Review Paper

Do physicians reserve the right to refuse treating patients on moral or personal beliefs? A scoping review, examining the extent of Conscientious Objection

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ABSTRACT

Conscientious objection (CO) is the refusal to perform a legal role or responsibility because of personal beliefs. The right to conscientious objection is founded on human rights to act according to individuals' religious and other conscience. In health care, conscientious objection can involve practitioners not providing certain treatments to their patients and hence affects someone else's access to care because the refusal interrupts the delivery of health services. The goal of this study is to analyses the role of conscientious objection in scenarios a physician faces in the real world today namely: abortion, physician assisted death and critical care and attempt to look at the solutions being formulated globally for the same. We also give a global overview of laws formulated protecting and limiting the physician's rights of conscience and their duties in morally complex scenarios. PRISMA Guidelines for scoping review was followed. We searched on Pubmed, Embase and Cochrane databases. Search Terms like *"Contentious"* and *"objection"*; *"Contentious"* and *"refusal"* etc. were used. After exclusion 47 articles were finally reviewed. We found that most countries that legally allow doctors to conscientiously object to treat their patients are required to refer the patient to a non-objecting doctor without any delay. They were also not allowed to object when a patient required emergency treatment**.** Studies included also shed light on the social and religious dimension of CO.

Key Words: Conscientious objection, refusing patients, refusal, doctor patient relationship, abortion rights, organ donation.

Introduction

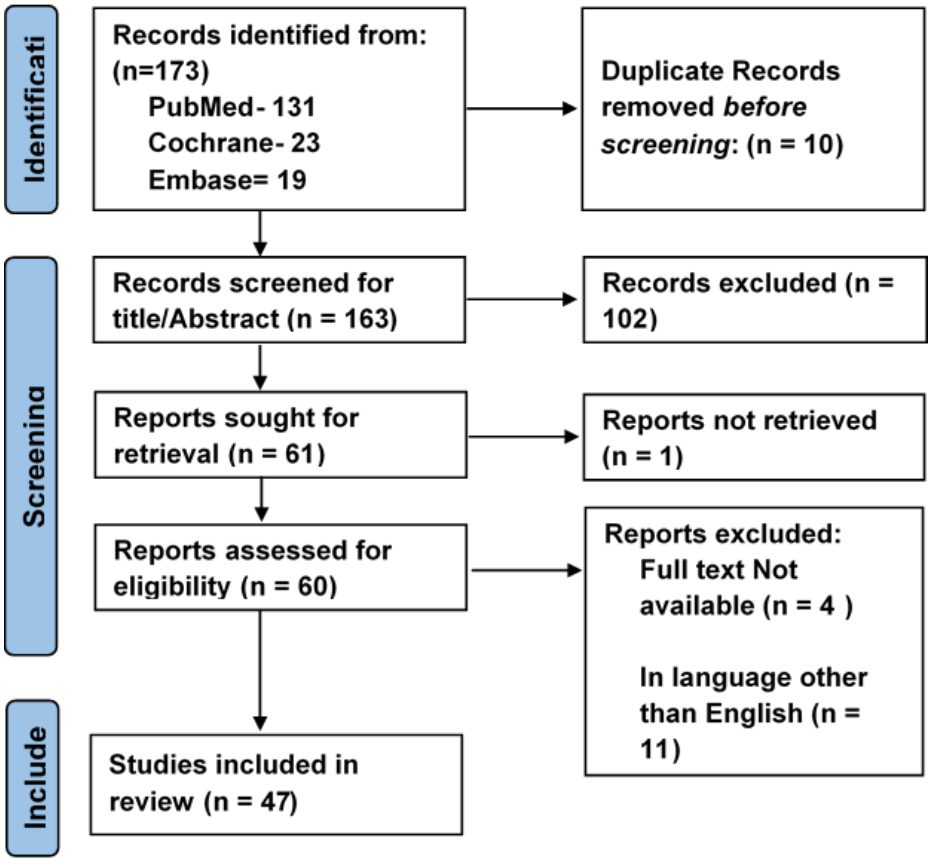
Conscientious objection (CO) has been defined as *"the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs."* [1]. CO in the West originates in Christianity in the form of pacifism – the belief that taking human life under any circumstances is evil [2]. The original expression of conscientious objection was the refusal to perform mandatory military service because of personal or religious moral objections to killing. However, in recent years, the concept has been used by some in the medical profession to refuse to provide services with which they personally disagree, such as euthanasia, abortion, contraception, sterilization, assisted reproduction, and other health services – even when these services are legal and within the scope of their qualifications and practice [2].

