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Managing Conscientious Objection in Health Care Institutions

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Abstract It is argued that the primary aim of institutional management is to protect the moral integrity of health professionals without significantly compromising other important values and interests. Institutional policies are recommended as a means to promote fair, consistent, and transparent management of conscience-based refusals. It is further recommended that those policies include the following four requirements: (1) Conscience-based refusals will be accommodated only if a requested accommodation will not impede a patient's/surrogate's timely access to information, counseling, and referral. (2) Conscience-based refusals will be accommodated only if a requested accommodation will not impede a patient's timely access to health care services offered within the institution. (3) Conscience-based refusals will be accommodated only if the accommodation will not impose excessive burdens on colleagues, supervisors, department heads, other administrators, or the institution. (4) Whenever feasible, health professionals should provide advance notification to department heads or supervisors. Formal review may not be required in all cases, but when it is appropriate, several recommendations are offered about standards and the review process. A key recommendation is that when reviewing an objector's reasons, contrary to what some have proposed, it is not appropriate to adopt an adversarial approach modelled on military review boards' assessments of requests for conscientious objector status. According to the approach recommended, the primary function of reviews of objectors' reasons is to engage them in a process of reflecting on the nature and depth of their objections, with the objective of facilitating moral clarity on the part of objectors rather than enabling

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department heads, supervisors, or ethics committees to determine whether conscientious objections are sufficiently genuine.

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Health professionals can refuse to provide, assist in providing, or offer information about a health care good or service for a number of reasons. (1) Refusals can be based exclusively on clinical considerations. For example, surgeons can refuse to operate if they believe that a brain tumor is "inoperable." (2) Physicians and nurses can refuse to provide medical interventions to avoid harm to themselves. For example, to avoid the risk of infection, physicians and nurses might refuse to treat patients with highly contagious and deadly diseases such as SARS or Ebola. Or, in view of the many instances of violent attacks on abortion providers, ob-gyns might refuse to provide, and nurses may refuse to assist in providing, abortions due to concerns about their safety. (3) Health professionals can refuse to provide medical goods and services due to concerns about their income. For example physicians may refuse to provide medical services to Medicaid patients due to reimbursement rates that are perceived as inadequate. (4) Health professionals can refuse to provide or assist in providing medical services because both are legally prohibited and/or prohibited by accepted professional norms and standards. For example, physicians outside the five states in which physician-assisted suicide is legally permitted (Washington, Oregon, Vermont, Montana, and New Mexico) might refuse a request for it because it is legally prohibited and providing it would subject them to legal sanctions and possible loss of their license to practice medicine. Physicians in all states might refuse to satisfy requests for active euthanasia because it is legally prohibited and contrary to accepted professional norms and standards. (5) Health professionals can refuse to provide a service because it is not within the scope of their clinical competence. For example, an internist might refuse to provide palliative care to patients because she lacks the appropriate training and expertise. (6) Health professionals can refuse to provide, assist in providing, or offer information about a health care good or service because it is contrary to their *moral convictions*.[1] It is only when refusals are based on the provider's moral convictions that they can be characterized as instances of *conscientious objection*. Such refusals will be referred to as *conscience-based* to distinguish them from other types of refusals.

Generally, occasions for health professionals to assert *conscience-based* refusals arise only when they refuse to provide, assist in providing, or offer information about a legal, professionally accepted, and clinically appropriate medical service within the scope of their competence. In institutional contexts, an occasion to assert a conscience-based refusal generally arises only when the medical service in question is offered within the institution and is not incompatible with the institution's mission.

[1] As I am using the term, "moral convictions" can be either non-religiously or religiously based.

Institutional Policies: Four Recommended Requirements

It is incumbent upon health care institutions to be prepared to respond to requests for accommodation from health professionals with conscientious objections. Fair, consistent, and transparent management of conscience-based refusals requires an institutional policy. One clear aim of such policies should be to protect the moral integrity of clinicians.[2] This goal favors accommodation. However, accommodation can also adversely affect patients and impose significant burdens on other clinicians, supervisors, department heads, and the institution (Wicclair 2011). Accordingly, a general goal of institutional conscientious objection policies should be to strike an appropriate balance between: (1) protecting the moral integrity of clinicians and (2) protecting patients, other clinicians, supervisors, department heads, and the institution. Institutional policies can foster this general goal by incorporating the following four requirements:

1. Conscience-based refusals will be accommodated only if a requested accommodation will not impede a patient's/surrogate's timely access to information, counseling, and referral.
2. Conscience-based refusals will be accommodated only if a requested accommodation will not impede a patient's timely access to health care goods and services offered within the institution.
3. Conscience-based refusals will be accommodated only if the accommodation will not impose excessive burdens on other clinicians, supervisors, department heads, or the institution.
4. Whenever feasible, health professionals should provide advance notification to department heads or supervisors.

