Exhibit 375

Theor Med Bioeth (2008) 29:201–212
DOI 10.1007/s11017-008-9077-x

Adjudicating rights or analyzing interests: ethicists' role in the debate over conscience in clinical practice

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Published online: 28 September 2008
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Abstract The analysis of a dispute can focus on either interests, rights, or power. Commentators often frame the conflict over conscience in clinical practice as a dispute between a patient's right to legally available medical treatment and a clinician's right to refuse to provide interventions the clinician finds morally objectionable. Multiple sources of unresolvable moral disagreement make resolution in these terms unlikely. One should instead focus on the parties' interests and the different ways in which the health care delivery system can accommodate them. In the specific case of pharmacists refusing to dispense emergency contraception, alternative systems such as advanced prescription, pharmacist provision, and over-the-counter sales may better reconcile the client's interest in preventing unintended pregnancy and the pharmacist's interest in not contravening his or her conscience. Within such an analysis, the ethicist's role becomes identifying and clarifying the parties' morally relevant interests.

Keywords Conscientious objection · Emergency contraception · Conflict resolution · Interests

> "This (sex) was with someone I did not even know and did not want to have intercourse with, and I am in no place now to have children," she said. "I just don't think this should be the pharmacist's decision" [1].

> Because I regard that complicity in making available products that are intended for the termination of human life to be immoral, I will not stock or have dispensed these therapies in my pharmacies. If the Governor forces our

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pharmacies to comply, I will not be able—in good conscience—to continue to run a pharmacy [2].

In the conflict over the role of conscience in clinical practice, ethicists use arguments to adjudicate the claims of the parties involved. One common framing characterizes the problem as patients' right to legally available medical treatments versus health care providers' right to refuse to participate in any intervention they find morally objectionable. After arraying arguments for and against each of these putative rights, ethicists state which position they find most compelling. There are, however, good reasons to believe that ethicists cannot provide a single, best answer to this dispute. In addition, the implicit characterization of the dispute as a zero-sum game may lead to undesirable consequences. Rather than focus on the parties' rights or relative power, one should instead focus on the parties' interests and various ways in which these interests can be reconciled. The principal parties in this dispute are a subset of clinicians, who believe particular medical interventions are immoral, and their potential patients or clients. The clinicians' primary interest is not being complicit in an action they consider immoral and the patients' primary interest is access to health care services. Alternative systems of providing health care accommodate these interests to different degrees. Ethical argumentation can help identify and clarify what the parties' relevant moral interests are.

In this paper, I will focus on the dispute regarding the prescribing and dispensing of emergency, hormonal contraception.[1] Consider, for example, the situation of a seventeen-year-old woman who has intercourse with her boyfriend on a Friday night. They regularly use condoms, but this time the condom breaks. The following day, she relays her anxiety about becoming pregnant to a friend who tells her about emergency contraception. She is finally able to get an appointment on Monday afternoon with her pediatrician, who she has not seen in years. The pediatrician, discusses testing for sexually transmitted diseases and writes her a prescription for Plan B®. The patient takes the prescription to a local, independent pharmacy. The owner and pharmacist on duty is an evangelical Protestant who refuses to stock emergency contraception and who, after telling the woman that emergency contraception is immoral, refuses to return or transfer her prescription.[2]

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[1] Women can use several drugs or devices after un- or under-protected intercourse to prevent unintended pregnancy. Under-protected intercourse includes when a condom slips or breaks or a woman misses two or more of the first seven oral contraceptive pills. I will focus on the use of oral contraceptive pills or pharmacologically equivalent dedicated products for this purpose. Women can also use copper-containing intrauterine devices (IUDs) for emergency contraception but this is more logistically difficult because a trained provider must place them. I will also not discuss the use of mifepristone (RU-486) because, unlike oral contraceptive pills, it can interrupt an established pregnancy and, at higher doses, can cause a medical abortion. The Food and Drug Administration has also not approved its lower, emergency contraceptive dose [3].

The literature also refers to emergency contraception as postcoital contraception and the morning after pill. Experts criticize the term morning after pill as misleading individuals to believe treatment must wait until or is ineffective after the next morning and prefer the term emergency contraception, in part, because it conveys that it is not intended for ongoing use [4, p. 44].

[2] For news reports of similar cases, see [1, 5].

Interest, rights, and power disputes

Disputes, which involve one person's or organization's claim or demand on another who rejects it, contain three basic elements: interests, rights, and power. Interests are the needs, desires, concerns, and fears that people care about or want and which underlie people's positions, the tangible items they say they want [6, pp. 4–5; see also 7, pp. 40–41]. For example, in a salary negotiation, positions may include annual salary, weeks of paid vacation, health insurance, and retirement benefits. The potential employee's interests could include financial security, including the ability to purchase a home, and a balance among work, family, and recreation. There are also relevant standards or rights that can direct a fair outcome and a certain balance of power between the parties. In resolving disputes, the parties may focus primarily on one of these elements [6, pp. 3–10].

Rights disputes

Parties in a dispute may seek to determine who is right, based on some independent standard. Law, contract, or socially accepted standards of behavior may provide standards. If the parties themselves are unable to reach an agreement, they may turn to a third party. Adjudication, in which the parties present evidence and arguments to a neutral third party with decision making authority, is the prototypical rights procedure. Courts and administrative agencies provide public adjudication while arbitrators provide private adjudication [6, p. 7].

One can analyze the aforementioned dispute between the pharmacist and the woman in terms of the parties' rights: the client's right to procreative liberty and the pharmacist's right not to contravene his or her conscience. John Robertson characterizes procreative liberty as "the freedom to reproduce or not to reproduce in the genetic sense, which may also include rearing or not, as intended by the parties" [8, pp. 22–23]. Robertson asserts that this liberty should enjoy presumptive primacy because it is central to personal identity, dignity, and the meaning of one's life [8, p. 24].

Robertson's characterization of procreative liberty as a negative right, however, makes its application in this case complex. He argues that others have a duty not to interfere with one's procreative choices but they are not obligated to provide resources or services [8, p. 23]. He states: "Procreative freedom does not entitle one to the services of providers who profoundly disagree with the means that one is willing to use to achieve procreative goals" [8, p. 172]. While the pharmacist's refusal to return or transfer the woman's prescription interferes with her freedom, it is not clear within Robertson's framework that the client has a right to have her prescription filled. For example, pharmacies may not stock emergency contraception for reasons unrelated to conscientious objection [9]. If patients have a right to emergency contraception in spite of pharmacists' conscientious objection, are pharmacies also obligated to stock it in spite of low consumer demand or inventory constraints?

Conversely, the pharmacist may assert a putative right not to contravene his or her conscience. For example, in its Model Legislation, Americans United for Life asserts: "A healthcare provider has the right not to participate, and no healthcare provider shall be required to participate, in a healthcare service that violates his or her conscience" [10, p. 6]. This putative right is also inadequately circumscribed. May a health care provider thereby refuse to participate in any service without justifying or validating his or her objection?

Ethicists may position themselves as neutral third parties adjudicating between these conflicting rights claims. Julian Savulescu, for example, frames the issue as a conflict between physicians and patients and considers arguments for and against conscientious objection. On the one hand, conscientious objection is inequitable and inefficient, inconsistent with the high standard required to justify compromising patient care, contrary to doctors' commitments, and discriminatory against secular moral values. On the other hand, precluding conscientious objection is harmful to doctors and constrains their liberty. While Savulescu briefly states that doctors' values should be accommodated if this can be done without compromising the quality and efficiency of medical care, he nevertheless concludes, "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors" [11, p. 294].

Unresolvable moral disagreements

There are, however, good ethical reasons to believe that neutral adjudication is not possible in this dispute. Gert et al. argue that a moral theory need not provide a unique right answer to every moral problem [12, pp. 3–5, 21–22] and identify five sources of unresolvable moral disagreement [12, pp. 16, 59–60]. A number of these sources are present in the dispute regarding dispensing emergency contraception.

Disagreement about the facts

Parties disagree about whether and how often emergency contraception acts by preventing implantation of a fertilized egg into the uterine wall. This potential mechanism is morally relevant to those who believe embryos have full moral status from conception [13]. Opponents question the generalizability of experimental data from animal models and tissue culture system and proponents face logistical difficulties in overcoming the limitations of the statistical analysis of actual use studies [14]. Neither group is likely to definitively resolve the factual issues in the near future.

Differences in the rankings of the harms (evils) and benefits (goods)

Patients and pharmacists experience different harms and benefits and there is no objective ranking which provides a clear resolution of this conflict.

Differences about human nature and the nature of human societies

Parties disagree about the likely effect of widespread access to emergency contraception on sexual behavior and the use of more reliable forms of contraception and methods to prevent sexually transmitted diseases [15]. To the extent that there is evidence about these effects [16], this may become a disagreement about the facts.

Differences about the interpretation of a moral rule

While there may be differences about the interpretation of moral rules, the dispute about emergency contraception primarily rests on differences about the scope of morality.

Differences about the scope of morality

Parties in this conflict disagree about whether embryos deserve full, partial, or no moral protection. Some individuals and moral communities believe that the embryo has full moral status from the time of fertilization [13] while others believe that the developing embryo and fetus obtain partial moral protection only later in gestation [8].[3]

The dispute over conscientious objection in clinical practice contains multiple sources of unresolvable moral disagreement. One can legitimately question ethicists' ability to provide a single correct resolution to this dispute. Gert et al. argue that recognition of legitimate disagreement can provide the precondition for individuals to "cooperate in trying to discover a compromise that comes closest to satisfying both of their positions" [12, p. 105].

Power disputes

If one cannot determine who is right, one can shift one's focus to the question of who is more powerful. Ury et al. define power as "the ability to coerce someone to do something he would not otherwise do" [6, p. 7]. In the dispute about emergency contraception, pharmacists initially had more power than individual clients due to the legal constraints on obtaining prescription medication. Both sides in this dispute have subsequently sought to augment their power through judicial, legislative, and regulatory processes. Ury et al. note that it is difficult to assess which party is more powerful without resorting to a potentially destructive power contest [6, p. 8].

Interests disputes

Rather than engage in a power contest, disputants can seek to reconcile their underlying interests [6, pp. 4–5]. Again, interests are the needs, desires, concerns,

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[3] Commentators should carefully distinguish differences about the scope of morality from disagreements about the facts. Some advocates of access to emergency contraception, for example, argue that it is not abortifacient because it does not prevent the interruption of an established pregnancy. They cite definitions of pregnancy and abortion offered by medical organizations and the U.S. government [17, p. 847]. This is a terminological disagreement based on differing evaluations of the moral status of the embryo rather than a dispute regarding the facts. Groups that consider some or all uses of emergency contraception to be immoral do not contend that it causes the expulsion of a fertilized egg after implantation. Rather, they believe that the fertilized egg has full moral status and use the term abortifacient to include drugs and devices that prevent implantation.

and fears that underlie parties' positions. Positions, by contrast, are concrete outcomes. Interests can potentially be reconciled because they may be satisfied by several possible positions or because more shared and differing but compatible interests may underlie opposed positions than do conflicting interests [7, pp. 42–43].

In addition to the aforementioned ethical reasons why a rights based approach to the dispute over emergency contraception is likely to be ineffective, there are other reasons to favor interest based over rights or power based approaches. Criteria for comparing approaches include transaction costs, satisfaction with outcomes, effect on the relationship, and recurrence of disputes. Ury et al. enumerate a number of potential transaction costs: "the time, money, and emotional energy expended in disputing; the resources consumed and destroyed; and the opportunities lost" [6, p. 11]. Parties' satisfaction with outcomes also involves a number of considerations including fulfillment of underlying interests and the perceived justice of both the outcome and process. These costs are interrelated and typically increase or decrease together. Ury et al. argue that interest-based approaches are typically less costly because they can uncover hidden problems and identify issues of greater concern to each of the parties [6, pp. 13–14].

The parties and their interests

There are a variety of parties in the debate regarding conscience in clinical practice, each with their own interests.

Clinicians

Some clinicians articulate an interest in not contravening their consciences. The contemporary literature on conscience emphasizes its relationship to integrity. These analyses provide a justification for respecting conscience which acknowledges that it can err [18, 19]. In the dispute over dispensing emergency contraception, the scope of the claim to conscientious objection requires clarification because clinicians are not claiming the right not to use emergency contraception themselves, but are, instead, claiming the right not to participate in another's action that they consider immoral.

The Roman Catholic moral tradition provides the most extensive analysis of the concept of cooperation. Daniel Sulmasy reviews this analysis in his contribution to this issue [20], and I will highlight three key points. One, aside from the categorical distinction between formal and material cooperation, the determination of whether cooperation is morally licit is a matter of degree. Whether cooperation is licit, therefore, can itself become a matter of conscience. Two, the external environment, including legal and licensing requirements, can influence this evaluation [see also 21, pp. 307–308, 326–328]. Policy makers can modify these factors and thereby influence the parties' behavior. Three, not contravening one's conscience through illicit cooperation is a significant interest that may obligate one to forego other important interests, such as one's job or even career [see also 21, pp. 311–313, 317, 360, 373].

Patients or clients

In this case, the patient's primary interest is preventing unintended pregnancy, which is closely tied to access given the limited time frame during which emergency contraception is effective [3]. Patients also have interests in respectful treatment, privacy, and cost. Some women report feeling judged by clinicians or being verbally abused by pharmacists. Patients have an interest in privacy and confidentiality, neither wanting private information overheard by other patients nor wanting to disclose information only for a clinician's moral evaluation. Finally, patients also have an interest in obtaining emergency contraception without unnecessary additional cost.

Others

There are a variety of additional stakeholders in this dispute, including moralists and public health officials, who have articulated further interests. These interests include regulating sexuality or promoting good sexual conduct; protecting women from sexual abuse; reducing unintended pregnancies and their associated costs; reducing the incidence of abortion; and/or decreasing sexually transmitted diseases [22].

System design

In the dispute regarding emergency contraception, the health care system places the patients' and objecting pharmacists' interests in conflict. Under certain circumstances a particular pharmacist must dispense the medication in order for the patient to receive treatment in a timely manner. It is unlikely that there are other shared or differing but compatible interests that would incline the parties to forgo their respective interests in preventing unintended pregnancy or not contravening their consciences. Other positions, however, may permit the principal parties to fulfill their interests. (I will set aside the interests of the other parties because these parties can address their interests in multiple ways unrelated to the distribution of emergency contraception.) Alternative systems to clinicians prescribing and pharmacist dispensing at the time of use include advanced prescription, pharmacist provision, and over-the-counter sales.[4] Reviewing these alternatives will demonstrate that conflict resolution need not be a zero-sum game in which gains to one party must come at the expense of the other.

Clinician prescribes and pharmacist dispenses

The default system prior to the Food and Drug Administration's (FDA's) approval of limited over-the-counter sales involved clinicians prescribing and pharmacists dispensing emergency contraception at the time of use. A. Albert Yuzpe first published studies demonstrating the safety and efficacy of using combined estrogen-progestin oral contraceptive pills as emergency contraception in 1974. Because oral

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[4] Other alternatives include educational initiatives and public awareness campaigns, information and referral hotlines [23], and telephone prescription services [24].

contraceptive pills were FDA approved for another indication, clinicians could legally prescribe them "off-label" for emergency contraception. The law, however, prohibited manufacturers from marketing them for this use. In 1997, the FDA issued a notice declaring the use of certain oral contraceptives for emergency contraception safe and effective. It also solicited new drug applications noting that it would accept citations of the existing literature as evidence of safety and effectiveness. It subsequently approved the dedicated products Preven™ (Gynetics, Inc.) in 1998 and Plan B® (Women's Capital Corporation) in 1999. (Gynetics subsequently withdrew Preven™ after research showed Plan B® was more effective and had fewer side-effects.) While clinicians may prescribe emergency contraception, state law may prohibit clinicians from directly dispensing it to their patients or impose constraints such as packaging and labeling requirements. Obtaining emergency contraception, therefore, typically involves having a pharmacist dispense the prescription.

There are multiple potential barriers to access in this system, including identifying a clinician, obtaining an appointment, and filling a prescription. Many individuals do not have a primary care provider. Even if one does, the primary care provider may be difficult to reach at nights and on weekends when intercourse is more likely to occur. Some clinicians refuse to provide a prescription over the telephone without an office visit. Besides the time involved, an office visit is also an additional expense. While acute care centers and emergency departments may be more accessible, co-payments for their use are typically higher [see, in general, 25]. Finally, independent of conscientious objection, pharmacies may not stock emergency contraception due to lack of consumer demand or constraints on inventory space [9].

Advance prescription

As an alternative, some providers advocate providing a prescription in advance of actual need that patients could then fill for future use. They propose discussing the topic of emergency contraception at an appointment for another purpose, such as health care maintenance, rather than at a separate visit for this specific purpose [26]. While increasing access, research has not shown this system to decrease unintended pregnancies. A recent systematic review concludes that none of the eight individual randomized controlled trials, including two adequately powered studies, or the pooled analyses showed significant differences in pregnancy rates [16].

Pharmacist provision

Another potential way to address clinician inaccessibility as well as cost is to permit pharmacists to prescribe and dispense emergency contraception. In the United States, medications are either prescription or over-the-counter. In most other countries, there are intermediate categories of drugs, including pharmacist and pharmacy classes—medications that can only be sold after an interaction with a pharmacist and that must be sold in pharmacies, as opposed to grocery stores or gas stations [27, p. 810]. Individual states, however, have authority over who can prescribe medications and some states permit pharmacists to prescribe under an arrangement known as "dependant-prescribing authority." Under such regimes an independent prescriber, such as a physician, delegates his or her authority to a pharmacist [28, p. 288]. Nine states permit dispensing emergency contraception under such agreements [29].

Dependant-prescribing of emergency contraception has a number of potential benefits and limitations. Pharmacies are widely available and have extended hours of operation compared with clinicians' offices. Pharmacists may be accessible to patients without a primary care provider and women may be more comfortable approaching a pharmacist for emergency contraception. Pharmacists can provide counseling, such as referral for ongoing contraceptive care or diagnosis and treatment of sexually transmitted diseases. While pharmacists may charge an additional fee for counseling, it is typically less than the fee charged by a clinician. Third party payers, however, may not reimburse for counseling. Other potential limitations include a lack of privacy for counseling at the pharmacy counter, which is particularly important given the use of emergency contraception following rape. Pharmacists have also expressed a concern regarding the increased liability risk [25, 28].

Over-the-counter sales

Over-the-counter sales are a third alternative. The FDA can approve medications for over-the-counter sales if they are not habit-forming and patients can use them safely and effectively without the supervision of a licensed health care practitioner. The FDA uses several different mechanisms, the most common of which is approval of a new-drug application, to change prescription drugs to over-the-counter status. It may require studies of label comprehension and "actual use." Examples of drugs switched to over-the-counter include diphenhydramine (Benadryl®), ranitidine (Zantac®), nicotine (gum and patches) and ketoconazole (an antifungal medication used to treat vaginal yeast infections) [27].

Emergency contraception is a strong candidate for over-the-counter status. It has no potential for addiction. The indication for use (un- or under-protected intercourse) is identifiable by a nonprofessional. The dose is the same for all women, so patients do not need clinicians to tailor the dose to patient characteristic or therapeutic response. Its most common side-effects are nausea and lower abdominal pain and it is safer than some available over-the-counter medications. Emergency contraception's only contraindication is pregnancy—not because of teratogenicity, but due to ineffectiveness [30].

While initially rejecting over-the-counter sales of Plan B®, the FDA eventually approved its sale without a prescription to individuals 18 years of age and older in 2006 [31]. Overruling its advisory panels, the FDA originally asserted that an insufficient number of women ages fourteen to sixteen participated in the actual use study to permit valid inferences of safety and effectiveness in this age group. Critics accused the FDA of basing its decision not on the stated reasons but on broader political and moral interests [15]. Because minors continue to require a prescription to purchase emergency contraception, sales to adults are "behind-the-counter" rather than truly "over-the-counter."

System design and the parties' interests

Each of these potential modes of dispensing emergency contraception accommodates the principal parties' interests differently. For example, each of the successive modes potentially decreases the cost of dispensing. Advance prescription avoids the charge for a separate clinician visit, pharmacists typically charge a lower counseling fee than other clinicians, and, finally, over-the-counter sales eliminates professional fees altogether. It should be noted, however, that insurance typically does not reimburse for over-the-counter medication so that the direct cost to the consumer may be higher [25, p. 608; 27, p. 815].

Each of these successive alternative systems also potentially increases access and, thereby, increases the scope for accommodating conscientious objection. Advanced prescription, while still requiring a clinician visit, makes emergency contraception available when patients need it. Pharmacist provision may make it more readily available, given that pharmacies are open on nights and weekends, while still providing counseling. Finally, true over-the-counter sales would make emergency contraception available in multiple outlets including grocery stores and gas stations. To the extent that conscientious objection is problematic because it interferes with timely access, these alternative systems make accommodation feasible. In addition, clerks' attenuated participation in over-the-counter sales precludes justifiable claims that such participation amounts to immoral cooperation. Alternatively, clerks' ability to find alternative employment is significantly less constrained than pharmacists'. The dispute need not be a zero-sum game in which gains to one party come at the expense of the other.

The framing of the dispute in terms of interests also changes the role of the ethicist. When one focuses on the parties' rights, the ethicist is a judge. Given the multiple sources of unresolvable moral disagreement represented in this dispute, commentators' adjudication of the competing claims rests on assumptions the parties do not necessarily share. When one focuses instead on the parties' interests, the ethicist has a different role: that of an analyst. In the debate regarding emergency contraception, ethicists can analyze the types of moral disagreement and the evidence that might resolve them and examine the concept of illicit cooperation.

Conclusions

Framing the dispute over dispensing emergency contraception in terms of pharmacists' and clients' rights creates a zero-sum game. There are good ethical reasons to believe that this dispute cannot be resolved objectively at this level because of persistent disagreements about the facts and the scope of morality. Rather than pursue a potentially costly power struggle, analyzing the parties' interests and alternative systems of pharmaceutical distribution may contribute to greater social cohesion. Multiple systems of distribution are possible that may better accommodate both the pharmacists' and the clients' interests. In addition, these alternatives address barriers to obtaining emergency contraception apart from conscientious objection including access to clinics, the cost of medical visits, and pharmacies' decisions not to stock emergency contraception. With such a reframing, the ethicist's role changes from that of judge to analyst.

Acknowledgements I would especially like to thank Lainie Freidman Ross for her encouragement; the Conscience in Clinical Practice organizers and participants; and Tess Jones, Michelle Hawes, Grace Chung, Ryan Lawrence, and Farr Curlin for their constructive criticisms of this manuscript.

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Exhibit 376

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Obstet Gynecol. Author manuscript; available in PMC 2014 October 04.

NIH-PA Author Manuscript

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Published in final edited form as:
Obstet Gynecol. 2011 October ; 118(4): 905–912. doi:10.1097/AOG.0b013e31822f12b7.

Obstetrician–Gynecologists' Objections to and Willingness to Help Patients Obtain an Abortion

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Abstract

Objective—To describe obstetrician–gynecologists' (ob-gyns) views and willingness to help women seeking abortion in a variety of clinical scenarios.

Methods—We conducted a mailed survey of 1,800 U.S. ob-gyns. We presented seven scenarios in which patients sought abortion. For each, respondents indicated if they morally objected to abortion and if they would help patients obtain an abortion. We analyzed predictors of objection and assistance.

Results—The response rate was 66%. Objection to abortion ranged from 16% (cardiopulmonary disease) to 82% (sex selection); willingness to assist ranged from 64% (sex selection) to 93% (cardiopulmonary disease). Excluding sex selection, objection was less likely among ob-gyns who were female (odds ratio [OR] 0.5, 95% confidence interval [CI] 0.4–0.8), urban (OR 0.3, CI 0.1–0.7), or Jewish (OR 0.3, CI 0.1–0.7) compared to male, rural, or unaffiliated ob-gyns. Objection was more likely among ob-gyns from the South (OR 1.9, CI 1.2–3.0) or Midwest (OR 1.9, CI 1.2–3.1), and among Catholic, evangelical Protestant, or Muslim ob-gyns, or those for whom religion was most important, compared to reference. Among ob-gyns who objected to abortion in a given case, approximately two-thirds nevertheless help patients obtain an abortion. Excluding sex selection, assistance despite objection was more likely among female (OR 1.8, CI 1.1–2.9) and US-born ob-gyns (OR 2.2, CI 1.1–4.7), and less likely among Southern ob-gyns (OR 0.3, CI 0.2–0.6), or those for whom religion was most important (OR 0.3, CI 0.1–0.7).

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Financial Disclosure: The authors did not report any potential conflicts of interest.

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Conclusions—Most ob-gyns help patients obtain an abortion even when they morally object to abortion in that case. Willingness to assist varies by clinical context and physician characteristics.

Ethicists, clinicians, and policy-makers debate the role of conscientious refusals in medical practice. Recently, the Obama administration rescinded a Bush administration rule that would have required every health care entity receiving federal funding to certify that none of its employees were required to assist in any way with medical services that would violate that employee's "individual moral beliefs or religious convictions"(1,2). At the same time, the administration affirmed a 1973 federal law that states that a health care worker cannot be required to participate in abortion or sterilization procedures that conflict with "his [sic] religious beliefs or moral convictions"(3).

These debates about federal regulations are part of broader debates about conscience in healthcare (4). Some bioethicists argue that physicians who refuse to provide legal and professionally permitted services should leave the profession (5); others argue that physicians have a basic obligation and right to act in accordance with their moral convictions (6). Most professional medical organizations endorse a limited right of refusal, balanced against patients' interests and professional obligations (7)(8). Previous studies suggest that the majority of physicians agree that doctors may not be obligated to provide an intervention to which they have a moral objection (9), but that they are obligated to refer patients for interventions they are unwilling to provide themselves (10)(11).

Obstetrician-gynecologists (ob-gyns) find themselves at the center of these debates, because many practices in women's health and reproductive medicine generate controversy, including, of course, abortion. Little is known about how ob-gyns view abortion, morally speaking, or how their views influence the care they provide. In order to describe ob-gyns' views and willingness to help women seeking abortion in a variety of clinical scenarios, we analyzed data from a national survey of practicing ob-gyns.

Methods

From October 2008 until January 2009, we mailed a confidential, self-administered questionnaire to a stratified random sample consisting of 1800 US general ob-gyns, 65 years of age or younger (from a universe of 34,689 ob-gyns) in the American Medical Association Physician Masterfile. The questionnaire addressed a variety of practices in sexual and reproductive healthcare, including abortion. Sample size was chosen to yield a margin of error of < 3% for a dichotomous variable that is distributed 50% in the population. To increase religious minority representation, we used validated ethnic surname lists to create four strata, and oversampled in these strata (12)(13)(14). Physicians received up to three separate mailings of the questionnaire; the first included $20, and the third offered an additional $30 for participating. Physicians also received an advance letter and a postcard reminder after the first questionnaire mailing. All data were double-keyed, cross-compared, and corrected against the original questionnaire. The study was approved by the University of Chicago Institutional Review Board. Methods for this study have been described in depth elsewhere (15).

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In one section of the questionnaire, respondents were presented with seven scenarios in which a patient sought an abortion, and were asked to indicate whether they: 1) have any ethical or moral objection to abortion in each case (Yes/No); and 2) would help the patient obtain an abortion if asked, either by providing the abortion themselves or referring the patient to someone who would (Yes/No). We defined assistance as either provision or referral, because although providing abortion and referring for abortion are not equivalent, current ethical debates center on whether ob-gyns are required to refer for or otherwise help patients obtain an abortion when asked. The seven scenarios were: a) a 22-year-old single woman 6 weeks pregnant after failed hormonal contraception (hereafter failed contraception); b) a 38-year-old with five daughters and no sons, after chorionic villus sampling reveals the fetus is a chromosomally normal female (sex selection); c) a 36-year-old in the first trimester of pregnancy who needs radiation and chemotherapy for newly diagnosed breast cancer (breast cancer); d) a 28-year-old with type I diabetes, for whom glucose management has become very difficult at 16 weeks' gestation (difficult-to-control diabetes); e) a 34-year-old woman six weeks pregnant after being raped (rape); f) selective reduction in a healthy 37-year-old with a quintuplet pregnancy (selective reduction); and g) a 24-year-old with a cardiopulmonary abnormality associated with a 25% chance of death with gestation (cardiopulmonary disease). Demographic covariates included physician age, sex, race/ethnicity, marital status, number of children, whether they were US-born, geographic region, urbanicity of location (measured as the proportion of people in the physician's zip code that live in an urban area), religious affiliation, importance of religion in the respondent's life, and membership in the American Congress of Obstetricians and Gynecologists (ACOG).

Stratum weights were incorporated to account for the oversampling in the ethnic surname strata and to correct for differences in response rates observed among the surname categories and between U.S. and foreign medical school graduates, as described in previous reports on this data (15). By incorporating stratum weights, we are able to generate estimates for the population of U.S. ob-gyns. After generating population estimates for responses to each item, we used survey-design-adjusted multivariable logistic regression to identify independent predictors of moral objection to one or more scenarios. Because significant predictors were different for sex selection compared to other scenarios, we repeated this analysis for the scenario sex selection alone, and for objecting to one or more scenarios, excluding sex selection. Finally, we analyzed the prevalence and predictors of being willing to help a patient obtain an abortion despite having a moral objection to abortion in that case (assistance despite objection). All analyses were adjusted for survey design and were conducted using Stata MP software, v11.1.

Results

The response rate was 66% (1154/1760) after excluding 40 potential respondents who were retired or who could not be located after two attempts to obtain a valid address. The response rate varied by stratum, and graduates of foreign medical schools were less likely to respond than graduates of US medical schools (58% vs. 68%, p=0.001). Response rate did not differ significantly by age, sex, region, or board certification. Respondents' demographic characteristics are reported in Table 1.

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The percentage of physicians with moral objection to abortion varied substantially by clinical case (Table 2). The majority (82%) of ob-gyns objected in the case of sex selection, but fewer than half objected in the other scenarios: 43% for the case of difficult-to-control diabetes; 41% for failed contraception; 29% for selective reduction; 20% for rape, 18% for breast cancer, and 16% for cardiopulmonary disease. Overall (excluding sex selection) 50% objected to one or more scenarios.

Across scenarios, most ob-gyns were willing to help patients obtain an abortion. As seen in Table 2, 64% would help a patient obtain an abortion for sex selection, and ≥80% would help in a patient obtain an abortion in each of the other scenarios. Overall, 60% would help a patient obtain an abortion in all scenarios; 35% would help in some scenarios, and 5% would help in none of the scenarios. When the case of sex selection was excluded, those percentages were 76%, 19% and 5% respectively.

Table 3 presents the adjusted odds ratios for reporting a moral objection to abortion in one or more scenarios, in the scenario of sex selection alone, and in one or more scenarios excluding sex selection. Odds ratios are adjusted for all variables in the table. Considering all seven scenarios, objection was less likely among black ob-gyns (OR 0.4, 95% CI 0.2–0.9) and Jewish ob-gyns (OR 0.5, 95% CI 0.2–1.0) compared to whites and those without religious affiliation. Compared to ob-gyns for whom religion was not very/not at all important, objection was more likely among ob-gyns for whom religion was very important (OR, 2.0, 95% CI 1.1–3.4) or most important (OR 6.3, 95% CI 2.3–17.6) in their lives. Significant covariates were different for objection to sex selection alone and objection to one or more cases other than sex selection. Objection to sex selection was more likely among Midwest ob-gyns (OR 1.9, 95% CI 1.1–3.5), Muslims (OR 4.4, 95% CI 1.0–18.8) and respondents for whom religion was very important (OR 2.2; 95% CI 1.3–3.8) or most important in their life (OR 6.1, 95% CI 2.3–15.8) compared to their respective reference groups. Objection to sex selection was less likely among black (OR 0.4, 95% CI 0.2–0.9), Jewish (OR 0.5, 95% CI 0.2–0.9) and older (OR.98, 95% CI 0.95–0.99) respondents. Excluding sex selection, objection in one or more scenarios was less likely among women (OR 0.5; 95% CI 0.4–0.8), Jewish (OR 0.3; 95% CI 0.1–0.7), older (OR 0.96, 95% CI 0.94–.98) and more urban (OR 0.3, 95% CI 0.1–0.7) ob-gyns compared to respective reference groups. Objection was more likely among those practicing in the South (OR 1.9, 95% CI 1.2–3.0) or Midwest (OR 1.9; 95% CI 1.2–3.1), who had Catholic (OR 2.7, 95% CI 1.4–5.1), Evangelical Protestant (OR 3.7, 95% CI 1.4–10.0) or Muslim (OR 3.4, 95% CI 1.2–9.6) affiliation, or who indicated religion was fairly (OR 1.7, 95% CI 1.1–2.8), very (OR 3.6; 95% CI 2.2–5.9) or most (OR 16.9, 95% CI 7.7–37.1) important in their life compared to reference groups. Marital status, number of children, ACOG membership, or being US-born was not associated with objection to abortion.

For each clinical scenario, approximately two-thirds of ob-gyns who object to abortion in that case would still assist the patient to obtain an abortion: 57% in cases of sex selection and difficult-to-control diabetes; 64% in cases of rape and selective reduction, 65% in the case of failed contraception; 67% in the case of breast cancer, and 70% in the case of heart disease. Overall, 55% would assist patients in all scenarios to which they have a moral objection to abortion, 18% would assist in some scenarios but not others, and 26% would

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not assist in any scenario to which they had an objection. Excluding the sex selection case, those percentages were 58%, 17% and 23%, respectively.

Table 4 displays the adjusted odds of being willing to assist despite objection in: one or more cases in which one has a moral objection; in the case of sex selection alone; and in one or more scenarios when sex selection was excluded. Considering all scenarios, assistance despite objection was more likely among Jewish ob-gyns (OR 3.0; 95% CI 1.4–6.5) and less likely among older ob-gyns (OR 0.98, 95% CI 0.95–0.99), ob-gyns from the South (OR 0.6, 95% CI 0.4–1.0), or ob-gyns for whom religion was most important (OR 0.4, 95% CI 0.2–0.7) compared to their respective reference groups. We observed similar demographic predictors of assistance despite objection when we examined the sex selection case alone. Considering all cases except sex selection, female ob-gyns were more likely to assist despite objection than male ob-gyns (OR 1.8; 95% CI 1.1–2.9) as were US born ob-gyns compared to those born outside of the US (OR 2.2, 95% CI 1.1–4.7). Southern ob-gyns were less likely to assist despite objection (OR 0.3, 95% CI 0.2–0.6), as were those who said that religion was most important in their life (OR 0.3; 95% CI 0.1–0.7).

We conducted a separate analysis of the 194 respondents who indicated that they perform abortions. Sixty-five percent (95%CI, 57–72%) objected to abortion for sex selection, but 81% (95%CI, 75–88%) were willing to assist despite objection. Otherwise, abortion providers morally objected to abortion at low rates: 4% (95%CI, 0–8%) in failed contraception; <1% in the case of breast cancer; 8% (95%CI, 4–13%) for diabetes; 2% (95%CI, 0–4%) in the setting of rape; 3% (95%CI, 0–6%) for selective reduction, and <1% for a potentially fatal cardiopulmonary anomaly. Most assisted – 81%–100%, depending upon the scenario). Seventy percent of abortion providers assist despite objection in all scenarios (95%CI, 61–80%), 3% in some scenarios (95%CI, 0–6%), and 27% (95%CI, 17–36%) in no scenarios. When the sex selection case was excluded, very few (n=16) abortion providers with objections remained in the sample. Among these, 11 assist despite objection in all scenarios, 1 in some, and 4 in none.

