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Current characterization of conscientious objection: a critical and renewed proposal

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Abstract

This article characterizes "conscientious objection" – surrounded by controversies and marked by the absence of a unified definition – and the limits of its exercise. From a critical literature review approach, the objective is to propose a definition for the term. For such, situations where conscientious objection is wrongly invoked or serves as a pretext for unethical behavior were identified, and an attempt to establish the elements that truly compose such objection was made. The proposed concept intends to contribute to clarifying the matter and establishing fair limits to the ethical exercise of this right.

Keywords: Professional autonomy. Conscious refusal to be treated. Medical ethics.

Resumo

Caracterização atual da objeção de consciência: proposta crítica e renovada

O artigo caracteriza a "objeção de consciência" – cercada por controvérsias e marcada pela ausência de definição unificada – e os limites de seu exercício. O objetivo da pesquisa, baseada na abordagem de revisão crítica de literatura, é propor uma definição para o termo. Para isso, identificaram-se situações em que a objeção de consciência é erroneamente invocada ou serve de pretexto para comportamentos antiéticos, e se procurou estabelecer os elementos que verdadeiramente compõem tal objeção. O conceito proposto pretende contribuir para esclarecer o assunto e estabelecer limites justos ao exercício ético desse direito.

Palavras-chave: Autonomía profesional. Recusa consciente em tratar-se. Ética médica.

Resumen

Caracterización actual de la objeción de conciencia: propuesta crítica y renovada

El artículo caracteriza la "objeción de conciencia", rodeada de controversias y marcada por la ausencia de una definición unificada, y los límites de su ejercicio. El objetivo de la investigación, basada en el enfoque de la revisión crítica de la literatura, es proponer una definición para el término. Para ello, se identificaron situaciones en las que la objeción de conciencia se invoca erróneamente o sirve de pretexto para conductas poco éticas, y se intentó establecer los elementos que verdaderamente componen dicha objeción. El concepto propuesto pretende contribuir a clarificar el tema y establecer límites justos al ejercicio ético de este derecho.

Palabras clave: Autonomía profesional. Rechazo conciente al tratamiento. Ética médica.

Update

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Conscientious objection is the refusal to perform a certain action that goes against the dictates of one's own conscience [1-3]. These are resources used by several health professionals when faced with ethical conflicts between the nature of a certain professional act requested and the freedom of conscience itself. As a rich subject of study in the field of bioethics, it involves the interaction between moral, legal and deontological aspects and, by definition, its use necessarily occurs during an ethical conflict.

Although this feature is easily identifiable in deontological documents and in the Brazilian Constitution, its application still presents some limitation to the patient's autonomy and, depending on circumstances, to the accessibility of certain procedures in the health system [4]. Furthermore, its conceptualization is significantly heterogeneous, and conscientious objection is often wrongly used as a false justification for discriminatory behavior, a situation created and aggravated by the absence of criteria that clearly identify it. Reflecting on these issues from a bioethical perspective is essential.

In Brazil, conscientious objection is clearly provided for in the current Code of Medical Ethics (CEM) and its previous versions. Brazil's first medical ethics code appeared in 1929 and its ninth version is currently in force, published in 2018 [5]. The excerpt from the CEM that most clearly represents conscientious objection is found in Article VII of Chapter I, which reads: *the physician will exercise his profession with autonomy, not being obliged to provide services that contravene the dictates of their conscience or to those who do not wish to, except in situations where another physician is absent, in case of urgency or emergency, or when their refusal could harm the patient's health* [5]. A second excerpt, which is fundamental for understanding the subject, is item IX of Chapter II, which establishes to the ability to *refuse to perform medical acts that, although permitted by law, are contrary to the dictates of their conscience* [5] as a professional right of this category.

Despite being used in the field of bioethics for several decades, the term "conscientious objection" has no single definition and is used in quite a variable manner – with differences in meaning that substantially alter the character of the discussion and understanding of the theme. Thus, this article proposes a definition for conscientious objection, identifying situations in which the term should not be used and relating elements that in fact characterize it. The methodological approach of this work is that of a critical literature review. We sought to select sources from renowned authors, as well as articles from journals that address the topic with a present-day perspective. The Brazilian Code of Medical Ethics in its most recent version was also widely used.