The first requirement is less demanding of objectors than a corresponding requirement in what Dan Brock refers to as the "conventional compromise," which requires practitioners who object to providing a medical intervention to *inform* patients about it "if it is medically relevant to their medical condition" (Brock 2008, p. 194). The first requirement states only that the patient/surrogate must *receive* the relevant information in a timely manner. It does not require that the objecting practitioner provide it. This can be a significant difference for health professionals with a moral objection to a medical intervention who believe that informing patients/surrogates about it makes them morally complicit in wrongdoing and thereby undermines their moral integrity. For example, an emergency department (ED) physician who has a conscience-based objection to emergency contraception (EC) might believe that he would be morally complicit in the perceived wrongdoing of others e.g., (health professionals who provide EC and patients who take it) and, therefore, morally culpable if he were to inform patients about it.

To be sure, this conception of moral complicity is subject to challenge. However, for health professionals who accept it, providing information about medical interventions that are contrary to their moral convictions can undermine their moral

[2] For a discussion of moral integrity and reasons to protect it, see (Wicclair 2011).

integrity. The first requirement does not require such health professionals to compromise their moral integrity unless there are no acceptable alternative means for patients/surrogates to receive information about the medical intervention at issue in a timely manner. To satisfy the first requirement, a clinician may need only to direct the patient or surrogate to another health professional who will disclose additional information about her options that he is unable to provide. If another health professional can provide the information in a timely manner, it may be possible to accommodate and protect the objecting clinician's moral integrity without compromising patient health or well-being. Hence, the conventional compromise requirement that clinicians inform patients/surrogates about medical interventions that are contrary to their moral convictions can unnecessarily compromise the moral integrity of health professionals.

Like the first requirement, the second is also less demanding of objectors than the corresponding requirement of the conventional compromise, which obligates practitioners who refuse to provide a medical intervention to *refer* patients to another health professional who is willing and able to provide it. (Brock 2008, p. 194) The second requirement states only that accommodation must not *impede a patient's timely access* to health care goods and services offered within the institution. It does not require referral or any other specific action by objecting practitioners. This can be a significant difference for health professionals with a moral objection to a medical intervention who believe that referral to a health professional who will provide it makes them morally complicit in wrongdoing and thereby undermines their moral integrity. For example, an intensivist who is morally opposed to palliative sedation to unconsciousness, a procedure that is offered within the hospital, might believe that it would compromise her moral integrity to refer a patient or surrogate to an intensivist who will provide it. The second requirement does not obligate the intensivist to provide a referral and undermine her moral integrity unless her failure to do so will impede a patient's timely access to the procedure. However, it might be possible to satisfy the second requirement without requiring the intensivist to provide referrals. For example, it might be feasible to arrange for other practitioners to review the charts of the objecting intensivist's patients to identify those for whom palliative sedation to unconsciousness is an acceptable option.[3] It might be possible to assign the responsibility of offering the procedure to intensivists who have no moral objection to offering it. Or, if patients or surrogates request palliative sedation to unconsciousness, it may suffice for the intensivist to alert the department head, who can assign the responsibility of offering the option of palliative sedation to unconsciousness to intensivists with no moral objections. When referral by an objecting clinician is not required for a patient to receive a medical intervention in a timely manner, it might be possible to accommodate and protect an objector's moral integrity without compromising

[3] A Report of the AMA Council on Ethical and Judicial Affairs (CEJA) provides criteria for determining when it is appropriate to offer palliative sedation to unconsciousness (CEJA Report 5-A-08, "Sedation to Unconsciousness in End-of-Life Care"). Available online at: http://www.ama-assn.org/resources/doc/ethics/ceja_5a08.pdf; accessed December 24, 2013.

patient health or well-being. Hence, the conventional compromise requirement that practitioners provide referrals can unnecessarily compromise their moral integrity.

Although the second requirement might not require objectors to provide referrals, it does prohibit them from *obstructing* access to legal, professionally accepted, and clinically appropriate medical interventions that are contrary to their moral convictions. Failing to inform can cross the line into obstruction when a health professional has the exclusive responsibility to inform patients/surrogates about a medical intervention that is offered within the institution, and she intentionally refrains from informing patients/surrogates about it when it is a clinically appropriate option because it is contrary to her moral convictions. Lying to patients/surrogates can be another means of obstruction within an institutional setting. For example, in response to a parent's question, a pediatric nurse who is morally opposed to forgoing medically provided nutrition and hydration (MPNH) might falsely state that forgoing MPNH is illegal or contrary to hospital policy.

The third requirement sets context-dependent practical limits to accommodation. Unfortunately, there is no simple rule for determining when burdens are "excessive," in part because excessiveness is largely context dependent. Whether an accommodation will impose excessive burdens depends on a variety of contextual factors, including the number of staff members whose clinical competencies overlap with those of the objector; the willingness of other practitioners to provide the medical service at issue; the number of health professionals within a service, a unit, and the institution who request accommodation; the frequency of such requests; the existing responsibilities and work-loads of health professionals, administrators and staff; and the availability of funds to pay overtime or hire additional staff. Moreover, in assessing burdensomeness, it may be necessary to consider factors outside the institutional environment, such as a practitioner's overall life circumstances.