Discussion

In this national survey, we found that the context in which a woman seeks abortion matters to many ob-gyns—both to their judgments about the morality of abortion and to whether they will help a woman obtain the abortion she seeks. These findings contrast with public debates about the ethics of abortion, which often focus only on the moral status of the fetus: if the fetus is a person, then abortion is the moral equivalent of murder; if the fetus is not a person, abortion may be permissible. These data suggest that ob-gyns also consider contextual factors, including risk of physical harm to the woman by continuing pregnancy (breast cancer, cardiopulmonary disease), the circumstances of the sexual encounter that resulted in pregnancy (rape), the impact abortion may have on pregnancy outcome (selective reduction), the potential for fetal anomaly (diabetes), and the duration of pregnancy (second versus first trimester). Ob-gyns may be more likely to object to abortion when they believe that the health risks of pregnancy can be mitigated with careful medical management (e.g., in diabetes); when the patient had the capacity to prevent the pregnancy with better compliance with contraception; or when the request for abortion is motivated by unjustified

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prejudice (e.g., sex selection). However, that context matters raises concerns that socioeconomic, racial, or other power imbalances might result in inequities in meaningful access to abortion: to the extent a woman's reasons for seeking abortion are relevant, ob-gyns are in the position of determining if those reasons are "good enough."

In addition to context, physician characteristics matter, in that they are associated with objecting to and being willing to help a patient obtain abortion. Apart from the case of sex selection, female ob-gyns are less likely to object to abortion than their male counterparts. When they do object, women are more likely to assist despite their objections. Nearly 30 years ago psychologist Carol Gilligan found that men tend to mediate moral decisions by using universal principles or well-defined rules, while women are more likely to make moral decisions by appealing to context, particularity, and relationships (16). Our data show that apart from sex selection, male ob-gyns were less likely to assist despite objection, consistent with a more rule or principle-oriented view that abortion is either acceptable or not. Female ob-gyns on the other hand were more likely to assist when they objected. They may experience abortion as simultaneously objectionable and acceptable, depending on nuances of the particular clinical context.

Geographic variations in objection and assistance despite objection highlight concerns that ob-gyns' refusals to help patients obtain a requested abortion contribute to unequal access to abortion services (7). For example, despite the fact that refusals of abortion services have the potential to significantly impact patient access to abortion more in rural areas where there are fewer providers, working in a more rural setting was not associated with willingness to assist despite objection. With respect to religion, aside from the case of sex selection, religious affiliation was not independently associated with assistance despite objection, whereas physician religiosity was. This suggests that the lived experience of religion shapes ob-gyns' decisions about abortion more than religious affiliation per se.

One way to interpret these findings is that most (but not all) ob-gyns embrace what has been called the "conventional compromise" regarding conscientious refusals (17). According to Brock, the conventional compromise holds that if a physician has a conscientious objection to a legal and professionally permitted medical intervention, under certain circumstances the physician may not be obligated to provide the intervention, but he or she is obligated to refer to someone who will. However, sometimes a physician might consider even referring the patient to be immoral; indeed, a recent study found that 43% of US physicians do not believe doctors are obligated to refer in such cases (14).

Of note, while current debates tend to attach the term "conscientious" only to refusals to provide or refer for abortion, these data suggest that providing or helping a patient obtain an abortion can also be a conscientious act—an act done with due moral consideration and done even in the face of personal moral objection to abortion (18). Our data further suggest that acting "conscientiously" does not necessarily mean providing only medical interventions to which one has no moral objections. This study includes both ob-gyns who object to abortion but nevertheless help a woman obtain one, and ob-gyns who generally support abortion – even provide abortion – but who would not help a patient obtain an abortion for sex selection. Whether conscientious provisions or refusals of abortion care are

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ethical is the subject of ongoing debate, even among the authors of this study. Either way, these findings point to an understanding of conscience as a capacity that judges the moral quality of one's actions, (19) all things considered (20).

Finally, public discourse sometimes makes it seem as if there are only two categories of providers in the US with respect to abortion: those who do not object to abortion, and therefore assist women seeking abortion, or those who oppose abortion and do not. In contrast, our data indicate at least two further categories: ob-gyns who oppose abortion in general but still find it acceptable sometimes, and those who support abortion in general—even provide it—but still find it unacceptable sometimes. Ongoing debates about abortion should take note of these nuances regarding abortion practices.

This study has several limitations. We did not ask about other common situations in which patients might seek abortion, including situations in which contraception was not used, in which the patient faces financial hardships, in which women's work or educational goals led to the decision to seek abortion, or in which a patient seeks an abortion in the setting of fetal anomaly. In addition, trimester of pregnancy was not uniformly identified in case scenarios, so we cannot be sure the extent to which ob-gyns' responses reflected their inferences regarding the duration of pregnancy in each scenario. We used the zip codes of physicians' primary mailing address, which might be a home address and might not represent the level of urbanicity of the zip code in which they practice. Finally, as is characteristic of studies such as ours, data may not reflect how physicians practice in real life; further, non-respondents may differ from respondents in ways that bias the findings.

Notwithstanding these limitations, this study has important implications for understanding the relationship between physicians' personal moral views and the clinical care they provide. Among ob-gyns, support for abortion varies widely depending on the context in which abortion is sought and physician characteristics. Furthermore, most ob-gyns assist a patient seeking abortion even when they object to abortion in that patient's case. A broader appreciation of the moral considerations that shape physician decisions will be critical to shaping practice guidelines and public policy that both meet patients' needs and promote moral integrity among the physicians who care for them.

Acknowledgments

Funding: Supported by grants from the Greenwall Foundation (Harris, Curlin) and the John Templeton Foundation (Curlin), as well as the National Heart Lung and Blood Institute, the National Institutes of Health (Lyerly, 5K01HL072437-05)

The authors thank John Yoon for his assistance with the overall study, and Stacy Lindau for her assistance in questionnaire development.

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Table 1

Demographics of sample[*]

Characteristic	No	(%)
Age, mean (SD)	47.8	9.2 SD
Percent urban[†], median (1st, 3rd quartiles)	99.9	91.4, 1
Female sex	537	(46)
Region		
Northeast	288	(25)
South	373	(32)
Midwest	249	(22)
West	242	(21)
Race/Ethnicity		
Asian	202	(18)
Hispanic or Latino	64	(6)
Black, non-Hispanic	67	(6)
White, non-Hispanic	774	(68)
Other	22	(2)
Marital Status		
Married	965	(84)
Single/Divorced/Widowed	178	(16)
Children		
None	162	(14)
1 or more	973	(86)
Immigration History		
Born in the USA	817	(72)
Immigrated to USA as a child or adult	323	(28)
Religious affiliation		
None	119	(11)
Hindu	91	(8)
Jewish	160	(14)
Muslim	54	(5)
Roman Catholic/Eastern Orthodox	262	(23)
Protestant, Evangelical	91	(8)
Protestant, Non- Evangelical	300	(27)
Other Religion	48	(4)
Importance of religion in life		
Most important	157	(14)
Very important	385	(34)
Fairly important	321	(28)
Not very important	272	(24)
ACOG Member	1052	(92)

[*] Total sample size is 1,152. Some groups add up to less than that number because of missing responses. Numbers and percentages are unweighted.

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[†] Percent Urban was obtained from 2000 Census data linked to zipcodes. It is calculated as the total population in a zipcode living in an urban area divided by the total population in that zipcode.

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Table 2

The percentage of US Ob/Gyns [lsqb]N = 1154[rsqb] that reports moral objection to abortion, and willingness to help patients obtain abortion, in seven hypothetical clinical scenarios

Clinical Scenario	**Do you morally object to abortion in this case? (Yes)**	**Would you help the patient obtain the abortion if asked? (Yes)**
	N (%)	**N (%)**
	(95% CI)	**(95% CI)**
A. A 22-year-old single woman 6 weeks pregnant after failed hormonal contraception	420 (**41**)	970 (**85**)
	(38–44)	(82–87)
B. A 38 year old with five daughters and no sons, after chorionic villus testing at 10 weeks gestation reveals the fetus is a chromosomally normal female	923 (**82**)	719 (**64**)
	(80–85)	(61–67)
C. A 36 year old in the first trimester of pregnancy who needs radiation and chemotherapy for newly diagnosed breast cancer	178 (**18**)	1046 (**91**)
	(16–21)	(89–93)
D. A 28 year old with brittle type 1 diabetes, for whom glucose management has become very difficult at 16 weeks gestation	445 (**43**)	915 (**80**)
	(40–46)	(78–83)
E. A 34-year-old woman 6 weeks pregnant after being raped	206 (**20**)	1041 (**91**)
	(18–23)	(89–93)
F. Selective reduction in a healthy 37-year-old patient with quintuplet pregnancy	294 (**29**)	1001 (**88**)
	(26–32)	(86–90)
G. A 24 year old with a cardiopulmonary abnormality associated with a 25% chance of death with gestation	155 (**16**)	1060 (**93**)
	(14–18)	(91–95)

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Table 3

Adjusted odds of reporting a moral objection to abortion in one or more scenarios, in the case of sex selection, and in one or more scenarios other than sex selection, by physician characteristics

	Object		
	To one or more scenarios	**To sex selection**	**To one or more scenarios other than sex selection**
	OR (95% CI)	**OR (95% CI)**	**OR (95% CI)**
Characteristic			
Age, yrs	.98 (.95–1.0)	.98 (.95–.99)*	.96 (0.94–.98)*
Female sex	1.3 (0.9–2.0)	1.2 (0.8–1.8)	0.5 (0.4–0.8)*
Race/Ethnicity			
White, non- Hispanic	Referent	Referent	Referent
Black, non- Hispanic	0.4 (0.2–0.9)*	0.4 (0.2–0.9)*	0.8 (0.4–1.6)
Asian	0.7 (0.3–1.5)	0.8 (0.4–1.6)	0.7 (0.3–1.3)
Hispanic/Latino	0.5 (0.2–1.1)	0.6 (0.3–1.3)	0.7 (0.3–1.4)
Other	1.4 (0.4–4.9)	1.7 (0.5–6.1)	1.0 (0.1–10.0)
Married	1.2 (0.7–2.0)	1.4 (0.8–2.3)	1.1 (0.6–1.8)
Children	1.4 (0.8–2.6)	1.3 (0.7–2.3)	1.5 (0.9–2.6)
US born	1.0 (0.5–1.8)	1.3 (0.7–2.3)	0.8 (0.4–1.3)
Region			
Northeast	Referent	Referent	Referent
South	1.8 (1.1–3.1)*	1.6 (1.0–2.7)	1.9 (1.2–3.0)*
idwest	1.9 (1.1–3.4)*	1.9 (1.1–3.5)*	1.9 (1.2–3.1)*
West	0.9 (0.6–1.6)	0.8 (0.5–1.3)	1.3 (0.8–2.1)
Religious affiliation			
None	Referent	Referent	Referent
Hindu	0.5 (0.2–1.4)	0.6 (0.2–1.6)	1.0 (0.4–2.8)
Jewish	0.5 (0.2–1.0)*	0.5 (0.2–0.9)*	0.3 (0.1–0.7)*
Muslim	2.7 (0.7–10.3)	4.4 (1.0–18.8)*	3.4 (1.2–9.6)*
Roman	1.5 (0.8–3.1)	1.3 (0.7–2.6)	2.7 (1.4–5.1)*
Catholic/Eastern Orthodox			
Protestant, Evangelical	2.6 (0.8–8.8)	2.7 (0.8–9.3)	3.7 (1.4–10.0)*
Protestant, Non– Evangelical	1.4 (0.7–2.7)	1.4 (0.8–2.8)	1.7 (0.9–3.2)
Other Religion Importance of religion in life	0.7 (0.2–1.8)	0.6 (0.2–1.6)	0.8 (0.3–2.2)
Not very/not at all important	Referent	Referent	Referent
Fairly important	1.6 (1.0–2.6)	1.7 (1.0–2.8)	1.7 (1.1–2.8)*
Very important	2.0 (1.1–3.4)*	2.2 (1.3–3.8)*	3.6 (2.2–5.9)*
Most important	6.3 (2.3–17.6)*	6.1 (2.3–15.8)*	16.9 (7.7–37.1)*
ACOG Member	1.0 (0.5–2.0)	1.0 (0.5–2.0)	0.7 (0.4–1.3)
Percent Urban	1.5 (0.5–4.9)	1.7 (0.6–5.2)	0.3 (0.1–0.7)*

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Table presents results of multivariable logistic regression analyses that adjust for all variables in the table.

[*] p[lt].05

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Table 4

Adjusted odds of being willing to assist in all scenarios objected to, in the case of objecting to sex selection, and in all scenarios objected to other than sex selection, by physician characteristics

	Willing to assist despite objection		
	All scenarios	**Sex selection**	**All scenarios other than sex selection**
	OR (95% CI)	OR (95% CI)	OR (95% CI)
Characteristic			
Age, yrs	.98 (.95–.99)*	.98 (.95–.99)*	.99 (.96–1.02)
Female sex	1.3 (0.9–1.8)	1.3 (0.9–1.8)	1.8 (1.1–2.9)*
Race/Ethnicity			
White, non- Hispanic	Referent	Referent	Referent
Black, non- Hispanic	0.6 (0.3–1.2)	0.6 (0.3–1.2)	0.7 (0.3–1.4)
Asian	1.1 (0.6–2.1)	1.2 (0.6–2.5)	1.6 (0.6–4.3)
Hispanic/Latino	1.0 (0.5–2.1)	1.2 (0.5–2.5)	1.6 (0.6–4.3)
Other	1.9 (0.3–10.6)	4.8 (1.0–22.4)*	0.6 (0.1–4.5)
Married	0.8 (0.5–1.3)	0.7 (0.4–1.2)	0.9 (0.5–1.7)
Children	0.6 (0.3–1.1)	0.6 (0.3–1.1)	0.6 (0.3–1.4)
US born	1.2 (0.7–1.9)	1.0 (0.6–1.7)	2.2 (1.1–4.7)*
Region			
Northeast	Referent	Referent	Referent
South	0.6 (0.4–1.0)*	0.6 (0.4–0.9)*	0.3 (0.2–0.6)*
Midwest	0.7 (0.4–1.2)	0.7 (0.4–1.2)	0.5 (0.3–1.1)
West	1.1 (0.7–1.8)	1.1 (0.6–1.8)	0.8 (0.4–1.7)
Religious affiliation			
None	Referent	Referent	Referent
Hindu	0.6 (0.2–2.1)	0.5 (0.1–1.7)	3.0 (0.5–17.3)
Jewish	3.0 (1.4–6.5)*	2.9 (1.3–6.5)*	2.5 (0.5–13.3)
Muslim	0.8 (0.3–2.1)	0.7 (0.3–1.9)	0.8 (0.2–3.5)
Roman	1.4 (0.7–2.7)	1.4 (0.7–2.7)	1.1 (0.4–3.5)
Catholic/Eastern Orthodox			
Protestant, Evangelical	0.9 (0.4–2.0)	1.1 (0.5–2.6)	1.0 (0.3–3.4)
Protestant, Non- Evangelical	1.5 (0.8–2.9)	1.5 (0.8–3.0)	1.2 (0.4–3.9)
Other Religion	0.6 (0.2–1.8)	0.6 (0.2–1.9)	1.0 (0.2–5.2)
Importance of religion in life			
Not very/not at all important	Referent	Referent	Referent
Fairly important	1.0 (0.6–1.7)	1.0 (0.6–1.7)	1.0 (0.4–2.3)
Very important	0.7 (0.4–1.2)	0.7 (0.4–1.2)	0.6 (0.3–1.3)
Most important	0.4 (0.2–0.7)*	0.4 (0.2–0.7)*	0.3 (0.1–0.7)*
ACOG Member	1.2 (0.7–2.1)	1.2 (0.7–2.2)	1.1 (0.5–2.1)
Percent Urban	1.4 (0.5–3.7)	1.1 (0.4–2.9)	1.1 (0.4–3.2)

Table presents results of multivariable logistic regression analyses that adjust for all variables in the table.

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[*] $p[lt].05$

Exhibit 377

Would Accommodating Some Conscientious Objections by Physicians Promote Quality in Medical Care?

Douglas B. White, MD, MAS
Baruch Brody, PhD

MORAL PLURALISM IS A VALUABLE ASPECT OF A free society[1] but sometimes creates conflicts in medical care when individual physicians object to providing certain legal but morally controversial services, such as abortion, physician-assisted suicide (where it is legal), and palliative sedation to unconsciousness. Genuine conscience-based refusals (CBRs) are refusals in which a physician believes that providing the requested service would violate his or her core moral beliefs (religious or secular), thereby causing personal moral harm.[2] Conscience-based refusals should be a "shield" to protect individual physicians from being compelled to violate their core moral beliefs rather than a "sword" to force their beliefs onto patients. This partially explains why many physicians who invoke CBRs refer their patients to physicians willing to provide the requested care.

Savulescu[3] has characterized CBRs as self-serving acts accomplished at the expense of patients. Others accept CBRs as legitimate acts to protect moral integrity despite the potential negative consequences for patients. Both characterizations neglect a complexity: society may obtain higher-quality medical care in aggregate by accommodating some CBRs. In this Commentary, CBRs are addressed from this societal perspective.

Does Physicians' Integrity Foster Quality Medical Care?

Moral integrity is the virtue of being "faithful to moral norms and standing up in their defense when necessary."[4] When coupled with medicine's ethical norms, physicians' integrity should be protected. Doing so allows patients to have confidence that physicians will promote their welfare, resist conflicts of interest, and refuse to administer treatments that are harmful or nonbeneficial.

However, some physicians have personal moral commitments that conflict with aspects of accepted medical practice. This causes "conflicting oughts" between an individual's personal beliefs and those that arise from his or her role as a physician. Internal integrity involves being true to a person's core moral beliefs. External (professional) integrity partially involves fulfilling a professional role to help patients achieve their medical objectives. For instance, a physician morally opposed to palliative sedation who performs it when requested and when required to achieve the patient's medical objectives compromises his internal integrity but satisfies external integrity. Benjamin[5] noted that "in more modern . . . pluralistic societies, the tensions between internal and external integrity are more pronounced."

Why not mandate that external/professional integrity should always take precedence over internal/personal commitments? Doing so would create risk of serious moral harm to physicians. Although the usual arguments against this are grounded in respect for physicians' autonomy, there is another argument grounded in maintaining medical quality as defined by the Institute of Medicine[6] at the societal level. There are 5 ways that accommodating some CBRs could achieve this.

First, prohibiting CBRs may negatively influence the type of persons who enter medicine. Individuals who value moral integrity may not become physicians if they might be forced to violate their personal integrity when it conflicts with professional commitments. Society benefits from having "morally serious persons in the profession who are unwilling to just follow orders and who contribute to the rich moral debate."[7] Disallowing CBRs also may work against the goal of increasing diversity in the profession because physicians from diverse backgrounds are more likely to have views that diverge from the dominant medical model.

Second, prohibiting CBRs also may negatively influence how practicing physicians attend to professional obligations. Cherniss suggested that there are important effects on patient care when physicians experience emotional and moral distress in the workplace.[8] Physicians react by redirecting attention from others' needs to their

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own needs. This occurs by leaving public service careers for more lucrative private jobs, serving less-challenging patients, and developing more restricted views of professional responsibilities to patients. These constitute moral divestiture, in which "the value of responding with care to others becomes less centrally . . . constitutive of [physicians'] personal and professional identity."[9]

A third potential effect of disallowing CBRs is the development of physician "callousness," which can manifest as a belief that patients do not deserve caring responses from their physicians.[9] Evidence suggests a moderate association between clinicians' reports that they must "deaden their conscience" at work and higher levels of callousness toward patients.[10] Callousness diminishes medical quality when quality requires sensitivity to and empathy for patients' vulnerabilities.

Fourth, disallowing CBRs may reciprocally diminish physicians' willingness to be sympathetic to and accommodating of patients' diverse moral beliefs. Such intolerance clearly threatens quality care.

Fifth, if physicians do not have loyalty and fidelity to their own core moral beliefs, it is unrealistic to expect them to have loyalty and fidelity to their professional responsibilities.

Medicine is the social institution charged with promoting the health of the population by treating patients. In this way, high-quality medical care is a public good. Conceptualizing quality medical care as a public good and physicians' integrity as central to it justifies policies that allow certain CBRs. Just as society accepts some negative effects to secure other public goods, so too might it be sound public policy to allow some CBRs in pursuit of medical quality at the societal level.

Objections

One objection is that only physicians willing to adhere to all norms of medicine should practice. However, this would likely shrink the diversity of the profession. It also does not consider that the norms of medicine constantly evolve. For example, withdrawing life support from dying patients who request doing so has rapidly evolved from an impermissible act to an obligatory one. It seems untenable to require that physicians agree in advance to override any core moral beliefs if the norms of medicine shift.

Another objection is that accommodating some CBRs results in an unfair distribution of burdens because only some patients will experience CBRs. However, public policy often allows a degree of asymmetry in distribution of burdens when the public interest requires it. Moreover, all patients face the possibility of experiencing a CBR. Physicians should also be asked to make sacrifices by requesting accommodation only for core moral beliefs, not lesser beliefs.

A third objection is that it cannot be determined that the benefits of allowing some CBRs would outweigh the harms. This is true of any argument assessing future benefits and burdens. However, the nature of the patient-physician relationship, the relatively rare occurrence of CBRs compared with the total number of medical encounters, and the placing of well-defined limits on the accommodation of CBRs should optimize the burden-benefit ratio, especially if there is open, respectful communication between the physician and patient about CBRs.

Conclusion

The notion that protecting physicians' consciences benefits physicians at the expense of patients has created an overly simplistic dialogue about conscience in medicine. Viewing the issue from a societal perspective and conceptualizing medical quality as a public good allow a more robust understanding of the relationship between CBR and quality medical care. Policies that allow some CBRs while also ensuring patients' access to the requested services may yield better overall medical quality by fostering a diverse workforce that possesses integrity, sensitivity to patients' needs, and respect for diversity. This analysis is necessary for a genuine public discussion about how to handle moral pluralism among patients and physicians. The societal perspective should be incorporated into efforts to develop a comprehensive framework for when CBRs should and should not be accommodated.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Additional Contributions: We thank Mark Wicclair, PhD, David Barnard, JD, PhD, Daniel Hall, MD, MDiv, and Robert Arnold, MD, of the University of Pittsburgh, and Scott Halpern, MD, PhD, of the University of Pennsylvania School of Medicine, for their thoughtful critiques of early drafts of this article. They were not remunerated for their contributions.

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Exhibit 378

Recognizing Moral Disengagement and Its Impact on Patient Safety

Josh Hyatt, DHSc, MHL, CPHRM, FASHRM

Moral disengagement refers to a process that involves justifying one's unethical actions by altering one's moral perception of those actions. The moral disengagement that occurs in the health care industry poses serious threats to patient safety, the culture of the institution, and even the mental health of care providers. This article describes the factors that create moral distress and impact moral disengagement among health care professionals, as well as ways to identify moral disengagement.

Keywords: Moral disengagement, moral distress

Objectives

- Differentiate moral disengagement and moral distress.
- Identify causes of moral distress.
- Discuss mechanisms of moral disengagement.

An 87-year-old woman, known to the emergency room as a "frequent flyer," arrives there late one evening with her caretaker complaining of abdominal pain. While in the lobby, she begins vomiting in a garbage pail. The caretaker notifies the triage nurse of the vomiting who states, "She always has stomach problems, I'm sure it is nothing serious. She probably hasn't taken her meds." As the evening passes, the patient continues vomiting and sweating, and the caretaker continues to ask about her being seen by the physician. One of the front desk staff tells the caretaker, "We will see her as soon as a bed opens up. It's not that bad, she will be fine." After 4 hours of not being seen, the patient faints and a rapid response team is called. She is later diagnosed with a perforated stomach ulcer. When asked by the investigator why it took the patient fainting to be seen, the triage nurse said, "I was just following the policy. Blame the hospital."

Institutional culture and systems influence the actions and behaviors of staff and physicians. Behaviors that are not permissible at one institution may be culturally accepted or tolerated at another, sometimes within the same corporate enterprise. When staff or physicians begin to justify adverse behaviors that impact a culture of safety or resort to sullying patients or families to redirect attention from those behaviors, the institutional culture and individual practitioner are negatively impacted. These cultural and system foundations are found to impact many aspects of regulatory and compliance expectations, as well as patient safety and employee satisfaction. This fundamental concept is foundational to the social psychology phenomenon known as moral disengagement, which is a defense mechanism and displacement of responsibility related to a sense of moral distress.

Displacement of responsibility is often linked to the "just following orders" mindset, which has significant impact to culture and safety. Such claims dominated the Nuremberg Trials at the end of World War II. In day-to-day examples, it is not uncommon to see health care professionals undermedicating patients for pain because of a fear of addiction, ignoring inpatient call-bells because they consider the patient to be "problematic," or undermining the fear of patients by saying "it could be worse" or "it isn't that bad." This article describes the factors that create moral distress and impact moral disengagement among health care professionals, as well as ways to identify moral disengagement.

Moral Disengagement and Moral Distress

Moral disengagement refers to a process that involves justifying one's unethical actions by altering one's moral perception of those actions (Bandura, 1999). Predictably, moral disengagement is associated with several negative outcomes for those experiencing it and those affected by it. Thus, efforts have been made to understand how moral disengagement can be avoided or minimized. Simply, it "is a process that enables people to engage in negative behaviors, from small misdeeds to great atrocities, without believing that they are causing harm or doing wrong" (Sucher & Moore, 2011). The moral disengagement that occurs in the health care industry poses serious threats to patient safety, the culture of the institution (Just Culture and Culture of Safety), and even the mental health of care providers.

A significant precursor of moral disengagement in health care is the moral distress that results from working in an institution in which the systems and processes are dysfunctional and/or cultural issues exist related to power differentials or disruptive behaviors. *Moral distress* can be a condition in which one identifies the correct ethical action and wants to execute it but is prevented from doing so by barriers, such as bureaucratic rules and time constraints (Barlem & Ramos, 2015; Musto & Rodney, 2015).

Moral distress can also be related to health care providers who are not self-aware of personal discomfort and who project it onto others. For example, a nurse is ordered to provide a 24-year-old Marine an injection. However, the patient fears needles and flinches when the needle is brought near the skin. The nurses says, "You're a Marine. Buck up and act like a man." In such a situation, the nurse is generally acting out of his or her own discomfort by embarrassing the patient rather than by addressing the personal discomfort and the patient's fear in a constructive manner.

Moral distress is related to but distinguishable from other moral concepts that can also lead to moral disengagement, including *moral courage*, which refers to the tendency to do what is right regardless of other pressures; *obedience*, which refers to the tendency to do what one is told regardless of what is right; and *ethical dilemmas*, which occur when one needs to choose between two options that are not ethically discriminable (Ganz, Wagner, & Toren, 2015).

The phenomenon of moral distress was first studied in 1987 by Judith Wilkinson, who was interested in the role of moral distress in nurses and patients. Based on work with nursing students, Andrew Jameton coined the term 3 years earlier (1984). In 2015, McCarthy and Gastmans published a systematic review of the literature on moral distress and identified three key contributory features:

- Health care providers who undergo moral distress endure suffering that is psychological, emotional, and physiologic.
- These providers participate in unethical behavior or wrongdoing.
- Their acts result from environmental or cultural constraints.

The tension involved in the combination of these features of moral distress represents a type of cognitive dissonance or tension between principles. The dissonance is between what one knows is right and what one feels he or she must do. Cognitive dissonance is a well-studied phenomenon, known to be averse. When a person experiences cognitive dissonance, he or she attempts to reduce the perceived friction. With moral distress, the cognitive dissonance leads to moral numbness and moral disengagement (Epstein & Delgado, 2010). Moral disengagement reduces cognitive dissonance by reframing the situation so the person performing the unethical act no longer perceives it as unethical (Bandura, 1999; Bustamante & Chaux, 2014; Hinrichs, Wang, Hinrichs, & Romero, 2012).

Although moral distress was first studied in nurses, it affects all health care professionals, including physicians, psychologists, therapists, pharmacists, social workers, patient care technicians, and administrators (Varcoe, Pauly, Webster, & Storch, 2012). For the sake of patient outcomes and the well being of health care professionals, moral distress and its ability to lead to moral disengagement must be minimized. Understanding the factors that create moral distress and impact moral disengagement is therefore a critical area of study.

Identifying Moral Distress

Identifying the initial behaviors linked to moral distress and addressing them constructively can aide in reducing the impact long term. Affective, cognitive, somatic, and behavioral indicators can assist in identifying moral distress. The affective symptoms of moral distress include frustration, guilt, depression, anger, resentment, shame, powerlessness, and helplessness (Corley, 2002); cognitive symptoms may include a loss of self-worth and a loss of a sense of self (Payne, 2011).

Although the affective and cognitive symptoms are intuitive, the physiologic and behavioral symptoms may not be. The somatic symptoms are fatigue, aches, pain, sleeplessness, heart palpitations, and nightmares (McCarthy & Gastmans, 2015; Payne, 2011). These symptoms reflect the significant stress health care providers facing morally distressing situations undergo. Behavioral symptoms of moral distress include gossiping, being late or absent, distancing from patients, avoiding work-related tasks, and engaging in horizontal violence (Payne, 2011). *Horizontal violence*, also called lateral violence, refers to nonphysical bullying caused by feelings of oppression that lead to anger and resentment. Like the physiologic symptoms, these symptoms signify how deeply moral distress affects people.

Of course, the symptoms of moral distress can result from other causes. For example, *compassion fatigue*—a diminished desire to help—can produce the physical symptoms of moral distress as well as anger, frustration, hopelessness, and depression. However, compassion fatigue results from consistent exposure to stressful situations. Moral distress, on the other hand, involves compromising moral integrity and experiencing a conflict between moral conscience and behavior. Therefore, it needs to be addressed before it progresses to moral disengagement.

Causes of Moral Distress

Moral distress can occur for reasons related to a person's experiences with his or her organization, work, and those with whom he or she works. The biomedical model, especially in the intensive care, surgical, and emergency room milieus, is based on a vitalistic perspective of "maintaining life at all costs." This perspective may undervalue the question, "What is the acceptable quality of life for the patient?" According to the biomedical model, because health care systems tend to emphasize cure over compassion, body over mind, and treatment over prevention, those involved in the system are particularly susceptible to moral distress (Crowley-Matoka, Saha, Dobscha, & Burgess, 2009). Because the ethical act often involves being compassionate, catering to the mind, and helping prevent or avoid illness, the relative devaluation of these concepts in health care can be distressing to those who must act in ways that are inconsistent with what they believe is the ethical approach.

An example of this the moral distress is experienced by nurses and other health care providers when providing nonbeneficial care to a dying patient. In many cases, the nurse understands that the care is nonbeneficial and can prolong suffering. Providing nonbeneficial care to the patient can be perceived by the provider as engaging in a maleficent act. Without the proper tools or support to express their concerns, and without appropriate ways to channel these concerns, these perceptions often contribute to unethical actions or "provider blindness" to other serious issues.

Specific clinical- and treatment-related factors in health care can also contribute to moral distress. Feeling pressure to pursue interventions that are not in the best interest of the patient, such as ordering unnecessary tests or having terminal patients undergo aggressive treatment, are examples. Similarly, having to provide false hope to patients and their families or perceiving inadequate communication with them can cause similar distress. Seeing that staff members are not properly trained to care for patients and that patient care may suffer because of a lack of continuity of care are other stressors (Barlem & Ramos, 2015; Choe, Kang, & Park, 2015; Corley, 2002; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015).

Organizational factors that contribute to moral distress include health care regulations, priorities that emphasize fiscal matters, an emphasis on efficiency over quality of care, an insufficient number of staff members, incompetent or inadequate caretaking, and a poor ethical climate (Choe et al., 2015; Lamiani, Borghi, & Argentero, 2015; Musto & Rodney, 2015; Burston & Tuckett, 2013). Work-related factors, including heavy caseloads, perceived time pressures, resource constraints, lack of authority and support, and an inability to be heard, can also lead to moral distress (Burston & Tuckett, 2013; de Veer, Francke, Struijs, & Willems, 2013; McCarthy & Gastmans, 2015).

Moreover, interpersonal factors can produce moral distress. Imbalances of power in relationships among health care providers can be a source of such stress, as can conflicts arising with others in the work setting. Observing others act in unethical ways and feeling that collaboration between nurses and physicians is poor have also been reported as reasons for moral distress (Barlem & Ramos, 2015; Lamiani et al., 2015; McCarthy & Gastmans, 2015).

Finally, issues related to the individual can make him or her vulnerable to moral distress. Being new to the health care setting, for instance, may increase the chances that one experiences moral distress (Burston & Tuckett, 2013; Wilkinson, 1987). Further, those who lack moral competency or courage tend to experience moral distress if they have a strong sense of moral integrity or moral sensitivity (Corley, 2002).

Mechanisms of Moral Disengagement

Moral distress can become moral disengagement via a host of mechanisms (Bandura, 1999; Dineen, 2013), each of which represents a way of coping with and thereby minimizing the moral distress. Some mechanisms focus on shifting blame, whereas others involve altering the meaning of the unethical act or its consequences. Figure 1 presents a high-level view of the transition from moral distress to moral disengagement.

FIGURE 1

Path from Moral Distress to Moral Disengagement

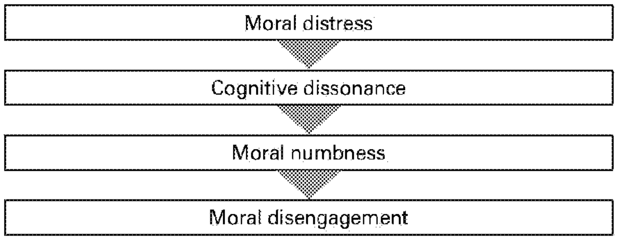
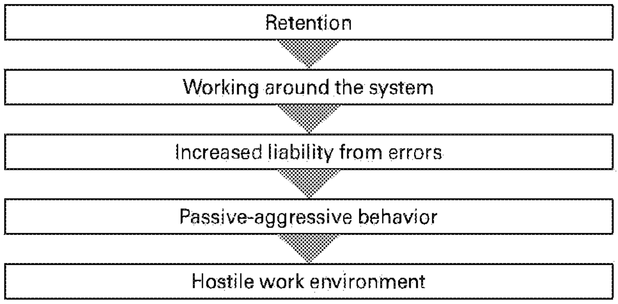


FIGURE 2

The Impact of Moral Distress on Organizations



Shifting Blame

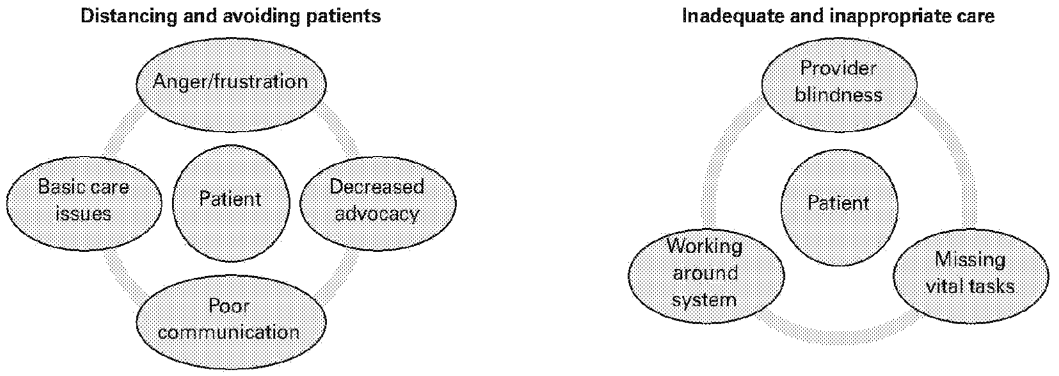
One mechanism that entails shifting blame is *displacement of responsibility*. Rather than take accountability for the unethical act, the health care provider attributes responsibility to another party, such as a person of higher authority. For instance, providers may claim that they engaged in an act because they were following hospital policy or because their supervisor gave them no other option. Another mechanism related to blame shifting is *attribution of blame*, in which one blames the unethical act on an enemy, the victim, or the circumstances. Often, attribution of blame involves labeling the patient or his or her family as difficult or attributing bad intentions, such drug seeking, to the patient. In both displacement of responsibility and attribution of blame, the person experiencing moral distress attempts to suppress it by reducing the sense of personal responsibility for the act.

