

ences in study populations and designs, rather than in methods. The article by Kuhle et al. (Jan. 25 issue)³ demonstrates these differences. First, apart from antimyelin antibodies, other factors — such as a monofocal or multifocal clinical presentation, the presence or absence of oligoclonal bands in the cerebrospinal fluid, and the lesion load or number of gadolinium-enhancing lesions on magnetic resonance imaging (MRI) — lacked an association with progression to multiple sclerosis. Second, as compared with multicenter trials, single-center studies may benefit from study populations with homogenous genetic backgrounds or from well-established standard operating procedures. Finally, blood sampling within 14 days after the onset of disease, which was done in only one study,¹ may limit the routine use of antimyelin antibodies as a prognostic biomarker in patients with a clinically isolated syndrome.

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THE AUTHORS REPLY: We thank Reindl and Berger for their generous support in establishing the method,¹ and we agree that our study's failure to confirm their results is not due to technical differences. Serum antibodies against myelin oligodendrocyte glycoprotein and myelin basic protein had no prognostic value for progression to multiple sclerosis either in the total population or in

subgroups analyzed in the Betaferon in Newly Emerging Multiple Sclerosis for Initial Treatment (BENEFIT) study, whereas other factors with known prognostic relevance, such as the number of hyperintense lesions on T₂-weighted MRI scans or of gadolinium-enhancing lesions on T₁-weighted MRI scans or the presence of oligoclonal bands in cerebrospinal fluid, were confirmed.² A potential effect of genetic variability may be further elucidated in the ongoing analysis of DNA and RNA expression in the BENEFIT study. We doubt that the longer mean interval between blood sampling and the initial event had a major effect on the results, because we did not find any increased association by comparing patients who had shorter intervals with those who had longer intervals.

We remain convinced that our study provided an ideal basis for a definitive validation of claims such as those raised by Berger et al.³: it included a large number of patients from a representative sample of centers across Europe and Canada and was carefully monitored according to Good Clinical Practice standards.⁴ Patients were selected and observed according to predefined, independently evaluated and centrally reconfirmed inclusion and outcome criteria.

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Religion, Conscience, and Controversial Clinical Practices

TO THE EDITOR: The policy of the American Medical Association states, "The patient has the right to receive information from physicians and to

discuss the benefits, risks, and costs of appropriate treatment alternatives."¹ In their study of controversial clinical practices associated with reli-

gious beliefs, Curlin et al. (Feb. 8 issue)² found that many physicians would refuse to tell patients about all legal treatment options in several critical situations. The authors advise patients to discuss these issues with their physicians in advance and change physicians if necessary.

It is unrealistic and unfair to expect patients to anticipate all conditions that may befall them, identify which ones might be problematic for their physicians, and agree either to reach a compromise or to seek care elsewhere. Medical visits are short and focused on current needs. Many people cannot change physicians. People encounter different physicians in different clinical situations.

The onus is on our profession to confront the willingness of so many of our colleagues to substitute their personal values for the fundamental right of their patients to know their treatment options.

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TO THE EDITOR: More disturbing than the data described by Curlin et al. is the authors' conclusion: "Patients who want information about and access to such procedures may need to inquire proactively to determine whether their physicians would accommodate such requests." The authors suggest that patients have the obligation to know which procedures they might want or need and to query their physicians about whether they would provide or even discuss such procedures. The unspoken corollary is that if the physician says no, the patient is left to find a more responsive provider. To impose the philosophy of caveat emptor is morally inadequate, given the differences in power and class between many physicians and their patients. Physicians must not be permitted to disavow responsibility on the grounds of conscientious objection; rather, such practitioners must choose careers in which their fundamental values do not interfere with the autonomy and well-being of patients. Like conscientious objectors to military service, medical conscientious objectors must bear the consequences of their beliefs. A philosophy that permits

physicians' rights to trump their obligations to patients is unconscionable.

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TO THE EDITOR: Curlin et al. provide documentation that patients may not receive information about medical options because of the religious beliefs of their physicians. The history of Poland shows how a conscience clause can lead to the systemic deprivation of services. The Catholic Church's significant influence in the post-socialist government, after 1989, led to the widespread use of the conscience clause, with de facto elimination of access to abortion, prenatal diagnosis, and most contraception. Four years later, the law actually criminalized abortion services, except in rare conditions, but abortion had already been made virtually inaccessible because of the use of the conscience clause.

Similarly, access to services is reduced in the United States with the mergers of nonsectarian and religious hospitals when religious restrictions are adopted by the merged entity. Survey research found that the scope of the care that doctors provide in such hospitals is significantly narrowed by the imposition of the conscience clause, especially limiting access to emergency contraception.¹

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1. MergerWatch Project. Hospitals and religious restrictions. (Accessed April 13, 2007, at http://www.mergerwatch.org/hospital_mergers.html.)

TO THE EDITOR: The findings of Curlin et al. are timely for Chile, where there is a fierce controversy about whether the morning-after pill should be prescribed for girls as young as 14 years of age without their parents' consent. The Chilean government, through a presidential decree, introduced the pill as a public health intervention. Opposition parties and the Catholic Church are against this new policy, stating that the pill is an abortion method and is illegal under Chilean law.

Those implementing this policy will certainly face difficulties. Physicians and pharmacists may object to the policy or even refuse to distribute the pill on moral or religious grounds. A health care system must establish clear criteria to allow the right balance between paternalism and the autonomy of patients in the case of medical issues that are controversial among health care professionals.