A willingness to accept a burden, provided it is not a result of coercion or undue pressure and the agent is not overly servile or self-deprecating, may warrant inferring that the burden is not excessive. However, since there are situations in which it is justified to expect agents to bear burdens that they are unwilling to accept, an unwillingness to accept a burden does not warrant inferring that the burden is excessive. Hence, although the standard of excessiveness is partially subjective, it is not exclusively subjective.

To be sure, there undoubtedly are clear cases of burdens that are excessive and burdens that are not excessive. For example, if a nurse needs to be home to care for her young children during the night, requiring her to change from a day to a night shift would be an excessive burden. Similarly, it would be an excessive burden to require the only intensivist who is not morally opposed to donation after circulatory determination of death (DCDD) to be on call throughout the year for DCDD cases. By contrast, if accommodating a nurse who is morally opposed to DCDD does not require other nurses in the unit to significantly increase their workloads or alter their schedules, it would not be an excessive burden on the nurses. Setting up the accommodation also is unlikely to be an excessive burden on the nursing supervisor or administrator. Despite such clear cases, there is no bright line that separates burdens that are excessive from those that are not excessive, and there is no

consensus on a standard of excessiveness.[4] A fair process approach along the lines recommended below ("Procedures for Reviewing Requests for Accommodation") can help to develop standards for an institution and reduce actual and perceived arbitrariness in determining whether burdens are excessive.

The fourth requirement, advance notification, enables department heads and supervisors to accommodate conscience-based objections with a minimum of inconvenience and disruption. Moreover, since advance notification can give practitioners who are asked to substitute more time to make necessary professional and personal adjustments, such notification also can minimize burdens to them. Advance notification also can increase the likelihood that staffing assignments and schedule changes can be made to facilitate accommodation. For example, if a newly hired ob-gyn nurse informs a supervisor that she has a conscience-based objection to participating in second and third trimester abortions, an accommodation is more likely to be feasible than if she waits to inform the supervisor until she is asked to participate in a second trimester abortion. Finally, by facilitating continuity of services within the institution, advance notification also can minimize the burdens that patients will experience as a result of conscience-based refusals.

When health professionals do not object in principle to a medical intervention, such as abortion, DCDD, palliative sedation to unconsciousness, or forgoing MPNH, advance notification can be more challenging but still not infeasible. For example, a neonatal intensive care unit (NICU) physician and an NICU nurse are not ethically opposed in principle to providing aggressive treatment to pre-term neonates. Indeed, they both routinely provide such care. However, they both have conscience-based objections to continuing aggressive life support for one NICU patient, a pre-term infant with an extremely poor prognosis. Although continued aggressive treatment is contrary to the physician's conception of "good medicine" and the nurse's conception of "good nursing practice," it does not violate established professional norms and is not outside the boundaries of "appropriate medical/nursing care." To facilitate advance notification of NICU administrators, the physician and the nurse should attempt to identify their respective general criteria for deciding when providing aggressive treatment to premature newborns is contrary to their conceptions of "good medicine" and "good nursing practice," respectively. Generally, to facilitate advance notification, health professionals should attempt to anticipate the types of situations in which they are likely to request exemptions.

An Objection to the Four Recommended Requirements

It might be objected that the four recommended requirements are unsatisfactory because they can require health professionals to compromise their moral integrity.

[4] Title VII of the 1964 Civil Rights Act (42 USCS § 2000e et seq. (2005)) and regulations and guidelines issued by the United States Equal Employment Opportunity Commission (EEOC) govern the accommodations that employers in the U.S. are legally required to make. Employers are required to "reasonably accommodate" conscience-based objections of health professional employees unless it would result in an "undue hardship" on the employer. The EEOC provides interpretive guidelines and case examples that help to specify the concept of "undue hardship." They are posted on the EEOC Web site: http://www.eeoc.gov/; accessed December 29, 2013.

Undeniably, since the requirements are context dependent, satisfying them can require health professionals to compromise their moral integrity. For example, an ED physician with a conscience-based objection to EC is accommodated by arranging for other health professionals to provide information to patients about EC. However, in order to assure that rape victims receive timely information about EC, the physician is required to direct rape victims to another practitioner who will provide important medical information that he is unable to offer. However, the physician objects on grounds of moral complicity. Karen Brauer, president of Pharmacists for Life, exemplifies this conception of moral complicity when she defends the view that pharmacists with a conscience-based objection to filling prescriptions should not be expected to facilitate a transfer or provide referrals: "That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.' What's that saying? 'I will not off your husband, but I know a buddy who will?' It's the same thing" (Stein 2005).[5] Similarly, physicians with a conscience-based objection to offering palliative sedation to unconsciousness or writing orders to forgo MPNH might be required to compromise their moral integrity if they cannot be exempted without placing an excessive burden on other physicians, or if accommodation would impede timely disclosure to patients or their access.