What conscientious objection is not?

Below, we seek to identify and briefly analyze situations in which conscientious objection has been wrongly applied.

Conscientious objection is not discrimination

In a public knowledge case that occurred in 2016, a pediatrician, working in Porto Alegre, informed a patient, affiliated to a certain political party, that she could no longer continue to regularly treat her 1-year-old son, due to the parent's political position. The child was sick and had an appointment scheduled for a few days after the information was given, and the mother reports having found it difficult to arrange appointments with a new professional, as the situation happened on the eve of a holiday [6].

This illustrates a situation that could be erroneously labeled a conscientious objection, but that is, in fact, discrimination of a political nature. Analysis of this case shows that the physician's objection was not related to the professional act itself, that is, to the act of medical consultation in pediatrics, but to the people involved – in this case, the patient's parents. This example provides the first characteristic of conscientious objection that was not present in such a situation: true conscientious objection never refers to the people involved, but rather to the actions expected from the professional.

Conscientious objection is not an omission of help

In emergencies, a physician is not allowed to refuse care, regardless of the circumstances. In such situations, one must act quickly to ensure the best care for the individual – there is no room for discrimination of any kind, whether political, ethnic, economic or due to sexuality, gender, personal affinity, etc. The value of a life at risk outweighs the importance of any other circumstance. CEM, in its Chapter V, article 33, declares that physicians are forbidden *from not attending to patients who seek professional care in urgent or emergency cases when there is no other physician or medical service able to do so* [5].

A very common situation in the clinical practice of trauma hospitals is the care of patients caught in the act and injured during police actions, or who were already serving time and needed medical care, taken to the hospital by the police. What would medical practice be like if a professional refused to care for these patients based on the individual's character, conduct or suitability? Physicians cannot make assessments of this kind in emergency contexts – life-threatening relief must always be their priority.

Likewise, in the classic situation of conscientious objection to abortion, the same physician who refuses to participate in an abortion cannot legitimately refuse care to a woman with complications arising from an abortion that is already in progress. In the first situation, even if arguably, the professional refuses to induce abortion, an act that can be morally questioned. On the other hand, when the professional is expected to treat a patient with severe vaginal bleeding – no matter if it results from a miscarriage, induced abortion or any other clinical situation – there is no room for conscientious objection. This occurs for two reasons: the fact that it is an emergency situation and the fact that, as already argued, the professional's expected act is not loaded with moral weight.

Conscientious objection is not self-preservation

Some authors argue that conscientious objection would be related to an unjustified desire for self-preservation. Savulescu [7], for example, identifies inconsistency in the exercise of such an objection. For the author, the objector's attitude would be similar to that of the physician who refuses to treat patients in an epidemic for fear of being contaminated. Savulescu then questions how is it possible that religious values serve as an argument for conscientious objection, given that the very need for physical preservation – which in his opinion is hierarchically superior to religious values – cannot prevail over the professional's duty. The same view is shared by Stahl and Emanuel [8].

In part, the confusion arises because conscientious objection is often considered a professional's individual right. Undoubtedly, its exercise is personal and optional, however, it is not a right that aims at the good of the individual who exercises it, but rather not to cause supposed harm to others [9]. It can be said that conscientious objection is primarily an attempt at *hetero-preservation*, not *self-preservation*.

Not by chance, this right is exercised in extreme situations often related to the beginning or end of life [1]. In such situations, there is no consensus on the best conduct, as there is no unanimity on how to rank the different values at stake – hence the need for a contribution from bioethics. Placed in conflict and confronted with some component in relation to which society has already defined, with greater or lesser depth of discussion, its particular priority of values (country legislation, health system, hospital regulations, etc.), the professional chooses not to act out of fear of causing harm to the patient, however debatable such fear may be.

Conscientious objection is not simple refusal

The CEM [5], in its item VII of Chapter I, differentiates the refusal of care for reasons of conscience and the refusal of care to whom the professional does not wish to serve, which we propose to call, for didactic purposes, "simple refusal." But what is the need to differentiate between simple refusal and refusal for reasons of conscience? And why is confusion between these two terms so frequent?

