Literature Review:
Conscientious Objection

Sulmasy, D.P. 2017. Tolerance, Professional Judgment, and the Discretionary Space of the Physician. *Cambridge Quarterly of Healthcare Ethics* 26: 18-31.

Physician and bioethicist Daniel Sulmasy argues that the rejection of physician claims of conscientious objection are often based on two premises that are rarely made explicit. The first is that the protection of religious liberty should be limited to freedom of worship, assembly, and belief. The second is that because professions are licensed by state, those who practice a licensed profession should be required to provide all the goods and services determined to fall within the scope of practice and permitted in that state, regardless of any personal philosophical, moral, or religious objection. In this paper, Sulmasy argues that these premises ought to be rejected.

The first premise is incompatible with Locke's concept of tolerance, which recognizes that fundamental, self-identifying beliefs affect public as well as private acts and deserve a broad measure of tolerance. According to Locke, private worship and belief should be granted almost complete tolerance by the state, limited only by proscription of acts deemed against natural law or the good of the state. While the breadth of tolerance for conscientious objection in the public space should be narrower than tolerance for private belief and worship, this ability to refuse to provide certain tests or treatments based on one's conscience is necessary for the flourishing of a truly pluralistic liberal democracy. Sulmasy addresses an important critique of this point by arguing that tolerance does not necessarily lead to moral relativism or subjectivism. Just because one firmly believes her convictions are true does not mean she is infallible, and she may confirm, without contradiction, that she could be mistaken in her views. Thus, as Sulmasy aptly notes, "epistemic moral humility" and "honest acknowledgment that one's moral judgments are fallible" are the "true root[s] of tolerance" (p. 22).

The second premise, which claims that professionals licensed by the state should be required to perform any action that is legally permitted and under the scope of their practice, undermines the concept of professional judgment and shrinks what Edmund Pellegrino calls the "discretionary space" of the provider (p. 19). By examining the nature of a profession versus an occupation, Sulmasy poignantly argues that physician judgment is not only prudent but necessary to good medical care. He rightly claims that "professional licensure is permissive, not proscriptive" (p. 24) and highlights the importance to society of "cultivating physicians of conscience" (p. 25) who are able to make both technical and moral judgments in caring for their patients.

Sulmasy proposes, however, several Lockean limits to tolerance for physician claims of conscientious objection that would be "destructive of society." First, we must ask, "does the act for which a claim of conscientious objection is made undermine or contradict the principle of tolerance itself?" (p. 27). Objections should only be respected if they refer to a class of actions, not to a class of persons. Second, Sulmasy asks, "does the act entail a substantial risk of serious illness, injury, or death for those who do not share the belief that is said to justify the practice?" (p. 28). If a patient faces imminent death, this might constitute grounds to compel conscience. However, such cases in medicine are rare, and a physician willing to perform the act in question can usually be found. Lastly, as a final limit to tolerance, we must ask, "is the act an action or a refraining from an action?" (p. 28). Generally, greater moral justification should be required to compel someone to perform an action than to compel someone to refrain from an action. Overall, Sulmasy's careful and measured argumentation provides a convincing justification for the need to protect physician claims of conscientious objection in a pluralistic liberal democracy.

Lamb, C., Evans, M., Babenko-Mould, Y., et al. 2019. Conscience, conscientious objection, and nursing: A concept analysis. *Nursing Ethics* 26(1): 37-49.

The literature arguing for and against health care professionals' right to conscientiously refuse to perform certain medical procedures they personally consider immoral typically focuses on the perspective of physicians. Lamb and colleagues conducted a concept analysis of conscience and conscientious objection in the nursing literature in an effort to provide greater conceptual awareness and clarity for the nursing profession. By outlining definitions, key attributes, antecedents and consequences, and case studies, the authors successfully explore these concepts in a nursing context, which is important to advance the ethical practice of nursing.

One of the authors' most insightful points is the distinction between moral distress and stress of conscience. While moral distress has been discussed extensively in the nursing literature and beyond, the authors note that there is significantly less discussion of the related but distinct concept of stress of conscience. Moral distress, in its original formulation, occurs when the nurse knows the right course of action to pursue but is hindered from doing so. Stress of conscience is a type of stress that can arise for nurses "when they repeatedly experience stressful situations that trouble their conscience" (p. 39). The main distinction between moral distress and stress of conscience is that the latter is concerned with "one's core sense of fundamental morality," or the faculty that helps them determine their moral actions (p. 40). Stress of conscience can lead to burnout, changing clinical areas, or even leaving the nursing profession (p. 43). Stress of conscience, however, should not be misconstrued with mere opinion. Rather, the beliefs and values each person holds are core to who they are and how they perceive themselves and others.