Re-evaluating the Gravity of the Act

Some mechanisms aim to alter the meaning of the act itself, such as those that involve reframing the act to make it seem less negative or less serious. *Moral justification*, also referred to as sanitizing the act, involves portraying the act as commendable, either socially or morally. A provider who withholds opioid analgesics and uses the rationale that the patient could become addicted is an example of moral

FIGURE 3

Impact of Moral Distress on Patients



justification. Similarly, *euphemistic labeling* allows a reframing of the unethical behavior by describing it in positive terms. Specialized jargon can help achieve this mechanism as can using the passive voice, which provides distance between the actor and the act. Using specific word choices, such as replacing the words "taken off medication" with "weaning from medication" is euphemistic labeling. An act can also be made to seem less severe by viewing it relative to a more severe act. *Advantageous comparison* uses the contrast principle to compare the unethical act to a worse scenario, thereby making the act seem less adverse. In each of these cases, moral distress is attenuated by a re-evaluation of the gravity of the act.

Minimizing the Consequences

Some mechanisms of moral disengagement focus on the consequences of the act. *Minimization of consequences* occurs when a person distorts the impact of the unethical act, such as claiming that the pain associated with the act is not as great as it is. A related mechanism is *dehumanization,* in which victims of the unethical act are objectified. Dehumanization may include referring to a patient by his or her bed number or condition rather than by his or her name. Viewing victims as objects rather than as human beings allows one to minimize the consequences of the act. As with mechanisms that involve re-evaluating the gravity of the act, those that allow one to minimize the consequences enable people to minimize their moral distress.

Effects of Moral Distress and Moral Disengagement

Moral distress and moral disengagement have negative consequences for all involved: the health care provider, the organization, and the patient. Moral distress is associated with burnout or loss of purpose (Burston & Tuckett, 2013) and low job satisfaction in health care providers (Lamiani et al., 2015). Those who experience moral distress also tend to become demoralized and passive (Burston & Tuckett, 2013; McCarthy & Gastmans, 2015) and feel deadened to moral issues regarding patients' welfare (McCarthy & Gastmans, 2015).

The organization is affected when people decide to leave and cause retention issues. Further, those undergoing moral issues are more likely to try to find ways to work around the rules of the organization, which can lead to a negative working environment that involves hostility and passive-aggressive behavior (Burston & Tucket, 2013) and causes increased liability from errors. Figure 2 summarizes the impact of moral distress on organizations.

Perhaps, patients experience the most significant and dangerous consequences of moral distress and moral disengagement (Figure 3). As health care providers reduce their communications with patients, patients may feel less safe and less satisfied with their medical experiences, and their clinical progress may be hindered (Peleki et al., 2015). Further, if health care providers avoid patients or distance themselves from patients emotionally, they minimize their ability to advocate for their patients' welfare (Peleki et al., 2015; Corley, 2002; Wilkinson, 1987). Providers' emotional transition can also manifest as frustration toward patients (Pauly, Varcoe, & Storch, 2012), which may impair the quality of care. If health care providers do not fulfill their commitments (Pauly et al., 2012) or perform at a mediocre level (Burston & Tuckett, 2013), patient care can become inadequate or inappropriate (McCarthy & Gastmans, 2015).

Lower quality of care leads to several costs for the patient. Patients may have to stay longer in the hospital (McCarthy & Gastmans, 2015; Wilson, Goettemoeller, Bevan, & McCord, 2013) or may miss care (Winters & Neville, 2012). Patient autonomy may also be threatened (Choe et al., 2015), and patients can be more likely to be coerced into pursuing therapeutic options they would otherwise decide against (McCarthy & Gastmans, 2015). Care can then become less patient centered and more paternalistic (Lee & Lin, 2010), a structure associated with worse health outcomes.

Conclusion

Moral disengagement results from moral distress, which stems from the stress found in the health care environment and complex health care systems. Efforts have been initiated to develop and optimize instruments that can measure moral distress, such as the Moral Distress Scale (Payne, 2011). Such tools hold promise for improving the knowledge of moral distress and moral disengagement and implementing strategies to halt them. When dealt with properly, the phenomenon of moral distress can foster self-awareness, promote critical thinking, generate dialogue among providers across disciplines, and lead to professional growth.

Despite progress in the areas of moral distress and moral disengagement, research efforts should continue to strive to elucidate their features. Although the general symptoms associated with moral distress are known, understanding more thoroughly how they manifest could help to more easily identify moral distress, just as a deeper understanding of the factors that contribute to that distress could help prevent it. Understanding better how structures and processes associated with the health care industry may lead to these problematic phenomena is critical when decisions are made regarding the reinstatement or alteration of policies. Similarly, demonstrating the specific consequences of moral distress and moral disengagement on professionals, patients, and institutions is an important prerequisite to addressing what needs to change in the health care system and why. This understanding can be especially useful for regulators as they discipline and remediate nursing behavior that could potentially lead to patient harm. As research into the symptoms, causes, mechanisms, and consequences of moral distress and moral disengagement becomes more robust, so too will the recommendations for dealing with them.

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Recognizing Moral Disengagement and Its Impact on Patient Safety

Objectives

- Differentiate moral disengagement and moral distress.
- Identify causes of moral distress.
- Discuss mechanisms of moral disengagement.

CE Posttest

If you reside in the United States and wish to obtain 1.0 contact hour of continuing education (CE) credit, please review these instructions.

Instructions

Go online to take the posttest and earn CE credit:

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If you cannot take the posttest online, complete the print form and mail it to the address (nonmembers **must** include a check for $15, payable to NCSBN) included at bottom of form.

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The information in this CE does not imply endorsement of any product, service, or company referred to in this activity.

Contact hours: 1.0
Posttest passing score is 75%.
Expiration: January 2020

Posttest

Please circle the correct answer.

1. Moral disengagement refers to:
a. Knowing the correct course of action to take but being unable to do so because of barriers.
b. Justifying one's unethical actions by changing one's moral perception of those actions.
c. Being able to take correct action only when competing demands do not exist.
d. Needing to choose between two options that are equally undesirable in practice.

2. The second step on the path to moral disengagement is:
a. Moral distress.
b. Cognitive dissonance.
c. Moral numbness.
d. Horizontal violence.

3. Consistent exposure to stressful situations in health care that result in a diminished desire to help is called:
a. Cognitive dissonance.
b. Moral justification.
c. Moral disengagement.
d. Compassion fatigue.

4. An example of a cause of moral distress is:
a. Providing nonbeneficial care to a dying patient.
b. Feeling an excessive need to provide assistance.
c. Labeling an unethical event in euphemistic terms.
d. Providing hope to patients and their families.

5. Which of the following is NOT an organizational factor that contributes to moral distress?
a. Priorities that emphasize finance.
b. Emphasis on efficiency over quality.
c. Inadequate number of staff.
d. Perceived time pressures.

6. Which of the following statements about the causes of moral distress is correct?
a. Observing others acting in unethical ways does not lead to personal moral distress.
b. Being new to the health care setting reduces the likelihood that one will experience moral distress.
c. Poor collaboration between nurses and physicians has been reported to cause moral distress.
d. Power imbalances in relationships may cause ethical dilemmas, but not moral distress.

7. A nurse refuses to give pain medication to a patient with a substance abuse problem because she says the patient is engaging in drug-seeking behavior. This scenario is an example of which mechanism of moral disengagement?
a. Euphemistic labeling.
b. Moral justification.
c. Minimization of consequences.
d. Attribution of blame.

8. A nurse who withholds pain medication because he says the patient could become addicted is using the rationale of:
a. Moral justification.
b. Advantageous comparison.
c. Minimization of consequences.
d. Displacement of responsibility.

9. Which comment indicates that the speaker is engaging in displacement of responsibility when defending an act?

a. "The pain wasn't as bad as she said."
b. "It wasn't as harmful as it could have been."
c. "I was just following hospital policy."
d. "I was weaning off the pain medication."

10. Which of the following is an example of the negative effect of moral distress on patients, as opposed to the organization?

a. Hostile work environment.
b. Increased liability from errors.
c. Provider blindness.
d. Reduced staff retention.

11. Which of the following is an example of an effect of moral distress on an organization, as opposed to patients?

a. Missing performance of vital tasks.
b. Increased liability from errors.
c. Poor staff-to-patient communication.
d. Excessive retention of staff members.

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

- Differentiate moral disengagement and moral distress.

1 2 3 4 5

- Identify causes of moral distress.

1 2 3 4 5

- Discuss mechanisms of moral disengagement.

1 2 3 4 5

2. Rate each of the following items from 5 (very effective) to 1 (ineffective):

- Were the authors knowledgeable about the subject?

1 2 3 4 5

- Were the methods of presentation (text, tables, figures, etc.) effective?

1 2 3 4 5

- Was the content relevant to the objectives?

1 2 3 4 5

- Was the article useful to you in your work?

1 2 3 4 5

- Was there enough time allotted for this activity?

1 2 3 4 5

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Moral distress: A review of the argument-based nursing ethics literature

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Abstract

Aim: The aim of this review is to examine the ways in which the concept of moral distress has been delineated and deployed in the argument-based nursing ethics literature. It adds to what we already know about moral distress from reviews of the qualitative and quantitative research.

Data sources: CINAHL, PubMed, Web of Knowledge, EMBASE, Academic Search Complete, PsycInfo, Philosophers' Index and Socindex.

Review methods: A total of 20 argument-based articles published between January 1984 and December 2013 were analysed.

Results: We found that like the empirical literature, most authors in this review draw on Jameton's original definition and describe moral distress in psychological–emotional–physiological terms. They also agree that moral distress is linked to the presence of some kind of constraint on nurses' moral agency, and that it is best understood as a two-staged process that can intensify over time. There is also consensus that moral distress has an important normative meaning, although different views concerning the normative meaning of moral distress are expressed. Finally, the authors generally agree that moral distress arises from a number of different sources and that it (mostly) affects negatively on nurses' personal and professional lives and, ultimately, harms patients. However, despite this consensus, many authors take issue with the way in which moral distress is conceptualized and operationalized. Moreover, while some worry that identifying nurses as a group of health professionals whose voices are ignored or marginalized might disempower nurses and encourage them to avoid their moral responsibilities, others take situations involving moral distress as indicative of more fundamental, structural inequities at the heart of contemporary healthcare provision.

Conclusion: We conclude that research on moral distress in nursing is timely and important because it highlights the specifically moral labour of nurses. However, we suggest that significant concerns about the conceptual fuzziness and operationalization of moral distress also flag the need to proceed with caution.

Keywords

Argument-based, ethics, literature, moral distress, moral stress, nursing, review

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Introduction

The term 'moral distress' has been deployed to describe the psychological, emotional and physiological suffering that nurses and other health professionals experience when they act in ways that are inconsistent with deeply held ethical values, principles or commitments. In 1984, Andrew Jameton[1] adapted the term in order to articulate what he saw to be the case among the nursing students whom he was teaching; that the nursing role is morally constrained in a significant way: 'Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action' (p. 6). Since then, various accounts of moral distress (MD) have been developed along with a range of empirical tools to measure its frequency and intensity, to identify the sources of MD and to assess its impact on nurses and other health professionals.[2,3]

In 1987/1998, Judith Wilkinson[4] carried out the very first piece of empirical research on nurses' experiences of MD that deployed Jameton's definition. In the qualitative part of her mixed method study, she interviewed 24 hospital nurses in order to identify situations that gave rise to MD as well as the effects of MD on nurses and patients. Wilkinson[4] defined it as 'the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision' (p. 16). Wilkinson's work developed Jameton's definition of MD in three ways. First, she identified clinical situations that gave rise to MD, for example, providing treatment believed to be futile and lying to patients. Second, she confirmed Jameton's claim that nurses were externally constrained and added internal constraints, that is, 'being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage' (p. 21) as a source of MD.[4] Third, while her research confirmed that nurses suffer from MD as a result of what they fail to do, it also indicated that nurses suffer as a result of what they actually do, that is, the wrong thing.

The findings of many qualitative studies carried out since and captured in reviews such as Huffman and Rittenmeyer[3] confirm the results of Wilkinson's study; they summarize the root causes of MD as related to clinical situations as well as internal and external constraints.

Drawing, mainly, on Jameton's definition refined by Wilkinson's research, MD has also been measured quantitatively.[2] Although other tools exist,[5,6] the most widely used tool has been Corley's[7] Moral Distress Scale (MDS) – to measure the frequency and intensity of MD among nurses working in intensive care unit (ICU) settings. Questions in the MDS focused on moral issues and dilemmas that usually arise in critical care settings and included, for example, items relating to carrying out treatment perceived to be futile, discharging patients too early and working in unsafe or understaffed conditions. Since then, it has been adapted by Corley et al.[8] and others.[9,10] Reviews of these studies indicate that nurses experience MD frequently, and that its impact is largely negative: it comes at a personal psychological and emotional cost and leads to unsafe or poor quality of patient care, decreasing job satisfaction, moves to less stressful jobs and jobs outside of nursing altogether.[8,11,12]

Given the cost of educating nurses, the demand for qualified nurses, the toll that MD takes on the personal and professional lives of nurses, the quality of patient care and the ever-increasing needs of healthcare provision, it would seem that MD is a phenomenon that needs to be urgently addressed. However, while we have indicated that there is some consensus in the definition and operationalization of the concept of MD in the empirical research, there is an unsettling level of ambiguity and vagueness as well. Serious criticisms have been made as to the conceptual clarity of MD, and it is evident that a closer interrogation of the parameters and scope of MD is needed.[13–15] To clear the way for such an inquiry and to add to the reviews of the empirical research that have already been carried out, we have engaged in a review of the argument-based nursing ethics literature on MD. By argument-based literature, we mean articles that analyse concepts and present arguments to draw conclusions about the clinical conduct that nurses ought to undertake.[16–18] This literature contrasts sharply with *empirical* nursing ethics literature – articles that report on qualitative and quantitative data to describe what nurses actually do, or experience, in clinical practice.

Aim

The aim of this review is to examine the ways in which the concept of MD has been delineated and deployed in the argument-based nursing ethics literature.

Methods

Our review was constructed following an adaptation of the four-step method for systematic reviews of argument-based literature developed by McCullough et al.[16,17] This involved (1) identifying focused questions, (2) carrying out a literature search for articles that addressed one or more of the focused questions, (3) evaluating the methodological adequacy of the articles identified and (4) identifying the position of the author(s) in relation to the focused questions.

Focused questions

We formulated the following questions on the basis of our concerns about the conceptualization of MD:

1. How is the concept of MD defined?
2. What are the related terms used to describe MD?
3. What is the normative meaning of MD?
4. What are the sources of MD?
5. What is the impact of MD?

The conceptualizations of MD and the related positions and conclusions of the articles included in the review are presented in the ‘Results’ section of this article.

Literature search

Figure 1 illustrates the literature search process. The inclusion criteria were any article that addressed at least one of the focused questions. We searched for the terms, ‘moral distress’, ‘ethical distress’, ‘moral stress’, ‘ethical stress’, ‘moral residue’, ‘stress of conscience’ combined with nurs* in the following databases: CINAHL, PubMed, Web of Knowledge, EMBASE, Academic Search Complete, PsycInfo, Philosophers’ Index and Socindex. We limited our search to publications in English between January 1984 (the year that Jameton applied the term ‘moral distress’ to nursing practice) and 31 December 2013. The outputs of the different database searches were merged, and the duplicates were removed prior to excluding empirical studies, editorials, commentaries, case studies, dissertations, book chapters and letters. We also searched the reference lists of appropriate articles in order to identify any additional relevant publications.

Search outcome and quality appraisal

The literature review yielded 20 relevant articles. We adapted the formal tool developed by McCullough et al.[16,17] for critically appraising the argument-based medical ethics literature to assess the articles identified: we only included articles that addressed the issue of MD in relation to nursing in a clear and focused way and that presented analyses of relevant concepts and arguments clearly and offered coherent conclusions that are relevant to nursing practice. One researcher (J.M.) carried out the literature search in a systematic way, and the results of the search were checked by the second author (C.G.). In cases of doubt about inclusion/exclusion of some articles, both of the researchers discussed the issues of concern until a consensus was reached.

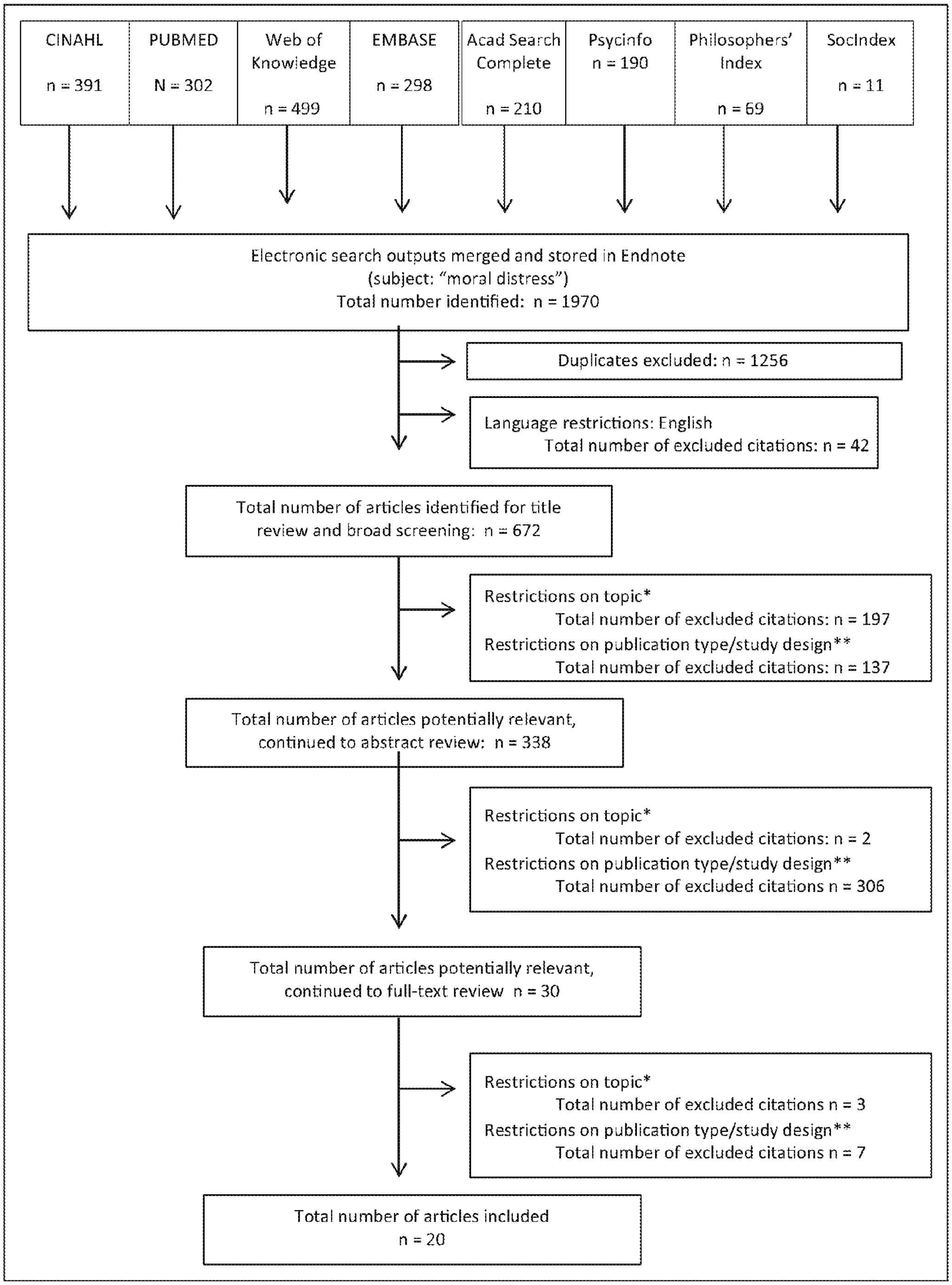

Figure 1. Literature search process.
*Only articles addressing moral distress within a nursing context included.
**Only argument-based articles with a clear focus on the concept of moral distress included: no empirical studies, editorials, commentaries, theses, book chapters, conference proceedings, reviews and so on.

The included articles come from United States (9), Canada (3), Canada and United States (2), Sweden (2), United Kingdom (2), Australia (1) and Ireland (1). All of the articles discussed MD, primarily, in relation to nurses. The first author of 15 of the articles has a background in nursing.

Data abstraction and synthesis

We abstracted and synthesized the data from the 20 articles included in the review through a process of reading and re-reading them in order to identify key concepts, explanations and normative meanings, arguments and conclusions. After repeated readings and a process of identifying, comparing and categorizing relevant passages, we were able to determine how the authors defined the phenomenon of MD and understood its relationship to other moral concepts and to the terrain of morality more generally. A summary of the definitions, related concepts, normative meanings, sources and impact of MD is presented in Table 1.

Results

Definitions

There is a general consensus in the argument-based literature that the term 'moral distress' refers to the psychological–emotional–physiological suffering that nurses may experience when, constrained by circumstances, they participate in perceived wrongdoing by action or omission. Several authors[19–21,25,30] deploy what we would call the standard definition of MD that was initially offered by Jameton[19] in 1984 and slightly modified in his 1993 and 2013 articles:

> [A] nurse experiences moral distress when the nurse makes a moral judgment about a case in which he or she is involved and the institution or co-workers make it difficult or impossible for the nurse to act on that judgment. (p. 542)

The consensus breaks down, however, in the further unpacking of the following features of MD: (1) the conceptualization of MD as a discrete entity, (2) the precise elements that supposedly constrain nurses' moral agency and (3) the view of moral agency that underpins accounts of MD. We will delineate each of these features in turn.

Conceptualization of MD. The majority of the articles reviewed describe MD as a discrete entity – an experience or set of experiences – that they characterize in psychological–emotional–physiological terms. Beginning with Jameton's[19] and Corley's[20] accounts, MD is described in terms of feelings that range from rage (e.g. anger, frustration and resentment) to feelings of anxiety and sadness (e.g. embarrassment, shame, guilt, dread, anxiety, grief and depression). It may also involve feelings associated with a lack of power (e.g. sense of helplessness, powerlessness, self-blame and a loss of self-worth). Physiological attributes include heart palpitations, diarrhoea, headaches and sleeplessness.

Some of the authors acknowledge that while MD can be delineated in terms of these psychological–emotional–physiological attributes 'they are not reducible to them'.[5,14] They, along with others, draw attention to the moral component of 'moral distress' and argue that more attention should be given to the latter.[13,15,21,28] Moreover, a number of authors link MD more explicitly with what might be viewed as more obviously 'moral' attributes, for example, compromised integrity,[20] serious moral compromise,[29] interior suffering,[5] disconnection from personal values and beliefs,[5] powerlessness described as a felt inability to fix a wrong,[24] discomfort with moral subjectivity[15] and conflicting values and feelings.[28]

Finally, a few of the authors reviewed query whether it is even possible to conceptualize MD as a discrete phenomenon with clear parameters that can be described and measured. For Hanna[5] and McCarthy and Deady,[14] for example, MD is best understood as a kind of umbrella concept that captures situations of moral

Table 1. Articles included in the literature review (date order).

Author, country	Definition	Related terms	Normative meaning	Sources	Impact
Jameton,[19] United States	'[A] nurse experiences moral distress when the nurse makes a moral judgment about a case in which he or she is involved and the institution or co-workers make it difficult or impossible for the nurse to act on that judgment' (p. 542)	Initial distress; reactive distress	Moral judgement; sees nurses as, ideally, 'responsible actors' (as distinct from wholly free or wholly oppressed)	Inadequate patient consent; overtreatment; cost cuts; economic efficiencies; prioritizing technological interventions; hierarchical structures; imbalance of power; focus on measurable outcomes; attribution of emotional labour to nurses; unequal status of pay and conditions between nurses and doctors	*Negative*: burnout; decision to leave nursing
Corley,[20] United States	'Moral distress is the psychological disequilibrium, negative feeling state, and suffering experienced when nurses make a moral decision and then either do not or feel that they cannot follow through with the chosen action because of institutional constraints' (p. 643)	Initial distress; reactive distress; moral residue	Moral judgement; moral integrity; moral certainty; moral courage; moral sensitivity; moral comportment; moral competency; moral imagination	Harm to patients; treating patients as objects; institutional constraints; aggressive care; inadequate informed consent; poor staffing; cost cuts; poor pain management; incompetent care; grim choices with unpredictable outcomes; risk of unpleasantness/more work that might follow an action; need to obtain the cooperation of others	*Negative*: high staff turnover; burnout; resignations; leaving nursing; inadequate care; denying responsibility; detachment; avoiding patient; longer hospital stays *Positive*: learning from failure; greater resolve; personal and professional growth; compassionate care; coping strategies
Lützén et al.,[21] Sweden	'[M]oral stress is experienced when nurses are aware of what ethical principles are at stake in a specific situation and external factors prevent them from making a decision that would reduce the conflict between contradicting principles' (p. 314)	Stress with a moral component	Moral decision; moral sensitivity; caring as an ethical activity; doing good	Sensitivity to patients' vulnerability and lack of autonomy; experience of external factors preventing them from doing what they think is best for patients; no control over the specific situation	*Negative*: coercion of patients; long-term health problems *Positive*: 'Feeling of accomplishment of professional goals' (p. 315)

(continued)

Table 1. (continued)

Author, country	Definition	Related terms	Normative meaning	Sources	Impact
Hanna,[5] United States	An 'umbrella category' that could include the experience of anguish or suffering associated with facing a moral dilemma, moral uncertainty as well as certainty accompanied by constraint '[N]ot exclusively an external constraint on right action . . . [it] involves a perceived violation of the person [that] can produce a disconnection from self and others' (p. 76)	Conscience	Right action; role morality (what nurses do to meet the goals of nursing); moral integrity; whistle-blowing and advocacy; universal objective moral norms; perceived violation of the person	Harming the purpose of another person; role morality – whistle-blowing; patient advocacy; truth-telling; clinical conflicts	*Negative*: disconnection from personal values and beliefs; burnout; blunting *Positive*: develops moral character; a potential therapeutic intervention for certain groups of people; personal transformation and growth
Peter and Liaschenko,[22] Canada and United States	'On the one hand, [. . .] in order to experience moral distress, an agent is required to possess at least some autonomy in recognizing and reflecting upon moral concerns. Yet on the other hand, an agent's autonomy must be at least somewhat constrained in acting upon the very moral responsibilities he/she understands him/herself to have. This apparently irresolvable contradiction is experienced as moral distress' (p. 221)	Not stated	Moral agency; integrity; responsiveness; sustained proximity (to patients); moral agency as situated – enabled and disabled by social context; interpersonal morality	Difficult working conditions: corporatization of healthcare; proximity to patients and acute awareness of moral responsibility	*Negative*: the urge to flee and abandon the patient
Kopala and Burkhart,[23] United States	'Moral distress is a response experienced when a decision-maker's ability to carry out a chosen ethical or moral action is thwarted by some barrier. Barriers or constraints have been identified as internal . . . external . . . institutional . . . and situational' (p. 8)	Not stated	Moral judgement; universal moral norms; ideals and virtues to avoid ethical harms and maximize good	Lack of support; security; time constraints; distance from hospital; exercise of medical power; futility of past actions; self-doubt or lack of courage; legal concerns; administrative and institutional policies	*Positive*: addressing causes of MD by confronting barriers to patient choice and empowering patients through educational interventions

(continued)

Table 1. (continued)

Author, country	Definition	Related terms	Normative meaning	Sources	Impact
McCarthy and Deady,[14] Ireland	'[A]n umbrella concept that captures the range of experiences of individuals who are morally constrained. Generally speaking, when individuals make moral judgements about the right course of action to take in a situation, and they are unable to carry it out, they may experience moral distress' (p. 254)	Initial distress; reactive distress	Moral judgement; personal integrity; moral values; moral sensitivity; occupational role	Personal failing; hierarchical decision-making; lack of resources; aggressive treatment; unnecessary tests; deception; incompetent or inadequate treatment; power imbalances; lack of institutional support	*Negative*: negative coping strategies, for example, leaving the unit, blaming nursing and hospital administration, excusing one's actions, avoiding patients *Positive*: positive coping strategies, for example, self-care, working part-time, assertiveness, collective action, greater self-awareness and resolve
Epstein and Hamric,[24] United States	'A hallmark of moral distress is the presence of constraints, either internal (personal) or external (institutional) . . . that prevent one from taking actions that one perceives to be morally right' (p. 330)	Initial distress; reactive distress; moral residue; crescendo effect	Acting on one's ethical obligations; damaged moral integrity; professional integrity; perceived violation of core values and duties	Aggressive treatment; lack of resources; inability to provide necessary treatments; problems with team; poor communication; poor leadership; lack of policies	*Negative*: self-blame; powerlessness; passivity; conscientious objection; burnout; withdrawal from position/profession
Repenshek,[15] United States	'[T]he current definition is not moral distress as defined by Jameton, but rather, in large part, nursing's discomfort with moral subjectivity in end-of-life decision making' (p. 734)	Not stated	Right action; moral subjectivity; role morality; personal and professional integrity	Aggressive and/or futile care; whistle-blowing and advocacy	*Negative*: inability to act on patients' behalf; professional integrity at risk; professional blunting; burnout
Walsh,[25] United Kingdom	'[T]he feelings and experiences that result from a moral conflict, where one knows the correct action to take but constraints lead to an inability to implement this action' (p. 746)	Not stated	Moral knowledge; integrity; sense of responsibility; misplaced guilt	Futile medical care	*Negative*: flight from patients
Cribb,[26] United Kingdom	'I am interested in how we can work with the routine and constant tensions and	Stress that has a moral burden	Ethical judgement; moral integrity; professional role; moral burden; role	Gap between the normative expectations attached to a professional role and the	Not stated

(continued)

Table 1. (continued)

Author, country	Definition	Related terms	Normative meaning	Sources	Impact
	dilemmas that professional role occupancy thus generates; and also in the implications the recognition of these routine tensions has for role construction' (p. 124)		construction; professional ethical identity; moral compass; professional autonomy; authenticity; institutional and personal values	'personal moral compass' of the healthcare professional (p. 120); managerialism (e.g. funding pressures and the colonizing of the subjectivities of health professionals with institutional norms for institutional ends)	
Austin,[27] Canada	'[E]xperiences of frustration and failure arising from struggles to fulfill their moral obligations to patients, families, and the public' (p. 28)	Not stated	Moral agency; professional identity; fiduciary duty; moral responsibility; situated and relational; moral agency as diminished; ethical canary	Healthcare reform; cuts to services; efficiency measures; technological advances; unable to fulfil one's perceived responsibilities; unrealistic expectations; aggressive treatment; inability to advocate for patients; lack of recognition of one's expertise; professional and inter-professional relationships; poor care	*Negative*: leaving positions *Positive*: carrying out acts of resistance; advocating for patients
Hamric,[11] United States	Refers to Jameton's definition as well as several others that refer to situations when nurses are unable to practice ethically because of internal and external constraints	Reactive distress; moral residue; crescendo effect	Moral judgement; moral integrity; occupational role; erosion and compromise of core moral values; desensitization	Internal factors, for example, perceived powerlessness; external factors, for example, inadequate staffing; clinical situations, for example, unnecessary/futile treatment, inadequate informed consent	*Negative*: desensitization; withdrawal; conscientious objection; leaving the position/ profession
Lützén and Kvist,[28] Sweden	'[A] person's experiences of external factors preventing him/her from doing what he or she thinks is the right thing to do, at the same time as being aware of his or her inability to take action according to internalized moral guidelines' (pp. 16–17)	Stress; stress of conscience; initial distress; reactive distress; moral residue	Doing the right thing; judgement; occupational role; moral guidelines; moral sensitivity; moral knowledge; moral climate; moral responsibility	Technological advances; scarce resources; economic and political structures; absence of guidelines; value conflicts; unhealthy ethical climate	*Positive*: 'positive catalyst' (p. 13); prevents moral blindness; reflection on moral duties

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Table 1. (continued)

Author, country	Definition	Related terms	Normative meaning	Sources	Impact
Pauly et al.,[12] Canada	'[A]ssociated with the ethical dimensions of practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties' (p. 2)	Initial distress; reactive distress; moral residue	Moral agency; personal integrity; professional values, responsibilities, duties; structural conditions that give rise to moral distress	Professional position; policies; workload; efficiency measures	*Negative*: withdrawal from patients; unsafe/poor patient care; decreasing job satisfaction; leaving nursing
Varcoe et al.,[29] Canada	'[T]he experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment' (p. 59)	Moral residue	Moral agency; personal integrity and identity; serious compromise of deeply held personal/professional values; contextual; relational; interpersonal, structural	Social and health inequities; discrimination; scarce resources; individual and structural factors, for example, deception, non-disclosure; inability to enact standards	*Negative*: desensitization; disengagement; moral silence, deafness, blindness *Positive*: clarifies ethical commitments and strengthens resolve
Jameton,[30] United States	'Moral distress . . . arises when individuals have clear moral judgments about societal practices, but have difficulty in finding a venue in which to express concerns' (p. 297) '[M]oral distress expresses a decision point, a moment of emotive immobility, where ambivalence needs to be resolved toward a choice' (p. 303)	Not stated	Moral judgement; moral choice; moral actions; involvement in moral wrongdoing; lacking authority; constrained agency; constrained advocacy	Aggressive treatment; contributing to patients' suffering; proximity to patients; power imbalances; nurse–physician conflicts; lack of support; lack of opportunity to voice concerns	*Negative*: ambivalence; passivity *Positive*: energizing response – activism
Johnstone and Hutchinson,[13] Australia	'Linchpin to the theory of moral distress is the idea that nurses know what is the right thing to do but are unable to carry it out' (p. 4) Considers the standard definition of MD but argues that it	Initial distress; reactive distress; moral residue	Moral judgement; moral integrity; moral competency; moral intuition; moral imposition; moral disagreement	Nurses' own perceptions; lack of moral competency; external environments; disagreement/conflict about ethical values; views not respected	*Negative*: threat to quality of patient care; job dissatisfaction; burnout; leaving positions/profession; harm to patients' and families' significant moral interests

(continued)

Table 1. (continued)

Author, country	Definition	Related terms	Normative meaning	Sources	Impact
	conceptually and empirically problematic				
Peter and Liaschenko,[31] Canada and United States	MD is an umbrella concept, the 'response to constraints experienced by nurses to their moral identities, responsibilities, and relationships' (p. 337)	Not stated	Moral response; damaged moral identity; relational; moral responsibility; moral habitability; 'morality is a socially embodied accomplishment' (p. 339)	Damage to moral identity; breakdown in trust; recognition that values and expectations are not shared; devaluation of nursing perspectives; power imbalances; focus on cost-containment and efficiency; proximity to patients; perceived responsibility to relieve suffering; aggressive treatment; morally uninhabitable workplaces	*Positive*: critical questioning; open up dialogue and communication about values, assumptions and expectations; nurses can create counter-stories; can evaluate the moral habitability of environments
Rushton et al.,[32] United States	'Moral distress' is defined as 'the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing'. (p. 1074; cited from Nathaniel A: Moral distress among nurses. American Nurses Association Ethics and Human Rights Issues Updates 2002; 1(3a))	Conscience; secondary stress; crescendo effect	Moral judgement; individual and professional integrity; moral sensitivity; principled compassion; empathy; resilience	Pain and suffering of dying patients; conflicting moral demands and value conflicts; perceived inappropriate or burdensome use of technology	*Negative*: unregulated action; burnout; avoidance and/or abandonment of the patient and family; self-focused behaviours; desensitization *Positive*: empathy or positive regard; compassionate action; advocacy; requests for ethics consultation; integrity; resilience

constraint as well as the feelings that flow from them. McCarthy and Deady[14] and Johnstone and Hutchinson[13] are also very critical of the operationalization of the concept of MD in empirical literature. The former suggest that the parameters of MD should be more clearly delineated based on a deeper engagement with theorists from other disciplines such as philosophy and psychology who have examined the emotions that accompany moral decision-making from their disciplinary perspectives. Taking this view even further, Johnstone and Hutchinson[13] claim that the notion of MD should be abandoned altogether as it will 'at best have only dubious value in nursing ethics discourse' (p. 8). They dispute whether or not the concept of MD represents any discrete matter of fact in clinical practice given that empirical studies generally assume, rather than demonstrate, its existence.