Wicclair emphasizes the importance of differentiating these terms. According to the author, *refusals that are not conscience-based*

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can include those that derive from self-interested reasons and considerations of professional integrity. (...) However, insofar as a refusal is based exclusively on one or both of these reasons and not on a practitioner's core moral beliefs, it is not conscience-based [10].

Considering that simple refusal has no motivation specified in the medical professional regulations, being simply the refusal to care for whom the professional does not wish to, the reasons behind such refusal are not particularly relevant, as long as the three exception conditions are respected: possibility of replacement by another professional, absence of urgency or emergency and absence of harm to the patient. In this context, why not place the motives of conscience in the category of unspecified motives?

Assessing the interaction between refusal for reasons of conscience and its respective exceptions is more complex than simple refusal. This is precisely because the values compared are more equivalent in refusal for reasons of conscience than in simple refusal. In other words, in conscientious objection, the patient's autonomy and the physician's autonomy are much more aligned. In this case, medical autonomy is exercised based on more relevant arguments. The real refusal by conscience is necessarily based on reasons considered serious by the objector. These are, necessarily, moral issues, and not just practical ones, as in simple refusal.

Conscientious objection is not exercised by the patient

It is evident that the patient, as well as the physician, has a conscience, and that this can also be contradicted. The patient can choose not to perform a certain action for reasons of conscience. However, the concept of conscientious objection refers to situations of conflict of conscience of the professional, and not the patient.

This is not because the physician's conscience would be more important than the patient's. When the patient, for some reason, including conscience, decides to refuse a certain procedure or treatment, this conflict is already covered in issues related to their autonomy, such as the elaboration of advance directives of will or even the therapeutic refusal itself. After this discussion, we move on to the next section, where we shed some light on the nature of true conscientious objection.

What is conscientious objection?

Below are the definitions cited by authors who have written about the topic. Fiala and Arthur state that conscientious objection is *usually defined as the refusal by a health professional to provide a legal medical service or treatment for which they would normally be responsible, based on their objection to the treatment for personal or religious reasons* [11]. Later, in the same article, the authors propose a slightly different definition: conscientious objection would be *the refusal to provide a legal treatment that the patient requests and needs, based on the provider's subjective, personal belief that the treatment is immoral* [12].

According to the Canadian Nurses Code of Ethics, conscientious objection is *a situation in which nurses inform their employer about a conflict of conscience and the need to stop providing care because a practice or procedure conflicts with the nurse's moral beliefs* [13]. According to the most recent version of the CEM, the element of conscientious objection includes two main aspects: the right to refuse care for reasons of conscience and the right to stand by such a decision, even if opposed to the current law [5]. In addition, three exceptions to the exercise of this right are mentioned: the absence of a substitute, cases of urgency or emergency, and the risk that the refusal will cause harm to the patient.

Based on the exposed so far, we then seek to identify elements that we consider essential for true conscientious objection, as opposed to those that should be rejected in the search for an adequate definition.

Freedom of conscience and refusal

The CEM establishes that *the aim of all physicians' attention is human health, for the benefit of which they must act with the utmost zeal and to the best of their professional capacity* [5]. Sgreccia states that *the physician is the professional*

called and freely chosen by the patients and accepted by them (...) *to help prevent the disease or treat it or rehabilitate the person's strengths and capacities* [14].

CEM [5] itself contains several excerpts that show the search for the ideal balance between respect for the patient, seeking to do good and professional freedom. In chapter I, items XIX and XX, we see that *the physicians will be responsible, in a personal and never presumed way, for their professional acts, resulting from a private relationship of trust, and carried out with diligence, competence and prudence*, and that *the very personal nature of the physician's professional relationship does not characterize a consumption relationship* [5]. Additionally, chapter V of the same document, article 31, prohibits the physician from *disrespecting the right of the patient or their legal representative to freely decide on the execution of diagnostic or therapeutic practices, except in case of imminent risk of death* [5].