In response, this objection fails to consider that individuals acquire special obligations when they enter a health profession. Obligations to respect patient autonomy and promote the health and well-being of patients are among the core professional obligations of clinicians. They are cited in major professional codes, such as the American Medical Association (AMA) *Code of Medical Ethics* (American Medical Association Council on Ethical and Judicial Affairs 2010) and the American Nurses Association (ANA) *Code of Ethics for Nurses* (Fowler 2008). The AMA *Code of Medical Ethics* even includes an obligation to give priority to the interests of patients: "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare (The Patient–Physician Relationship, Opinion 10.015). The ANA *Code of Ethics for Nurses* includes a similar obligation. Provision 2 states: "The nurse's primary commitment is to the patient…" (Fowler 2008, p. 150); and Provision 3 states: "the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient" (Fowler 2008, p. 152).

Depending on the circumstances, fulfilling one's professional obligations may require compromising one's moral integrity. Herein is a grain of truth in Julian Savulescu's claim that people who are "not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values…should not be doctors" (Savulescu 2006, p. 94).[6] Taken literally, this

[5] For a conception of complicity that accepts the ED physician's claim, see (Bayles 1979). For a conception of complicity that rejects the ED physician's claim, see (Chervenak and McCullough 2008). For a nuanced conception of complicity in the context of health care, see (Sulmasy 2008).

[6] Savulescu eventually qualifies this claim to permit conscientious refusals as long as they do not restrict patient access to health services. In addition, his primary concern is with physicians who are government employees, such as physicians within the British National Health Service.

advice would unnecessarily discourage individuals who have moral objections to providing legal and professionally accepted medical interventions and value their moral integrity from entering a health profession. However, it does serve as a reminder that individuals who plan to enter a health profession can minimize the risk of being in situations that threaten their moral integrity by judiciously selecting practice disciplines and specialties or sub-specialties. For example, pediatric residents who plan to pursue a fellowship and who have conscience-based objections to offering parents a full range of legal and professionally accepted end-of-life options should consider fellowships in areas other than critical care. Health professionals can further minimize the risk of finding themselves in situations that compromise their moral integrity by a careful choice of practice environments and locations. For example, a physician or nurse with a conscience-based objection to caring for patients who refuse MPNH should not practice in a hospice setting. Similarly, health professionals with a conscience-based objection to a medical service may find a more accommodation-friendly environment in a large urban medical center than in a small rural community hospital.

Procedures for Reviewing Requests for Accommodation

In some situations, there may be no need for a formal procedure to review and approve or deny requests for accommodation. For example, when an intensivist objects to continuing life support for a particular patient, common practice is for the physician to arrange a transfer of care to an intensivist who is willing to continue life support for the patient. And as long as there is a physician who is willing and able to accept the patient and continue life support, prior review and approval generally is not required. A similar practice is common when physicians object to discontinuing life support.

However, when health professionals are unable to find willing substitutes or when accommodation requires more pervasive reallocations of responsibilities within a service, unit, or institution, it may be appropriate to require a formal review of requests for accommodation. Criteria for triggering a formal review process may differ from institution to institution, but each institution's accommodation policy should specify when formal approval is required.

The assignment of responsibility for an initial review of accommodation requests may vary depending on the size and culture of the institution and frequency of requests. Options include department heads and supervisors, a designated administrator or ombudsperson, or the institutional ethics committee. However, considerations of efficiency may favor limiting the role of the ethics committee to providing assistance with hard cases, hearing appeals, conducting periodic reviews of past decisions, and fine tuning the policy. Whatever mechanism is chosen for initial review, it should be specified in the institution's accommodation policy.

If requests for accommodation are denied, health professionals should have an opportunity to appeal the decision. An opportunity for appeal can help to reduce the perception of arbitrariness as well as actual arbitrariness. It also can contribute to achieving the aim of properly determining when it is and is not justified to deny

requests to accommodate. The institutional ethics committee is an appropriate body to hear appeals. Review by a committee with a diverse membership is especially appropriate insofar as the four recommended requirements include unspecified context-dependent terms such as "timely" and "excessive." Whatever mechanism is chosen to review appeals, it should be specified in the institution's accommodation policy.

Reviewing Objectors' Reasons

The four recommended requirements provide a suitable framework for evaluating requests for accommodation and determining whether to approve or deny them or offer partial accommodation. They are limited to the expected impact on others (e.g., patients, other clinicians, department heads, and supervisors). However, some have maintained that a careful review of the objector's reasoning is also required.