Elements of constraint. The standard definition of MD draws attention to the way in which *external* influences (e.g. institutional policies and practices, nurse–physician conflicts and staff shortages) limit nurses' ability to act according to their personal and/or professional moral values and beliefs. Expanding on the standard definition, several authors also extend the circumstances that constrain nurses' moral agency to include *internal* factors such as fear, lack of knowledge and personal moral failure.[5,11,14,15,23,24,28,32] As Epstein and Hamric[24] put it: 'A hallmark of moral distress is the presence of constraints, either internal (personal) or external (institutional) ... that prevent one from taking actions that one perceives to be morally right' (p. 330).

View of moral agency. While the authors listed above may differ in the emphasis they place on external and/or internal constraints on nurses' agency, they all agree that there are constraints and they rely on a particular view of the moral agent who is thus constrained. The moral agent, on their view, is conceived as having the capacity to make moral judgements and to act upon them, sometimes, in spite of being constrained internally or externally. However, other authors in the literature reviewed have a more structural and politicized view of moral agency, and this has implications for the way that they define MD. For them, there is no moral agent on one side and moral constraints on the other; moral agency itself is enabled and constituted by situational, contextual and structural features of the moral terrain.[12,22,27–29,31] Varcoe et al.[29] express this in the following way:

> [M]oral distress must be defined as a relational concept. That is, moral distress must be seen as a phenomenon that is experienced by individuals, but shaped not only by the characteristics of each individual (e.g., moral character, values, beliefs), but also by the multiple contexts within which the individual is operating, including the immediate interpersonal context, the health care environment and the wider socio-political and cultural context. (p. 56)

Related terms

We have identified several terms that the articles reviewed posit as fundamentally related to the concept of MD – 'initial distress', 'reactive distress', 'moral residue', 'crescendo effect', 'stress' and 'conscience'. These terms draw attention to (1) the stages of MD and (2) the scope of the meaning of MD.

Stages on MD. Many of the authors in this review refer to Jameton's 1993 delineation of MD as a two-staged process.[11–14,20,24,28,29] Jameton[19] originally distinguished between 'initial' and 'reactive' MD in the following way:

> Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values.

and

> Reactive distress is the distress that people feel when they do not act upon their initial distress. (p. 544)

Drawing on Wilkinson,[4] Jameton[19] suggests that reactive MD involves crying, depression, nightmares, feelings of worthlessness, heart palpitations, diarrhoea and headaches. Corley also understands MD as a process but views 'reactive distress' as 'moral residue', that is, according to a definition she borrows from Webster and Baylis[33]: 'that which each of us carries with us from those times when in the face of distress we have seriously compromised ourselves or allowed ourselves to be compromised' (p. 645). In effect, moral residue is a lingering sense of moral unease that persists after the crisis that lead to the experience of MD has passed. Building on Jameton and Corley's work, Epstein and Hamric[24] propose a theoretical model that explains the relationship between MD and moral residue. They suggest that in crisis situations, the intensity of the experience of MD increases to a point and then abates as the acute phase of the crisis passes – the crescendo of MD. However, the moral residue that remains acts as a new baseline from which the next crescendo of MD builds. Over time, repeated crescendos of MD contribute to a build up, or crescendo, of moral residue so that each new morally challenging situation provokes an even stronger reaction – higher levels of moral residue contribute to increased levels of MD. Hamric[11] acknowledges that the 'crescendo effect' model has not been empirically tested but claims that there is evidence of some of its elements in the nursing literature and that left unaddressed, 'crescendos can erode care providers' moral integrity, resulting in desensitization to the moral aspects of care' (p. 42).

The Scope of MD. Five of the articles deploy terms such as 'moral stress' and 'conscience' in order to broaden their inquiry into the unease that nurses experience when negotiating morally challenging situations. Cribb[26] deploys the term 'moral stress' rather than 'moral distress' in order to interrogate the moral burdens that nurses undertake in their everyday enactment of their professional role and to distinguish these routine tensions from the more acute ethical crises that he considers are usually discussed in the literature on MD:

> I am using the expression 'moral stress' rather then 'moral distress' to indicate the routine and pervasive nature of the burden of role occupation – much of which is not overtly distressing and is not tied in with felt crises about whether or not to fulfil one's official duties. [. . .]. This is because in these instances we can see that the possible harms or wrongs at stake are relatively contestable or relatively minor ones, and we recognize that there are good reasons – stemming from the legitimate demands of role occupation [. . .] to do what is expected of us. (p. 124)

Lützén et al.[21] and Lützén and Kvist[28] also deploy the term 'moral stress' rather than 'moral distress' because it broadens the field of enquiry. The focus for them is on the ethical conflicts that arise for nurses when they must negotiate between the demands of competing ethical principles. Lützén and Kvist[28] cast moral stress as closely related to physiological responses to morally demanding situations and they argue that deploying the term 'stress' rather than '*dis*-tress' signifies more clearly that the impact of moral stress can be both positive and negative, for example, it may prevent moral blindness. They also introduce a further term, 'stress of conscience', to describe a more theological or philosophical response to ethical conflicts where conscience might be understood as 'an intellectual ability that determines whether an action is right or wrong, good or bad' (p. 18).[28] Hanna[5] also suggests that the term 'conscience' is related to 'moral distress' when, appealing to the Catholic theologian, Thomas Aquinas, she explains it as a mode of knowing that enables individuals to discern right from wrong and good from evil and, in cases of wrongdoing – accuses, rebukes and torments.

Finally, Rushton et al.[32] also refer to conscience as a faculty that sensitizes the individual to the morally salient features of distressing situations and triggers MD in situations where moral values conflict or are compromised. More generally, they understand the experience of MD in terms of a broad framework adapted from moral psychology that includes other components such as moral sensitivity, emotional and cognitive attunement and memory.

Normative meaning

All of the articles deploy a range of normative terms in an effort to capture the specifically moral elements of MD. We have already referred to some of these (e.g. moral agency and conscience) above, but there are others that we think important to delineate in order to paint a complete picture of the moral terrain of MD. The normative meaning of MD, as the authors in our review articulate it, relates to (1) making a moral judgement, (2) personal and professional identity and integrity, (3) a range of moral competencies and (4) the scope of moral responsibility.

Making a moral judgement. One of the key reasons MD is viewed as having a moral component is because it involves moral judgement. Without exception, all of the articles reviewed acknowledge this core feature of MD and refer to it in terms of moral judgement/decision/action/response. As McCarthy and Deady[14] put it:

> It is important to explain what we mean when we say that 'individuals make moral judgements' or 'individuals know what is the right thing to do'. Making a moral judgement about the rightness or wrongness of an action may be understood as evaluating an action from the perspective of a particular set of moral values. (p. 254)

Jameton[19] uses the term 'moral judgement' very deliberately in order to distinguish between the meanings of 'moral dilemma' and 'moral distress'. In the case of a moral dilemma for Jameton, the nurse is torn between the demands of competing ethical principles and is *unsure* what to do; however, in the situations that give rise to MD, the nurse *knows* what she ought to do but is unable to act on her moral convictions because of institutional constraints.

The vast majority of the other articles in this review view Jameton's understanding of moral judgement as unproblematic and deploy it in their accounts of MD. Moreover, almost 30 years after he first delineated it, Jameton[30] reiterates his original distinction, although he does make the more modest claim that in situations of MD, individuals make 'clear' moral judgements (but are constrained) rather than that they 'know' or have a certain knowledge of what the morally right thing to do is.

However, the accounts of moral stress of Lützén et al.,[21] Lützén and Kvist[28] and Rushton et al.[32] which draw attention to a broad range of psychological responses to stressful situations imply that the lines between moral dilemmas (involving confusion about the demands of conflicting moral principles) and situations of MD (where a moral judgement is made, but acting on it is constrained) are more blurred than Jameton allows. Putting it more directly, Repenshek[15] and Johnstone and Hutchinson[13] claim that the idea that nurses have some kind of certain or sure knowledge of what is the morally right thing to do is deeply problematic. They draw attention to what might result from paying too much attention to nurses' personal moral crises and conflicts to the neglect of patient's autonomy and the quality and safety of patient care. Repenshek argues that accounts of MD to date fail to give due moral weight to patients' views of what is the morally right thing to do. As a result, for Repenshek,[15] much of the research to date fails to distinguish between what he sees as genuine instances of MD where nurses feel compelled to act in ways that are inconsistent with their professional values and instances of 'moral discomfort' where nurses' own subjective beliefs about what might be in patients' best interests do not come to pass.

In a similar vein, Johnstone and Hutchinson[13] distinguish between 'ordinary moral judgements' based on personal opinion and moral judgements that are based on 'sound critical reflection and wise reasoning' and suggest that Jameton's account of MD refers to the former kind of subjective judgements:

> Linchpin to the theory of moral distress is the idea that nurses know what is the right thing to do but are unable to carry it out. [. . .] it assumes, without supporting evidence, the unequivocal correctness and justification of nurses' moral judgments in given situations (rarely are the bases of the nurses' moral judgments revealed, and

> rarely is it admitted that nurses might be mistaken or misguided in their moral judgments, or that their moral judgments may be just plain wrong)[13]. (p. 4)

They warn that if nurses assume that their views of the right thing to do are the only correct ones, there is a danger that they will impose these views on patients:

> where the rightness of the nurses' ethical judgments is assumed rather than shown, there will remain an unacceptable risk of nurses promulgating 'moral imposition' whereby their own personal views are imposed onto others in ways that are not only unwelcome but can result in otherwise preventable harm to people's significant moral interests[13]. (p. 8)

Personal and professional identity and integrity. With the exception of Jameton,[19] Lützén et al.,[21] Kopala and Burkhart,[23] Lützén and Kvist[28] and Jameton,[30] who do not refer to it, all of the articles in our review distinguish MD from psychological and emotional distress by linking it, implicitly or explicitly, with a threat or loss to moral and professional integrity and, ultimately, to a loss of personal and professional identity.

Starting with Corley,[20] many of the authors reviewed accept Webster and Baylis'[33] account of moral integrity which McCarthy and Deady[14] define as 'involving a coherence between beliefs and actions' (p. 257). Corley[20] describes moral integrity thus:

> Moral integrity refers to adherence to moral values affecting the sense of dignity and self-respect. Moral distress is a consequence of the effort to preserve moral integrity when the persons act against their moral convictions. (p. 645)

In a similar vein, Epstein and Hamric[24] understand MD as a result of 'a perceived violation of one's core values and duties' (p. 331), which, left unaddressed, can lead to an erosion of moral integrity.

According to McCarthy and Deady,[14] 'Webster and Baylis argue that the setting aside of cherished values can deeply wound a person's sense of moral conscience' (p. 257), and that compromised integrity and serious moral compromise can ultimately and irreversibly alter one's sense of self and personal identity.

Hanna,[5] Repenshek[15] and Cribb[26] pay particular attention to the relationship between MD, personal integrity and professional identity. First, Hanna[5] finds fault with Jameton's[1] account of MD precisely because it does not pay sufficient attention to issues of personal and professional integrity and identity. For her, when he attributes MD to external constraints alone, he downplays nurses' own moral integrity as well as the possible lack of fit between professional obligations and individual conscience. Where Jameton links MD solely with institutional constraints, Hanna[5] suggests that nurses, such as whistle-blowers, sometimes take action in spite of such constraints:

> Retaining their moral freedom, whistle-blowers disregard institutional constraints. While their professional and personal losses accumulated, nurse whistle-blowers carried out actions they believed to be morally good or right, but still suffered moral distress. (p. 87)

For Hanna, the obligations of the nurse's professional role can also be a source of MD for nurses. She introduces the term 'role morality' to describe what 'nurses do to meet the goal of nursing' (p. 85).[5] While we found some difficulty in determining her precise views on the matter, we believe that, for Hanna, individuals can experience MD when their personal beliefs and values are at risk as well as when their professional values are compromised. She also queries whether or not separating out personal and professional values is possible and suggests that while failure to act as a good nurse also implies failure to act as a good human being, the contrary may also be true if the demands of professional practice (e.g. to assist with euthanasia or elective abortions) are contrary to a nurse's own conscience. As indicated earlier, Hanna[5] sees human conscience as informed by objective moral norms that are created by 'supernatural design' (p. 76). To act in a way that is contrary to one's conscience is to invite 'torment' or 'rebuke' and to risk a 'violation of the person' and a 'disconnection from self and others',[5] in other words, MD. In this way, Hanna[5] distinguishes MD from psychological and emotional distress and from what she sees as the 'individualistic relativistic ideas' that inform Jameton's position (p. 76).

Repenshek[15] develops Hanna's account of 'role morality' in order to distinguish between professional integrity and nurses' personal opinions about what is in the best interests of patients. For Repenshek:[15]

> a distinction should be made between a true inability to act on patients' behalf when professional integrity is seen as being jeopardized and the potential lack of clarity and decisiveness on the part of nurses regarding their more concrete ethical obligations. (p. 738)

In order to avoid applying their own subjective moral stances to their professional lives, Repenshek suggests that nurses could appeal to moral norms such as those supplied by the Catholic tradition which are objective but also leave some room for subjectivity – the prudential views of patients in the determination of their best interests – as distinct from the subjective views of nurses.

Other authors also pay close attention to the relationship between personal integrity, professional identity and the experience of MD.[26,27,29] Cribb[26] is particularly concerned with the moral stress that follows on tensions between personal moral integrity and role occupation. His article addresses 'the routine moral burden of occupying a professional role and having to negotiate tensions between the normative expectations attached to that role and one's own personal moral compass' (p. 119).[26]

Cribb acknowledges that given the complex nature of human beings, there will always be some incoherence among the different roles we play. Viewing professional roles as only one aspect of 'plural self-identities', Cribb,[26] nevertheless, suggests that we become who we are as ethical selves, in part, through our professional roles: 'the ethical identity of a practitioner is partly *constituted* by their membership of a professional community, because this is one community through which he or she negotiates and achieves their self-identity' (p. 122).

For Cribb,[26] as with Hanna, it is not a straightforward matter to untangle one's personal and professional identity:

> If we assume a role such as being a nurse or doctor we become part of a demanding and complex set of accountabilities to profession, colleagues, institutions, etc. that has a *prima facie* claim on what we do. We may exercise conscientious objection to involvement in certain activities but surely we cannot entirely float above the network of obligations in which we have immersed ourselves. In short, much of the time we exercise our independent ethical agency partly *through* role agency. (p. 122)

Cribb's concern is the extent to which individual health professionals must negotiate between their role morality and their personal morality. This involves, for Cribb, a balancing act where they must do the jobs that they are expected to do, even though that may sometimes make them ethically uneasy, and also discern the tipping point where that uneasiness prompts them to challenge the status quo. In short, for Cribb,[26] we have 'an ethical duty to accommodate some level of moral stress' as a result of role compliance '[...] because there may not be a comfortable "fit" between the reasonable normative expectations of role occupancy and the independent judgement of role-holders' (p. 124). As challenging as this might be, Cribb argues that negotiating the expectations conferred by a professional role is an acceptable feature of professional membership, and that, therefore, some level of moral stress is to be expected. However, he is concerned about a new threat from the corporatization of healthcare that, in his view, is far from benign. He describes the increasing power of 'managerialism' to reconstruct nurses' professional identity and, in turn, their experience of moral stress:

> As roles are constructed – for example, through processes of regulation, the development and dissemination of policy and professional norms and innumerable local institutional exigencies – we are, more or less deliberately and self-consciously, changing the frequency of, and kinds of, moral stress experienced by professionals.[26] (p. 127)

Like Cribb, Austin[27] and Varcoe et al.[29] are also concerned about the relationship between professional identity and personal integrity. They worry that with increasing social and health inequities and dwindling healthcare resources around the globe, nurses will be less able to provide the care needed or confront discriminatory and marginalizing social processes that perpetuate inequity. In this way, the demands of a profession that they view as 'rooted in social justice' will, inevitably generate MD which will, in turn, be viewed as an 'acceptable' feature of the professional role.

Finally, a number of authors express concern that the discourse of MD in nursing literature will adversely impact on the professional identity of nurses because it implies that nurses are powerless to fulfil their moral obligations in situations of constraint.[13,14,31] Johnstone and Hutchinson[13] make the point:

> There is a risk, however, that ongoing nursing narratives on moral distress will serve more to cement the view of nurses being 'powerless victims of the system' rather than seasoned professionals working to challenge and change the status quo. There is also a risk that moral distress discourse may become apologist for nurses ceding their moral responsibilities to act as morally competent professionals thereby further entrenching the status quo. (p. 5)

Peter and Liaschenko[29,31] also worry about the discourse of MD but for different reasons. They see the professional identity of nurses as inextricably bound up with their sustained proximity to patients. Their 'sustained proximity' to patients distinguishes nursing practice at the bedside from that of other health professionals and 'compels nurses to experience their moral responsibilities [. . .] acutely'[22] (p. 221) and, in turn, to experience MD when patients and families are treated badly. Such proximity exposes them to the vulnerability of patients and confers particular moral responsibilities, such as the obligation to relieve suffering, that are not well acknowledged or articulated in the literature. For Peter and Liaschenko, the invisibility of their holistic role leads to MD and damages the professional identity of nurses. Their solution is, not to downplay nurses' experiences of MD but, rather, to better articulate what it is that nurses do and the ethical and clinical skills they must possess in order to meet the demands of their caring role. Instead of accounts of MD that imply that nurses are powerless, they encourage the telling of counter-stories that reflect their social knowledge and achievements and repair their damaged identity.

Moral competencies. Several of the authors reviewed refer to a range of moral competencies that moral agents have and on the basis of which they experience MD. These include moral sensitivity,[11,14,20,21,32] moral imagination,[20] moral responsiveness,[22] moral comportment,[20] moral virtues,[23] principled compassion,[32] moral courage,[20,32] moral knowledge[28] and moral empathy and resilience.[32]

Scope of moral responsibility. All of the authors in this review view MD as profoundly related to a sense of moral responsibility. However, their understanding of the scope of moral responsibility varies. Jameton[19] sees the nurse as a 'responsible actor', someone who considers what she can take responsibility for, what she can hold others responsible for and what she can do in limited and constrained circumstances. Walsh[25] also attempts to reduce the level of responsibility that nurses should see themselves as burdened with. She distinguishes between nurses' responsibility for medical decisions and responsibility for nursing care. Her argument rests on the idea that nurses' autonomy and the scope of their responsibility for medical decisions is limited. In turn, the necessity to suffer MD when patients are harmed by those decisions is also limited. She suggests that nurses should not waste time that is needed for patient care engaging in 'what is seen to be lofty debate about the rightness of medical intervention' (p. 747).[25] Instead, she advocates, '[a]ccept that, in this world, you can only do your best under the circumstances' (p. 748).[25]

On the other hand, while Jameton and Walsh place emphasis on the limits of nurses' moral responsibility, Johnstone and Hutchinson[13] are more focused on what nurses can do when they have the right mix of knowledge, skills and attitude. For them, 'it is not the case that all nurses feel or perceive themselves to be powerless to act. Whether they do or not is very much a matter of personal character and aptitude, not "other" constraints' (p. 5).[13] Referring to the achievements of nursing legend, Florence Nightingale, they point to the need to research the 'moral successes' of nurses rather than their failures.

Alternatively, a number of authors take a more politicized view of the relationship between moral responsibility and MD: they posit MD as a concrete phenomenon that should best be understood and addressed from an organizational and structural, rather than an individual, perspective. Austin,[27] Pauly et al.,[12] Varcoe et al.[29] and Peter and Liaschenko[31] refer to the embodied, contextual and structural nature of moral responsibility and MD. On this view, moral responsibilities and moral obligations are divided out and experienced in the context of particular socio-cultural and structural arrangements and understandings – people are differently positioned in healthcare organizations with different levels of authority, credibility and accountability, and as a result, they respond to what they see as their moral duties in different ways. Applied to nurses, this perspective draws attention to the way in which nurses' professional identity, their place in hierarchical and gendered relationships and their proximity to patients set the parameters of what they, and others, see them as responsible for. Varcoe et al.[29] point out:

> Locating the locus of moral distress as an individual failing is misattribution, and ignores the influence of organizational structures on an individual's practice. When we see moral distress as just an 'individual's problem' we pathologize the individual and our gaze shifts from a broad systemic lens to one that is narrowly focused on an individual who is somehow upset or 'not coping'. This deflection away from organizational and systemic factors can camouflage the unethical features of organizational life and can often perpetuate questionable practices.

In a similar vein, Austin[27] describes MD as an 'ethical canary' whose prevalence warns of the increasing toxicity of contemporary healthcare environments.

Sources

There is a general consensus among the authors of the articles reviewed that MD arises from a number of sources. These can be clustered into the following groups: clinical situations, difficult working conditions and limited resources, structural conditions and moral sources.

MD arises in clinical situations which involve harm to patients, for example, aggressive and futile treatment, the carrying out of unnecessary tests, lack of treatment, poor pain management, incompetent or inadequate care, deception and inadequate consent for treatment.

MD also arises in difficult working conditions and where there are resource constraints, for example, the increased corporatization of healthcare, administrative, organizational and legal policies, lack of policies and guidelines, the shift in focus from patients and families to organizations, poor staffing, cost cuts, economic efficiencies and increased workloads.

A number of authors also take a more structural perspective of the causes of MD.[14,19,23,26–31] They highlight a number of sources of MD that are linked with asymmetries of power and authority, for example, lack of authority and support, imbalances of power, inability to advocate, lack of recognition of nursing expertise and devaluation of nursing perspectives, lack of opportunity to voice concerns, poor team work and team support, professional and inter-professional conflicts especially nurse–physician conflicts. Varcoe et al.[29] also point to social and health inequities and discrimination as sources of MD.

Some of the authors also draw attention to what might be viewed as, more directly, *moral* sources of MD. For example, Lützén et al.[21] refer to moral sensitivity as a source of MD while Lützén and Kvist,[28] Johnstone and Hutchinson,[13] Peter and Liaschenko[31] and Rushton et al.[32] all refer to value conflicts as a contributor to

MD. Lützén and Kvist[28] refer to unhealthy ethical climates while Peter and Liaschenko[31] refer to morally uninhabitable workplaces. Other authors view the challenges that nurses meet in order to enact their professional roles as a source of MD. For example, Cribb[26] refers to the gap between the normative expectations attached to a professional role and the 'personal moral compass' (p. 120) of the healthcare professional, while Austin[27] and Peter and Liaschenko[31] refer to the damage to nurses' moral identity because of their inability to fulfil their responsibilities. Other authors pay more attention to what they see as more personal failings, for example, lack of resolve,[14] the lack of moral competency,[13] lack of knowledge[11] and lack of courage and self-doubt.[23] More positively, some authors reviewed suggest that MD can arise when nurses enact their agency in spite of constraints to address moral wrongs through whistle-blowing, patient advocacy and truth-telling.[5,15]

Impact

Generally, the authors in this review indicate that MD has a negative impact on nurses' personal and professional lives.[11–15,19–21,24,28,29,30] At the level of practice, nurses are more likely to excuse their actions or deny responsibility, work fewer hours, blame nursing and hospital administration and become increasingly dissatisfied with their jobs. MD ultimately leads to burnout, resignations, nurses leaving the profession and high staff turnover.

According to some authors, MD can also deaden nurses' moral sensitivities. Nurses can become desensitized, or passive, silent, deaf and blind to moral challenges.[11,24,28,29] Ultimately, MD leads to poor, unsafe, patient care, for example, inadequate care, coercion of patients, avoiding, fleeing from or abandoning patients, harm to patients' and families' interests and longer hospital stays.[11–14,20,22,24,25,28]

More positively, some of the authors argue that MD can also have a positive impact on nurses' personal and professional lives and, ultimately, on the quality of patient care. As Hanna[5] points out: 'The absence of moral distress in some lives might produce more social harm than the experience of moral distress' (p. 89). On this understanding, the experience of MD indicates sensitivity to moral wrongdoing that is a necessary condition of doing the right thing. Along similar lines, Lützén and Kvist[28] describe MD as a 'positive catalyst' (p. 13) that prevents moral blindness and triggers reflection on moral duties. For several authors, MD facilitates learning and personal and professional growth because it can lead to greater self-awareness and resilience, better coping strategies (e.g. self-care and collective action), stronger moral resolve and moral character and clearer ethical commitments.[5,14,20,21,29,32] For Peter and Liaschenko,[31] MD can prompt critical questions, open up dialogue and communication about values, assumptions and expectations and enable nurses to create counter-stories that challenge the meta-narratives that represent nurses as passive and powerless.

In turn, some authors suggest that MD leads to more compassionate and empowering nursing care – nurses may regret their actions and conscientiously object when similar situations arise again,[11,24,30] confront barriers to patient choice,[20,32] empower patients through educational interventions,[23,32] carry out acts of resistance and advocate for patients,[27] engage in activism[30,32] and evaluate the moral habitability of environments.[31]

Discussion

Methodological strengths and limitations

As far as we know, this is the first argument-based literature review of the topic of MD. In writing it, we followed a clear methodological approach of reviews of argument-based literature developed by McCullough et al.[16,17] Given the constraints of access and time, we limited our search to relevant journal articles on MD and excluded other possible sources of material such as book chapters and books. However, we are reasonably satisfied that while our search may not be completely comprehensive, it has captured the most pertinent ideas and arguments in relation to MD. This is in keeping with McDougall's[18] claim that complete comprehensiveness is not always an appropriate goal of a literature review in bioethics because the latter, as in our case, may sometimes be more concerned with capturing all of the relevant ideas on a topic than with capturing all of the literature. A further limit is that our review includes only articles written in the English language, and that these are largely drawn from the United States and Canada; clearly, further research with a broader linguistic and cultural reach is needed.

Substantive findings

A brief comparison of the results of this review with the results of the reviews of qualitative[3] and quantitative[2] literature described in the introduction of this article indicates that there are many similarities between these different reviews. Like the empirical literature, most authors in this argument-based review draw on Jameton's original definition and describe MD in psychological–emotional–physiological terms. They also agree that MD is linked to the presence of some kind of constraint on nurses' moral agency, and that it is best understood as a two-staged process that can intensify over time. There is also a general consensus among the reviews that MD arises from a number of different sources, and that it (mostly) impacts negatively on nurses' personal and professional lives and, ultimately, harms patients.

However, despite this consensus, many authors of the argument-based literature also indicate a good deal of uneasiness with the way in which MD is conceptualized. A number of authors highlight the specifically moral features of MD, and they do this by explicitly linking MD with normative terms such as 'conscience', 'moral sensitivity', 'moral judgement', 'moral integrity' and 'professional integrity'. In doing so, they signal differences between Jameton's[1,19] understanding of MD and their own. Repenshek[15] and Johnstone and Hutchinson,[13] in particular, take issue with Jameton's starting point and his claim that MD can arise in situations when a nurse makes moral judgement about the right thing to do but is prevented from acting on her judgement. They interpret Jameton as implying by this that nurses have some kind of high moral ground and they counter this with the argument that respect for the moral views of patients, families and other members of the multidisciplinary team are also part of the nurse's professional responsibilities and, indeed, a feature of ethical engagement. However, we think that Jameton has some room for manoeuvre here because he is concerned that nurses' views of what is the morally right thing to do are not heeded or respected – *not* that their views are the only ones that count. This is clear from his 2013 article where he explains his rationale for developing his account of MD almost 30 years before as a means of 'putting a nursing perspective across in a stratified bureaucratic environment' (p. 298) where nurses lack confidence and expect little support from their co-workers and where they hold strong moral views but express them indirectly in order to avoid conflict.[30] As Jameton himself acknowledges, similar concerns about the ambiguity of the nursing role and the limits that it places on nurses' moral agency have been and continue to be discussed in the broader nursing ethics literature.[34,35]

Some authors also take issue with what they see as Jameton's inadequate attention to the relationship between personal and professional morality. They argue that professional responsibilities necessarily confer some level of MD on nurses because of tensions between one's personal moral integrity and one's professional role.[5,15,26] However, some also share Jameton's worry that the nurse's role is itself becoming unbearable due to the way in which it is currently constituted and the toxic conditions of the healthcare environments within which nurses work.[26,27,29,30] The solutions offered include a 'narrative repair' that should highlight more precisely the work that nurses do, the institutional constraints that they actually resist and the moral competencies and skills required to do so.[11,27,30,32,31]

Conclusion

The current interest in conceptualizing and operationalizing MD indicates that Jameton's distinction between standard ethical dilemmas and, as he put it, 'dilemmas of distress' captures something significant about the moral terrain within which nurses work. While the authors may suggest different strategies to bring this moral work to the fore, for example, a 'system-oriented preventive approach' (p. 8) from Johnstone and Hutchinson[13] that is intended to make healthcare organizations morally 'safe place[s]'[13] (p. 7) or a structure-oriented approach from Austin,[27] Varcoe et al.[29] and Peter and Liaschenko[31] that is intended to foreground the socio-political context within which moralizing takes place, we suggest that these strategies are not incompatible. What is certain is that there is a need for further philosophical enquiry that engages with some of the issues that we have raised in this review. While the basic consensus on MD expressed here may encourage empirical researchers to continue in their attempts to describe, measure and assess its impact, significant concerns about the conceptual fuzziness of MD and its operationalization also flag the need to proceed with caution.

Conflict of interest

The authors declare that there is no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Exhibit 380

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Religion, Conscience, and Controversial Clinical Practices

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ABSTRACT

BACKGROUND

There is a heated debate about whether health professionals may refuse to provide treatments to which they object on moral grounds. It is important to understand how physicians think about their ethical rights and obligations when such conflicts emerge in clinical practice.

METHODS

We conducted a cross-sectional survey of a stratified, random sample of 2000 practicing U.S. physicians from all specialties by mail. The primary criterion variables were physicians' judgments about their ethical rights and obligations when patients request a legal medical procedure to which the physician objects for religious or moral reasons. These procedures included administering terminal sedation in dying patients, providing abortion for failed contraception, and prescribing birth control to adolescents without parental approval.

RESULTS

A total of 1144 of 1820 physicians (63%) responded to our survey. On the basis of our results, we estimate that most physicians believe that it is ethically permissible for doctors to explain their moral objections to patients (63%). Most also believe that physicians are obligated to present all options (86%) and to refer the patient to another clinician who does not object to the requested procedure (71%). Physicians who were male, those who were religious, and those who had personal objections to morally controversial clinical practices were less likely to report that doctors must disclose information about or refer patients for medical procedures to which the physician objected on moral grounds (multivariate odds ratios, 0.3 to 0.5).

CONCLUSIONS

Many physicians do not consider themselves obligated to disclose information about or refer patients for legal but morally controversial medical procedures. Patients who want information about and access to such procedures may need to inquire proactively to determine whether their physicians would accommodate such requests.

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N Engl J Med 2007;356:593-600.

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RECENT CONTROVERSIES REGARDING PHYsicians and pharmacists who refuse to prescribe or dispense emergency and other contraceptives have sparked a debate about conscientious objection in health care.[1-5] On the one hand, most people believe that health professionals should not have to engage in medical practices about which they have moral qualms. On the other hand, most people also believe that patients should have access to legal treatments, even in situations in which their physicians are troubled about the moral implications of those treatments.[6] Such situations raise a number of questions about the balance of rights and obligations within the doctor–patient relationship. Is it ethical for physicians to describe their objections to patients? Should physicians have the right to refuse to discuss, provide, or refer patients for medical interventions to which they have moral objections?

The medical profession appears to be divided on this issue. Historically, doctors and nurses have not been required to participate in abortions or assist patients in suicide, even where those interventions are legally sanctioned. In recent years, several states have passed laws that shield physicians and other health care providers from adverse consequences for refusing to participate in medical services that would violate their consciences.[7] For example, the Illinois Health Care Right of Conscience Act protects a health care provider from all liability or discrimination that might result as a consequence of "his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel."[8] In the wake of recent controversies over emergency contraception, editorials in leading clinical journals have criticized these "conscience clauses" and challenged the idea that physicians may deny legally and medically permitted medical interventions, particularly if their objections are personal and religious. Charo, for example, suggests that the conflict about conscience clauses "represents the latest struggle with regard to religion in America," and she criticizes those medical professionals who would claim "an unfettered right to personal autonomy while holding monopolistic control over a public good."[2] Savulescu takes a stronger stance, arguing that "a doctor's conscience has little place in the delivery of modern medical care" and that "if people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."[9]

In spite of such debates, there have been few empirical studies of how physicians think about their responsibilities when their own moral convictions conflict with their patients' requests for legal medical procedures. We examined data from a national survey of U.S. physicians to determine what practicing physicians think their obligations are when a patient requests a legal medical procedure to which the physician has a religious or other moral objection. We quantify the percentage of physicians who might refrain from presenting all treatment options to patients or refuse to refer them to an accommodating provider, and we examine whether particular subgroups of physicians are more likely to do so. We then discuss the implications for ongoing debates concerning the ethics of the doctor–patient relationship.

METHODS

This study's methods have been described in detail elsewhere.[10,11] In 2003, we mailed a confidential, self-administered, 12-page questionnaire (see the Supplementary Appendix, available with the full text of this article at www.nejm.org) to a random sample of 2000 practicing U.S. physicians 65 years of age or younger. The sample was stratified according to specialty. These physicians were chosen from the American Medical Association Physician Masterfile — a database intended to include all physicians in the United States. We included modest oversamples of psychiatrists and physicians who work in several other subspecialties that deal particularly with death and severe suffering, in order to enhance the power of analyses that are not central to this article. Physicians received up to three separate mailings of the questionnaire, and the third mailing offered $20 for participation. The study was approved by the institutional review board of the University of Chicago.