It is evident that both the physician and the patient are entitled to some degree of freedom [15]. Neither the physician has the right to make authoritarian decisions, nor does medical practice characterize a consumption relationship, in which the patient would be a client who pays for a service and can unequivocally demand its fulfillement [16]. Wicclair [17] proposes that medical professionals' decision-making should be guided, on the one hand, by a sense of obligation towards the patient (and not by self-interest) and, on the other, by ethical values and professional standards. Physicians cannot act as technicians who perform services on demand. And it is precisely at the interface between these two freedoms – the patient's and the professional's – that the conflict of conscientious objection arises.

To understand the professional's freedom, the concept of responsibility must be addressed. According to CEM, Chapter III, Article 4, the physician cannot *fail to assume responsibility for any professional act that he/she has practiced or indicated, even if requested or consented to by the patient or their* legal representative [5]. It is inferred, therefore, that the patient's choice, even if absolutely free, does not relieve the physician of their own responsibility in a given professional act.

Understanding this idea is useful to review the concept of "human act." According to Silveira, while talking about Thomistic anthropology, *there is no exclusively human act that does not proceed from intelligence and will, understanding and volition. In other words, involuntary acts are not a human property, as other animals also perform them. We are, therefore, free in the act of choice (electione) which is rooted in the will, i.e., the intellectual appetite for the good* [18]. In the words of St. Thomas himself, *as man fully knows the end of his action and moves himself, it is in his actions that the volunteer manifests himself to the full* [19]. Orr [20] also draws attention to the issue of moral complicity in matters of conscience, stipulating that this complicity is greater the more directly involved the individual in the act in question.

It is essential to understand the medical act as a human act that, as such, depends on the use of intelligence and will and presupposes a responsibility that goes beyond mere acquiescence to the patient's desire. Thus, the first element to characterize conscientious objection is identified: the professional freedom of conscience and refusal.

Patient autonomy, which has brought unquestionable gains to the balance of clinical practice in recent decades, is not neglected in this perspective. However, as Pellegrino and Thomasma point out, autonomy is not absolute or unlimited *and cannot be used for purposes that are hostile to the intrinsic goods of individuals and society* (...) *without moral danger* [21]. Although models based solely on patient autonomy are often contrasted with the paternalistic model [22], Pellegrino and Thomasma suggest an unexpected similarity between them: *we do not see a real difference between the autonomist model and medical paternalism. Both models emphasize individual decision making; both emphasize the freedom from restriction that society can impose on individuals. For the autonomy model, freedom belongs to the patient. For the paternalistic model, it belongs to the physician* [23].

It is clear that conscientious objection – despite being seen by some as just another facet of the well-known medical paternalism [24,25] – concerns a much deeper theme: the interaction between two valuable types of freedom. The patient's freedom, or autonomy, cannot in any way be abolished. However, the freedom of the professional, who is also a moral subject, must have a place in clinical practice. From these considerations, we identify that conscientious

objection presupposes a health professional capable of acting in a moral manner, that is, freely and in line with their own values.

Objection to the act

As exemplified in the previous section, true conscientious objection refers to the proposed acts, not the person requesting them. This is a key condition, as it is through it that the very frequent confusion between conscientious objection and discriminatory acts is avoided.

For conscientious objection to be considered legitimate, the professionals must refuse to perform the act in question consistently, that is, their objection extends to all analogous cases with which they are confronted. This condition is necessary because, from the objector's point of view, the immorality of the act must be intrinsic, not circumstantial.

For this condition (consistency) to be satisfied, a logical reasoning behind the refusal is necessary. Otherwise, it has an arbitrary character that makes it invalid. Therefore, the philosophical or religious basis that motivated the refusal must be rationally defended, otherwise it is unreasonable. In summary, it is essential that the objectors, after choosing the criterion they consider correct, maintain a logical and consistent set of subsequent actions [26]. It is also extremely important that conscientious objection refers to the specifically proposed act and not to the person requesting it [8].

Objection with the sole intention of non-harm

To be acceptable, it is imperative that conscientious objection be exercised with the intention of not harming others, and not for one's own benefit; however, great confusion lies in this argument. As already noted, for many authors, the claim of conscientious objection is nothing more than a way for professionals to satisfy some of their own needs [24,25,27], as to alleviate psychological discomfort. For such authors, it seems absolutely immoral that the professional's subjective need is superimposed on the patient's autonomy.