Reasonableness

Robert Card claims that a "*critical evaluation* of the reasons for proposed conscientious objector status is essential," and he proposes the following requirement: "The beliefs on which conscientious objection is based must be reasonable and should be subject to evaluation in terms of their justifiability" (Card 2007, p. 13). He endorses a review of objectors' reasons that is "similar to the manner in which determinations of conscientious objector status work within the military" (Card 2007, p. 13).

Requiring health professionals to convince department heads, supervisors, or ethics committees that their reasons are *reasonable* and *justified* risks undermining a central objective of accommodation, which is to provide health professionals moral space to act according to *their* moral convictions and maintain *their* moral integrity. Card unwittingly illustrates this danger when he considers a hypothetical case of a pharmacist whose refusal to dispense contraceptives is based on the belief that "no contraception is morally permissible" (Card 2007, p. 12). Card maintains that this belief is unreasonable, and he defends this assessment by claiming that it "is inconsistent with the compelling fundamental idea that adults possess a moral reproductive right founded in autonomy" (Card 2007, p. 12). To be sure many, myself included, will agree that there is such a moral right. However, the point of accommodation is to give health professionals moral space in which they can act according to *their* convictions, and to shield them from being subject to the moral approval or disapproval of department heads, supervisors, and ethics committees.

Also subject to challenge is Card's claim that an appropriate model for reviewing requests for accommodation by health professionals is the review process for determining who qualifies for conscientious objector status in the military. First, it is doubtful that the objective of the military review process is to determine whether an applicant's reasons for requesting objector status are reasonable or justified. Rather, the primary objective is to determine whether they are the "right" reasons according to US law. As the Supreme Court identified the relevant right reasons in a landmark

1965 decision about Selective Service Act requirements for conscientious objector status, applicants must oppose *all* wars and their objections must be based on genuine, and deeply held moral or religious beliefs.[7] Requiring a substantive "right reason" from health professionals who request accommodation generally is inconsistent with the goal of providing them moral space to act according to their moral convictions and maintain their moral integrity.

Second, the rigorousness of the military review process does not provide an appropriate model for reviewing requests for accommodation by health professionals. Compelling reasons for requiring a rigorous review in the case of applicants for conscientious objector status in the military do not apply to health professionals. Conscientious objectors in the military receive exemptions from serving in combat that can significantly reduce the risk of death, serious injury, and emotional and psychological trauma. Arguably, fairness requires a rigorous test when determining which individuals to exempt from such substantial potential burdens and harms. By contrast, the conscience-based accommodations that that health care professionals receive generally do not exempt them from comparable burdens and harms. Moreover the third of the recommended requirements significantly reduces the risk of unfairly shifting burdens from health professionals who request exemptions to those who do not. In addition, in view of the substantial risks and burdens that military personnel can face, compared to health professionals there are much stronger incentives to feign conscientious objection to military service.

Genuineness

Some have proposed that reviews include an assessment of the *genuineness* or *sincerity* of a health professional's claimed moral objection (Meyers and Woods 2007; Kantymir and McLeod 2014). But what is the appropriate standard for determining whether a health professional's conscientious objection is sufficiently genuine or sincere to warrant accommodation? Kimberly Brownlee offers a possible standard (Brownlee 2012). Although she does not consider it specifically in relation to reviews of health professionals' requests for accommodation, it is a clearly articulated standard that warrants consideration.

Brownlee offers an analysis of "sincere moral conviction" in terms of the following four conditions (Brownlee 2012, pp. 29–30)[8]:

[7] *United States v Seeger* (380 U.S. 163 (1965)). The Selective Service Act in effect at the time required opposition to all war based on "religious training and belief" which was defined in the Act as "an individual's belief in a relation to a Supreme Being involving duties superior to those arising from any human relation, but [not including] essentially political, sociological, or philosophical views or a merely personal moral code." In *Seeger*, the Supreme Court held that the test of whether a belief is "in a relation to a Supreme Being" is "whether a given belief that is sincere and meaningful occupies a place in the life of its possessor parallel to that filled by the orthodox belief in God of one who clearly qualifies for the exemption. Where such beliefs have parallel positions in the lives of their respective holders we cannot say that one is 'in a relation to a Supreme Being' and the other is not."

[8] The four conditions are the characteristics of what Brownlee refers to as "the communicative principle of conscientiousness." That principle, she claims, "lies at the core of my analysis of what counts as 'sincere moral conviction'" (p. 29). Elsewhere, she refers to *genuine* moral conviction, and she appears to use these two terms interchangeably.

1. a *consistency condition* that holds between our judgements, motivations, and conduct to the best extent that we are able;
2. a *universality condition* that holds between our judgements of ourselves and our judgments of others;
3. a *non-evasion condition* that we bear the risks of honouring our conviction, which means that we not seek to evade the consequences for reasons of self-protection, and, in some cases, take positive action when appropriate to support our conviction; and
4. a *dialogic condition* that *ceteris paribus* we be willing to communicate our conviction to others so as to engage them in reasoned deliberation about its merits. Our willingness to defend our conviction to others is a mark of both our non-evasion and our belief that our conviction is sufficiently credible that it can be given a reasoned defense.

