. Socially, conscientious objection may expose a physician's ethical and religious beliefs to colleagues and associates who find such beliefs either unsophisticated or repugnant.

For all physicians, it is wise to consider in advance situations that might force them to invoke conscientious objection and plan how to fulfill their professional responsibilities while remaining true to their beliefs. To begin with, the physician should consult their institution's policy (if any) on conscientious objection. Most institutions have policies that reflect both the state and federal law on the subject as well as the culture of the institution. At our institution, for example, a physician invoking conscientious objection is required to "refer the patient to other persons who will either provide the intervention or facilitate appropriate referral," and the policy states that "[t]his process must not create undue delay, inconvenience, or impediment to receiving requested services for the patient" [50]. In addition to the hospital policy, the physician should review the relevant state and federal laws as it pertains to their anticipated area of objection.

Once having completed the above research, the physician should attempt to avoid situations that would require conscientious objection. In general, this will require the physician to reveal personal ethical beliefs at least to a limited degree. And while it may be uncomfortable to make even a limited revelation for fear of being ostracized, a limited revelation in advance generally generates less exposure than that created by actual invocation of conscientious objection. The precise method of avoiding patients and cases that may lead to conscientious objection will obviously vary by practice, locale, and situation. However, with some planning, it can usually be accomplished. In the anesthesia department at our institution, for example, we maintain lists of providers who do not wish to be involved in abortion or artificial insemination. Perhaps 10% of our group falls on one or the other list. The lists are available to schedulers (but are not made public) who try not to assign objectionable cases. In the rare instance that a provider is assigned to a case they object to, a simple case swap is carried out before either provider comes into contact with the patient. In this way, the rights of both the patient and the provider are honored without embarrassment.

In most circumstances, referral of a patient to another provider who is willing to provide the requested care will be adequate to fulfill professional responsibilities. However, in situations in which another provider is not available either due to time (i.e. emergency) or skill set, the treating physician will have to be prepared to choose between their professional responsibilities to their patient and their conscience. If

possible, involvement of the patient advocate and ethics consult team is advisable, but neither is likely to protect a physician from legal liability or board investigation in the event that a patient's care is compromised.

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