Currently, at least 70 jurisdictions (national and subnational) have provisions that allow refusal to treat in the context of unwanted pregnancies. As per literature review conducted 2 reviews on topic of abortion and CO [3-4] were found which discussed the reasons given by Nurses and Doctors respectively for not indulging in abortion. Our objective of the current article is to review the literature on Conscientious objection by the healthcare professionals

- In order to provide a global perspective from different nations and professional bodies
- On the issue of abortion
- On the issue of critical care and organ donation

Literature search on PubMed, Cochrane library, Embase was conducted (Figure 1)

Figure 1- PRISMA 2020 flow diagram for Scoping Review which included searches of database [5]



The terms used for search were

- Conscientious, religious, ethical
- Objection, Refusal

A combination of one term from bullet 1 and 2 was combined using and for eg. (conscientious) and (objection); (contentious) and (Refusal)
There was no date restriction put while searching, and all the articles that were free to view full text and were in English language were included for review. All the three authors were involved in screening and selecting the final studies to be included. The studies pertaining to objectives 1, 2, 3 were reviewed respectively by AS and RR, GL respectively

Results

A total of 47 (17 pertaining to global perspective, 10 pertaining to abortion and rest on critical care and organ donation), studies were finally included in the review

Global perspective

The International Federation of Gynecology and Obstetrics (FIGO) affirms that to behave ethically, practitioners shall [6]

- Provide prior public notice of professional services they decline to undertake on grounds of conscience;
- Refer patients who request such services to other practitioners who do not object;
- Provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and
- In emergency situations, provide care regardless of practitioners' personal objections

The General Medical Council (GMC) in UK has similar ethical guidelines on CO [7]

12. If you have a conscientious objection to a treatment or procedure that may be clinically appropriate for the patient, you must do the following.

- Tell the patient that you do not provide the particular treatment or procedure, being careful not to cause distress.
- Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.

13. If it's not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made without delay. In emergencies, you must not refuse to provide treatment necessary to save the life

As per the World Medical Association's statement on medically-indicated termination of pregnancy [8]

"8. Physicians have a right to conscientious objection to performing an abortion; therefore, they may withdraw while ensuring the continuity of medical care by a qualified colleague. In all cases, physician must perform those procedures necessary to save the woman's life and to prevent serious injury to her health"

Countries can be divided into three categories based on their CO laws. Countries that ban CO, those who allow CO but with obligations upon doctors and those who allow CO without any restriction or obligations.

Countries that Allow CO with restrictions

The obligations that most countries put on objecting doctors are similar to ones that FIGO and the GMC put. However, countries like South Africa, Chile put additional obligations as well. In Chile, Objecting providers need to register as objectors. When registering as an objector, the provider must first notify the hospital or clinic director in writing before they can object to an abortion procedure and they must indicate for which of the three legal grounds (i.e. abortions to save a woman's life, lethal fetal anomaly, or rape) they object. Registration must occur before a patient requests the abortion. The hospital or clinic director must honour the objecting provider's status. Moreover the law does not allow conscience-based refusal claims for pre-abortion (diagnosis) or post-abortion care [9]. In South Africa a health care provider must also lodge in writing to the employer refusal to participate in performing an abortion. A study found 87% of South African medical students agreed that CO should be allowed to health care professionals [10].