QUESTIONNAIRE

The primary criterion variables were physicians' responses to the following three questions: "If a patient requests a legal medical procedure, but the patient's physician objects to the procedure for religious or moral reasons, would it be ethical for the physician to plainly describe to the patient why he or she objects to the requested procedure? Does the physician have an obligation to present all possible options to the patient, including infor-

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mation about obtaining the requested procedure? Does the physician have an obligation to refer the patient to someone who does not object to the requested procedure?" Response categories were yes, no, and undecided.

We also assessed physicians' intrinsic religiosity and religious affiliations. Intrinsic religiosity — the extent to which a person embraces his or her religion as the "master motive" that guides and gives meaning to his or her life[12] — was measured on the basis of agreement or disagreement with two statements: "I try hard to carry my religious beliefs over into all my other dealings in life" and "My whole approach to life is based on my religion." Both statements are derived from Hoge's Intrinsic Religious Motivation Scale[13] and have been validated extensively in previous research.[13-15] Intrinsic religiosity was categorized as being low if physicians disagreed with both statements, moderate if they agreed with one but not the other, and high if they agreed with both.

The religious affiliations of the physicians in the survey were categorized as none (a category that included atheist, agnostic, and none), Protestant, Catholic, Jewish, or other (a category that included Buddhist, Hindu, Mormon, Muslim, Eastern Orthodox, and other). Organizational[16] or participatory[17] religiosity was measured according to the frequency of attendance at religious services (never, once a month or less, or twice a month or more).

To determine whether physicians' judgments about their ethical obligations are associated with their views on controversial clinical practices, we asked the survey respondents whether they have a religious or moral objection to terminal sedation (administering sedation that leads to unconsciousness in dying patients), abortion for failed contraception, and the prescription of birth control to adolescents without parental approval. Secondary predictors were the demographic characteristics (age, sex, race or ethnic group, and region) of the physicians surveyed and whether they worked in an academic health center or a religiously oriented or faith-based institution. The primary medical specialty was included as a control variable in the multivariate analyses.

STATISTICAL ANALYSIS

Weights[18] were assigned and included in the analyses to account for the sampling strategy and the modest differences in response rates according to the respondents' sex and whether they had graduated from a U.S. or foreign medical school. We first generated overall population estimates for agreement with each of the criterion measures. We then used a Mantel–Haenszel test for trend with one degree of freedom (for ordinal predictors) and the chi-square test (for nonordinal predictors) to examine the associations between each predictor and each criterion measure. Finally, we used multivariate logistic regression to examine whether associations persisted after controlling for other covariates. All reported P values are two-sided and have not been adjusted for multiple statistical testing. All analyses were conducted with Stata SE statistical software (version 9.0).

RESULTS

Of the 2000 potential respondents, an estimated 9% could not be contacted because their addresses were incorrect or they had died (see the Supplementary Appendix). Among physicians who could be contacted, the response rate was 63% (1144 of 1820). Graduates of foreign medical schools were less likely to respond than graduates of U.S. medical schools (54% vs. 65%, $P<0.001$), and men were less likely to respond than women (61% vs. 67%, $P=0.03$). These differences were accounted for by assigning case weights. The response rates did not differ significantly according to age, region, or board certification. The characteristics of the respondents are listed in Table 1.

On the basis of these results, we estimated that when a patient requests a legal medical procedure to which the doctor objects for religious or moral reasons, most physicians believe it is ethically permissible for the doctor to describe that objection to the patient (63%) and that the doctor is obligated to present all options (86%) and to refer the patient to someone who does not object to the requested procedure (71%) (Table 2).

Physicians who were more religious (as measured by either their attendance at religious services or their intrinsic religiosity) were more likely to report that doctors may describe their objections to patients, and they were less likely to report that physicians must present all options and refer patients to someone who does not object to the requested procedure (Table 3). As compared with those with no religious affiliation, Catholics and Protestants were more likely to report that physicians may describe their religious or moral objections and less likely to report that physicians are obligated to refer patients to

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Table 1. Characteristics of the 1144 Survey Respondents and Objections to Controversial Clinical Practices.*

Characteristic	No./Total No. (%)
Female sex	300/1142 (26)
Race or ethnic group†	
White, non-Hispanic	869/1121 (78)
Asian	138/1121 (12)
Hispanic or Latino	57/1121 (5)
Black, non-Hispanic	26/1121 (2)
Other	31/1121 (3)
Region	
South	386/1142 (34)
Midwest	276/1142 (24)
Northeast	264/1142 (23)
West	216/1142 (19)
Practice in academic medical center	353/1115 (32)
Practice in religiously oriented center	138/1111 (12)
Primary specialty	
Medical and subspecialties	231/1142 (20)
Family practice	158/1142 (14)
Pediatrics and subspecialties	147/1142 (13)
General internal medicine	129/1142 (11)
Psychiatry	100/1142 (9)
Surgery and subspecialties	100/1142 (9)
Obstetrics and gynecology	80/1142 (7)
Other	197/1142 (17)

Characteristic	No./Total No. (%)
Religious characteristics	
Intrinsic religiosity	
Low	407/1098 (37)
Moderate	292/1098 (27)
High	399/1098 (36)
Attendance at religious services	
Never	114/1128 (10)
Once a month or less	499/1128 (44)
Twice a month or more	515/1128 (46)
Religious affiliation	
Protestant	428/1127 (38)
Catholic	244/1127 (22)
Jewish	181/1127 (16)
None	117/1127 (10)
Other	157/1127 (14)
Opinions about controversial clinical practices	
Terminal sedation	
Do not object	915/1097 (83)
Object	182/1097 (17)
Abortion due to failed contraception	
Do not object	527/1091 (48)
Object	564/1091 (52)
Prescription of birth control to adolescents without parental consent	
Do not object	647/1108 (58)
Object	461/1108 (42)

* Numbers do not all sum to 1144 because not all respondents answered all the questions. The mean (±SD) age of respondents was 49.0±8.3 years.

† Race and ethnic group were reported by patients on the survey.

someone who does not object to the requested procedure.

Physicians who objected to abortion for failed contraception and prescription of birth control for adolescents without parental consent were more likely than those who did not oppose these practices to report that doctors may describe their objections to patients ($P<0.001$ for both comparisons); the association for the objection to terminal sedation was not significant ($P=0.11$) (Table 4). Physicians who objected to the three controversial medical practices were less likely to report that doctors must present all options and refer patients to other providers ($P<0.001$ for all comparisons). The associations for religious characteristics and objections to controversial clinical practices persisted after controlling for age, sex, ethnic group, region, and specialty.

After adjustment for religious characteristics and other covariates, region, race or ethnic group, practice in an academic medical center, and practice in a religiously oriented health center were not significantly associated with any of the criterion variables. However, with increasing age, physicians were more likely to report that doctors may describe their objections to patients (odds ratio for each additional year of age, 1.02; 95% confidence interval [CI], 1.00 to 1.04). Men were more likely

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than women to report that physicians may describe their objections (odds ratio, 1.8; 95% CI, 1.3 to 2.5) and less likely to report that physicians are obligated to present all options (odds ratio, 0.5; 95% CI, 0.3 to 0.9) and refer patients to an accommodating provider (odds ratio, 0.5; 95% CI, 0.3 to 0.7).

DISCUSSION

Most of the physicians in our survey reported that when a patient requests a legal medical intervention to which the physician objects for religious or moral reasons, it is ethically permissible for the physician to describe the reason for the objection but that the physician must also disclose information about the intervention and refer the patient to someone who will provide it. However, the number of physicians who disagreed with or were undecided about these majority opinions was not trivial. If physicians' ideas translate into their practices, then 14% of patients — more than 40 million Americans — may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29% of patients — or nearly 100 million Americans — may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments. The proportion of physicians who object to certain treatments is substantial. For example, 52% of the physicians in this study reported objections to abortion for failed contraception, and 42% reported objections to contraception for adolescents without parental consent.

The findings of this study may be important primarily for patients. They should know that many physicians do not believe they are obligated to disclose information about or provide referrals for legal yet controversial treatments. Patients who want full disclosure from their own physicians might inform themselves of possible medical interventions — a task that is not always easy — and might proactively question their physicians about these matters. Patients may not have ready access to information about physicians' religious characteristics and moral convictions. Thus, if patients are concerned about certain interventions for sexual and reproductive health and end-of-life care, they should ask their doctors ahead of time whether they will discuss such options. If a patient wants a treatment that the physician will not provide, the patient may choose to consult a different physician.

Table 2. **Opinions about the Ethical Obligations of a Physician Who Objects to a Legal Medical Procedure Requested by a Patient.**

Question and Response	No. (%)*
Would it be ethical for the physician to plainly describe to the patient why he or she objects to the requested procedure?	
Yes	715 (63)
Undecided	168 (15)
No	244 (22)
Does the physician have an obligation to present all possible options to the patient, including information about obtaining the requested procedure?	
Yes	981 (86)
Undecided	61 (6)
No	86 (8)
Does the physician have an obligation to refer the patient to someone who does not object to the requested procedure?	
Yes	820 (71)
Undecided	114 (11)
No	194 (18)

* Population estimates account for the survey design. Percentages reflect weighted results.

Physicians' judgments about their obligations are significantly associated with their own religious characteristics, sex, and beliefs about morally controversial clinical practices. Female physicians are more supportive of full disclosure and referral than are male physicians, perhaps because many controversial issues in medicine (e.g., abortion, contraception, and assisted reproductive technologies) disproportionately involve the sexual and reproductive health of women. Religious physicians are less likely to endorse full disclosure and referral than are nonreligious physicians, perhaps because, as many previous studies have shown, religious physicians are more likely to have personal objections to many controversial medical interventions. Thus, those physicians who are most likely to be asked to act against their consciences are the ones who are most likely to say that physicians should not have to do so.

These conflicts might be understood in the context of perennial debates about medical paternalism and patient autonomy. Strong forms of

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Table 3. Opinions about Physicians' Ethical Obligations According to the Religious Characteristics of the Respondents.*

Religious Characteristic	No. of Respondents (N=1144)	Physicians May Describe Their Moral Objections			Physicians Are Obligated to Disclose All Possible Options			Physicians Are Obligated to Refer the Patient		
		%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value	Multivariate Odds Ratio (95% CI)
Intrinsic religiosity			0.001			0.001			0.001	
Low†	405	56		1.0	92		1.0	82		1.0
Moderate	290	62		1.4 (1.0–2.0)	84		0.4 (0.2–0.7)	73		0.6 (0.4–0.8)
High	397	73		2.5 (1.7–3.5)	81		0.3 (0.2–0.5)	56		0.3 (0.2–0.4)
Attendance at religious services			0.001			0.001			0.001	
Never†	111	51		1.0	94		1.0	84		1.0
Once a month or less	496	59		1.5 (0.9–2.4)	89		0.5 (0.2–1.3)	79		0.7 (0.4–1.3)
Twice a month or more	513	71		2.7 (1.6–4.3)	82		0.3 (0.1–0.7)	60		0.3 (0.2–0.6)
Religious affiliation			0.003			0.002			0.001	
Protestant	427	70		2.3 (1.4–3.8)	86		0.5 (0.2–1.3)	65		0.3 (0.2–0.6)
Catholic	243	63		1.8 (1.1–3.0)	79		0.2 (0.1–0.6)	66		0.3 (0.2–0.6)
Jewish	179	56		1.1 (0.6–1.9)	93		0.9 (0.3–2.7)	80		0.6 (0.3–1.4)
None†	116	52		1.0	92		1.0	88		1.0
Other	153	63		1.5 (0.8–2.7)	89		0.4 (0.1–1.2)	71		0.4 (0.2–0.9)

* Population estimates account for the survey design. Percentages reflect weighted results.
† This was the reference category.

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paternalism are based on the assumption that physicians know what is best for their patients and may therefore make decisions without informing their patients of all the facts, alternatives, or risks. Paternalism is widely criticized for violating the right of adults to self-determination. The inverse of strong paternalism is a strict emphasis on patient autonomy, which suggests that physicians must simply disclose all options and allow patients to choose among them. Models that emphasize patient autonomy to such an extent have been criticized for diminishing the moral agency and responsibility of physicians by making them mere technicians or vendors of health care goods and services.[2,19-23]

This study suggests that the balance that most physicians strike between paternalism and autonomy involves both full disclosure and an open dialogue about the options at hand. This balance resembles the interactive models proposed by Emanuel and Emanuel,[19] Quill and Brody,[20] Siegler,[23] and Thomasma.[21] These ethicists have all recommended models for the doctor–patient relationship that retain the moral agency of both the physician and the patient by encouraging them to engage in a dialogue and negotiate mutually acceptable accommodations that do not require either of the parties to violate their own convictions. In Emanuel and Emanuel's terms, these interactive models retain a role for the influence of "the physician's values, the physician's understanding of the patient's values, [and] his or her judgment of the worth of the patient's values."[19] Although these models require physicians to disclose all information relevant to patients' decisions, they do not require physicians to be value-neutral. Rather, they allow physicians to explain the reasons for their objections to the requested procedures.

The lack of consensus among physicians about whether referrals to other providers who will offer a controversial treatment should be required mirrors the ambivalence about this point within the field of bioethics. Childress and Siegler[22] say that physicians "may" have a duty to inform patients about other physicians who would provide what the patient requests, and Quill and Brody[20] comment that physicians are "perhaps" obligated to facilitate the transfer of care. This ambivalence stems from a long-standing concern that physicians not be asked to act in ways that "would violate [their] personal sense of responsible con-

Table 4. Opinions about Physicians' Ethical Obligations According to Views on Controversial Clinical Practices.*

View on Controversial Clinical Practice	Respondents (N = 1144)	Physicians May Describe Their Moral Objections			Physicians Are Obligated to Disclose All Possible Options			Physicians Are Obligated to Refer the Patient		
		%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value	Multivariate Odds Ratio (95% CI)	%	P Value	Multivariate Odds Ratio (95% CI)
Terminal sedation			0.11			0.001			0.001	
Do not object†	911	62		1.0	78		1.0	75		1.0
Object	182	69		1.4 (0.9– 2.0)	89		0.4 (0.2–0.6)	58		0.5 (0.3–0.7)
Abortion for failed contraception			0.001			0.001			0.001	
Do not object†	524	55		1.0	91		1.0	83		1.0
Object	562	70		2.0 (1.5– 2.7)	83		0.4 (0.3–0.7)	60		0.3 (0.3–0.5)
Prescription of birth control to adolescents without parental consent			0.001			0.001			0.001	
Do not object†	646	58		1.0	92		1.0	83		1.0
Object	459	72		1.6 (1.2– 2.2)	78		0.3 (0.2–0.5)	71		0.3 (0.2–0.4)

* Population estimates account for the survey design. Percentages reflect weighted results.

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duct."[23] Unfortunately, at times the only accommodation that is acceptable to both the patient and the physician may be termination of the clinical relationship.[19,20,22,23]

Our study has several important limitations. Although we did not find substantial evidence of a response bias,[10,11] unmeasured characteristics may have systematically affected physicians' willingness to respond in ways that bias our results. In addition, physicians in different specialties face different arrays of morally controversial practices. Because this study included physicians from all specialties, many participants were asked to report moral judgments about medical practices with which they may have had little or no clinical experience. Moreover, physicians' judgments about their general obligations do not necessarily correspond with their judgments about any particular clinical scenario, and we do not know how their judgments about their obligations translate into their actual practices. Finally, we had three criterion measures and several predictors. Therefore, although hypotheses were theoretically specified and the expected associations were consistently observed, there was the risk of an inflated type 1 error due to multiple comparisons. For all of these reasons, our findings should be considered preliminary, and future studies should use vignettes, patients' reports, or direct observation to measure more directly the ways in which physicians respond to moral conflict in the clinical encounter.

Notwithstanding these limitations, the results of our study suggest that when patients request morally controversial clinical interventions, male physicians and those who are religious will be most likely to express personal objections and least likely to disclose information about the interventions or to refer patients to more accommodating providers. Ongoing debates about conscientious objections in medicine should take account of the complex relationships among sex, religious commitments, and physicians' approaches to morally controversial clinical practices. In the meantime, physicians and patients might engage in a respectful dialogue to anticipate areas of moral disagreement and to negotiate acceptable accommodations before crises develop.

Supported by grants from the Greenwall Foundation and the Robert Wood Johnson Clinical Scholars Program (to Drs. Curlin, Chin, and Lantos) and the National Center for Complementary and Alternative Medicine (1 K23 AT002749, to Dr. Curlin).

No potential conflict of interest relevant to this article was reported.

We thank Lainie Ross, Debra Stulberg, and Lynn Vance for their insightful comments on earlier drafts of this manuscript and Ted Karrison, Jack Iwashyna, and Anirban Basu for their assistance with the statistical analysis.

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Exhibit 381

Journal of Medicine and Philosophy, 33: 27–43, 2008
doi:10.1093/jmp/jhm006

Moral Damage to Health Care Professionals and Trainees: Legalism and other Consequences for Patients and Colleagues

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Health care professionals' and trainees' conceptions of their responsibilities to patients can change over time for a number of reasons: evolving career goals, desires to serve different patient populations, and changing family obligations, for example. Some changes in conceptions of responsibility are healthy, but others express moral damage. Clinicians' changes in their conceptions of what they are responsible for express moral damage when their responses to others express a meager, rather than robust, sense of what they owe others. At least two important expressions of moral damage in the context of health care are these: callousness and divestiture. Callousness describes the poor condition of a clinician's capacity for moral perception; when her capacity to accurately appreciate features of moral relevance that configure others' needs, vulnerabilities, and desert of care diminishes, such that she fails to respond with care to those for whom she has duties to care, she is callous. Callousness has been explored in detail elsewhere,[1] and so the focus of this paper is divestiture. A clinician divests when the value of responding with care to others becomes less centrally and importantly constitutive of his personal and professional identity. Divestiture has important consequences for patients and health professions education, which I will explore here.

Keywords: *callousness, clinical moral perception, legalism, moral damage, professionlism*

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I. INTRODUCTION

A clinician with a robust sense of what she owes others responds to patients with care, rather than impersonally. What it means for a clinician to respond to someone with care is for her to respond, within reasonable limits of her professional capacity, to that person's particular vulnerabilities. A clinician with a robust sense of what she owes others also responds to patients with understanding that *how* she responds to others expresses who she is as a person and professional; she cares deeply about what her actions (and dispositions while executing those actions) express about her identity.[2] This is one normative account of the relationship between who a person is and what he does. Another, normative account of the relationship between health care professionals' identities and their practices might appear to compete with the account I just mentioned, however. It suggests that health care professionals ought to be able to express healthy self-interest by reserving time, space, and physical and emotional energy for their own lives and personal relationships away from a health care workplace. These two normative accounts about the personal and professional identities of caregivers prompt broad, but interesting, important, and complex questions about how health-care professionals balance their duties to themselves and others: "How ought professional caregivers prioritize their duties to care for patients and their duties to care for themselves?" and "How ought professional caregivers attribute moral significance to their own needs and to the needs of patients?"

There are a variety of ways to respond to these questions. For example, one might suggest a model of professional character that strives to balance healthy self-interest with service to others by setting forth criteria by which health care professionals can prioritize and collate their personal and professional goals. Such a model would do well to consider, in general terms, variables that could be modified and applied to a particular practitioner's own personal and professional life to adjust for some of the following factors that change over time: evolving needs of maturing children or aging parents, urgency to eliminate debt, adjustments to periods of temporary stress and temporary relief from stress, and gradual increases in professional responsibility over one's training and professional development. In this paper, however, I do not endorse a particular model for professionals to use to "weigh" the moral value of their own and patients' specific needs. Rather, my task is to clarify, in moral theoretical terms, what professionals' responses to demands in their work environments express about their patterns of moral perception and personal and professional identities over time.

Throughout their careers, professional caregivers are called upon to respond to patients who are sick, vulnerable, and suffering. Patients' needs and neediness can be overwhelming, and conscientious clinicians often struggle to balance their motivations to respond to patients with their needs to manage their own lives, care for themselves, and care for those with

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whom they are close.[3] Health care professionals' struggles to manage personal and professional demands are well represented in the literature on burnout. Most of this literature appeared in the late 1970s to early 1990s, but some studies on burnout and kindred phenomena of "compassion fatigue,"[4] "callousness,"[5] and becoming "jaded"[6] have been explored more recently. These studies make clear that, though first used over 25 years ago, the Maslach Burnout Inventory (MBI)[7] remains the "gold standard"[8] tool for collecting data about professionals' responses to workplace demands and stress.

One social scientist, Cary Cherniss, used the MBI in his *Beyond Burnout*, and his work is remarkable and worthy of moral philosophical focus because it looks closely at professionals' dispositional changes over time.[9] Specifically, his observations suggest that workplace organizational structures have important impact upon professionals' satisfaction with their jobs, influence how professionals orient themselves morally to serving patients for whom they have duties to care, and situate how professionals direct or redirect their careers over time. In *Beyond Burnout*, Cherniss tracks how the value "service to others," for some professionals, went from centrally identity-constituting to peripheral and less importantly configurative of their personal and professional identities.[10] A moral theoretical analysis of how the value of service to others can become less centrally definitive of personal and professional identity and of how this transition can influence a professional's conception of her character over time in the context of health care has never been done, however. This is the project I take up here.

In what follows, I offer interpretations, in moral terms, of one particular behavioral response to emotional distress in the workplace, which Cherniss called "cutting back."[11] I canvass ways in which cutting back personal investment in serving others can affect how health care professionals and trainees orient themselves toward patients and colleagues, and I explore the question "How might this process of divestiture affect one's own view of one's moral character?" Concisely, I argue that when a person divests, he sees himself as responsible for less and less, and he limits the scope of particulars he recognizes as constitutive of reasons to act in service to others. I motivate the view that divestiture, like callousness, is a form of moral damage that can be corrosive to a professional's relationships with patients and colleagues.

II. "CUTTING BACK" AND "SURVIVAL MODE": BEHAVIORAL RESPONSES AND MORAL PERCEPTION

Cultivating a richer understanding of how health care professionals and trainees express moral damage requires us to take a close look at how health care professionals and trainees respond to emotional and moral distress in their work environments. Physiological, psychological, and spiritual effects of

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stress have, in the past few years, received medical and scientific attention.[12] Despite this, the emotional and moral dimensions of stress in the context of health professions education and their impact on health care professionalism have been neglected. Here, I will consider emotional distress first.

Emotional distress in the health care work environment can come from several different sources: working amidst tight time constraints, working long hours, witnessing human suffering and harrowing particulars of illnesses, negotiating communication on difficult and awkward topics with patients and their loved ones, and inflicting pain. This is not an exhaustive list; sources of emotional distress and effects of emotional distress have on individual caregivers can vary at least as much as individual caregivers vary. Cherniss observed an important common response among the health care practitioners he studied, however. According to Cherniss, they reduced their involvement in their work when they felt that their abilities to meet their own needs were compromised by demands in their work environments. As I mentioned, Cherniss called this response cutting back, and he characterizes it as a feature of *survival mode*. Survival mode is a reorientation of one's attention from the needs of others to one's own needs. Cherniss suggests that survival mode is voluntary and purposeful; practitioners "cut back," reduce their involvement in their work and redirect their attention from others' needs to their own needs to "look out for number one."[13] In moral terms, when a practitioner works in survival mode, he refocuses his perception from others' vulnerabilities to his own.

It is not obvious how such reorientation of one's perception is a poor response to emotional distress. Indeed, when cutting back to look out for number one corresponds to improved self-care, it can be an appropriate or even the best response to emotional distress. It might be the case, for example, that a practitioner has good reasons for cutting back or for "looking out" for herself; perhaps she *should* focus more on meeting her own needs. Perhaps a practitioner makes a change to a new environment, one with different patients and different colleagues, for example. In the cases of cutting back, it is not clear whether and when cutting back expresses moral damage. Not all reductions in a practitioner's sense of what he is responsible for express a practitioner's reduced sense of what she owes others. A distinction is needed.

Recall the definition of moral damage I introduced earlier: a practitioner's response expresses moral damage when "her sense of what she owes others is meager, rather than robust," and "her sense of what she owes others is robust when she responds to patients' particular vulnerabilities." As I have suggested, cutting back to survival mode can be understood as a redirection of a practitioner's moral perception. In moral terms, this means that "when a practitioner "cuts back," she narrows the scope of what counts as a reason to respond with care to others." When practitioners who cut back to survival mode narrow the scope of their moral perception such that their perception

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of others' needs and vulnerabilities is muddled, clouded, or at the mere periphery of their fields of moral perception, they express moral damage.

Cutting back to survival mode is not an "all-or-none," but a variable phenomenon. The moral impact of cutting back on a practitioner's discernment of others' needs and vulnerabilities will vary, thus, in degree and kind. For example, the quality of a practitioner's moral perception might erode slowly over time with respect to all features of others' needs and vulnerabilities. Or, the quality of a practitioner's moral perception might diminish when he begins to attribute salience to some features disproportionately. To be clear about defining *poor* moral perception, however, we first need a picture of what *good* moral perception is. This has been developed fully elsewhere,[14] but a concise explanation is appropriate here: "A practitioner with good moral perception sees the reasons there are for responding with care to others' vulnerabilities; what a practitioner thinks she has a reason to do is guided by who she is, what she thinks is important, and what she thinks others deserve from her." In other words, what a person sees as morally at stake in a situation is a function of his own identity; when a health care professional sees well clinically and morally, he is invested in being responsive to others. Divestiture, then, is one source of poor clinical moral perception.

Consistently, Cherniss noticed that the professionals he observed responded to distressing workplace conditions by modifying the relationship between who they are and what they did professionally; they adopted more modest goals, dropped out of their professions,[15] left public service to practice in more lucrative private sector jobs, and sought to serve less difficult clients.[16] He remarked that those who entered a profession because they "want[ed] to serve others" became those who "began to focus more and more on their own needs."[17] In moral terms, the behavioral responses Cherniss observed can be understood as a practitioner's reconfiguration of the relationship between who she is and what she does; the value of responding with care to others becomes less centrally and importantly constitutive of her personal and professional identity. Cherniss observed the behavioral manifestations of divestiture.

III. MORAL DAMAGE AND PROFESSIONALISM

As I have mentioned, practitioners can suffer several forms of moral damage. I will consider two here that can have significant effects on professionalism: degraded self-conception and narrowed moral perception. There are also a number of reasons practitioners become morally damaged. For example, depression can prompt a practitioner to cut back, withdraw, and reduce his sense of what he owes others. Furthermore, depression can manifest in a number of ways including self-pity, apathy, defensiveness, or

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a disproportionately inflated sense of guilt. Although we should take care not to attribute all instances of moral damage among health care professionals to emotional distress within the health care work or training environment, we should also carefully consider features of the health care work and education environment that are well known sources of emotional and moral distress. Cultivating a better understanding of the moral implications of students', residents', and professionals' behavioral responses to emotional distress in the workplace should prompt health professions educators to consider and assess whether and when health care work and training environments effectively and compassionately motivate trainees' learning and professional development.

Degraded Self-Conception

Consider, for example, medical student "Andrea Fricchione,"[18] who appears to have cut back:

> When I arrived in medical school, I was eager to get involved, I was excited about addressing important issues because, as medical students, I was sure that we would have some clout and certainly a commitment to the well-being of others.

She suggested that responding with care to others is an important source of enjoyment, self-worth, and self-respect for her and that she was enthusiastic about sharing her commitment to serving others with other medical students. But then she described feeling conflict between the values that motivated her to attend medical school and the ones she viewed her mentors and teachers endorsing: "People are rude, the hours are long … [L]ife is brutal … [M]edical school is an utter drain." She also revealed ways that she disengaged from activities that were important to her, as a way of coping with emotional distress:

> In some sense I think activism is futile. It isn't just that there will always be more to do—it's that most projects are BandAid treatments that provide an opportunity to feel good about oneself that isn't justified … [R]ather than try to change everything that I consider wrong in the hospital or the community at large, I just try to get through school.

On ethics and professionalism, Andrea said, "I regret not having spoken up on more issues. But I was often too tired."

She expressed hopelessness about her future, regret about her past, guilt, and blame, which she directed toward herself. She described what she felt as a need to "just make it through school," and she recounted having made a choice she thought might enable her to do so; she cut back and, as she says, "I decided to focus more on my own life." If her decisions to focus more on her own life were not accompanied by descriptions of herself as guilty, regretful, and blameworthy, it might be sufficient to regard her cutting back as a mature reorientation of her life's path rather than as a desperate

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attempt to avoid annihilation in a system of medical education and professionalization she suggests is brutal.

Morally, Andrea's self-conception changed from someone who was "eager to get involved" to someone who was "just try[ing] to get through school." Not everyone would characterize that change in self-conception as a degradation of self-conception, but it seems reasonable to think Andrea would. For example, if we interpret Andrea's referral to 'activism' as actions or series of actions that constitute political responses to injustices with social, institutional, or economic dimensions, we understand Andrea to say that she no longer sees features of the situations she faces as configuring reasons to respond politically; she has come to believe that "activism is futile." I do not suggest that Andrea's determination of the futility of activism is necessarily right or wrong, but that her perception of what is worth doing has narrowed. I also do not suggest that Andrea's decision to cut back by making "activist" a less important feature of her professional identity is necessarily an indicator that she is completely divested or that she cannot regain a devotion to activism in her future. Rather, my point is that she has become morally damaged in the process of her education and early professionalization; her moral perception became less capacious. The scope of what Andrea came to see herself responsible for and what she sees as worth doing have narrowed as she was professionalized into medicine. This and other kinds of moral damage have been overlooked features of how systems of health professions education in the United States make physicians and nurses out of students.

Andrea seems to have some awareness that the patterns of perception and professionalization that she has internalized are harmful to her, and this worries her. She states, "I do believe that habits formed now will rarely be overcome in the future." This kind of despair should prompt health professions educators to consider how, when, by whom, and under which circumstances moral damage is passed on to next generations of clinicians. Additionally, there is no good reason to feel confident that moral damage suffered by one professional or trainee is isolated to that person's individual experience, since patterns of perception are modeled to students throughout their training.

Specific behavioral manifestations of cutting back and specific expressions of moral damage will, expectedly, differ in important ways according to the varying needs and maturational trends of different groups of workers in the health care environment: residents, nurses, students, attending physicians in academic medicine, or physicians in private practice, for example. It is beyond the scope of this paper for me to canvass specific needs and trends for each of the groups I have identified, but perhaps it is most worthwhile to consider first that, generally, faculty mentors adopt habits (consciously or unconsciously) that they think (rightly or wrongly) make their jobs easier and their practices more efficient. Faculty mentors are likely to pass along to trainees

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the practices of perception to which they have become habituated during the courses of their careers. Some of these strategies for negotiating demands of the health care work environment can propagate damage within professions over time; one of them, which I'll call *legalism*, tries to negotiate a common source of emotional distress among caregivers: fear of being sued.

Narrowed Moral Perception

Recall that in moral terms, when a practitioner enters survival mode, he refocuses his attention from others' needs to his own. In the context of health care practice, fear of being sued appears to perpetuate practitioners' needs to stay in "survival mode." That is, to try to keep fear of being sued at bay in clinical practice, some professionals practice "defensively," according to legalism. Legalistic practice is *doing an action or series of actions, suspected to be unlikely to benefit patients and unlikely to generate new information or knowledge about how to help patients, out of a sense that doing it anyway will promote the impression that a practitioner is "thorough" and "covered" from an imagined legal point of view.* A professional caregiver who practices defensively and legalistically draws her attention away from the needs of her patient and refocuses her attention upon her own self-protection.

In terms of moral perception, legalistic practice models two important expressions of moral damage to trainees: narrow instead of capacious moral perception, and meager rather than generous conceptions of what counts as a reason to respond with care to others. A moral impact of faculty mentors' modeling of legalistic, defensive practice to trainees is that patients' vulnerabilities become obscured; patients and their loved ones are perceived as threatening antagonists to practitioners' professional interests and personal prosperity. When faculty mentors model legalistic patterns of perception, they model a habit of perception of patients' intentions, motivations, and characters that muddles the clarity with which patients' needs and vulnerabilities can be perceived. When faculty mentors model legalistic practice, they model habits of perception that are narrow, exclusive, and meager. Contrastingly, practitioners with a robust and generous sense of duty to respond to patients' needs and vulnerabilities practice open, capacious, inclusive moral perception that enables them to field the information they need to treat patients well, to make good judgments, and to cultivate good relationships with patients and their loved ones. Practitioners with capacious moral perception cultivate the best opportunities to be capable, effective healers whose actions are guided by the goal of responding to others with care and whose identities are defined in terms of being responsive to patients' needs, vulnerabilities, and suffering.

To be clear, I am not suggesting that practitioners ought never be concerned about being sued. (Nor am I denying that health care professionals do have legitimate interests—in personal safety and financial security, for

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example—that can be threatened and ought to be protected in excessively litigious societies.) Rather, I have tried to show how defensive, legalistic practice is about responding to practitioners' needs and vulnerabilities, rather than to patients' needs and vulnerabilities, and I have tried to show how legalistic practice expresses damaged moral perception. In doing so, I have tried to briefly problematize the zeal with which and the reasons for which legalistic practice is taught to young practitioners without any explicit consideration of how they can be morally damaged.

IV. PRACTITIONERS' IDENTITIES AND PATIENT CARE

When a practitioner suffers moral damage and reduces what he sees himself responsible for, his patients and colleagues can be profoundly affected. Cherniss observed, for example, that some professionals cut back involvement in their work by "cherry picking" less difficult people to serve, and he observed that some professionals cut back by leaving public service-oriented jobs to take more lucrative, high-paying jobs with private companies.[19] Changing the kinds of patients practitioners serve or changing the kinds of places at which they practice might be seen as morally neutral career moves. Even these forms of cutting back, however, are not always morally neutral, particularly in the context of health care.

Some nurses and physicians, for example, might leave practice in urban or rural hospitals and clinics for suburban practice because it is believed to be indicative of higher status and productive of higher pay. In moral terms, this is problematic when decisions about where to practice and whom to serve (implicitly or explicitly) express views that responding to certain patients or groups of patients is less worth doing. A health care practitioner who makes a transition from practicing in a poor urban hospital to practicing in a suburban medical center, for example, shifts the focus of her moral perception differently than Andrea Fricchione did. Instead of narrowing the scope of what she sees herself responsible for, she focuses upon working amidst one patient population instead of another, and she chooses to situate herself among patients whom she sees as more compliant, more effective in managing their health, more likely to have substantial support from friends or family members, or less likely to be living in conditions of poverty. The values those career choices express and how those values guide clinicians' perception and career orientations are morally significant because they benefit some patients and disadvantage others. The impact of such patterns of value expression and perception cannot be neglected in light of persistent, pervasive inequalities in global and local (American) health care.

A transition from an urban to a suburban health care work environment can often be accompanied by a transition in the wealth of the patients professionals serve. Poor uninsured or underinsured people often cannot

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easily access or afford care in suburban clinics or hospitals, so professionals who leave urban organizations to practice in surburbia will serve poor uninsured patients much less frequently, and the features of dealing with poor, uninsured, or underinsured patients are less likely to emerge in the majority of situations they see as they practice. Making a choice to practice in suburban organizations is one way to try to exclude a field of particulars (commonly associated with dealing with patients who are poor, uninsured, or underinsured) from the moral landscapes one sees during the workday. Alternatively, a practitioner could remove herself from situations in which she will expect to see patients who do not speak English well, patients who are poor single mothers, or patients with severe mental illnesses. Such selectivity could suggest that a practitioner has reduced the field of particulars to which he sees himself obliged to respond and has reduced the scope of what counts as a reason *for him* to respond as a person and professional to patients he perceives as members of those categories.