It is therefore appropriate to question the intention of those who refuse to perform a certain act for reasons of conscience. Undoubtedly, if the professional's objective is solely personal gain, such as working less or preserving themselves from the inconvenience of participating in a procedure, there is no ethical justification for the objection. Lamb [9] also points out that, when exercised based on inadequate motivations, such as racism, preferences and power imbalances, conscientious objection is ethically compromised.

For this reason, objection must be based on the nobility of intention, that is, the professional must act in a virtuous manner. According to Pellegrino and Thomasma, *virtue implies a character trait; an internal disposition that habitually seeks the moral perfection of living life in accordance with the moral law, and to achieve a balance between noble intention and mere action* [28]. According to the authors, no *civilized society could last without a significant number of citizens committed to this concept of virtue* [28]. Based on these considerations, another important point is outlined for the proper exercise of conscientious objection: the intention of not harming, never refusing by self-interest.

Non-coincidence between objector and the one who is affected

As already argued, it is not convenient to call the patient's refusal to a given procedure a "conscience objection." This is because the conflict of objection arises precisely from the contradiction between the one who objects (the professional) and the one who is most directly affected by such objection (the patient). Precisely because it is a decision made by someone other than the patient, conscientious objection is quite complex.

A purely semantic issue motivates the stipulation of this criterion. Naturally, when a patient refuses treatment, they may do it, among other reasons, for reasons of conscience. *Lato sensu*, this act of the patient could be called "conscience objection." In that case, however, the vagueness surrounding the term would be further aggravated.

Since conscientious objection, in the context of health, is a concept created and studied regarding a *professional* decision, it would not be enlightening to confuse the term with issues that concern the *patient*. Thus, it is suggested that the "conscientious objection" exercised by the patient to be simply called "autonomy."

Absence of imminent risk of death

Among the three exceptions to conscientious objection suggested by CEM [5], the one that seems most relevant is the absence of an urgent/emergency situation. It is understandable that, if the clinical situation in question brings imminent risk of death (which would constitute an emergency, more than urgency), the professional's main focus should be the maintenance of the patient's life, above any other value. What differentiates urgency and emergency is mostly the fact that, in the latter, the risk of death is not only present but also imminent [29].

Also in other topics, the CEM establishes the imminent risk of death as a limitation on the exercise of rights. With regard to obtaining the patient's consent – considered mandatory from the ethical point of view – the physician is under no obligation to request it in case of imminent risk of death, according to article 22 of CEM's Chapter IV [5]. Moreover, chapter V, article 31, prohibits the physician from *disrespecting the right of the patient or their legal representative to freely decide on the execution of diagnostic or therapeutic practices, except in case of imminent risk of death* [5]. In these cases, the imminent risk of death, and not just an emergency situation, is necessary so that another important value is placed in the background.

Urgency is not enough to legitimize the exception. There must be an emergency condition, i.e., an imminent risk of death, to justify the overlap with another important value. In the examples cited, this risk is stipulated as a condition for the patient's consent and right of decision, which are very important values, to remain in the background. Likewise, conscientious objection – also an important value, as a manifestation of professional freedom – should only be overcome when there is a condition serious enough. Therefore, we propose to limit it only to the *imminent* risk of death, without extending it to urgency, which is a serious condition, but not immediately fatal.

Contraposition to current law

Despite being an infra-legal document, it is interesting to observe how CEM contraposes conscientious objection to the current law. Justice and law bear a significant axiological dimension. From the Aristotelian point of view, law and virtue are inseparable. According to Pegoraro, *justice is the total virtue, as it prescribes obedience to the laws and respect for equality among citizens* [30]. The author adds that justice, in Aristotelian ethics, is a virtue inherent to the subject, and our actions can only be considered fair or unfair if voluntary.

This conception of justice is completely dependent on the value it contains. Thus, it is at the interface with the value aspect contained in the law that conscientious objection operates. As it is an exercise in moral, responsible, and conscientious action, according to the principles defended by the objector, although conscientious objection confronts current law, it can be justified as an ethical way of defending moral principles dear to society.