A few nations that permit CO, only allow it for private institutions (eg. Uruguay, France) while some like Bolivia and Mexico [11] prohibit entire institutions (institutional conscientious objection) from being registered as CO but countries like Argentina allow CO from both private and public institutions [12].

Although many jurisdictions allow physicians to exercise CO, the same doesn't recognize the nurses, paramedic's right to exercise the same. eg- As per the Australian law "a registered nurse is under a duty to assist a registered medical practitioner in performing an abortion in an emergency" [13].

The 1967 UK Abortion Act, states that "No one is under any duty to participate, contrary to his or her conscience, in any treatment authorized by the Act"; although the exemption does not apply where treatment "is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman". The UK Supreme Court in the case of Greater Glasgow Health Board v Doogan [14] held that midwives can't claim CO under this section

Countries that Don't allow CO

Countries like Sweden, Finland, Bulgaria, Iceland, Czech Republic and South Korea don't allow CO [1]. In South Korea this ban is enforced under Article 15(1) of the Medical Service Act 1995 [15]. Sweden has stricter restrictions on CO. Medical authorities have stated that those who object to performing abortions (or inserting intrauterine contraception) cannot become obstetricians/gynecologists or midwives [16].

Sweden, Iceland and Finland nations rank in the top five in the world when it comes to the well-being of mothers and children, showing that excellent maternal health outcomes are closely correlated with a lack of 'CO' [17]. A key feature common to the three countries is the mandatory training in abortion care for Ob/Gyns. This aspect has a significantly positive effect for everyone involved [18].

Of the EU member states where induced abortion is legal, invoking CO is granted by law in 21 countries. The same applies to the non-EU countries Norway and Switzerland [19]. The prevalence of CO in European nations varies with 70% of OB/GYN in and 50% of anesthesiologists have registered as professionals with CO in Italy [20] which goes to as high as 80% in Portugal [21].

Countries that allow CO without restriction

Poland lies on the other side of spectrum or the "conscience absolutism", meaning doctors neither have an obligation to provide care that conflicts with their conscience nor any obligation to facilitate access to care by another provider [22].

However, the European Court of Human Rights In the 2011 case of R.R. v. Poland and case of S. v. Poland, ruled that unregulated practice of conscientious refusal to be in violation of the EHCR. It determined that Poland had violated the individuals' right to be free from inhuman and degrading treatment, as well as the right to privacy. Furthermore, for the first time, the Court recognized that states have an obligation under the Convention to regulate the exercise of "conscientious objection," in order to guarantee patients access to lawful reproductive health care services [23].

Conscientious objection in Abortion

Freedom of conscience is a core element of human rights that in Europe is protected in documents such as the European Convention on Human Rights (EHCR). As safe abortion laws became enacted in each country, for the most part, they included a conscience clause which permitted opting out of providing such services on conscience grounds. Abortion remains a morally contentious issue with some midwives and nurses declining to participate in it on the grounds of conscience. Of the reasons to deny abortion under conscientious objection, four categories, which encompassed all the reasons: legal, moral, practical and religious reasons [24].

Practical and legal reasons

As the only legal way to refuse to provide abortions that are permitted by law, conscientious objection can become a safety valve for clinicians under pressure and may be claimed by clinicians who do not have moral or religious objections. This is of significance in areas with high numbers of clinicians identifying as objectors and there is a real possibility of non-objectors having an increased workload due to referred cases [25].

Impact of this provision of conscientious abortion: Case study Italy

Despite the European Union's liberal policy on abortions they have a clause for conscientious objection. According to the Italian abortion law, in the first ninety days of pregnancy, abortion is permitted whenever childbearing, birth or motherhood could undermine the mother's physical or

mental health. This law also grants healthcare personnel the right to refuse to partake in procedures specifically directed at the termination of pregnancy, on grounds of conscientious objection [26].