To be clear, I am not suggesting that health care professionals ought never be free to situate themselves in certain work environments or among certain patient populations. I do suggest, however, that such choices are not without morally relevant consequences to patients and also to fellow practitioners. For example, a colleague of a practitioner who has cut back by transitioning from urban or rural to suburban practice is left with an increased demand to respond to the patients that remain; workloads among remaining caregivers must be redistributed and replacement workers need to be trained. In depressed urban areas, in particular, it might be the case that cutting back contributes to burnout, turnover, vacancies, and disparities in care received by patients in urban versus suburban facilities. Making a change to one's practice environment by transitioning from urban or rural to suburban practice raises many often neglected questions. One open question raised by considering the moral implications of cutting back in the context of health care is this: "Ought a practitioner be allowed to cut back or implement a desired change in her work environment whenever she wants to, regardless of the consequences to her colleagues and regardless of its impact on the patients (and patient populations) she serves?"

So far, I have tried to motivate the view that moral damage suffered by individual practitioners has important consequences for patients and health professions education. I have also tried to develop a view, in moral theoretical terms, of how emotional distress in the workplace can generate two specific forms of moral damage: poor moral perception and divestiture. Moral distress can generate these, too.

V. MORAL DISTRESS IN THE HEALTH CARE WORK ENVIRONMENT

Moral distress has been a prominent topic in the health professionalism literature, particularly during the period between 1995 and 2005. One of the

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most recent definitions of moral distress has been offered by the philosopher Judith Andre, in her *Bioethics As Practice.*[20] The definition she offers is useful here because it articulates that moral distress is not just a psychological product of, as the common cliché connotes, "circumstances beyond one's control," but a deep anguish that comes from the nature of those circumstances as *systemic, persistently recurrent,* and *pervasively productive of crises of conscience.* According to Andre, moral distress is a sense of complicity in doing wrong. This sense of complicity does not come from uncertainty about what is right but from the experience that one's power to resist participation in doing wrong is severely restricted by one's work environment and from the experience that resisting participation in doing wrong exposes one to harm. Moral distress is generated in the health care work environment when a practitioner is aware that he is acting other than how he is motivated to act, but he believes that he cannot act as he is motivated to act without suffering some morally significant harm.

A number of situations can generate moral distress. Broad systemic changes in the recent past in health care—in how health care institutions are organized, how health care is financed, and how health care resources are managed, for example—have *de facto* demanded that individual practitioners adjust to being treated more like laborers than autonomous professionals and less like trusted fiduciaries than like employees with suspicious conflicts of interest. The trends and changes in health policy, which have come to be known generically by the concept "managed care," instantiated substantial changes in health care work environments. For example, managed care significantly reduces the amount of time caregivers are allotted to spend with patients. Situations in which practitioners are pressed for time are worthwhile to consider here because they illuminate how cutting back is not always voluntary and purposeful, as Cherniss has suggested. I have argued so far that voluntary cutting back can be morally damaging; now let us consider involuntary cutting back and its impact on practitioners' moral perception and self-conceptions.

VI. MORAL DISTRESS, INVOLUNTARY CUTTING BACK, AND PRACTITIONERS' DEGRADED SELF-CONCEPTIONS

Consider the following case in which a physician talks about how she prefers to approach a patient who might not suspect that she is pregnant.

> A patient misses a period, and she thinks it's just because she's really stressed out. Sometimes, the patient is right. Other times, I learn that she's pregnant. I've been in this situation before, and you never know if a patient is going to be ecstatic or devastated when you tell her that she's pregnant. What I like to do is talk with her about how she feels about it, present some of the options she has, and just try to be supportive of however she feels about it. In my experience, most women learn they're pregnant when they're alone, or at least alone with me, and many of them don't have many supportive people in their lives, and if they do, they're not always

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> with them when I tell them about the pregnancy. So, I like to stay with these patients and see how they're doing with the news. I just think it's important and the right thing to do when you tell someone news like that.

This case illustrates how this physician's self-conception guides what she thinks she has a reason to do: she sees herself as doing the right thing for her patient when she is attentive to how her patient receives the news that she is pregnant and when she stays with her to observe how she processes the news. She suggests an important distinction between delivering the news to her patient impersonally and delivering it with care; when she does it with care, she feels like she is done it right. Doing it right is meaningfully expressive of who this physician is and what she cares about.

Now consider the following continuation of the above case.

> But, things get so hectic; I don't have time anymore. Now, I tell a patient she's pregnant, I give her some papers that have lists of websites and I give her some brochures that talk about abortion and adoption and parenting. She walks out looking dazed and I walk out feeling like I've not done my job very well.

This continuation reveals how this physician sees herself acting differently under conditions in which she is pressed to see patients under restrictive time constraints. Under these conditions, she is not really free to respond to her patient as she is motivated to respond, to respond with care; she knows she is not responding to her patients with care under these conditions, and this makes her feel like she is not doing her job properly. This physician recognizes herself, under these conditions, as a provider of poor care, she enjoys little job satisfaction, and experiences moral distress as a result.

This case could be read as this physician's failure to plan to allow time to counsel pregnant women with poor social support. Or, perhaps the amount of time she spends with the patient is less important than she suspects, and her patients could be better counseled by a patient educator, for example. It is true that her patients can probably be served well in a variety of ways, not just by spending more time with them. However, my point just now is not to focus on the patient's care but on this physician's view of herself as a caregiver and her experience of how her working conditions undermine her professional agency. She appears to respond to clinical time restrictions by doing the best she can in the time she has with patients, but she feels this is inadequate and she suffers the harm of seeing herself in degraded moral terms.

She could respond to clinical time restrictions in another way and spend the amount of time with each patient she feels is therapeutic and appropriate. But this also exposes her to harm: she will likely fall behind schedule in seeing patients, which typically generates other problems, such as declining patient satisfaction and lengthening already long, stressful work days for colleagues and staff. Additionally, she might be reprimanded, penalized, or denied bonuses by the company that pays her salary.

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Or, she could respond to clinical time restrictions by becoming more active in changing policies that situate her work environment. It is certainly true that health care professionals can and do act in positions of policy- and decision-making authority within the organizational structures of health care institutions. But few clinicians who are devoted full time to patient care have time reserved to participate and are not always invited to participate in committee meetings in which policies are formulated, analyzed, revised, and questioned. Ethics committees are one substantial source of policy development in health care institutions, for example, and physician participation on health care ethics committees is significant.[21] However, residents are rarely encouraged to or rewarded for attending meetings and certainly not regularly enough to have significant impact on an organization's development of policies that shape their working conditions. Increasing clinicians' involvement in policy-making can probably have long-term impact on improving health care work environments, but it holds little promise to alleviate current moral distress experienced by students, residents, and others who have little power to change their working conditions; residents, for example, already typically work 80-hour weeks. This has important consequences; a cursory review of the professionalism and student wellness literature since 2000 in medicine and nursing reveals the pervasiveness of situations in which students and residents experience moral distress during their training.

Even if, in the physician's case above, we are right to question whether her motivation to spend more time with her patients is professionally justifiable, we ought to take care not to reduce her moral motivation to spend more time with patients to mere content of professional judgment. As I have tried to show, what a practitioner thinks she has a reason to do is an expression of who she thinks she is and the kind of professional she thinks is worth being. What happens morally to a health care professional's character when she does not act as she is motivated to act is as important as what happens to her patient.

The physician in the case "cuts back"—not voluntarily to "look out for number one," but involuntarily, or at least nonvoluntarily—to acquiesce to conditions of her practice, to accommodate the demands of her work environment, and to respond to the forces that situate that environment. Reducing the time she spends with each patient might not track a reduction in her *motivation* to serve each patient well, and thus, probably would not track a voluntary redirection of her perception from her patients to herself. But, reducing the time she spends with each patient interferes with her ability to endorse important values that make her practice worthwhile for her. She is *de facto* required to reduce what she sees herself responsible for doing during the time that she has with each patient; she narrows her perception of what counts as a reason to do something in service to her patient. Narrowed moral perception, then, appears to be an expression of moral damage that manifests voluntarily, as Cherniss suggests, but also involuntarily (or at least nonvoluntarily) when practitioners cut back in response to moral distress.

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Interestingly, the physician's awareness of her involuntary response to moral distress and demands of her work environment can be another source of emotional distress. For example, she is aware that she is not responding to patients as she is motivated to; she articulates feeling dissatisfied with her job performance. She might not be aware, however, of how the adaptations she has made to her practice have damaged her moral perception. In other words, a person can cut back voluntarily, as a result of emotional distress, and purposefully refocus one's moral perception; this is the kind of phenomenon Cherniss studied. As I have tried to show, however, this is not the only possible morally damaging result of cutting back. A practitioner can also cut back involuntarily as a result of moral distress, and he can be unconscious or conscious of doing so. If he is conscious that he is cutting back, even if he does so involuntarily, he can suffer emotional distress when he feels guilty for cutting back or disappointed in himself for doing his job poorly. Moral distress can generate emotional distress, and both generate moral damage. Additionally, however, if he is involuntarily cutting back and unconscious that he does so, he might not suffer emotional or moral distress, but his patients might get poorer care, poorer responses than they deserve from him.

VII. CONSEQUENCES OF MORAL DAMAGE TO HEALTH PROFESSIONALISM

Colleagues' perceptions of caregivers or students who have reduced conceptions of what they owe others have significant impact on interprofessional and interpersonal relationships in the context of the health care work environment. Earlier, I tried to show how health care professionals' decisions to cut back involvement in their work by cherry picking less difficult patients can negatively affect patient care, particularly from a population-based point of view. Also, Cherniss suggests that cherry picking has important effects on how colleagues treat each other and their students. I will continue exploring this idea from a moral theoretical standpoint by considering how cutting back can undermine the quality of the mentorship experiences young members of health professions have in their training.

Cherniss observed that professionals who cut back tended to blame others when things went wrong.[22] In moral terms, one way to understand a person's increased tendency to blame others is as a decrease in her ability to interpret others' actions with charity and humility. The value of charity is an important support of collegiality and professionalism; when a practitioner views a colleague charitably, she sees him as one who, probably like herself, is trying to do his best and cares deeply about doing his best. The value of humility also promotes collegiality because it places importance upon a practitioner's ability to appreciate that his own susceptibility to making mistakes and committing errors might be no less than his colleagues'. When collegiality among practitioners is damaged such that they no longer view

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each other with charity and humility, young practitioners and students are especially vulnerable to internalizing dysfunctional patterns of perception and behavior as normal for four reasons: they are just beginning their processes of socialization into health care practice, they might be particularly eager to internalize patterns of perception that are accepted parts of that socialization, they are sometimes ill-prepared to discern differences between good and poor patterns of perception that are modeled by their mentors, and their youth often corresponds to their being ill-equipped to recognize and reject dysfunctional patterns of relating to colleagues that can be modeled by divested or calloused mentors.

I have already discussed how students can learn poor habits of moral perception when their faculty mentors model defensive, legalistic clinical practice. A broader point to consider, however, is that even if students and young practitioners do recognize parts of their socialization as dysfunctional and are critical of them, they are particularly ill-equipped to resist or change them because they have little power and authority, and they are taught to accept their powerlessness and degraded status as proper and normal within the hierarchical health care work environment. Furthermore, students and young practitioners are vulnerable to losses if they try to assert their humanity or resist their status as "bottom dwellers" in firmly entrenched hierarchies of power and authority in health care work environments. If perceived by their mentors as uncooperative or unwilling to be professionalized as their mentors were professionalized (even if they were professionalized poorly or suffered moral damage), they might be labeled "unprofessional" or "lazy," for example. When collegiality erodes and relationships and habits of perception among professionals and students are dysfunctional, mentorship becomes a less reliable means of modeling caring professional demeanors, good clinical comportment, and good moral perception.

VIII. CUES FOR FUTURE EXPLORATION OF MORAL DAMAGE IN HEALTH CARE

Two important forms of moral damage common in the context of health care have now been explored in *The Journal of Medicine and Philosophy*: *callousness* (February 2007, 32, 43–64) and *divestiture* (here). This literature reinvigorates a stale literature on kindred phenomena such as *burnout*, *disillusionment*, and *cynicism* by focusing in particular on the nature of moral motivational erosion among health care professionals. Further investigation of moral damage in the context of health care could be devoted to a number of interesting, important, and complex moral and empirical questions, such as the following: "Which criteria for choices about the orientation of one's career in health care are legitimate and fair to colleagues and patients? Will expressions of moral damage among healthcare professionals

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diminish or change in the future, perhaps in response to increased emphasis in health professions curricula on issues of professionalism? When healthcare professionals become morally damaged, how ought organizations respond?" These and other questions suggest to health professions educators that rigorous attention should be paid not only to cultivating technically skilled, clinically savvy practitioners but also to guiding their development of moral perception and to nourishing their characters.

NOTES

1. In "Should a Good Healthcare Professional Be (at Least a Little) Callous?" (see references), I pose philosophical and empirical questions about callousness and consider its role in health professions training. In "Third and Fourth Year Medical Students' Attitudes and Experiences with Callousness: The Good, the Bad, and the Ambiguous" (see references), my coauthors and I report on students' attitudes about and experiences with callousness in their training and discuss the significance of callousness in informal professional dispositional modeling.

2. In her *Moral Understandings*, Margaret Urban Walker (1998) emphasizes that "a persistent history of valuation that can be seen in a good deal of what a person cares for, responds to, and takes care of" is expressive of a moral agent's "own *narrative of moral identity*" (112).

3. A wealth of literature considers professional caregivers' physical well being, mental health, stress management, and impairment. Selected authors who have recently and notably contributed to this literature are Reilly & Ring (2007), Spickard (2001), Weiner et al. (2001), Glasberg, Eriksso, & Norberg (2007), and Boisaubin & Levine (2001).

4. See references to Figley (1995).

5. See reference to Rentmeester, Badura Brack, & Kavan (forthcoming).

6. See reference to Levi et al. (2004).

7. See references to Maslach and Jackson (1981a, 1981b).

8. Several scholars continue to use the MBI to follow-up on Maslach's, Jackson's, and Cherniss's work on burnout among human service professionals. See references to Rafferty (2001), Anderson (2000), Borritz et al. (2005), McGrath, Reid, & Boor (2003), and Richardsen (2004).

9. It is worth noting that Cherniss did not just observe health care professionals but also teachers, therapists, and attorneys who serve vulnerable members of the public.

10. Cherniss's more recent work on emotional intelligence in the workplace grows from his previous work on burnout; it develops how conceptions of professional identity influence a person's knowledge about and management of emotions, recognition of others' emotions, motivation to respond empathically to others, and ability to manage relationships with significant emotional content and challenges.

11. Cherniss (1995), 42.

12. See reference to Sternberg (2000).

13. Cherniss (1995), 42.

14. Rentmeester (2007), 48–9.

15. Cherniss (1995), 37–45.

16. Cherniss (1995), 51–9.

17. Cherniss (1995), 42.

18. See the article by Coulehan & Williams (2001). Andrea's narrative is explored in detail in this article. These quotations are drawn from it.

19. Cherniss sees four different ways in which; professionals developed new types of goals. He calls these "going for the gold" (pp. 52–3), "the search for greater intellectual stimulation" (pp. 54–5), "seeking status" (pp. 55–6), "becoming one's own boss" (pp. 56–7), and "looking for less difficult clients" (pp. 57–9).

20. Andre (2002), 122.

21. See Fox, Myers, & Pearlman (2007).

22. Cherniss (1995), 51–9.

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Exhibit 382

REVIEW

Conscientious objection to abortion and reproductive healthcare: a review of recent literature and implications for adolescents

Kathleen M. Morrell[a] *and Wendy Chavkin*[b]

Purpose of review

Conscientious objection to reproductive healthcare (refusal to perform abortion, assisted reproductive technologies, prenatal diagnosis, contraception, including emergency contraception and sterilization, etc.) has become a widespread global phenomenon and constitutes a barrier to these services for many women. Adolescents are a particularly vulnerable group because some providers object to specific aspects of their reproductive healthcare because of their status as minors.

Recent findings

Recent peer-reviewed publications concerning conscientious objection address provider attitudes to abortion and emergency contraception, ethical arguments against conscientious objection, calls for clarification of the current laws regarding conscientious objection, legal case commentaries, and descriptions of the country-specific impact of policies in Russia and Italy.

Summary

Conscientious objection is understudied, complicated, and appears to constitute a barrier to care, especially for certain subgroups, although the degree to which conscientious objection has compromised sexual and reproductive healthcare for adolescents is unknown. Physicians are well positioned to support individual conscience while honoring their obligations to patients and to medical evidence.

Keywords

abortion, conscientious objection, contraception, reproductive health

INTRODUCTION

Conscientious objection is defined as the objection to participate in an activity on ethical or moral grounds. Conscientious objection to reproductive healthcare (refusal to perform abortion, assisted reproductive technologies, prenatal diagnosis, contraception, including emergency contraception and sterilization, etc.) has become a widespread global phenomenon and constitutes a barrier to these services for many women. Adolescents are a particularly vulnerable group because some providers object to specific aspects of their reproductive healthcare because of their status as minors.

TEXT OF REVIEW

The consensus of the international human rights community (the UN Committee on Economic, Social and Cultural Rights, the UN Committee on the Elimination of Discrimination against Women, and the UN Human Rights Committee, the European Court of Human Rights) and the medical and public health community (FIGO, ACOG, WHO, etc.) is that the rights of the provider need to be balanced with the rights of the patient to have access to healthcare [1] (Fig. 1). There must also be safeguards to ensure patients receive accurate information and timely care through referral. In emergency situations, a patient's needs should trump the provider's beliefs and objectors must provide necessary care. International and regional human rights bodies, governments, courts, and health professional associations have developed different guidelines with regards to conscientious

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Curr Opin Obstet Gynecol 2015, 27:333–338

DOI:10.1097/GCO.0000000000000196

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KEY POINTS

- Conscientious objection to reproductive healthcare has become a widespread global phenomenon and constitutes a barrier to these services for many women including adolescents.
- Conscientious objection is understudied, complicated, and appears to constitute a barrier to care, especially for certain subgroups.
- The degree to which conscientious objection has compromised sexual and reproductive healthcare for adolescents is unknown.
- International consensus on conscientious objection affirms that providers have a right to conscientious objection, but that right should be secondary to their primary conscientious duty as healthcare providers to provide benefit and prevent harm to patients.

objection, but all based on these generally accepted principles.

Previous research about conscientious objection has been mostly qualitative and/or of methodological limitations. A recent review of extensive research of medical, public health, legal, ethical, and social science examined the prevalence, character, and impact of conscience-based refusal, and reviewed policy efforts to balance individual conscience, autonomy in reproductive decision-making, safeguards for health, and professional medical integrity [1]. This White Paper concluded that prevalence of conscientious objection is difficult to measure, as there is no consensus about criteria for what it means to be an objector and no standard definition of the practice. Nonetheless, consistent trends indicate that the array of objectors includes pharmacists who object to dispensing both medication abortion and contraception (including emergency contraception), GPs who object to referring patients to abortion providers, and providers who object to performing an abortion for a minor without parental consent even when the law allows it. The literature has shown that some clinicians purport to be objectors when in fact they are uncomfortable with specific patient characteristics or circumstances, rather than because of deeply held religious or ethical convictions. Examples include some doctors in Brazil who described themselves as objectors but were willing to provide abortions for family members [2], and Polish physicians who objected to providing abortion in their public sector jobs but provided abortions in their fee-paying private practices [3]. Others suggest some providers object in order to avoid stigmatized work rather than for reasons of conscience [4].

Although no specific studies in the last 18 months tackled conscientious objection to abortion care pertaining to adolescents, peer-reviewed publications address provider attitudes to abortion and emergency contraception, ethical arguments against conscientious objection, calls for clarification of the current laws regarding conscientious objection, legal case commentaries, and descriptions of the country-specific impact of policies in Russia and Italy.

Recently published work investigating providers' attitudes regarding conscientious objection

International Consensus:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

FIGURE 1. Principles related to the management of conscientious objection to reproductive healthcare provision.

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has focused on physicians who object to providing referrals for abortion. Norway has more extensive regulation of conscientious objection than most: healthcare providers must provide written notice of conscientious objection, hospitals are required to report those individuals to government agencies, and a 2011 law explicitly prohibits conscientious objection by GPs for referral to abortion. Referral for abortion by a GP is a necessary step for women in Norway to obtain abortions in their healthcare system. One small qualitative Norwegian study of seven GPs who objected to referring was conducted in 2012–2013 when this law was being contested in the legislature [5▪▪]. These general practitioners perceived referral for an abortion as contributing to the abortion process in a way that they found to be morally problematic. They did, however, emphasize that they would give information on how patients could obtain referrals so as not to obstruct patients' legal right to abortion. Most of these GPs also stipulated that their refusal was not absolute; all but one would refer in cases of rape or incest, when the mother's life was in danger, and sometimes in other cases depending on the circumstances.

A survey of senior medical students in Norway revealed that 5% of respondents would object to referring for abortion and 15% of the total would object to performing a first-trimester abortion [6▪▪]. Consistent with the Norwegian social norms found in the qualitative interviews with GPs, 92% of the students felt that first-trimester abortion should remain legal and accessible. A total of 58% of the surveyed students said they support conscientious objection to performing or assisting with abortion, but only 10% support objection to referrals.

In Brazil, abortion is highly restricted but legal in the case of rape, requiring only the woman's consent to be permissible. In a recent mixed-methods study of 1690 Brazilian obstetrician–gynecologists who responded to an electronic, self-completed questionnaire, 82% said they request at least one physical document not required by law before agreeing to perform an abortion [7▪▪].

Nurses and midwives assist with abortion procedures in different ways depending on the setting. A qualitative study of 17 Italian midwives investigated their experiences taking care of women during second-trimester abortions in a hospital setting [8▪]. These midwives all struggled with the balance between empathy and their own personal belief, but firmly believed that caring for these women was part of their professional duty and that a woman should never be judged for her choices. A British nurse encouraged clinicians to thoroughly explore their own beliefs as a form of self-care, and also suggested that team leaders survey individuals' beliefs [9▪]. She explicitly asserts that conscientious objection during care for an emergency abortion is 'not valid'. Two Scottish midwife supervisors recently brought their conscientious objection case to court because they did not want to delegate or provide supervision or support at any stage of the abortion process [10▪]. They lost this case in the UK Supreme Court because the deputy president of the court Lady Hale concluded that their tasks did not constitute direct provision of the abortion. "'Participate' in my view means taking part in a 'hands-on' capacity," she argued [11]. In a qualitative study in Senegal where abortion is highly restricted but post-abortion care is supposed to be readily provided, several providers reported that they would withhold care from women who came to the hospital bleeding until the women admit to having induced abortion [12▪]. None of these providers actually were observed to withhold treatment in the study, but indicated that they would inform police or obscure the induced abortion by reporting it as a spontaneous miscarriage in the medical records.

Pharmacists also assert conscientious objection status and have refused to dispense different contraceptive methods or medication abortion. Medication abortion has been covered by Australia's national healthcare system since 2013, but pharmacists are legally able to object to dispensing. They must, however, facilitate continuity of care for the patient according to the Pharmaceutical Society of Australia's Code of Ethics. Yet, in a recent qualitative study, 41 randomly selected pharmacists in Australia were interviewed regarding their attitudes and knowledge around medication abortion [13▪]. Half of the pharmacists objected to providing medication abortion and some refused to refer patients to another willing pharmacist.

Recently published authors on conscientious objection argue that the autonomy of the provider should be a secondary consideration, as the needs of the patient should be considered paramount. Giubilini [14▪] contends that it is not possible to defend conscientious objection in healthcare because of the potentially negative consequences of the objection. In the specific case of abortion, he asserts that referrals from an objecting provider can cause a woman psychological distress, and that objection may limit a woman's access as there may be few other available providers. Diniz [15] maintains that the private realm of religious beliefs should not interfere with public healthcare policy.

Others argue that existing laws need to be clarified and that more regulation is needed to protect the rights of women. The White Paper's authors call on medical organizations to recognize

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their obligations to patients, as well as personal integrity, and therefore call for regulations that will balance these competing claims [1]. Zampas [16] points to the International Federation of Gynecology and Obstetrics' ethical guidelines on conscientious objection, the WHO Safe Abortion Guidelines, the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, and two recent decisions of the European Court of Human Rights as references for ethical and human rights standards. She illustrates the need for clear directives in order to balance the rights of women and the practice of conscientious objection. Johnson *et al.* [17] highlight the WHO Safe Abortion Guidelines and argue that countries should do more to ensure abortion access for women and ensure that conscientious objection is not abused. They stress that regulation of conscientious objection will help protect women's access to safe abortion. They also outline other health system interventions to increase abortion access: make effective contraception widely accessible, train midlevel clinicians in order to increase the number of abortion providers, provide abortion in the outpatient setting, and allow home use of medication abortion. Westeson [18] also references European Court of Human Rights decisions involving conscientious objection and explains why different country-level laws lead to varied outcomes for women. She implores medical professional societies to put forth guidelines, which can influence human rights courts. Heino *et al.* [19] explain the laws across Europe and again argue that the lack of current protection for women prevents some from gaining access to services, particularly in places where the prevalence of conscientious objection is high.

Shaw and Downie [20■■] underscore the confusion resulting from unclear policies regarding conscientious objection and the resultant obstruction to care in Canada, specifically in the northern territories. In Latin America where abortion laws are often restrictive, the prevalence of conscientious objection is highly problematic in those limited cases in which abortion is legally permitted. Russia passed a law in 2012 that allows physicians to conscientiously object to abortion by putting their objection in writing [21].

Faúndes *et al.* [22] explore the reasons behind conscientious objection, the consequences for women, and propose next steps for the FIGO Working Group for the Prevention of Unsafe Abortion. These include dispelling the myth that improved access increases the abortion rate, and promoting and normalizing the ethical principles that the primary duty of a physician is to provide benefit and prevent harm in an effort to break the stigma around abortion.

In Italy the prevalence of conscientious objection to abortion is high and prevalence of objection has been increasing for more than a decade [23■■]. Almost 70% of gynecologists, who are the sole legal providers of abortion, have registered as objectors. However, the criminal prosecution of almost 200 gynecologists is currently underway for claiming conscientious objection in their public sector jobs, but then performing unauthorized abortions in their private practices. One study analyzed Ministry of Health data in Italy and showed that the high prevalence of conscientious objection is leading to longer waits for abortion [24■■].

Kantymir and McLeod [25■] propose a regulatory model wherein objectors are required to defend their objection and ensure that their patients receive timely care. The authors feel this requirement will help expose 'morally weak or corrupt norms in healthcare' with regards to conscientious objection [25■]. Gallagher *et al.* [26] examine the dilemmas for pharmacists who object to emergency contraception, given the complexity of current regulations. They argue that guidelines should be consistent and restricted to the following two options: pharmacists should be compelled to dispense, or they can refuse to dispense or refer, and must accept the consequences.

DISCUSSION

As highlighted in this recent literature, the exercise of conscientious objection by clinicians occurs in many different aspects of reproductive healthcare. Conscientious objection appears to be inconsistently practiced by individual providers, witness the Norwegian GPs whose objection varied according to the reason for abortion and the Brazilian obstetrician–gynecologists whose objection varied according to patient characteristics [7■■]. This complexity illuminates the difficulty in defining conscientious objection and illustrates the need to disentangle prejudice from a consistently helpful moral position.

Another example of physicians who framed their bias as conscientious objection are the Brazilian physicians who interrogated rape victims and required unnecessary documentation of rape, and thus created obstacles for these women to abortion care. These providers knew such documentation was not required by law but defended their behavior claiming that it served to verify the truth of the rape allegation. The authors speculate that a physician's religious objection to abortion could cause them to have heightened suspicion of the truth of the rape allegation [7■■].

Italy is a country where physician behavior now constitutes a barrier to legal abortion care.

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Conscientious objection has become the norm, with a resultant lack of providers, and therefore access for Italian women seeking abortion.

Norway serves as a counter example as abortion care has been normalized; abortion is less controversial than euthanasia and circumcision [6■■]. Wide ranging variation in beliefs about conscientious objection in Norway illustrates the importance of context and normative values within that context.

Both authors writing about nurses and midwives who assist in abortion care emphasized the importance of respecting the personal decision and rights of the patients [8■,9■]. International agreements uphold respect for the moral integrity of individual clinicians but concur that patient care must take priority and that the health system is obligated to assure that all patients have access to legal care.

CONCLUSION

Conscientious objection is understudied, complicated, and appears to constitute a barrier to care, especially for certain subgroups. Clinicians treating adolescents who seek abortion may conflate conscientious objection with disapproval of parentally unsanctioned premarital sexual activity. The international community has stated, 'Governments should ensure the protection and promotion of the rights of adolescents, including married adolescent girls, to reproductive health education, information and care' [27]. Adolescents are a vulnerable group and need protection of their basic human rights and their access to comprehensive reproductive healthcare. The degree to which conscientious objection has compromised sexual and reproductive healthcare for adolescents is unknown.

Yet although physicians care about their own individual ethics, they also care about their obligations to patients and to the highest standards of evidence-based care. They are thus well positioned to help society negotiate the tensions between honoring the rights of objectors, limiting their impact on others, and honoring the rights of patients and those of willing providers. Physicians can contribute this multiangled perspective to balancing these competing interests, advancing medical integrity and reproductive health.

Acknowledgements

None.

Financial support and sponsorship

None.

Conflicts of interest

There are no conflicts of interest.

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Exhibit 383

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doi:10.1093/fampra/cmi113
Family Practice Advance Access published on 13 February 2006

Potential barriers to the use of health services among ethnic minorities: a review

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Scheppers E, van Dongen E, Dekker J, Geertzen J and Dekker J. Potential barriers to the use of health services among ethnic minorities: a review. *Family Practice* 2006; **23**: 325–348.

Background. Ethnic minority patients seem to be confronted with barriers when using health services. Yet, care providers are often oblivious to these barriers, although they may share to some extent the burden of responsibility for them. In order to enlighten care providers, as to the potential pitfalls that may exist, there is a need to explore the different factors in the creation of the barriers.

Objective. Therefore, the objective of this paper is to present an overview of the potential barriers and the factors, which may restrict ethnic minority patients from using health services, according to the literature available.

Methods. Articles published from 1990 to 2003 were identified by searching electronic databases and selected through titles and abstracts. The articles were included if deemed to be relevant to study health services use by ethnic minorities, i.e. the different factors in the creation of a barrier.

Results. There were 54 articles reviewed. They reported on studies carried out in different countries and among different ethnic minorities. Potential barriers occurred at three different levels: patient level, provider level and system level. The barriers at patient level were related to the patient characteristics: demographic variables, social structure variables, health beliefs and attitudes, personal enabling resources, community enabling resources, perceived illness and personal health practices. The barriers at provider level were related to the provider characteristics: skills and attitudes. The barriers at system level were related to the system characteristics: the organisation of the health care system.

Conclusion. This review has the goal of raising awareness about the myriad of potential barriers, so that the problem of barriers to health care for different ethnic minorities becomes transparent. In conclusion, there are many different potential barriers of which some are tied to ethnic minorities. The barriers are all tied to the particular situation of the individual patient and subject to constant adjustment. In other words, generalizations should not be made.

Keywords. Potential barriers, health services use, ethnic minorities.

Introduction

Populations in western industrialized countries become increasingly multi-ethnic as a result of the internationalization of the market place and the successive opening of borders.[1] The rise in migration is, contrary to popular belief, not a new phenomenon. It has taken on many forms, from labour migration in countries like the UK and France to the immigration of settlers in the USA, Canada and Australia. There has been the migration of refugees fleeing from hostilities and of asylum seekers seeking refuge in countries such as Sweden and the

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Received 11 January 2005; Accepted 28 December 2005.

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United States.[2–4] In receiving countries, newly arrived migrants have often been concentrated in poor, low status regions of major cities. They usually live in low standard accommodation and under less favourable living conditions and health.[5] The World Health Organizations objective of 'Health for all by the year 2000' suggests that we should ensure that 'ethnic minorities' also have equal access to health services, regardless of their standing in society.[1] Equal access to health care is a fundamental human right.[6]

Although migration is the norm and health care a natural right of every individual, ethnic minority patients seem to be confronted with barriers when using health services. Their use of health services is also lower, when compared with their non-immigrant counterparts.[4,7–10] Yet, care providers often are oblivious to these barriers, although they may share to some extent the burden of responsibility for them. Most of their attention is directed towards language discordance and cultural differences, which can lead to biased or false conclusions.[1] Language and culture are by no means the only factors that may act as a barrier. In order to enlighten care providers, as to the potential pitfalls that may exist, there is a need to explore the different factors in the creation of the barriers. Therefore, the objective of this paper is to present an overview of potential barriers and the factors, which may restrict ethnic minority patients from using health services, according to the literature available.

Methods

Definitions

Potential barrier. If patients' expectations or health beliefs are not in line with what is proposed by the care provider, they may experience barriers to the use of health services. When the end result is not in line with the treatment received, barriers may also come into existence. A barrier, as it is used in this paper, restricts the use of health services. It is a wall or limit that prevents people from going into an area or doing what they want to do. The lack of health insurance, for example, can prevent people from using health services. The limitation to speak the local language, for example, can prevent people from communicating adequately with their physician.

A potential barrier is a barrier that only afflicts us under certain circumstances or only afflicts some of us, mostly the socioeconomic vulnerable ones. As we will see, a barrier that only afflicts us under certain circumstances is, for instance, irregular public transport. If there is no need to use the public transport, irregular public transport does not act as a barrier (e.g. to car owners). If public transport is needed, irregular public transport acts as a barrier. A barrier that only afflicts some of us is for instance health insurance coverage. For the socioeconomic vulnerable ones, the price of health services can act as a barrier if a health service is not covered by their health insurance, or is only partly reimbursed.

Use of health services. The use of health services is defined as the process of seeking professional health care and submitting oneself to the application of regular health services, with the purpose to prevent or treat health problems. In this paper we focus on all possible barriers in relation to this process. Although the decision to use health services is stated to be an individual choice, we imagine that these choices are mostly framed in the social context through cultural, social and family ties; especially for ethnic minorities.[11] Many ethnic minorities first try to solve health problems on their own, or in the circle of family members and friends. If one does not succeed, the help of a 'great' man in the community is usually called upon (preachers, spiritual healers). The help of regular health services is often only called upon after an escalation of the complaints of illness.[12]

Ethnic minority. The concept 'ethnic minority' is broadly defined in this paper. It refers to many different ethnic groups of extreme heterogeneity. The concept is used for groups that share minority status in their country of residence due to ethnicity, place of birth, language, religion, citizenship and other (cultural) differences. It sets apart a particular group in both numerical and (often) socioeconomical terms. Members of these groups are considered to practice different cultural norms and values from the majority culture and (often) a different mother tongue.[1,4,13] Ethnic minorities vary in duration of stay and acculturation and between different ethnic minorities there exist different degrees of access to the majority culture. The concept 'ethnic minority' includes groups from newly arrived immigrants to (minority) groups that have been a part of a country's history for hundreds of years. Examples of the second type of these groups are the Aboriginals in Australia or American Indians in the USA. They are in fact the original inhabitants of the country.

Patient, provider and system level. Barriers can present themselves to patients, health care providers and the organization of health services, in other words the health care system itself. Therefore we say that barriers occur at patient level, provider level and system level. By patient level we mean related to patient characteristics, such as sex, ethnicity, income, etc. By provider level we mean related to provider characteristics, such as sex, skills, attitudes, etc. By system level we mean related to system characteristics, such as policy, organizational factors, structural factors, etc.