The first condition is uncontroversial and the second is a metaethical claim about the criterion of *moral* judgments and beliefs. It is beyond the scope of this paper to evaluate this metaethical claim. For the purpose of this discussion, the third and fourth conditions are particularly relevant, for they are said to distinguish all of our moral beliefs from those that are among "our deepest commitments" (Brownlee 2012, p. 7).[9]

Putting aside whether it is feasible for a department head, supervisor, or ethics committee to determine reliably whether a health professional satisfies the two conditions, arguably they are not suitable criteria for ascertaining the genuineness of conscientious objections in a health care context. Health professionals who refuse to provide a legal, professionally acceptable, and clinically appropriate medical intervention within the scope of their competence can fail to satisfy the non-evasion and dialogic conditions due to a number of factors other than their underlying moral convictions are not sincere or not among their "deepest commitments." Other factors include the following: (1) They are shy, non-assertive, non-confrontational, or risk averse. Even if these are considered flaws in moral character, it would not follow that their convictions are not sincere moral convictions. (2) Based on their own experience or the experience of others, they believe that attempting to engage in fruitful dialogue with individuals who do not share their values is futile, frustrating, aggravating, annoying, unproductive, and ultimately a waste of time. (3) They believe, contrary to Brownlee, that satisfying the dialogic condition is incompatible with respect for the agency and dignity of others. Even if Brownlee is correct, and that belief is mistaken, it does not follow that a health professional who accepts that (false) moral belief cannot have sincere moral convictions. Indeed, health professionals might fail to satisfy the dialogic condition when they refuse to provide a medical service that is contrary to their deep moral convictions because they believe that it is inappropriate to communicate moral disapproval to patients or to engage in what might (rightly or wrongly) be perceived as "badgering." Hence, there is reason to question the non-evasion and dialogic conditions as appropriate

[9] As Brownlee puts, it: "our deepest commitments come with non-evasive, dialogic efforts" (p. 7).

standards for assessing the sincerity or genuineness of health professionals' conscientious objections.

Unlike Brownlee, Christopher Meyers and Robert Woods offer a standard of genuineness that is intended specifically for evaluating health professionals' requests for accommodation (Meyers and Woods 2007). They propose an "extensive list" of six criteria for determining whether a claimed conscientious objection is genuine. Satisfying the six criteria "requires the petitioner to have and to be able to articulate a well-developed and sophisticated moral position" (Meyers and Woods 2007, p. 20). They agree with Card that the military review process is an appropriate model: "we recommend a system similar to that used for exemption from military service, one that incorporates a review board for evaluating genuine claims of conscientious objection" (Meyers and Woods 2007, p. 20). They also recommend that the review board include "a diversity of racial, ethnic and religious beliefs and academic training," members from a variety of disciplines, and community representatives (Meyers and Woods 2007, p. 20). The apparent intent of this diversity requirement is to protect the moral integrity of health professionals who request accommodation by ensuring that they will get a fair and unbiased hearing and that they will not be refused accommodation due to a judgment that their objection is based on unsound values.

To achieve this range of diversity, the review board would have to be relatively large (i.e., at least 12–15 members). From a practical standpoint such a large body is more suited to hear *appeals* of initial reviews by department heads and supervisors. More importantly, it is questionable that military review boards offer a model for assessing the genuineness of health professionals' conscientious objections that satisfactorily protects their moral integrity. According to the military model, the primary function of the review process is to ascertain whether health professionals who request accommodation are able to demonstrate to *others* (e.g., department heads, supervisors, or ethics committees) that they meet a specified standard of genuineness. There is a less adversarial conception of the review of genuineness that is more protective of health professionals' moral integrity. According to this conception, the primary function is to engage health professionals in a process of reflecting on the nature and depth of their objection. The objective is to facilitate moral clarity on the part of health professionals who request accommodation rather than to enable department heads, supervisors, or ethics committees to determine whether conscientious objections are sufficiently genuine.

Meyers and Woods report having discovered some local physicians "declared conscientious objection out of economic or aesthetic concerns, rather than genuinely moral or religious reasons" (Meyers and Woods 2007, p. 20). If these physicians would have had an opportunity to discuss their objections with someone who is designated to review requests for accommodation, they might have come to understand that that there are significant differences among economic, aesthetic, and moral reasons; and they also might have come to understand that accommodation of conscientious objection is intended exclusively for *moral* objections.