Religious and moral reasons

The prevalence of conscientious objection is often associated with religious beliefs, as the majority of the Italian population is Catholic and the critical stance of the Catholic Church against abortion may influence physicians' attitudes. Similarly 'moral cause' can be cited by midwives in the UK while refusing to participate in cases of abortions [27]. In any case, the empirical evidence consistently suggests that conscientious objection hampers access to abortion at the local level. It imposes longer waiting times and travel distances, and thus greater costs, on women who intend to terminate pregnancy. The evidence provided also suggests that women from poorer regions or experiencing other forms of economic disadvantage face steeper barriers to abortion access [28].
Conscientious objection policies and debates around the world generally do not take into account the social, political, and economic pressures that profoundly influence clinicians who must decide whether to claim objector status.

Reasons in favour of conscientious abortions

Given the gradually increasing trend of conscientious objectors impinging on an important legal and ethical provision of abortion worldwide and the complex, and sometimes dubious and difficult to verify reasons behind clinicians turning objectors the question arises of why we need this provision altogether. However, if a healthcare practitioner is forced to provide services contrary to their core moral beliefs, their moral integrity is compromised [29-30]. Moral integrity is part of the common good and is a particularly important quality for healthcare professionals.
Secondly, an uncompromising position on conscientious objection may result in staff shortages by discouraging entry into certain healthcare professions. For example, Sweden does not permit conscientious objection, despite having a chronic shortage of midwives for several years.

Reasons against retaining the conscientious objection clause

It can be argued that medical professionals voluntarily join a profession that is expected to serve society by providing essential services, all of which are legal and professionally accepted, and refusing to do so is incompatible with their professional responsibilities. They are expected to place their patient's interests above their own. Moreover, allowing conscientious objection places burdens on patients and compromises their care by lowering the quality of healthcare. It has also been observed that most doctors performing abortions reside in urban areas thus creating a geographical divide in access to essential medical services [31].

Solutions

There have been various suggestions made to the Italian government by the European Union that we can look into and modify to adopt for various scenarios. They are stipulated to maintain a healthy ratio of objectors to non-objectors. This is to prevent most gynecologists turning objectors as a career choice to avoid bearing the brunt of doing all the abortions refused by other clinicians. Another solution might be that we reserve a certain portion of specialist trainee intake as non-objectors. Other solutions suggested include financial incentives and paid leave guaranteed to non-objecting clinicians.
Ideally, the initial introduction of quotas should aim to minimize disruption. Quotas should initially be set as high as possible to avoid communicating that those with a conscientious objection are unwelcome in the specialty, whilst also reducing the likelihood that access to abortion services will be compromised. It is also possible that a clinician believes change during the course of training and any solution proposed must make room for accommodating such changes [32].

Conscientious objection in Euthanasia and Organ Donation

To be a doctor is to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system.
Euthanasia (Eu = good, thanatos = death)

Physician assisted dying refers to "the administration of a voluntary assisted dying substance and includes steps reasonably related to such administration", "for the purpose of causing a patient's death, within the final weeks or months of life", who may receive medical-assistance to 'choose the manner and timing of their death' [33].

Netherlands is among the first countries to legalize euthanasia if the following conditions are met:

- The disease is incurable/ the patient's condition is terminal.
- The patient requests death as the suffering is unbearable [34]

That being said, it is important to talk about the types of euthanasia

- Active Euthanasia is an act of commission,
  Eg. Administering large doses of drugs to hasten death (ex. Narcotics like opium which can cause respiratory depression) whereas
- Passive Euthanasia is an act of omission, i.e, to withhold any heroic measures to help prolong the life of a patient,
  Eg. Do not resuscitate, Do not intubate [35]

This helps to respect the autonomy of the patient which is one of the core pillars of ethical principles. However, with the advent of legalized medical assistance in dying [MAiD] in Canada in 2016 [36] and in the Australian state of Victoria [37-38], where voluntary assisted dying [VAD] has been legal since June 2019, intriguing new ethical and theoretical challenges are being faced. Among them is the concept of conscientious objection, which was built into the legislation as a safeguard to protect the rights of healthcare workers who feel they cannot participate in something that feels morally or ethically wrong [39]. While a large percentage of healthcare professionals agree upon the view point that euthanasia should be legalized, majority of them would conscientiously object in facilitating it, which leads to inefficiency and inequity [40].