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Search and selection

Research question. The research question of the literature research was 'What is known about the factors that hinder the use of health services among ethnic minorities?'

Search strategy. To answer the research question, articles were identified by searching the databases Medline, Embase, Psycinfo, Cinahl and Web of Science. The searches were limited to articles published between 1990 and 2003 and performed by the first author of this paper in September 2003. The databases were searched using keywords that covered the domains 'health services', 'use' of health services and 'ethnic minorities'. The different keywords used to search are presented in the appendix.

Selection. The articles were selected through titles and abstracts by the first author of this paper. The selection was based on inclusion and exclusion criteria. The results of the search were completed by tracking references from studies already included.

Inclusion criteria. The articles had to report on the results of research and contain information pertaining to migrants, health care and factors that may hinder health services use. The following inclusion criteria were employed in this study. Publication date: 1990–2003. The articles had to be published between 1990 and 2003. Type of population: ethnic minorities. The articles had to report on the use of health services by ethnic minorities. Type of study: all types of health research. The study of potential barriers to the use of health services among ethnic minorities is still a relatively uncharted course. Therefore, not only articles on quantitative research were included, but also articles on qualitative research, as well as literature reviews and a few published essays too. The studies had to report on health research, i.e. the use of health services. Type of outcome measures: potential barriers and the factors. Outcome measures had to be factors that hinder the use of health services and that can act as a barrier.

Exclusion criteria. The following exclusion criteria were employed in this study. Type of study: summaries. Articles in summary form only were not included in this study. Type of intervention: health education. Articles on health education were excluded.

Analysis

Quality assessment. Due to the heterogeneity of the included studies, the studies are not sufficiently comparable to each other. Therefore, the assessment of the methodological quality of each study seemed not appropriate to us. Although the literature search, the selection of studies and the extraction of data were done systematically, the review cannot to be compared with a systematic review; there was no quality assessment done. The aim of the study was to explore and identify as many (potential) barriers as possible. Also, the extracted (potential) barriers are not exclusively evidence-based phenomena.

Data extraction. Data extraction of the articles was compiled by the first author of this paper. The first author read the available titles and abstracts identified in the different database searches, as well as the selected articles. The articles were screened for the different variables as presented by the theoretical framework used.

Theoretical framework. We used Andersen's behaviour model of health services use as the theoretical framework.[14–16] The aim of using the Andersen-model is to reveal conditions that hinder the use of health services. The model is a valuable tool to select, identify and sequence the relevant variables in the process of health services use.

In the Andersen-model the use of health services is related to four main components: (i) 'Population characteristics'; (ii) 'Environment'; (iii) 'Health Behaviour' and (iv) 'Health outcomes'. (i) Population characteristics consists of 'predisposing characteristics' (demographic variables, social structure variables and health belief variables), 'enabling characteristics' (personal or family enabling resources, community enabling resources) and 'need characteristics' (individual perceived need, professional evaluated need). (ii) Environment consists of 'external environment' (physical, political and economic) and 'health care system' (policy, resources and organization). (iii) Health behaviour consists of 'use of health services' (type, site, purpose and time interval) and 'personal health practices' (do-it-yourself remedies). (iv) Health outcomes consist of 'consumer satisfaction' (convenience, availability, financing, provider characteristics and quality), health status' and 'perceived health status'.[14–17]

The Andersen-model was also used by us to help arrange the potential barriers. We present the barriers under the subject headings of the Andersen-model. We condensed the subject headings into three main groups which we have called 'Patient level', 'Provider level' and 'System level'. By doing so, the myriad of potential barriers is easier to oversee.

Results

Out of the 309 titles and abstracts, a total of 56 articles were selected for inclusion. Finally, 54 articles were reviewed, as 2 of the articles were not available through Dutch university libraries.

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The articles were classified into four different types of studies: Quantitative studies ($n = 28$); Qualitative studies ($n = 10$); Combined studies ($n = 6$), that combine quantitative and qualitative methods and Other studies ($n = 8$), like literature studies and essays. The reviewed studies were carried out in 11 different countries and a great number of ethnic minorities were involved. Different types of health services were studied. The different types were Health care in general; Preventive care; Dental care; Prenatal care; Primary health care; Care for the children; Care for the elderly and Mental health care.

A great number of potential barriers were identified. The identified potential barriers referred to population or patient characteristics (i.e. predisposing characteristics, enabling characteristics and need characteristics): health behaviour (i.e. patients' personal health practices); health outcomes (i.e. provider characteristics) and environment (i.e. the organizational factors of the health care system). The barriers are presented in three groups of barriers: (1) potential barriers at patient level; (2) potential barriers at provider level and (3) potential barriers at system level. An inventory of the potential barriers can be found in Table 1. The characteristics of the articles reviewed are summarized in Table 2.

Potential barriers at patient level

Demographic variables

Age. Being of younger age can act as a barrier for non-immigrant as well as immigrant patients.[9] Being younger than 24, acted as a potential barrier to ethnic minority gravida's beginning prenatal care in the later stages of pregnancy.[18]

Gender. Being a male or a female can act as a barrier for non-immigrant and immigrant patients.[9] Males and females have many similar life experiences and opportunities, but as they occupy different positions in the home and in the labour market they are exposed to different health risks.[19] Being an ethnic minority male and having a low acculturation level together with some kind of social support, acted as a potential barrier to the (hypothetical) notion of entering a nursing home.[20]

Marital status. Being unmarried can also act as a barrier, although marital status may be less of a barrier than a predictor of need.[8,20,21] Being married was one of the most influential determinants of health care access among ethnic minority patients. This is the conclusion of an analysis of the relationship between traditional health beliefs and practices, and the access to health care and use of preventive care. The predictive power of marital status was attributed to the fact that pregnancy and childbirth provide a point of entry into health care.[21]

Social structure variables

Ethnicity. One's ethnic background can act as a barrier and this may account for the less frequent use of more specialized services.[22]

Education. Low education can act as an barrier to the access of health care, health publicity and the measures it incorporates.[8,23,24]

Social class and economic status. Lower social and socioeconomic status can act as a barrier to health care and health advertising.[9,21,23,25–27] There can be a communication breakdown due to the difference in social status between the ethnic minority patient and care provider. These problems indeed have a disadvantageous effect on the patient's perceptions towards the use of services provided.[25]

Living conditions. Insecure living conditions can act as a barrier, especially in the case of pregnant women and their foetuses. Signs of insecurity include having to live in slum-like dwellings where there are drugs and crack houses within the neighbourhood. Even with burglar bars on windows and doors, the sense of insecurity in these environments is still very much apparent. If prenatal clinics are situated in such unsafe environments, the attendance figures may be in serious jeopardy. To raise attendance figures protection is needed to provide a safe and secure environment.[28]

Life style. Poor state of health due to drug addiction can be seen as a barrier to prenatal health care. Prostitutes and pregnant drug users often do not get prenatal care because of their plight. They are receiving assistance for substance abuse and this help is not offered in prenatal clinics.[28]

Eating habits that do not conform with medical dietary recommendations, like the use of traditional dishes, can also act as a barrier. People using high fat and high sugar in traditional diets may not accept a diet that is low in fat and low in sugar as they find it unappetizing because of its tastelessness.[29]

Family and social support. Lack of family and social support can act as a barrier to health care. Clearly family support is advantageous in providing emotional support to the (ethnic minority) patient.[30] Clearly kinship can furnish assistance, companionship and of course stability,[28] even though family support can be viewed only in an unconstructive way when collective family responsibilities take precedent to individual needs.[29,30]

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TABLE 1 *Inventory of potential barriers to the use of health services among ethnic minorities*

Patient level	Provider level	System level
Demographic variables	Provider characteristics	Medical paradigm[44]
Age[9,18]	Medical procedures and practices[9,18,37,50,62]	Consumerist approach[42]
Gender[9,19,20]		Organisational factors
Marital status[8,20,21]	Orientation on immediate complaint[42]	Referral system[10,38]
Social structure variables		Intake procedure and opening hours[27,35,62]
Ethnicity[22]	Program orientation and ethnic matching[40]	Consultancy appointments and waiting time[7,8,10,12,18,24,28,31,34,35,37]
Education[8,23,24]	Skills[1,8,27,28,31,35,36,48,63,64]	The length of consultation and treatment[7,18,27,28,35]
Social class and economic status[9,21,23,25–27]	Behaviour[7,8,27,28,35–38,44,48,64]	Printed materials and other media forms[38]
Living conditions[28]	Communication style[62]	Translation[7,30,35,62]
Life style[28,29]	Style of providing information[38]	
Family and social support[28–30]	Client approach[30,51]	
Culture[31]	Bilingualism[40,47,62]	
Duration of stay[8,11,12,26,32–34]	Translation[23,43]	
Acculturation[10,20,24,32,35,36]	Cultural knowledge[9,25,30]	
	Family involvement[25,30,51]	
	Religion/spirituality[10,28]	
	Parallel sets of belief and practices[9,26–28,36,49]	
Local language skills[1,8–10,26,28,30,31,33–35,37–45]		
Communication[42,43,46,47]		
Translation[9,23,35,38,39,42,43]		
Health beliefs and attitudes		
Time orientation and concepts of achievement[8,10,30]		
Values concerning health and illness[5,8–10,12,21,26–28,36,44,48–53]		
Perceptions and attitudes towards health services and personnel[9,18,24,26,27,30,35,38]		
Knowledge about physiology and disease[9,29,30,37,50]		
Personal enabling resources		
Immigration rules[9,25,30,35]		
Income/financial means[8,10,24,25,28–31,35,37,38,54–57]		
Entry to health insurance[25,37]		
Health insurance benefits[8,9,18,21,24,25,35,55,57,58]		
Sources of advise and regular source of care[8,21,30]		
Knowledge of health services and how to use them[27,28,31,37,39,44,49,59,60]		
Available time and stress constraint[9,10,29,35,37,50]		
Community enabling resources		
Availability and delivery of services[8,54]		
Price of health services[29,35,38]		
Transportation and travel time[8,9,10,18,28,31,35,37,54]		
Perceived illness		
Perceived cause[31]		
Personal health practices		
Traditional remedies and self-treatment[8,10,21,28,30,51,60,61]		

Table 1 shows an inventory of potential barriers as indicated by the literature reviewed. The objective of the review was the presentation of an overview of potential barriers to the use of health care services among ethnic minorities.

The potential barriers identified are presented under the subject headings of the Andersen's model of health services use. We condensed the subject headings into three main groups which we have called: 'Patient level', 'Provider level' and 'System level'. By doing so, the myriad of potential barriers is easier to oversee.

Potential barriers at patient level incorporate: demographic variables, social structure variables, health beliefs and attitudes, personal enabling resources, community enabling resources, perceived illness and personal health practices. Potential barriers at provider level incorporate: provider characteristics. Potential barriers at system level incorporate: organisational factors.

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TABLE 2 *Characteristics of the articles reviewed: health care sector, country, ethnic minority, level of occurrence and potential barrier, type of study, first author and reference*

HC sector	Country	Ethnic minority	Level of occurrence, potential barrier	Type of study	First author	Ref
HCG	Australia	Thai migrant women	Patient level Local language skills Translation Perceptions and attitudes towards health services and personnel Income/financial means Price of health services Provider level Behaviour Style of providing information System level Referral system Printed materials and other media forms	Combined study	Jirojwong (2002)	38
	Canada	Immigrants: born outside Canada or whose mother tongue (still understood) was neither French nor English	Patient level Local language skills Provider level Skills	Quantitative study	Blais (1999)	1
		Newcomers: Arab 42%; Spanish 19%; Polish 15%; Chinese 6%; East Indian 2%; Vietnamese 2%; Eastern Europe/South and Central America/Africa 14%	Patient level Duration of stay Local language skills System level Consultancy appointments and waiting time	Quantitative study	Matuk (1996)	34
	Germany	Turkish (im)migrant women	Patient level Values concerning health and illness	Other study	Berg (1997)	52
	The Netherlands	First generation immigrant groups: Surinamese, Netherlands Antilleans, Turkish and Moroccan people	Patient level Ethnicity	Quantitative study	Stronks (2001)	22
	New Zealand	Cambodians	Patient level Social class and economic status Duration of stay Local language skills Values concerning health and illness Perceptions and attitudes towards health services and personnel Provider level Parallel sets of beliefs and practices	Quantitative study	Cheung (1995)	26
	Switzerland	(Im)migrant patients in general	Patient level Local language skills Communication Translation Provider level Translation	Combined study	Singy (2003)	43

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	Thailand	Khmer and Burmese labour migrants	Patient level Traditional remedies and self-treatment	Quantitative study	Entz (2001)	61
HCG, PC	UK	Different ethnic groups: Carribeans, African Carribeans, West/South Africans, East Africans, South Asians, Indians, Indians form the subcontinent, Pakistanis, Bangladeshis, British Asians, African Asians, Indian Asians, Chinese, Scots, Irish, Europeans	Patient level Culture Local language skills Income/financial means Knowledge of health services and how to use them Transportation and travel time Perceived illness Provider level Skills System level Consultancy appointments and waiting time	Other study	Smith (2000)	31
HCG	UK	Migrants in general	Patient level Values concerning health and illness Provider level Skills Behaviour	Other study	Eshiett (2003)	48
	USA	(Im)migrants in general	Patient level Age Gender Social class and economic status Local language skills Translation Values concerning health and illness Perceptions and attitudes towards health services and personnel Knowledge about physiology and disease Immigration rules Health insurance benefits Available time and stress constraint Transportation and travel time Provider level Medical procedures and practices Cultural knowledge Parallel sets of belief and practices	Quantitative study	Garret (1998)	9
		American Indians and Alaska natives	Patient level Income/financial means Availability and delivery of services Transportation and travel time	Quantitative study	Cunningham (1995)	54
		Blacks, other races, Hispanic origin	Patient level Duration of stay	Quantitative study	Leclere (1994)	11

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TABLE 2 *Continued*

HC sector	Country	Ethnic minority	Level of occurrence, potential barrier	Type of study	First author	Ref
		American Latino immigrants, adults: Hispanic Americans, Cuban Americans, Mexican Americans, Puerto Rican Americans, South or Central America Americans	Provider level Bilingualism	Quantitative study	Pérez-Stable (1997)	47
		American Latino children	Patient level Marital status Education Duration of stay Local language skills Time orientation and concepts of achievement Values concerning health and illness Income/financial means Health insurance benefits Source of advise and regular source of care Availability and delivery of services Transportation and travel time Traditional remedies and self-treatment Provider level Skills Behaviour System level Consultancy appointments and waiting time	Other study	Flores (1998)	8
		Mexican American: children of Mexican ancestry	Patient level Education Acculturation Perceptions and attitudes towards health services and personnel Income/financial means Health insurance benefits System level Consultancy appointments and waiting time	Quantitative study	Smith (1996)	24
		African Americans, Latinos, Asians and other	Patient level Health insurance benefits	Quantitative study	Mueller (1998)	58
		Caribbean immigrant adolescents	Patient level Duration of stay Acculturation	Quantitative study	Sonis (1998)	32

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		Working poor immigrant women; countries of origin: Haiti, Jamaica, Dominican Republic and the Soviet Union	Patient level Income/financial means Health insurance benefits	Quantitative study	Weitzman (1992)	57
		Chinese immigrants	Patient level Values concerning health and illness Knowledge of health services and how to use them Provider level Parallel sets of belief and practices	Combined study	Ma (1999)	49
		Hmong (Southeast Asian) patients (former refugees)	Provider level Behaviour System level Consultancy appointments and waiting time Length of consultation and treatment Translation	Qualitative study	Barrett (1998)	7
		Cambodian, Laotian and Navajo cultures	Patient level Acculturation Local language skills Time orientation and concepts of achievement Values concerning health and illness Income/financial means Available time and stress constraint Transportation and travel time Traditional remedies and self-treatment Provider level Religion/spirituality System level Referral system Consultancy appointments and waiting time	Other study	Panos (2000)	10
		Vietnamese	Patient level Marital status Social class and economic status Values concerning health and illness Health insurance benefits Sources of advise and regular source of care Traditional remedies and self-treatment	Quantitative study	Jenkins (1996)	21
		Medicare beneficiaries	Patient level Income/financial means Health insurance benefits	Quantitative study	Gornick (1996)	55
MHC	Germany	Turkish migrants	Patient level Local language skills	Quantitative study	Grube (2001)	41
		Turkish families	Patient level Knowledge of health services and how to use them Traditional remedies and self treatment	Qualitative study	Schepker (1999)	60

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TABLE 2 *Continued*

HC sector	Country	Ethnic minority	Level of occurrence, potential barrier	Type of study	First author	Ref
	The Netherlands	Surinamese, Netherlands Antillean, Turkish and Moroccan women immigrants	Patient level Social class and economic status Values concerning health and illness Perceptions and attitudes towards health services and personnel Knowledge of health services and how to use them Provider level Skills Behaviour Parallel sets of belief and practices System level Intake procedures and opening hours Length of consultation and treatment	Quantitative study	Have (1999)	27
		Surinamese outpatients	Patient level Duration of stay Values concerning health and illness System level Consultancy appointments and waiting time	Combined study	Knipscheer (2001)	12
	Sweden	Turkish born immigrant women	Patient level Values concerning health and illness	Qualitative study	Bäärnhielm (2000)	5
	UK	Asian people of Pakistan and Bangladesh origin	Patient level Local language skills Values concerning health and illness Knowledge of health services and how to use them Provider level Behaviour System level Medical paradigm	Combined study	Hatfield (1996)	44
		Different ethnic groups; the most commonly reported aggregated categories were: Blacks, South Asians and Whites	Provider level Skills Behaviour	Other study	Bhui (2003)	64
	USA	Blacks	Patient level Values concerning health and illness	Quantitative study	Millet (1996)	53
		Low income Latinos	Patient level Values concerning health and illness Traditional remedies and self-treatment Provider level Patient approach Family involvement	Other study	Miranda (1996)	51

		Hispanics, African Americans, Asian and other ethnic groups	Patient level Local language skills Provider level Program orientation and ethnic matching Bilingualism	Quantitative study	Snowden (1995)	40
DC	UK	Asians	Patient level Local language skills	Quantitative study	Williams (1995)	45
PC	USA	American Latino immigrants, adults: Hispanic Americans, Cuban Americans, Mexican Americans, Puerto Rican Americans, South or Central America Americans	Patient level Acculturation Local language skills Translation Perceptions and attitudes towards health services and personnel Immigration rules Income/financial means Health insurance benefits Available time and stress constraint Price of health services Transportation and travel time Provider level Skills Behaviour System level Intake procedures and opening hours Consultancy appointments and waiting time Length of consultation and treatment Translation	Other study	Diaz (2002)	35
		Low income Hispanic immigrant women	Patient level Social class and economic status Immigration rules Income/financial means Entry to health insurance Health insurance benefits Provider level Cultural knowledge Family involvement	Quantitative study	Jones (2002)	25
PNC	Canada	First nation tribes	Patient level Values concerning health and illness Knowledge about physiology and disease Available time and stress constraint Provider level Medical procedures and practices	Qualitative study	Sokoloski (1995)	50
PNC, G&O,	Germany	Turkish (im)migrant women	Patient level Education Social class and economic status Translation Provider level Translation	Other study	David (1997)	23

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TABLE 2 *Continued*

HC sector	Country	Ethnic minority	Level of occurrence, potential barrier	Type of study	First author	Ref
PNC	UK	Asians originating from the Indian subcontinent	Patient level Acculturation Values concerning health and illness Provider level Skills Behaviour Parallel sets of belief and practices	Combined study	Woollett (1995)	36
	USA	Low income Hispanic immigrant women	Patient level Age Perceptions and attitudes towards health services and personnel Health insurance benefits Transportation and travel time Provider level Medical procedures and practices System level Consultancy appointments and waiting time Length of consultation and treatment	Qualitative study	Byrd (1996)	18
		African Americans	Patient level Living conditions Life style Family and social support Local language skills Values concerning health and illness Income/financial means Knowledge of health services and how to use them Transportation and travel time Traditional remedies and self-treatment Provider level Skills Behaviour Religion/spirituality Parallel sets of belief and practices System level Consultancy appointments and waiting time Length of consultation and treatment	Qualitative study	Morgan (1996)	28
		African American and Mexican American mothers and their newborns	Patient level Local language skills Knowledge about physiology and disease Income/financial means Entry to health insurance	Quantitative study	Gray (1995)	37

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			Knowledge of health services and how to use them Available time and stress constraint Transportation and travel time Provider level Medical procedures and practices Behaviour System level Consultancy appointments and waiting time			
		Hmong women clinic patients	Provider level Medical procedures and practices Communication style Bilingualism System level Intake procedures and opening hours Translation	Qualitative study	Spring (1995)	62
PHC	Israel	Soviet immigrants	Patient level Local language skills Communication Translation Provider level Orientation on immediate complaint System level Consumerist approach	Qualitative study	Remennick (1998)	42
	Netherlands	Ethnic minority parents who visited the GP with a child-patient: the parents were born in different countries: Morocco, Turkey, Surinam, Pakistan, Cape Verdi, Bosnia etc.	Patient level Communication	Quantitative study	Wieringen (2002)	46
	UK	Chinese	Patient level Local language skills Translation Knowledge of health services and how to use them	Quantitative study	Watt (1993)	39
HC	Switzerland	(Im)migrant patients in general	Provider level Skills	Quantitative study	Perron (2003)	63
	USA	Blacks	Patient level Life style Family and social support Knowledge about physiology and disease Income/financial means Available time and stress constraint Price of health services	Qualitative study	El-Kebbi (1996)	29
		American Latino immigrants, adults: Hispanic Americans, Cuban Americans, Mexican Americans, Puerto Rican Americans, South or Central America Americans	Patient level Family and social support Local language skills Time orientation and concepts of achievement	Qualitative study	Lipton (1998)	30

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			Perceptions and attitudes towards health services and personnel Knowledge about physiology and disease Immigration rules Income/financial means Sources of advise and regular source of care Traditional remedies and self-treatment Provider level Patient approach Cultural knowledge Family involvement System level Translation			
CE	USA	Latinos, the elderly	Patient level Income/financial means	Quantitative study	Wallace (1994)	56
		Korean-Americans	Patient level Knowledge of health services and how to use them	Quantitative study	Moon (1998)	59
		Japanese Americans	Patient level Gender Marital status Acculturation	Quantitative study	McCormick (1996)	20
CC	USA	Culturally diverse children	Patient level Duration of stay Local language skills	Combined study	Tharp (1991)	33

Table 2 shows the characteristics of the articles reviewed.
The objective of the literature review was the presentation of an overview of potential barriers to the use of health care services among ethnic minorities, see Table 1.
Health Care sector: refers to the type of health service studied.
Country: refers to the country where the study was undertaken.
Ethnic minority: refers to ethnic minority studied.
Type of level and potential barrier: refers to the potential barriers as indicated in the articles reviewed and to their level of occurrence. Potential barriers occurred at three different levels: at patient level, at provider level and at system level.
Type of study: refers to the type of study presented in the articles reviewed. The studies are classified into four types of studies: the (1) quantitative study, the (2) qualitative study, the (3) combined study, these are studies that combine quantitative and qualitative methods, and the (4) other study: these are the literature study and the essay.
First Author: refers to the first author and the year the article was published.
Reference: refers to the identification number of the publication presented in the list of References.
Abbreviations: HCG: Health Care in General; MHC: Mental Health Care; DC: Dental Care; PC: Preventive Care; PNC: Prenatal Care; G&O: Gynaecology and Obstetrics; PHC: Primary Health Care; HC: Hospital Care; CE: Care for the Elderly; CC: Care for the Children.

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Culture. Ethnic minority patients' cultural perceptions about symptoms may act as a barrier, as their needs may be differently expressed. Ethnic minority groups may present classical symptoms in a different way, which could result in a missed diagnosis (e.g. the symptoms of a confirmed heart attack). Also, referral rates from a general practice to radiological examinations may be higher, although the outcomes less often report abnormalities. Due to cultural perceptions about symptoms it seems more difficult to arrive at an appropriate diagnosis.[31]

Duration of stay. Duration of stay shows mixed results. Some studies suggest that short stay durations can act as a barrier. They have a disadvantageous effect as it is an important predictor of both health-seeking behaviour and attitudes and strongly effect immigrants' access and volume of care.[11,12,26,32,33] Newcomers are the most in need of education in the utility of health services; especially the most vulnerable, less knowledgeable ones, who have less access to ambulatory care.[12,32,33] They are almost as restricted in their access to health care as those without any health insurance, regardless of their health insurance status.[11] On the other hand, however, other findings report that there is no discernable evidence to support this view.[8,34]

Acculturation. Low level of acculturation can also be restrictive and act as a barrier.[10,20,24,32,35,36] Acculturation or familiarity with western health practices can bring ethnic minority patients to gradually subscribe to western values and practices, along with their own traditional methods of health care.[36] Hypothetically at least, high levels of acculturation are reportedly a powerful predictor for the intention of ethnic minority patients to join long-term health services in the form of nursing homes.[20]

Local language skills. Lack of local language skills can act as a barrier. It is one of the major factors that prohibit the use of health services because it jeopardizes effective communication between ethnic minority patients and health care personnel.[1,8,9,26,28,33,35,37–43] In view of the fact that most messages and instructions are communicated in the local tongue, people may feel embarrassed to seek out services. Conversely they may feel hindered because of their own ineptness at expressing their feelings due to language difficulties and reading ineptitudes.[30,34,39,42] The inability to communicate in what is not their mother tongue inevitably leads to discrimination; due to the lack of a common language they struggle to express their inner feelings, to ask questions or to represent themselves or their families.[10,43,44] This is especially apparent where personnel bypass the patient in question only to communicate instead with a family member.[44] Poor language skills also have an adverse affect on the confidence of the patient. It causes yet additional emotional stress and discomfort to the normal stress that often accompanies medical consultations. Language difficulties can have a detrimental effect upon the patient's ability to comprehend proposed treatments and remedies. They also hamper the physicians' attempts at obtaining vital medical history. Patient's ability to comprehend what is being prescribed is essential to prevent any misunderstandings with regard to obtaining informed consent to medicine and treatments that could present medical risks.[45]

In contrast to all this, it is reported that difficulties due to language are less of a problem than they appear to be. In certain younger ethnic minority groups the ability to speak the local language is high and up to 80% of these groups may be registered with a physician of their own ethnicity, speaking the same mother tongue.[31]

Communication. Ineffective communication is another major barrier in the partnership that should exist between patients and practitioners. The relationship between an ethnic minority patient and a physician is essentially vertical due to social differentials forced by unevenness on linguistic, cognitive and institutional levels. This gulf separates patients and physicians and invariably benefits the physician more than the patient.[43] Parents of ethnic minority child-patients experienced the communication with the physician of their children more negatively, when compared with their socially dominant counterparts. Differences in experience were associated with differences in understanding each other.[46,47] The problem of ineffective communication caused by language difficulties often stays unsolved, leading to frustration and exasperation with patients feeling neglected and detached.[42]

Translation. Attitudes of disapproval towards translation by an interpreter can act as a barrier. For certain ethnic minority patients the interpreters are usually friends, spouse, children or other family members.[39,42] As they too often lack the necessary skills to fully communicate their message, they may fair little better and even sometimes worse than the person they are representing.[39]

The presence of a professional interpreter can improve the quality of the conversation whilst at the same time providing the patient with more lucid explanations of his case scenario, through enhancing patient–provider's face-to-face dialogue and patient rapport.[9,23,35,42,43] There is however suspicion, on the part of some patients, who consider the interpreter to sometimes be economical with the truth. This suspicion arises from the abruptness of dialogue the interpreter conveys when translating from the patient's mother

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tongue. Patients are concerned too about the accuracy of the translation. This dubiousness is exacerbated by the reluctance of patients to reveal to the interpreter confidential information.[38]

Health beliefs and attitudes

Time orientation and concepts of achievement. Future-oriented goals and emphasis on individual achievements and orientation can act as a barrier.[8,10,30] In western societies future-oriented perspective is common place and corresponding with goal settings, and inherent of the western health care system. Examples of setting goals are the planning of care, treatment and discharge; the implementation of quality standards of improvement, etc. The patient's concept of individual achievement is another major factor. In many western societies the role of the family and community takes second place to the individual's needs and objectives. Here, personal ownership is applauded and efforts to realize one's own individual needs and financial security are valued greatly. In other cultures these virtues are viewed differently. One may aim at bringing honour to the family and community through virtues such as generosity, hospitality and conforming to the share.[10]

Values concerning health and illness. Differences in health beliefs between the patient and the provider, i.e. the explanatory model of health, illness and healing methods, can act as a barrier to the detriment of the ethnic minority patients.[5,8–10,12,26–28,36,44,48–53] Ethnic minority patients may have one of the following sets of belief patterns. (i) The belief that western concepts should be holistically defined; a holistic view integrates the body, mind and soul.[44,49,51] (ii) The belief that personal problems and illness are caused by external factors such as family relationships and less by internal influences such as damaging childhood experiences.[12,26,28] (iii) The belief that external causes can be natural or supernatural by nature. Natural in this context means a so-called 'Act Of God' (e.g. the 'tsunami'). By supernatural is meant karma (consequences of good or wrong doings in another life), magic, sorcery and voodoo. (iv) The belief that the concept of (mental) health should include religious/spiritual dimensions as well as bodily dimensions and that mental illness and psychiatric hospital admission is to be avoided (taboo).[27,44,50,51,53] One study suggests that there is no evidence to support the view that traditional belief patterns and practices (the cultural attributes of individuals) have a detrimental effect on the access and use of health services.[21]

Perceptions and attitudes towards health services and personnel. Disapproving perceptions and attitudes with regard to health services and personnel can act as a barrier. This is especially apparent when ethnic minority patients are dubious about the benefits of health services or simply do not see the benefits of it.[9,18,24,26,27,30,35,38] Demand in health services is influenced greatly by consumer tastes and preferences and the desire to purchase health care. Ethnic minority patients may see providers as a rather alien or distant group of people and foster too much respect for medical personnel. This may, in turn, restrain them from asking important questions about medical instructions, etc. and this form of abstract subordination prevents them from questioning authority as they see it.[9,30,35]

Knowledge about physiology and disease. Different understanding of the workings of the body in the case of the food exchange system and the limited ability of some to interpret food labels can also act as a barrier to dietary therapy adherence.[29] Non-recognition of medical needs by the patient is another barrier we have to overcome.[9,30] It may lead to the patient not receiving optimal medical care, e.g. in the case of pregnancy. Women patients of certain ethnic minorities think that prenatal care attendance is only required in case of past or present problems with pregnancy.[50] Non-recognition is also apparent when the reality of pregnancy is overlooked or ignored.[37]

Personal enabling resources

Immigration rules. Not having the right visa's and work permits can act as a barrier as it can have a restricted impact on the use of health services or funding sources.[9,25,30,35] Migrant patients may be fearful that care providers are in some way associated with law endorsement agencies such as the police or government. Consequently these patients are frightened that in the case of chronic sickness their chances of gaining citizenship may be jeopardized, for example, if they were to apply for state or government health funding.[9,25,35]

Income/financial means. Lack of financial resources or abstract poverty can also become a barrier to health care, as economic circumstances affect the life of people and their ability to get care that is not sponsored or indeed provided for.[8,10,24,28–31,35,37,38,54–57] Lack of financial support and extreme poverty is more problematical for immigrants because they are in a much more vulnerable position.[25]

Entry to health insurance. The inability to acquire health insurance can act as a barrier to prenatal optimal care.[37] In order to prove that they qualify for such medical benefits the ethnic minority patient must first provide a significant amount of documentation and personal information. These include proof of residency,

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annual income, along with more contrived documentation and information that inhibits the ethnic minority patient from pursuing his primary objective. Even when ethnic minority patients are eligible for state and government funding, there is still a risk that they may not be fully conversant with the rules and the meaning of eligibility in this particular context.[25]

Health insurance benefits. The lack of adequate health insurance is yet another barrier in seeking or receiving health care treatment.[8,9,18,21,24,25,35,55,57,58] One's insurance status is the determining factor when it comes to entry and volume of care.[58] The lack of health insurance often leaves a person vulnerable and limited when it comes down to paying for health care costs. Even when one is insured, one may experience barriers if certain services are not covered or deductibles are set at unaffordable levels. Among ethnic minority patients the percentage of those uninsured is higher than among the urban white population.[25,58]

Sources of advice and regular sources of care. Nonprofessional advice and the lack of a regular source of care can act as barriers and be restrictive for ethnic minority patients and their children.[8,21,30] Health care practitioners believed their patients to be strongly influenced by recommendations and stories from friends and family members which proved not always to be entirely true. As a result of this, patients resisted the required increase of their medical dosage, based on the misinformed view that their illness might worsen or there could be complications.[30] Having a regular source of care was reported to be one of the strongest indicators of preventive health care use.[21]

Knowledge of health services and how to use them. Unawareness of service availability or a lack of knowledge about the services at one's disposal can act as a barrier to the use of health services.[27,28,37,39,44,49,59,60] When the ethnic minority patient has no knowledge of e.g. the function and availability of primary care workers other than the physician, then the use of primary health care will inevitably be restricted and inappropriate to his or her needs.[39]

It is also reported that the use of screening services (e.g. breast and cervical cancer screening) is low among ethnic minorities, due to a general lack of knowledge about such services and a different understanding of the nature of preventive care. However, as immunization rates are generally high among ethnic minorities, the findings that ethnic minorities lack knowledge about preventive services are contradicted.[31]

Available time and stress constraint. Time limitations because of commitments to work or family can act as a barrier and promulgate stressful situations which prohibit the use of health care or prenatal care for mothers and newborns.[9,10,29,35,37,50]

Community enabling resources

Availability and delivery of services. Regional disadvantages can act as a barrier to the use of health services.[8,54] This rural versus urban and suburban versus inner city conflict means that living in the most remote and most sparsely populated regions, where there are no, or at least very few, medical providers around, inevitably has a detrimental effect on the health services on offer. The availability of outpatient services naturally increases the number of visits by patients.[54]

Price of health services. High medical costs can act as a barrier, as they hinder immigrants that are not yet entitled to subsidies for medical benefits, because they have recently arrived.[38] People may also experience difficulty in the paying of medical bills as a result of having to adhere to certain therapies; for example therapies which they perceive to be of the high cost–high risk category, with recommended meal plans and dietary products.[29,35]

Transportation and travel time. Irregular public transport in both cities and suburbs, combined with prolonged travelling times, is yet another barrier to the health care for ethnic minority patients in their endeavours to seek medical help.[8,9,10,18,28,35,37,54] This is particularly so, without access to a car.[31]

Perceived illness

Perceived cause. Ethnic minorities' different perceptions of the severity of the symptoms can act as a barrier, as the validation of symptoms influences the degree of urgency in seeking care. In comparison with the ethnic majority, some ethnic minorities are more concerned about the symptoms (e.g. chest pain) and more prone to seek immediate care. Also, some ethnic minorities are more prone to seek immediate care for an ailing child.[31] Although this is not a barrier in the obvious sense; it affects the workload of the care provider.