One way to address issues of conscience in nursing is through an appeal to conscientious objection. While conscientious objection is

addressed in various nursing codes of ethics and federations across different countries, a wide range of guidelines still exists, causing confusion for nurses and nurse leaders and a hesitancy to make claims based on conscientious objection. Studies have found that nurses are hesitant to make conscientious objection claims due to fears of patient abandonment, stigma, or perceived inability to go against professional authority.

This study reveals that there are substantial gaps in the literature related to 1) the meaning of conscience for nurses, 2) the conceptual distinction between moral distress and related topics of conscience, and 3) the precursors and consequences of conscience in nursing care (p. 45). The authors conclude that more research is needed to explore the ways in which nurses' conscience issues can be addressed in practice settings and to discover what contributes to or precipitates stress of conscience so that these experiences can be mitigated. The authors especially highlight the need for more studies on nurses' experiences of using conscientious objection and the impact such objections have for their nursing practice. These studies could be particularly important to dispel some of the prejudice surrounding claims of conscience. This concept analysis thus offers an important step in expanding the conscientious objection discussion into the nursing profession, as well as supporting ethics-based nursing theory and evidence-based practice.

Bedford, E.L. 2016. The reality of institutional conscience. *National Catholic Bioethics Quarterly* 16(2): 255-272.

In this interesting article, Bedford explores the topic of conscientious objection from a somewhat different angle by examining the role of institutional conscience. By presenting a metaphysical outline of a social anthropology and an open, relational conscience, Bedford claims that institutional conscience does, in fact, exist and ought to be respected.

According to Bedford, opponents of institutional conscience typically appeal to an individualist anthropology and a privatized conscience. They claim that institutions cannot make conscientious objections because they are not autonomous individuals and thus do not have a conscience. Spencer Durland, one opponent of institutional conscience, claims that ascribing conscience to a hospital is nonsensical: "a hospital is not a person; it is a physical structure within which providers give medical care. It does not perform procedures or counsel patients. It does not take lunch hours or vacations. And it does not have a conscience" (p. 256). Thus, Durland's argument follows that, because institutional conscience does not exist, Catholic hospitals should not receive conscientious protections. However, Bedford claims that this argument is based on a flawed understanding of the social nature of institutions and fails to consider the inherent relationality and dependency that characterize human institutions.

He first shows that institutions are characteristically human because they are "established to overcome human limitedness and dependence" (p. 26). Next, he argues that institutions are intrinsically social phenomena because 1) they produce goods that an individual is unable to produce on her own, and 2) they rely on social means, such as social agency and socially coordinated behavior, to pursue their institutional ends. Institutions rely

on the practical rationality of its members to apply institutional norms, manifested in values-content like policies or *Ethical and Religious Directives for Catholic Health Care Services (ERDs)*, to particular situations. Institutional conscience is thus not something the institution has or possesses but rather "something that members do on the institution's behalf" (p. 265).

Ultimately, Bedford defines institutional conscience as "a judgment of practical reason made by an individual on behalf of an institution, applying institutional norms to a particular situation" and directed toward institutional ends (p. 265). Through his careful explication of a social anthropology and an open, relational conscience, Bedford offers a compelling argument for the need to honor not only the institutional conscience of Catholic institutions but of all institutions. In our pluralistic society, Catholic institutions should not be barred from contributing to society and the common good simply because of the values and norms that guide their contributions (p. 265).

CONCLUDING OBSERVATIONS

These three articles explored the roles of conscience and conscience objection for the physician, the nurse, and the institution. While only Bedford explicitly examines the role of conscience in a Catholic health care setting, the conclusions drawn by both Sulmasy and Lamb et al. can certainly be applied to Catholic contexts as well. Furthermore, it is refreshing to see that authors are reflecting on the concept even outside of exclusively Catholic health care settings.

As new technologies continue to expand the range of what is medically possible, the church and those working in Catholic health care ethics will be forced to consider the limits of their personal and professional obligations, and these articles provide sound arguments for the need to respect claims of conscientious objection among physicians, nurses, and institutions.

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