Studies have found CO by healthcare professionals to euthanasia is influenced by their

- Previous personal and professional experiences,
- Comfort with death,
- Emotional impact.
- Preferred end-of-life care approaches,
- Faith or spirituality beliefs,
- Self-accountability and conceptualization of duty [41].

In this section we will explore core ethical issues and possible solutions related to critical care from the perspective of healthcare professionals (HCP) and ethicists such as –

- **Professional autonomy of the healthcare professional**
  A person's values and conscience have different roles in public and private life.
  Let's take the example of a physician who has right from the first day of medical school been under just the same societal impression as medical professionals to be caregivers and healers will find it challenging to assist ending the life of a patient he has closely formed a rapport with as it would shake the foundational belief of the person which led him into the field in the first place, While the person might be compelled to assist dying in their professional life, at the end of the day it might affect their private life as well. This can lead to,
  a. the HCP questioning themselves and not being able to live with their decisions
  b. Slowly finding themselves becoming accustomed towards the practice, thereby paralyzing them emotionally which can in turn lead to not putting in the optimal efforts in patient care [42,43]
- **Geographical Divide**
  a. Exercising CO to MAiD in rural and remote areas with limited staff, by way of policies developed with an urban focus, creates conditions that limit the ability to transfer care or call on a designated team [44] and hampering the efficiency and functioning of the healthcare practices.

- **Additional Vulnerability of Junior doctor, nurses and pharmacists**
    a. Nurses and pharmacists despite being equally involved in the end of life care, are subjected to unclear guidelines leading to role ambiguity and lack of inter professional collaboration [45,46,47]
    b. In a context where senior colleagues are supportive of VAD, the junior doctor's subordinate position in the medical hierarchy exposes them to potential significant harms: compromising their moral integrity by participating, or compromising their career progression by objecting [48].
- **Organ retrieval and death**

In the UK and USA, brainstem death is considered as legal death while most religions believe 'cardiorespiratory death' as the form of death [49]. Based on the discrepancy defining death, a practitioner with religious beliefs can conscientiously object to organ retrieval from 'legally deceased' persons as he believes to aid in precipitating death illicitly [50-52].
Hence,

- Evidence from various jurisdictions highlighted a need for clear guidelines and protocols that define each profession's role, scope of practice, and legal boundaries for MaiD [50].
- No healthcare provider could be compelled to participate in MAiD, they may opt out of participation if they conscientiously object to it,
- Institutions should develop and revise physician-assisted death policies,
- Conscientious objection and moral distress for health care providers must be considered;
- Any would-be conscientious objector must ensure that patients know about and receive care that they are entitled to from another professional in a timely manner that does not compromise their access to care [36]. The Canadian Nurses Association states that Nurses who conscientiously object to participation have a professional obligation to inform their employers of that objection, to report requests for MAiD, and to not abandon their clients [53].

Conclusions

Mahatma Gandhi once said "there is a higher court than courts of justice and that is the court of conscience. It supersedes all other courts". In that spirit we undertook this project and found a total of 51 articles to be included into this scoping review from three different databases. We conclude that

- Globally most professional bodies including FIGO, WMA and the GMC have allowed conscientious objection but with certain restrictions. However the law on CO across the globe countries is variable and is not codified into legislation of most countries.
- Traditionally CO as an objection is synonymous with refusing to undertake and refer the patient for abortion. However the reasons under which a healthcare provider might claim to be an objector status are complex and difficult to verify at best. Hence to codify a uniform protocol to protect and limit at the same time a physician's right of conscience is a work in progress.
- In the field of physician assisted death, we found that active euthanasia, which refers to active shortening of a patient's life, is the most contested issue. The most complex issue amongst all is the junior doctor's refusal to stay on the team of doctors providing assisted dying.

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