Health professionals also can have moral objections to actions when their objections are not based on core moral beliefs. Although performing such actions

might give rise to feelings of unease or discomfort, they do not rise to the level of threatening an agent's moral integrity. For example, an intensivist might object to maintaining a severely demented elderly patient on life support because she believes it is an unjust use of resources. When discussing the grounds of her objection with her department head, the intensivist might realize that maintaining the patient on life support does not threaten her moral integrity—she routinely accepts comparable injustices—and avoiding the discomfort she experiences would not justify placing additional burdens on her colleagues.

To be sure, there may be cases in which the person or persons conducting a review and a health professional disagree about the genuineness of the latter's conscientious objection. In cases in which health professionals steadfastly insist that their moral integrity is at stake, the value of protecting the moral integrity of health professionals favors a policy of deferring to their own assessment of genuineness. This deference to health professionals' own judgments applies only to an assessment of the genuineness of their conscientious objections. It is the responsibility of department heads, supervisors, and/or ethics committees to determine whether the recommended four requirements are satisfied and accommodation is warranted.

Three Reason-Based Grounds for Denying Accommodation

Although respect for moral integrity favors deferring to health professionals with respect to genuineness, there are three legitimate grounds for denying accommodation based on an assessment of the objector's reasons. Accommodation may be denied if a review of the objector's reasons ascertains that the refusal is based on: (1) invidious discrimination, (2) beliefs contrary to acknowledged goals of health care, or (3) demonstrably false clinical beliefs.

Invidious Discrimination

It is a settled view—one based on defensible and widely shared conceptions of justice, equality, dignity, and respect—that racial, ethnic, religious and gender-based prejudice or bias are ethically wrong. Various health care professional codes of ethics, such as the AMA *Code of Medical Ethics* (American Medical Association Council on Ethical and Judicial Affairs 2010) and the ANA *Code of Ethics for Nurses* (Fowler 2008), prohibit invidious discrimination. Hence, general ethical considerations as well as professional codes of ethics support a policy of denying accommodation if conscience-based refusals are based on invidious discrimination.

It is, of course, possible to question whether a particular specification of the scope of invidious discrimination is justified. For example, although it is a settled view that race-based prejudice is ethically unacceptable, it might be questioned whether moral disapproval of gay, lesbian, bisexual, or transgendered (LGBT) patients reflects prejudice or unjustified bias. The AMA added sexual orientation to the specified types of prohibited invidious discrimination in 1993 and gender

identity in 2007.[10] This expansion indicates that the scope of prohibited invidious discrimination within a profession can change over time. Such changes correspond to changes in accepted views within and outside the profession about the scope of invidious discrimination and, arguably, appropriately limit conscience-based refusals.[11]

Beliefs Contrary to Acknowledged Goals of Health Care

Accommodation may be denied if the objection is based on beliefs that are incompatible with acknowledged goals of health care, such as promotion of health and alleviation of pain (Callahan 1996). Suppose, for example, after experiencing a religious conversion, an internist no longer will provide pain medication to terminal cancer patients or refer them to a palliative care service. He now believes that pain is God's punishment for sin and promoting pain relief would thwart God's justice. He requests exemption from any direct or indirect involvement in alleviating patients' pain. Arguably, the internist's request for accommodation may be denied on the grounds that alleviating pain is a core goal of medicine. In such very unlikely situations, it justifiably can be said that someone who has a conscience-based objection to relieving pain should not enter disciplines, such as internal medicine, palliative care, or nursing, that are committed to that goal.

Demonstrably False Empirical Beliefs

Requests for accommodation based on demonstrably false empirical beliefs may be denied. Such cases are likely to be extremely rare. One example is a pharmacist whose conscience-based objection to dispense EC is based on mistaken beliefs about its mechanism of action. A study of South Dakota pharmacists reported that 36.6 % of the respondents did not correctly identify the mechanism of action of EC, and 19 % incorrectly identified it as most similar to that of the abortifacient mifepristone (Van Riper and Hellerstedt 2005). Another study reported that 35.8 % of New Mexico pharmacists surveyed mistakenly believed that "[o]ral emergency contraception is also known as RU-486" (Borrego et al. 2006, p. 37). Such mistaken beliefs about EC are not limited to pharmacists. For example, similar findings are reported for family medicine physicians and nurses (Wallace et al. 2004). If such demonstrably mistaken beliefs about the mechanism of action of EC are essential to a health professional's conscience-based objection to dispense it, no accommodation is warranted.

[10] The AMA Board of Trustees (BOT) approved adding discrimination on the basis of sexual orientation in 1993 and the House of Delegates (HOD) approved it five years later. See (Schneider and Levin 1999, pp. 1287–1288) The BOT approved the addition of gender identity in 2007 (BOT Report 11, E-9.03, "Recommendations to Modify AMA Policy to Ensure Inclusion for Transgender Physicians, Medical Students, and Patients"). The Council on Ethical and Judicial Affairs (CEJA) approved it in the same year (CEJA Report 2-I-07).

[11] An example outside the health care professions is the explicit prohibition of employment discrimination based on gender identity that was added to the US federal jobs website in January 2010. See (Knowlton 2010, A15).