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TO THE EDITOR: Curlin et al. note the association between physicians' religiosity and their decreased willingness to refer patients for interventions that the physicians find morally objectionable, and the authors place this association within the context of paternalism versus patient autonomy. However, as physicians in the "high religiosity" category, we suggest an additional dimension. Paternalism and autonomy are principles based on rights: the right of physicians not to violate their own consciences and the right of patients to decide what to do. In counterpoise to rights are responsibilities. Because of our responsibility to our patients, we certainly cannot willfully harm them, but we also cannot assist them in harming themselves without failing our responsibility. If we truly believe that a given procedure violates patients' intrinsic human dignity, then our responsibility to our patients mandates that we not help them procure that procedure. Thus, although our conscience is part of the picture, so too is our responsibility to our patients. Some circumstances do not allow us to assist in carrying out our patients' desires without violating that responsibility.

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TO THE EDITOR: Until recently, I was an attending physician for patients with spinal cord injury during their initial rehabilitation. Many of those patients were on life support and despaired of going on with life, voicing a request for termination of their lives. Decisions based on patient autonomy alone would have had us doing so. Negotiations to

"give life a try and wait at least a year before making any decisions" were successful and required frank discussion of the patients' values as well as my own. Most of my patients did find value in their lives after such injuries.

The "moral compass" of a physician should not be ignored. Both patients' autonomy and physicians' values must play a role. Coercing physicians is no more defensible than coercing patients.

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THE AUTHORS REPLY: If a judgment of conscience were merely a statement of personal preference or an expression of prejudice, the claims of Dr. Stotland and Drs. Ross and Clayton would be justified. But anyone who has been hounded by a sense that he or she has acted wrongly knows that is not how the conscience works. Those who act conscientiously do not "disavow responsibility" and "substitute their personal values for the fundamental rights of their patients." Rather, they are engaging in the struggle to know and do the right thing and to understand and fulfill their moral obligations in a particular situation. This task cannot be externalized or delegated. Indeed, acting conscientiously is the heart of the ethical life, and to the extent that physicians give it up, they are no longer acting as moral agents.

Of course, the profession of medicine cannot permit all purported judgments of conscience. For example, the profession cannot permit physicians to refuse treatment of the sick on the basis of a patient's ethnic background or sexual orientation. Such refusals undermine the primary goal of medicine, which is to restore the health of those who are sick. But the practices about which we surveyed physicians were not examples of treating sickness or restoring health. Unwanted pregnancy may have health risks associated with it, but it is not an illness. Terminal sedation is not the treatment of illness, unless the illness is consciousness itself. These practices are controversial precisely because there is disagreement about whether they are consistent with the goals of medicine.

With respect to controversial clinical practices, therefore, individual physicians should consider the moral arguments, take into account the particulars of each situation, and conscientiously determine the degree to which they can accommodate patients' requests. If they cannot in good

conscience accommodate certain requests or help patients obtain certain legal procedures, they should, as a matter of respect, make that clear to patients at the earliest possible point. Ensuing discussions can enhance patient autonomy by allowing patients to make informed decisions about which doctor they want to entrust with their care.

Conscientious practice in a pluralistic world is messy even when peaceable. Yet the alternative is a society in which physicians are required to forfeit conscience in order to join the profession. Pa-

tients will not be well served by moral automatons who shape their practices, without struggle or reflection, to the desires of patients and the dictates of whatever regime is currently in power.

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Anchors Away

TO THE EDITOR: In the Clinical Problem-Solving case presented by Calfee et al. (Feb. 1 issue),¹ the discussant identifies a common heuristic error inherent in clinical problem-solving. In this case, the clinician's reasoning became erroneously anchored to the nonspecific finding of granulomatous dermatitis provided by the pathologist on the basis of an initial skin biopsy. We agree that morphologic findings alone are not specific and should not be used as the single diagnostic tool for identification of idiopathic sarcoidosis. However, later in the discussion we are informed that the initial skin biopsy in fact showed a prominent lymphocytic infiltrate without frank granulomas.¹ We suspect that the pathologist was misled by another common heuristic error, the "clustering illusion"² — that is, seeing a pattern, in this case granulomas, where none existed. It would be interesting to know whether the original skin-biopsy findings were consistent with lymphomatoid granulomatosis, since the findings in the skin often mirror those in the lung.³ This case illustrates the importance of carefully reviewing with the pathologist "diagnostic" specimens in cases of idiopathic sarcoidosis, in particular when the course is atypical.

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TO THE EDITOR: In the case of a patient with lymphomatoid granulomatosis, the description in the text of an infiltrate composed of predominantly CD20+ B cells would be unusual for low-grade (grade I or II) lesions of lymphomatoid granulomatosis. Such lesions typically are composed of few, large, angiocentric, CD20+, Epstein-Barr virus (EBV)-encoded RNA (EBER+) B cells against a background of numerous CD3+ T cells. Sheets of large B cells are seen in grade III lymphomatoid granulomatosis, a variant of diffuse large-B-cell lymphoma.¹

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THE AUTHORS REPLY: Morgan and Berman appropriately highlight the importance of a careful review of pathological specimens with the pathologist (ideally face to face), particularly when the diagnosis is in question. In this case, a retrospective examination of the skin-biopsy specimen showed that it alone would not have provided the diagnosis of lymphomatoid granulomatosis. Knowing the final diagnosis obtained by lung biopsy,