In this regard, Finnis asks: *given that the legal obligation presumably entails a moral obligation, and that the legal system is generally fair, does an unfair law in particular impose on me any moral obligation to obey it?* [31]. The author begins by establishing that *the ruler does not, very strictly speaking, have the right to be obeyed* (...); *but he has the authority to give guidelines and make laws that are morally binding and which he has the responsibility to implement* [32]. After alerting to the fact that laws created against reasonable principles should not necessarily be regarded as unfair, and that those who are not unjustly affected by such law have no right to disobey it, Finnis concludes that unfair laws do not oblige the subject to their fulfillment, because they are devoid of moral authority.

Rawls, in turn, establishes a concept of conscientious objection that is not synonymous with civil disobedience, such as *non-compliance with a more or less direct legal requirement (or administrative command)* [34]. The author also emphasizes that the principles on which conscientious objection is based are not necessarily political.

The discussion leads us to a final feature that seems pertinent to an adequate definition of the concept of conscientious objection: true conscientious objection holds sufficient grounds to be exercised even when it contradicts the prevailing law. Also: such an objection only has reason to be when the act it objects is legal. If it were not, it would not be necessary to resort to it, but simply to justify that the proposed act is illegal.

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Final considerations

Considering all the important characteristics to delimit the term "conscientious objection" listed in this text, a more detailed and precise conceptualization is proposed below than those frequently found in academia. The proposition of this concept does not aim in any way to exhaust the discussion, but rather to breathe new life into it. It would be very useful if this concept served as a basis for further reflection, basing the debate on a common denominator, perhaps for further improvement. Thus, we seek to contribute, albeit minimally, to clarify the matter and reduce the inappropriate use of the term.

Considering all the elements previously explored, the following concept is proposed: conscientious objection is the physician's right to refuse to perform a certain legal medical act, one that is considered by the professional as harmful to the patient and intrinsically immoral, based on a well-founded, reasonable and clearly understood basis of values by the objector, and such right must be removed in situations of imminent risk of death, when the act is the only ethical way to save the life at risk.

In this conceptual proposal, all the elements considered relevant across this study can be found: the professional's right to freedom of conscience; the objection to the proposed act, and not to the person proposing it; logical and consistent motivation; refusal with the obligatory intention not to harm the patient; the fact that the one who objects is the professional, in contrast to other conflict situations such as therapeutic refusal; the impossibility of exercising it when the medical act is the only way to save a life at imminent risk; and the maintenance of the validity of conscientious objection even when it confronts the current law.

Although CEM proposes the absence of another substitute professional as an exception to the exercise of conscientious objection, we do not consider this exception valid enough. A professional who refuses to perform a certain procedure, according to all the criteria established here, does so in a way that does not go against their conscience, which indicates, according to his reasoning, that the proposed act is harmful to the patient. Thus, this refusal rather contradicts what the law establishes, as their conviction is robust and made despite any personal advantage. In this context, in the so-called "true conscientious objection," the absence of another available professional does not affect the disposition of the facts at all.

If the proposed act is perceived by the objector as an evil, even if consented to by the patient, and even if there is no other professional available to carry it out, the entire argument in relation to conscientious objection remains valid. It is unreasonable to propose that someone willing to take a strong stand against something they consider evil – to the point of confronting the law and generating a delicate and complex situation in the physician-patient relationship, sometimes being personally and professionally harmed by their choice – suddenly open up their principles only because he has no other colleague to replace him.

Contemporary society is extremely plural and diverse, and physicians are an integral part of it. Except in very isolated communities with few professionals, it is unlikely that among the group of physicians there is not also a sufficient diversity of beliefs and personal positions, where such a situation would be uncommon. It is up to the health system to structure itself in such a way as to guarantee an adequate number of professionals in all locations, so both the diverse demands from patients who are within the law and the freedom of conscience of legitimate objectors are accommodated. In the unlikely event that an act is rejected by 100% of available professionals, this would not mean the need to ban conscientious objection, but rather a symptom that such an act requires better discussion between the parties involved before being implemented.

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Clara Nasser Scherer was responsible for the research and literature review, for the formal data analysis and for the methodological definition, as well as for the writing and final review of the article. Mário Antônio Sanches supervised and advised the study, participating in the research design, formal data analysis, methodological definition, review, and approval of the final version of the article.

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