Conscientious Objection in Healthcare: What Should An Institution Accommodate?

Imagine these scenarios:

1. A Holocaust survivor working in long-term care refuses to care for a WW II German army officer.
2. A nurse declines to treat a woman who has had multiple abortions and a patient known to have perpetrated sexual abuse.
3. A pediatric nurse refuses to participate in neonatal circumcision because she believes it is poor medical practice.
4. A nurse objects to providing CPR and mouth-to-mouth resuscitation to a brittle 92-year-old patient with Hepatitis C.
5. A pharmacist refuses to dispense emergency contraception even though the emergency room provides it.
6. A home health clinician believes a family is using pain medication to euthanize a patient and the clinician refuses care.

In these scenarios, what, if anything, is the moral problem with refusing to act, and are there any moral differences among the cases? Which refusals would you permit, and why?

Conscientious objection (CO) occurs more often than imagined. While conscientious objection to war is the most notable example, the healthcare arena experiences refusals by employees to participate in abortion, euthanasia, organ transplantation, blood transfusion, involuntary psychiatric treatment, circumcision, and administering lethal injections to death row inmates. Outside the clinical realm, healthcare employees sometimes have qualms about certain business practices or implementing policies with which they disagree.

If you have ever been asked to do something that you sincerely believe is wrong, then you will understand the plight of the conscientious objector. Imagine also the challenge of both respecting an employee’s conscience and at the same time ensuring that the institution provides safe, effective care to patients. In wrestling with such cases, administrators often realize that they have no clear policy regarding staff requests to be excused from a duty on ethical reasons, or when to compel the employee to act. Organizations must ask: When should a supervisor excuse or temporarily reassign an employee? What are appropriate disciplinary measures for employees who do not comply? What criteria should organizations and managers use?

Some features of CO are agreed upon. Respect for individual conscience is at the heart of respect for human dignity and CO should be seriously considered and honored if possible. Further, the history of conscientious objection shows it can be tolerated under some, but not all circumstances, especially if there are negative consequences that affect the common good. Beyond these agreements, are there any other criteria for which we could find consensus? One method to build clearer points of agreement in ethics is to explore essential elements or criteria of an issue (e.g., CO), and see how defensible each element is.

Conscientious objection is described as refusal to follow orders/tasks based upon religious, personal, or cultural beliefs or values. Some logical questions that arise from this definition are: is any belief, religious or otherwise, defensible justification for CO? How long must the belief be held to warrant accommodation? What if the belief is based on a mistaken interpretation of medical facts or a religious doctrine? These questions draw attention to some potential criteria. For example, a refusal that is based on recent belief that an employee develops out of convenience or self-interest is less plausible than a religious employee who refuses to cooperate based on a known religious tenet. Moreover, an employee’s strong conviction alone is not reason enough for an institution to accommodate the choice if the conviction is based on prejudice (e.g., white supremacists’ convictions). Asked a slightly different way: Is the refusal based on the type of treatment or the patient’s behavior? While an institution might not accommodate CO based on self interest, convenience, prejudice or moral evaluation of a patient, should it accept refusal based on employee fear?

Another criterion for CO that is found in a few codes of ethics proposes that CO can only be accommodated in non-emergency situations. Why is that? Healthcare’s principle obligation is to the well-being and protection of the patient; staff actions that jeopardize this obligation cannot be accommodated. In emergency situations, normally there is not time to examine the refusal without jeopardizing the patient’s health.

Still another criterion proposed is that the conscientious objector proceeds only as a last resort. As is the case in many ethical dilemmas, a stand-off might be avoided if the alternatives are explored and discussed. For example, does the employee know where to turn to have
the request vetted? If the request is examined through the chain of command and denied, is there an option for appeal? During the vetting process, the rationale for the CO should be examined. Are the medical facts contested? Or, if the employee thinks the medical procedure is not permitted by the religious tradition, does the employee have an accurate understanding of the tradition? If the refusal is publicly contested or morally ambiguous, then there might be stronger reason to accommodate, but not if the view is idiosyncratic.

A final criterion asks whether the objection is so detrimental to carrying out the professional obligations that the employee should not be engaged in that type of professional work.

How do these criteria clarify the scenarios mentioned at the beginning? In Scenario 1, one should examine whether the Holocaust survivor refused because of fear and trauma or out of prejudice. The first reasons could be, and are frequently, accommodated, but the later rationale is more troubling. In Scenario 2, the nurse refused, based on a moral judgment of the patient’s sinfulness. This is an objection not about the treatment but about the patient’s moral character, which, if acted on consistently, would be a fundamental obstacle to the nurse remaining in the profession. In Scenario 3, the nurse held a view that is with greater frequency questioned and contested in the pediatric literature; therefore, the institutions should consider accommodation in this non-emergency situation. In Scenario 4 the motivation for the refusal should be clarified. Was care refused because of the woman’s age, her brittle condition, a view that CPR would be futile, or is the nurse fearful of contracting Hepatitis C? Universal precautions should provide much of the protection from Hepatitis C, and if contagion is still a concern this rationale might be a fundamental obstacle to carrying out her overall professional duties.

In Scenario 5, it would be important to understand whether this refusal is based on medical information or the application of moral principles. For example, is the pharmacist working under the mistaken belief that all emergency contraceptives are abortifacients? Or, does the pharmacist understand that religious traditions, such as Catholicism, allow for the provision of emergency contraception that is not an abortifacient? If, after reflective analysis, the institution believes it is obligated to offer non-abortifacient emergency rape treatment, and if the employee is the institution’s only pharmacist, then the institution might have no other choice then to replace the pharmacist. In Scenario 6, both the home health employee and the institution have obligations to refuse participation if the family intends that the pain medication be used to end the life of the patient, which strictly speaking is an act of euthanasia and unlawful. If the institution concludes the provision of pain medication is not for euthanasia, it should accommodate the employee and follow up with education.

The identification of criteria has also brought practical parameters to the surface that might be woven into a policy. For example, conscientious objection can never result in patients’ abandonment. Where appeal is an option, conscientious objection should be the last resort with an obligation to follow a chain of command. Conscientious objectors should have some protections in non-emergency cases and they should know the consequences for refusal in cases that place patients at risk.

Institutions that cultivate employees as the ethical eyes and ears of an organization, and that also promote courage and a reflective moral awareness should not be surprised when employees refuse to engage in an activity because of deeply held beliefs. Therefore, institutions need to have criteria available and managers trained to discern the circumstances under which an employee’s conscientious objection should be accommodated.

Educational considerations are not to be construed as policy recommendations.