Kantymir and McLeod propose a constraint against "baseless" empirical beliefs (Kantymir and McLeod 2014). They maintain that "empirical beliefs that ground a healthcare professional's objection need to be defensible" (Kantymir and McLeod 2014, p. 19).[12] Their language suggests, perhaps unintentionally, that health professionals have the burden of demonstrating that their empirical beliefs are defensible and not baseless. However, to better protect the moral integrity of health professionals, those who conduct reviews of objectors' reasons should have the burden of ascertaining that an empirical belief is demonstrably false.

Conclusion

Fair, consistent, and transparent management of conscience-based refusals requires an institutional policy. Institutional policies can promote the goal of accommodating health professionals' conscientious objections and protecting their moral integrity without significantly compromising other important values and interests by incorporating the following four requirements: (1) Conscience-based refusals will be accommodated only if a requested accommodation will not impede a patient's/surrogate's timely access to information, counseling, and referral. (2) Conscience-based refusals will be accommodated only if a requested accommodation will not impede a patient's timely access to health care services offered within the institution. (3) Conscience-based refusals will be accommodated only if the accommodation will not impose excessive burdens on other clinicians, supervisors, department heads, or the institution. (4) Whenever feasible, health professionals should provide advance notification to department heads or supervisors.

In some situations, for example if a physician who objects to providing care for a particular patient is able to facilitate an intra-institutional transfer to another physician, there may be no need for a formal procedure to review and approve or deny requests for accommodation. However, there will be situations, for example, when accommodation requires pervasive reallocations of responsibilities within a service, unit, or institution, when it is appropriate to require a formal review of requests for accommodation. Different institutions may adopt different criteria for triggering a formal review process, but each institution's accommodation policy should specify when formal approval is required.

The assignment of responsibility for an initial review of requests for accommodation may vary depending on the size and culture of the institution and frequency of requests for accommodation. Options include department heads and supervisors, a designated administrator or ombudsperson, or the institutional ethics committee.

[12] The example they cite is a physician who supports a refusal to give children the MMR (Measles, Mumps, and Rubella) vaccine by claiming there is a link between the vaccine and autism. There is a significant difference between this example and the example of mistaken beliefs about the mechanism of EC. In the MMR case, if the belief about the connection between the vaccine and autism were true, a physician would have a reason to object to giving it on *clinical* grounds. By contrast, if the belief that EC is an abortifacient were true, that belief would not give health professionals a reason to object to it on clinical grounds. Instead, health professionals who are morally opposed to abortifacients would then have an *ethical* reason to refuse to prescribe, dispense, and administer EC.

However, considerations of efficiency may suggest limiting the role of the ethics committee to providing assistance with hard cases, hearing appeals, conducting periodic reviews of past decisions, and fine tuning the policy. Whichever mechanism is chosen for initial review, it should be specified in the institution's accommodation policy.

If requests for accommodation are denied, health professionals should have an opportunity to appeal the decision. An opportunity for appeal can help to reduce the perception of arbitrariness as well as actual arbitrariness. It also can contribute to achieving the aim of properly determining when it is and is not justified to deny requests to accommodate. The institutional ethics committee is an appropriate body to hear appeals. An explanation of the appeals process should be included in the institution's accommodation policy.

When reviewing a health professional's reasons for requesting accommodation of a conscientious objection, the review process should avoid an adversarial approach, such as that adopted by military review boards when they assess applications for conscientious objector status. According to the recommended non-adversarial approach, the primary function of reviews of objectors' reasons is to engage them in a process of reflecting on the nature and depth of their objections. The objective is to facilitate moral clarity on the part of health professionals who request accommodation rather than to enable *others* (e.g., department heads, supervisors, or ethics committees) to determine whether conscientious objections are sufficiently genuine. Compared to an adversarial approach modeled on the military review process, this approach has the advantage of being more protective of health professionals' moral integrity.

When reviewing the genuineness of a health professional's conscientious objection and there is a disagreement between the person(s) conducting the review and the health professional, respect for moral integrity favors accepting the latter's assessment. However, there are three legitimate grounds for denying accommodation based on the objector's reasons. Accommodation may be denied if the objection is based on: (1) invidious discrimination, (2) beliefs that are contrary to acknowledged goals of health care, or (3) demonstrably false empirical beliefs.

Clinicians may refuse to provide medical goods and services for a variety of reasons other than conscience-based objections. One reason that appears to be increasing in frequency is economic: refusing to provide services to patients due to a physician's belief that reimbursement rates are inadequate (Bindman and Coffman 2014). The decision to limit the scope of this paper to conscience-based refusals in no way reflects a judgment that such refusals do not warrant careful ethical scrutiny. Rather, it is based on the recognition that the two reasons for refusing to provide a medical good or service are significantly different and require substantially different analyses and responses.

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