Personal health practices

Traditional remedies and self-treatment. The do-it-yourself home remedy treatments and traditional medicine practices hindering the acceptance of health services by ethnic minority patients can act as a barrier.[8,10,28,30,31,60,61] One study reported that no evidence was found to suggest that traditional health beliefs and practices had a detrimental effect on the access and use of preventive health services.[21]

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Potential barriers at provider level

Provider characteristics

Medical procedures and practices. Intrusive medical procedures and standard practices applied with insensitivity to patients needs can act as a barrier to the use of health services.[9,18,37,50,62] The performing of certain medical tests and examinations can act as a barrier when ethnic minority patients are frightened or start to fear the unknown.[37] Female patients may be embarrassed with a physical examination, especially if performed by (several) male physicians. Pelvic and vaginal examinations cause the maximum amount of embarrassment and shame.[18,50,62]

Orientation on immediate complaint. Orientation focusing on the immediate complaint alone can be experienced as a barrier to the treatment of health problems. The physician in the home country of ethnic minority patients may assess his patient in much more of a holistic manner. His assessment explores the family ramifications along with the social context and other health problems that may prevail. To supplement conventional treatment, referrals may also include resorts where mineral waters, sulphur baths and natural healing resources are used.[42]

Program orientation and ethnic matching. Treatment programmes that serve a relatively small proportion of minority clients and the absence of ethnic matching of patient and provider can act as a barrier. Minority-serving programmes and ethnic matching of patient and care provider can make care more accessible to ethnic minority patients. Participation in ethnic minority oriented programs, in comparison with generic programs, resulted in fewer (emergency) service visits. So did ethnic matching of patient and care provider, in comparison with patients who were unmatched on the basis of ethnicity and language.[40]

Skills. Weak communication skills and incorrect practices can act as a barrier.[1,8,27,28,31,35,36,48,63,64] If the physician is not able to arrive at the correct diagnosis, the outcome of the consultation may be inappropriate. The outcome is influenced by patient characteristics (including social class) and provider characteristics. It is not easy to arrive at a correct diagnosis as the cultural perceptions about symptoms may differ, as we have discussed under 'Culture'.[31]

False perceptions by providers can probably result in the ethnic minority patient not receiving pain medication for long bone fractures and follow-up appointments, or referrals from emergency department visits.[35] There may also be a tendency of the primary care physician to refer the patient more quickly to a specialist if it becomes difficult to diagnose the concerns of the ethnic minority patient.[1] Incorrect care for children of ethnic minorities included suboptimal management plans, decreased likelihood of receiving prescriptions, reduced screening and missed possibilities for vaccinations.[8]

People from certain ethnic minority groups traverse more complex pathways to specialist mental health services, as opposed to people from other ethnic minority groups or the ethnic majority. Some of these differences could be explained by variation in primary care assessments or primary care involvement. These patients are less likely to be referred to specialist services due to the unlikelihood of recognizing a psychiatric problem.[64] Also, the labelling of problematical behaviour and ways to manage the behaviour showed that there were significant differences.[48] These differences in assigning diagnostic labels and referring patients caused ethnic differences in the use of mental health services.[35]

Behaviour. Discourteous care and stereotypical attitudes towards ethnic minority patients can act as a barrier and have a detrimental effect.[7,8,27,28,35–38,44,64] Because ethnic minority patients do not often speak the language fluently they are sometimes treated differently to other patients.[35] Studies indicate the use of racially explicit language by bad-mannered staff, whose hostile attitudes are obviously influenced by the social and ethnic status of those in their care.[8,35,37,38,44,48]

Discrimination can also act as a barrier, as it has a detrimental effect on mental health (discrimination combined with perceived discrimination). It places the discriminated ethnic minority group at higher risk and perhaps more frequent use of mental health services. Some ethnic minority groups on mental health in-patient units are four times more likely to be admitted compulsorily than the ethnic majority. This finding is consistent with research in forensic and prison services. Here, less satisfaction or fear with the mental health services could be the reason. Well-recognized sources of inequalities are local variations in clinical practice and service provision. Contextual effects (e.g. lower ethnic density) can lead to higher rates of schizophrenia, requiring greater service use. Some ethnic minority groups were more likely to be in contact with mental health services than members of the ethnic majority. The reason could be the effective delivery of necessary care or the care provider's anxieties about perceived risk.[64]

Communication style. The authoritative communication style of the care provider can act as a barrier. The confrontational way in which health care personnel sometimes approach the ethnic minority patient can result in shame and discomfort, for example, when routine references are made about missed appointments and other forms of non-compliance. Another example

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is the fear factor engendered by unsympathetic staff that if one did not attend obstetric clinics, then forthcoming delivery assistance maybe withheld.[62]

Style of providing medical information. The undiplomatic style of conveying information and the way it is expressed can act as a barrier. Disease prognosis which is conveyed in a direct manner and the use of medical terminology can cause discomfort to the ethnic minority patient.[38]

Patient approach. Impersonal patient approach can act as a barrier. For certain groups of ethnic minority patients a very formal and dispassionate approach by the care provider can deter them from using the health care facilities available. Furthermore, recruiting and retaining participants into treatment outcome studies are hindered too. These patients have come to expect a dignified, personal and warm approach from health care professionals. This includes the use of formal language, greetings and titles. For them a dignified and personal approach encompasses sympathy and respect particularly for male figures as well as older adults in general. They themselves seem to appreciate such an approach and respond warmly, whilst at the same time showing great respect for the professionals that are treating them.[30,51]

Bilingualism. Being bilingual without the skills to fully articulate ones views can act as a barrier. Bilingual physicians face substantial language difficulties that can lead to a communication breakdown.[47] Although some physicians are able to care for patients without translators, clinical interaction about complex issues requires advance levels of language fluency for an effective patient–physician communication. Language, together with ethnicity matching of patient and physician, was found to reduce emergency service visits.[40,62]

Translation. Care providers too are not over enamoured with the role of translators. The vast majority of care providers prefer a word-for-word translation and only a small minority prefer the interpreter to orientate on the content of the consultation. For them, cultural aspects in the definition of somatic and psychiatric troubles are substantial.[43] Intercultural patient–provider communication usually leads to unsatisfactory *ad hoc* arrangements.[23]

Cultural knowledge. Lack of cultural knowledge can act as a barrier. Cultural knowledge about, e.g. traditional family patterns and values, is regarded as essential to the provision of health promotion and preventive care.[9,25,30]

Family involvement. Neglecting the influence of the family through non-involvement can act as a barrier, because some ethnic minority patients foster strong and traditional family values.[25,30,51] Traditional family patterns include immediate family and extended family members. For these families the individual is less important than the family, which is central to the family members. Strong bonds of loyalty and commitment to a collective responsibility hold these families together. All family members are duty bound to retain this status quo throughout their lives. Within the hierarchical nature of a traditional family pattern it is usually the father who is the most powerful family member. He makes most of the major decisions and provides the financial and emotional stability, thus protecting the family from potential danger. Therefore, he should be included in discussions about the treatment of other family members.[30,51]

Religion/spirituality. Denying the aspect of spirituality and religion for some (ethnic minority) patients can act as a barrier. These influences can greatly affect the well-being of people.[10,28] They were reported to be an essential element in the lives of certain migrant women which enabled them to face life with a sense of equality.[28]

Parallel sets of belief and practices. Ignoring the existence of parallel sets of beliefs and practices can act as a barrier to the use of health services. The belief in, or commitment to, traditional practices does not hinder the (acquired) perception that western health care can be very beneficial too. Ethnic minority patients may operate with parallel sets of beliefs and practices, on one hand be committed to western health practices and on the other sometimes travelling to their country of origin for non-western practices.[9,26–28,36,49]

Potential barriers at system level

Medical paradigm

The strictness of the medical paradigm can act as a barrier as it is based upon the biomedical explanatory model of health, illness and healing methods. Some ethnic minority patients are dissatisfied with it, as the dimension of religion and culture on health and healing is not recognized. Where there is lack of a common language of communication, ethnic minority patients seem unable to convey their inner feelings and needs. As a result these patients may lack the confidence to ask important questions. Especially when admitted to hospitals and separated from their families and communities, this can lead to a profound sense of isolation. People may feel ignored by other patients and staff. In a number of such instances, people need religion as a source of support but when requesting such services they feel a sense of disloyalty and neglect.[44]

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Consumerist approach

The dispassionate consumerist approach can act as a barrier, particularly the impersonal and technical attitude of the physician. Patients feel physicians forego their responsibility for patients' health. To some immigrant patients the consumerist approach to medical services is a novelty. The patient is encouraged to be a more assertive patient, but this often runs against the grain of older, more vulnerable patients. There are complaints too that the physician treats his patients in a matter-of-fact formal manner. This is contrary to the warm and sympathetic way some patients are used to in their country of birth.[42]

Organizational factors

Referral system. The referral system can act as a barrier, as some patients feel uncomfortable with monitoring procedures that hinder them from obtaining adequate care.[10,38] For example, in their own country they can usually go directly to a health specialist. Sometimes this encourages them to bypass the referral system using the services in their own country. Such a decision is based upon the nature of the illness and the effect of previous treatments, aligned to the cost of the treatment itself. We should also take on board the treatment they have received from health care workers in their own country which may influence their attitude towards the services available here.[38]

Intake procedures and opening hours. Complex intake procedures can act as a barrier. Therefore simplifying intake procedures with the use of flexible clinic hours, particularly for immigrant patients, has been fairly successful in adapting care to the need and expectations of these patients.[27] Limited and inconvenient clinic hours are also disadvantageous with regard to the use of health services.[35,62]

Consultancy appointments and waiting time. The cumbersome process of making and obtaining appointments and the prolonged waiting times can act as a barrier. Difficulties in accessing health services stem from the making and obtaining of appointments, the scheduling problems that exist at present and the unavailability of an appointment at a convenient time.[12,31,34,35] Long waiting times for appointments and during visits to clinics hinder the patient from using the services that they are entitled to.[7,8,10,18,24,28,31,37]

Patients of certain ethnic minority groups have to wait longer for specialist intervention as their European counterparts (up to twice as long). Where this barrier occurs is not clear. As some ethnic minority groups are more concerned about the symptoms and more prone to seek immediate care for themselves or their ailing children, it is likely that the barriers are more related to the use of health services than to the approach of it.[31]

Indeed, for some ethnic minority groups obtaining an appointment with the GP is harder due to (physical) access difficulties, when compared with the ethnic majority. On the other hand, these groups are more frequently reported to have communicated their needs satisfactorily. They leave the doctor's surgery less frequently with follow-up appointments or with offered services (e.g. district nursing services), although they like to acquire such services.[31]

The length of consultation and treatment. Consultations and treatments that are too abrupt can act as a barrier as distrust can arise.[7,18,28,35] There is a fear on the part of the patient that they are not being taken seriously enough. This undermines the fabric of trust which is essential for improved relations to occur between patient and provider. Ironically however, in some cases, these short-term treatment possibilities have made health care more accessible to ethnic minority patients.[27]

Printed materials and other media forms. Impersonal communication through printed matter and other media forms can act as a barrier. It is preferable to make direct personal contact with the ethnic minority patient, the spouse, friends and family and not rely too heavily on printed materials or other media forms. These forms only seem to discourage the ethnic minority patient from finding out more about clinics and the types of services available.[38]

Translation. The lack of appropriate translated information and educative materials can also be a hindrance; particularly where information and education is critical to the needs of adequate patient management. Information and education with regard to ethnic minority patients must take into account the different idiosyncratic expressions and the varying levels of literacy within the ethnic minorities' subgroups. It must acknowledge the value of traditional practices, explaining technical procedures and their rationale, address the concerns reported by the patient and inform them of their legal rights.[30,35,62] Linguistic and cultural translation are seen as problematical, especially in the light of the different sets of values concerning health, illness and healing methods employed by the care providers and their patients.[7]

Discussion

Summary

This literature review presents potential barriers that exist in the use of health services among ethnic minorities. The health services are applied in many different countries and received by patients of a large number of different ethnic minorities. A great number

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of potential barriers were identified. Obviously the presented barriers vary from country to country and what is a barrier to one ethnic grouping is not necessarily so to another. The potential barriers have been summarized in Table 1. By checking the inventory, the care provider may become aware of whether a potential barrier can be identified in the environment that he or she is dealing with. The characteristics of the articles reviewed are summarized in Table 2. With the help of this table the type of health service in a particular country, used by a particular ethnic minority, is easily recognized along with the corresponding potential barriers. We used Andersen's behaviour model of health services use as the theoretical framework. The articles were screened for the different variables as presented by this model. The Andersen-model was also used by us, to help arrange the potential barriers. We condensed the subject headings into three main groups which we have called: 'Patient level', 'Provider level' and 'System level'. By doing so, the myriad of potential barriers is easier to oversee. Although our review reflects and supports the different studies included, this study differs discernibly from most other literature in that it presents many different barriers among many different ethnic minorities living in many different countries and using different health services. It presents a state-of-the-art inventory of potential barriers, according to the literature available.

Theoretical framework

We used Andersen's behaviour model of health services use as the theoretical framework. To us the application of the Andersen-model was very useful. The model presents a rather complete set of variables important to the study of health services use by general population or (ethnic) minorities. Application of the model results in a better understanding of the health behaviour of the studied populations.

The Andersen-model however, is criticized in the literature for several reasons. A few examples are the characteristics of decision-taking processes that lead to actual use of services are not incorporated and the characteristics of the social-psychological processes involved in the perception, evaluation and response towards health are missing.[17] In our opinion, the health professionals' point of view is quite robustly involved in the Andersen-model. Another way of reporting results could start from the individual patient's point of view. Also, reporting results through the processing of variables does not render an account of the individuals' behaviour. It explains what is happening, not why the patient chooses to behave in the way he does.

The processing of the results into the Andersen-model did lead to some difficulties. (1) The subject heading 'provider characteristics' is specified unsatisfactorily. In our opinion, the provider characteristics should be incorporated in the population characteristics. In that way the provider is more clearly a subject of investigation. (2) Some variables of the subject heading 'community enabling resources' double up as some variables of the health care system components (e.g. distribution). Availability of health personnel and facilities is stated to be a variable of 'community enabling resources' whereas it is also a component of the health care system resources, i.e. distribution. (3) Presentation of some results under the subject headings of the Andersen-model seems arbitrary. The consumerist approach, for example, clearly is associated with the health care system. The consumerist approach by itself is dispassionate to the patient, but the attitude of the provider that applies that approach does not have to be dispassionate. Here the question arises, if this barrier should be presented under barriers at system level or at provider level. This question is one of the many examples that can be given. The fact that some placements do seem arbitrary does not affect the quality of the results. The arbitrary placement does not change the content of what is stated. However, the reader should be warned and should interpret the placements with some reservation.

Barriers and their consequences for daily practice

Universality and specificity. Many of the barriers are 'universal' problems that can afflict all of us. Long waiting lists, for example, hinder all patients from using the services that they are entitled to. Potential barriers only afflict us under certain circumstances or only afflict some of us, mostly the socioeconomic vulnerable ones. As we have seen, a barrier that can only afflict us under certain circumstances is for instance irregular public transport. If there is no need to use the public transport, irregular public transport does not act as a barrier (e.g. to car owners). If public transport is needed, irregular public transport acts as a barrier. A barrier that only afflicts some of us is for instance, health insurance coverage. For the socioeconomic vulnerable ones, the price of health services can act as a barrier, if a health service is not covered by their health insurance or is only partly reimbursed. The group of socioeconomic vulnerable ones exists of members of the ethnic majority and ethnic minorities. Ethnic minorities are often part of the most vulnerable category due to their lower educational, social and socioeconomic status, and due to lower income and lack of financial means. Potential barriers may have a greater impact on ethnic minorities, because they are alien to most of the barriers. They may lack knowledge about the existing health services and how to use them. In addiction, medical costs, for example, can be higher for immigrants who are not yet entitled to subsidies for benefits during their first 2 years of residence.[38]

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Ethnic minority specificity. As we have seen, some potential barriers only afflict ethnic minority patients. They only afflict these patients as they relate to their cultural attributes and explanatory models, as e.g. the view that illness is caused by an act of God or nature.[28] Indeed, there also exist 'cultural' differences and differences in explanatory models between patients and providers that share the same cultural background. Frequently stated causes are the patient–provider difference in social class, education, gender identification or generation. These potential barriers between two ostensible members of the 'same' culture can be also caused by difference in clinical reality. The clinical reality of the patient consists of the layman's perception of illness, which is a subjective certainty. This reality may differ from the clinical reality of the physician, which consists of the professional evaluation of illness, which is an objective certainty.[65,66] The difference in ethnic norms and values between an ethnic minority patient and a provider of the ethnic majority is superseded to the 'normal' difference in clinical reality between a patient and a provider that share the same ethnic norms and values.

Situation specificity. Barriers can only be understood in reference to the specific situations individual patients find themselves in. However, the reviewed studies were performed within contexts that differed enormously. In some countries, for example, the health care system uses a referral system, in other countries the health care system does not. Ethnic minority patients may see health care as something of a luxury rather than the necessity that we consider it to be. In that case the use of a gatekeeper, who must refer to all other more specialized forms of services, is seen as a barrier. Also the waiting list for appointments creates barriers, as we have come to describe it. Thus, it is important to consider the specific context we are dealing with when identifying barriers to the use of health services.

Patient and time specificity. We can see that not only do the circumstances differ enormously; but ethnic minority patients differ considerably too. Even when the motives for migration and the immigrants' expectations of the receiving country are similar, there may be discernable differences in their approach to a given situation. Personal attributes such as the geographical region people are coming from, the size of their family, their marital status, standard of education, occupation and social class, are all factors that can seriously influence the eventual outcome. These factors influence a person's ability to deal with health problems and as such with illness. At the same time it must be understood that the ideas of ethnic minority patients and their evaluations of medical experiences are indeed subject to constant adjustment through the changes of social situations, medical settings or because of personal medical experiences.[36,52] Consequently, even the barriers that prevent them from using health services may also change.

Conclusion

This review has the goal of raising awareness about the myriad of potential barriers, so that the problem of barriers to health care for different ethnic minorities becomes transparent. In conclusion, there are many different potential barriers of which some are tied to ethnic minorities. The barriers are all tied to the particular situation of the individual patient and subject to constant adjustment. In other words, generalizations should not be made.

Limitation

There are limits to this review. Firstly, the review presents only journal articles. This is the result of the search strategy. Therefore, materials published in books and reports that do not appear in Medline searches are not included. Secondly, the authors of this article do not belong to an ethnic minority group, as are the majority of the authors of the articles under review. The results are thus interpreted from a western perspective. Authors of ethnic minorities may hold different views. Having a western background leads us to certain ideas about health care provision; the referral system, for example, is valued as an asset to the health care system. Having a non-western background (may) lead to having other ideas about health care provision; the use of a referral system, for example, may be valued as a barrier. This difference in opinion due to difference in cultural background may affect the interpretation of results.

Further research

There is a need for further research. On one hand there is a need for qualitative case studies to be commissioned; studies that contextualize the content of the patient–provider interaction to account for the development of barriers. Conversely, there is a need for quantitative research; studies that determine whether a potential barrier realizes its full potential. Or, whether a potential barrier remains exactly that and therefore does not adversely affect the (ethnic minority) patient after all.

Acknowledgements

The study was financed by ZonMw, The Netherlands Organisation for Health Research and Development. Grant number 14350023.

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Appendix

The databases were searched using keywords that covered the domain 'health services', the domain 'use' (of health services) and the domain 'ethnic minorities'. The $ sign is used as the truncation symbol to replace one or more letters.

The keywords of the domain 'heath services' are Health services, Health care, Medical care, Rehabilitation, Rehabilitation medicine, Multi-disciplinary treatment.

The keywords of the domain 'use' (of health services) are Use, Utiliz$, Medical consum$, Acces$, Barrier, Hindrance, Obstacle, Exclusio$, Discrimina$, Compliance, Satisfact$.

The keywords of the domain 'ethnic minorities' are Ethni$, Minori$, Migran$, Immigran$.

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Exhibit 384

Conscientious refusals to refer: findings from a national physician survey

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Received 6 November 2010
Revised 29 December 2010
Accepted 16 January 2011
Published Online First
18 February 2011

ABSTRACT

Background Regarding controversial medical services, many have argued that if physicians cannot in good conscience provide a legal medical intervention for which a patient is a candidate, they should refer the requesting patient to an accommodating provider. This study examines what US physicians think a doctor is obligated to do when the doctor thinks it would be immoral to provide a referral.

Method The authors conducted a cross-sectional survey of a random sample of 2000 US physicians from all specialties. The primary criterion variable was agreement that physicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral.

Results Of 1895 eligible physicians, 1032 (55%) responded. 57% of physicians agreed that doctors must refer patients regardless of whether or not the doctor believes the referral itself is immoral. Holding this opinion was independently associated with being more theologically pluralistic, describing oneself as sociopolitically liberal, and indicating that respect for patient autonomy is the most important bioethical principle in one's practice (multivariable ORs, 1.6–2.4).

Conclusions Physicians are divided about a professional obligation to refer when the physician believes that referral itself is immoral. These data suggest there is no uncontroversial way to resolve conflicts posed when patients request interventions that their physicians cannot in good conscience provide.

INTRODUCTION

Few issues in medicine pique professional and public interest more than debates over physician conscientious refusals.[1–6] These debates take place within and are informed by broader disagreements over how to balance and prioritise different ethical principles and concerns in the practice of medicine. Physicians' freedom to refuse medical interventions for reasons of conscience has been defended on the grounds that medicine as a moral practice depends on physicians doing that which they in good faith believe is in the patient's interest, and also that physicians have a right to protect their integrity by acting according their values.[7–10] Yet, critics argue that such refusals violate patient autonomy[11–13] and unjustly make patients' access to healthcare services dependent on the personal values of individual physicians.[6 14]

A commonly proposed solution seeks to balance competing concerns by permitting refusals so long as the physician refers the patient to a provider who will accommodate the request.[8 15–17] Dan Brock argues that this 'conventional compromise' respects individual physicians' integrity while fulfilling the medical profession's obligation to make the full range of legal medical interventions available to patients.[15] Previous studies suggest that most physicians agree both that doctors are not obligated to do something they think is immoral and that they should provide a referral for services they are unwilling to provide themselves.[18 19] But what about those situations in which a physician believes that making a referral is itself immoral? Brock and others have argued that physicians must refer in these cases or face professional sanction,[15 20] but to date no empirical studies have examined the views of practicing physicians.

We examined data from a national survey to describe physicians' beliefs about whether or not they have a professional obligation to refer patients even when they believe the referral itself is immoral. In addition, we sought to clarify how theoretical ethics informs physicians' judgement in this area by asking physicians to indicate which bioethical principle—among beneficence, respect for autonomy, and justice[21]—is most important to their practice. Despite the prominence of these principles in medical ethics discourse, no empirical studies have assessed how physicians rank their priority with respect to clinical practice. Building on prior studies, we examined the relationships between believing that doctors are always obligated to refer, identifying autonomy as the most important principle in one's practice, and physicians' demographic, religious and sociopolitical characteristics.

METHODS

The methods of this study have been described elsewhere.[22] In 2009 we mailed a confidential, self-administered questionnaire up to three times to a random sample of 2000 practicing US physicians, aged 65 years or younger and from all specialties, selected from the American Medical Association Masterfile. The initial mailing included a gift, and an additional US$25 was promised to those who responded. The Mayo Clinic Institutional Review Board approved this study.

Questionnaire

Our primary criterion variable was agreement with the statement: 'Physicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral'. We also asked: 'Which of the following ethical principles is the most important in your practice as a physician? (1) Respect for autonomy—honouring the rights of patients to make decisions

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for themselves; (2) Justice—seeking fair treatment of patients based on medical need and fair distribution of healthcare resources; and (3) Beneficience/non-maleficence—promoting the wellbeing of patients and preventing illness, while minimising harm.'

Primary predictor variables were physicians' religious characteristics and sociopolitical views. Religious affiliation was categorised as: no religion, Jewish, Roman Catholic or Eastern Orthodox, non-evangelical Protestants (includes non-evangelical other Christians), evangelical Protestants (includes evangelical other Christians) and other religions. Religious salience[23 24] was assessed with the question: 'How important would you say your religion is in your life?' Responses were: 'the most important part of my life', 'very important', 'fairly important', 'not very important' and 'not applicable—I have no religion'; the last two categories were collapsed into one. Spirituality was measured by asking: 'To what extent do you consider yourself a spiritual person?' Responses were: 'very spiritual', 'moderately spiritual', 'fairly spiritual' and 'not very spiritual'.

Additionally, we scored physicians on a scale of theological pluralism—the extent to which physicians believe that no religion is uniquely and comprehensively true. An earlier study found that physicians with high theological pluralism were more likely to endorse nondirective counsel in areas of moral controversy.[25] We asked physicians to rate their level of agreement with three statements: (1) There is truth in one religion; (2) Different religions have different versions of the truth and each may be equally right in its own way; and (3) There is no one, true, right religion. Responses were scored on a four point scale from 'agree strongly' to 'disagree strongly'. After reverse-scoring the first statement, responses were summed (Cronbach α=0.75) and scores trichotomised into low, moderate and high theological pluralism.

Sociopolitical views were measured by responses to the question, 'How would you characterise yourself on social issues?' Responses were: 'conservative', 'moderate', 'liberal' and 'other'. Secondary predictors included age, sex, race, region of the country and medical specialty.

Statistical analyses

After generating population estimates from physicians' responses to each item, we used the χ^2 test to examine associations between the two primary criterion variables, and between each criterion and each predictor. We then used multiple logistic regression to test whether bivariate associations remained after adjustment for relevant covariates. All analyses were conducted with Stata SE statistical software V.11.0. Respondents who left items blank were omitted from analysis of those items.

RESULTS

Of the 2000 physicians surveyed, 5% (n=105) could not be contacted. Of 1895 eligible physicians, 1032 completed the survey, giving a cooperation rate of 55%.[26] Table 1 displays the demographic, religious and sociopolitical characteristics of respondents.

As seen in table 2, the majority (57%) of respondents agreed that physicians have a professional duty to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral. Almost two thirds (64%) indicated that beneficence was the most important ethical principle to their medical practice, one in four (26%) indicated respect for autonomy and one in 10 (10%) indicated justice.

Table 1 Demographic, religious, and sociopolitical characteristics of survey respondents (n=1032*)

Characteristics	n (%)
Male	728 (72)
Female	283 (28)
Race (n=1011)	
White	786 (78)
Asian	146 (14)
Other	54 (5)
Black	25 (2)
Region (n=1015)	
South	331 (33)
Midwest	251 (25)
Northeast	227 (22)
West	206 (20)
Medical specialty (n=1032)	
General medicine	183 (18)
Medicine subspecialty	197 (19)
Family practice	119 (12)
Surgery	158 (15)
OB/gyn	47 (5)
Psychiatry	66 (6)
Pediatrics & peds. subspecialties	131 (13)
Diagnostic (pathology & radiology)	54 (5)
Anaesthesiology	66 (6)
Non-clinical/other	11 (1)
Religious affiliation (n=994)	
No religion	146 (15)
Jewish	136 (14)
Roman Catholic/Eastern orthodox	238 (24)
Non-evangelical protestant†	249 (25)
Evangelical protestant†	87 (9)
Other religion	138 (14)
Religious Salience (n=1003)	
Not important	300 (30)
Fairly important	285 (28)
Very important	313 (31)
Most important thing in my life	105 (10)
Spirituality (n=1000)	
Not spiritual	115 (12)
Moderately spiritual	231 (23)
Slightly spiritual	397 (40)
Very spiritual	257 (26)
Theological pluralism (n=977)	
Low	274 (28)
Moderate	265 (27)
High	438 (45)
Sociopolitical views (n=1018)	
Conservative	291 (29)
Moderate	426 (42)
Liberal	281 (28)
Other	20 (2)

The mean age (SD) of respondents was 49.8 (8.7) years.
*Not all values sum to 1032 due to partial non-response.
†Protestant includes those who identified as 'Other Christian'.

Table 3 presents the incidence and odds of agreeing that physicians must refer even if they believe that referral is itself immoral, stratified by physicians' religious characteristics, sociopolitical views, and the ethical principle most important to their practice. After adjusting for potential covariates, physicians remained more likely to agree that they were obligated to refer if they had moderate or high theological pluralism (compared to low theological pluralism, OR 1.6, 95% CI 1.1 to 2.5 and OR 1.9, 95% CI 1.3 to 2.8, respectively), they self-identified as liberal

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Table 2 US physicians' responses regarding whether physicians are professionally obligated to refer even if the physician believes the referral is immoral, and which bioethical principle is most important to their practice

Response	n (%)
Survey item: Physicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral. ($n=997$)	
Strongly agree	268 (27)
Moderately agree	298 (30)
Moderately disagree	245 (25)
Strongly disagree	186 (19)
Survey item: Which of the following ethical principles is the most important to your practice as a physician? ($n=1000$)	
Beneficence/non-maleficence	641 (64)
Respect for autonomy	255 (26)
Justice	104 (10)

(OR 2.4, 95% CI 1.5 to 3.8, compared to conservative) or they rated respect for autonomy as the most important ethical principle (OR 1.6, 95% CI 1.1 to 2.3, compared to beneficence/nonmaleficence).

After adjusting for relevant covariates, physicians' beliefs about referral were not associated with age, gender or region.

Table 3 Association of physicians' religious, spiritual, theological and sociopolitical characteristics with agreement that physicians are professional obligated to refer patients even if they believe the referral is immoral

Characteristic	n (%)	p Value (χ2)	OR (95% CI)
Religious affiliation (n)			
No religion (144)	102 (71)		1.0 referent
Jewish (135)	83 (61)	<0.001	0.8 (0.3 to 1.7)
Roman Catholic/Eastern Orthodox (236)	112 (47)		0.7 (0.3 to 1.5)
Non-evangelical Protestant (235)	127 (54)		1 (0.5 to 2.1)
Evangelical Protestant (100)	45 (45)		0.8 (0.3 to 2.1)
Other religion (136)	91 (67)		1.9 (0.8 to 4.5)
Religious salience† (n)			
Not important	199 (67)		1.0 referent
Fairly important	179 (63)	<0.001	1.0 (0.7 to 1.6)
Very important	148 (48)		0.7 (0.4 to 1.1)
Most important thing in my life	39 (38)		0.5 (0.3 to 1.02)
Spirituality† (n)			
Not spiritual	71 (62)		1.0 referent
Moderately spiritual	140 (61)	0.005	1.2 (0.7 to 2.1)
Slightly spiritual	233 (59)		1.5 (0.8 to 2.6)
Very spiritual	121 (47)		1.2 (0.6 to 2.2)
Theological pluralism† (n)			
Low	111 (41)		1.0 referent
Moderate	156 (60)	<0.001	1.6* (1.1 to 2.5)
High	286 (66)		1.9* (1.3 to 2.8)
Sociopolitical views (n)			
Conservative	114 (41)		1.0 referent
Moderate	234 (57)	<0.001	1.3 (0.9 to 1.8)
Liberal	205 (75)		2.4* (1.5 to 3.8)
Other	8 (42)		0.6 (0.2 to 1.9)
Most important ethical principle (n)			
Beneficence/non-maleficence	334 (54)		1.0 referent
Respect for autonomy	159 (64)	0.02	1.6* (1.1 to 2.3)
Justice	61 (62)		1.3 (0.8 to 2.2)

*p value <0.05.

†Regression model includes sex, age, region, specialty, religious affiliation, sociopolitical views and most important ethical principle as covariates.

Asian physicians were less likely than white physicians (OR 0.6, 95% CI 0.4 to 0.95), and obstetrician/gynecologists were more likely than general medicine physicians (OR 2.6, 95% CI 1.1 to 5.9), to agree that they are always obligated to refer (data not shown in tables).

In multivariate analyses, pediatricians were much less likely than general medicine physicians (OR 0.1, 95% CI 0.04 to 0.3) to indicate that autonomy is the most important ethical principle in their practice, but choosing autonomy was not associated with any religious, sociopolitical or demographic characteristics.

DISCUSSION

In a large, contemporary survey of practicing US physicians from all specialties, we found that a small majority agrees that physicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral. This opinion is associated with being theologically pluralistic, sociopolitically liberal and/or believing that respect for patient autonomy is the most important bioethical principle in one's practice.

These data expand on previous findings about physicians' obligations when a patient requests a legal medical intervention to which their physician objects on moral grounds. Two prior studies found that most physicians (71%[18] and 82%[19]) agree that when a patient requests a legal medical procedure to which the physician objects, the physician is obligated to provide a referral to a willing physician. This study asked explicitly about physicians' obligations when they object even to referral and finds that only slightly more than half of doctors believe that physicians are obligated to refer in those instances.

Previous research into conscience and medicine suggested that many physicians are ambivalent about their obligations in areas of moral controversy. In a prior study, 42% of physicians agreed that 'a physician should never do what he or she believes is morally wrong, no matter what experts say', 22% agreed that 'sometimes physicians have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so,' and 36% agreed with both of these seemingly contradictory statements.[19] The percentage of physicians in that study who believed that physicians are never obligated to violate their consciences corresponds very closely to the percentage of physicians in this present study (43%) who did not agree that physicians are obligated to make referrals that they believe are immoral.

Physician's conflicting opinions regarding referrals mirror disagreements among bioethicists, with leading figures both rejecting and defending physicians' right to refuse to refer if they believe a referral is immoral.[15 27] Further complicating this issue is the reality that every clinical situation is unique; ethical rules do not always apply equally to different scenarios.[28] Moreover, patients and physicians often come from different moral communities and disparate worldviews.[29] As such, physicians and patients must at times negotiate complex clinical decisions without recourse to a shared ethical standard.

Our data highlight how this deliberative process depends to a real extent on the characteristics of the individual physician. Physicians who are more theologically pluralistic are more likely to believe they are always obligated to refer. Physicians who believe that neither their own nor any other religion is uniquely and comprehensively true, or that different religions or moral traditions may each be right in their own way, might sensibly accommodate requests that reflect the patient's moral valuations even if such valuations contradict those of the physician.

Likewise, physicians who describe their social views as liberal are also more likely to believe physicians should always refer. The term 'liberal' has many uses, so we are cautious to avoid overinterpreting this finding. However, this finding is consistent with what philosopher Charles Taylor calls 'the liberalism of neutrality', in which individuals make choices according to their own authentic convictions regarding what constitutes a good life.[30] In such a framework, the state, and perhaps public professions like medicine, should remain neutral regarding patients' choices.

Nor is it surprising that physicians who prioritise respect for autonomy would be more accommodating of patient requests. The principle of patient autonomy receives great emphasis in the bioethics literature,[31–33] and in our study one in four physicians rated autonomy as the most important bioethical principle in their clinical practice. However, we did not ask physicians to rank how they prioritise the ethical principles in morally complex scenarios and we cannot, therefore, infer which principle they believe is most important in such cases. Previous studies[25 34] suggest that this proportion would probably have been higher if we had specified a morally complex scenario rather than physicians' general clinical practice. Further study is needed to draw these sorts of distinctions.

Together with earlier findings, these data make clear that consensus is narrow regarding how physicians should respond when patients request interventions to which their physicians have moral objections. Few would deny that physicians should be candid and forthcoming, taking care to not deceive or mislead the patient about the reason for the refusal or the options available. Likewise, it is widely recognised that patients have a legal right to seek all legal medical interventions, and that physician refusals for these services are made problematic and consequential for patients because professional licensing makes physicians the gatekeepers to most such interventions. Yet beyond this area of agreement, there are no uncontroversial solutions to the dilemmas posed by conscientious refusals to refer.

One proposed resolution would have physicians either leave the profession or choose specialties where they will not be asked to violate their consciences.[3 14 20] Given the rapid evolution of medical practice, not to mention its segmentation and subspecialisation, those entering medical practice cannot fully anticipate whether a certain specialty will or will not coincide with their values in the future. Furthermore, this proposed resolution does not adequately address what is to be done with individuals who have a passionate interest in and aptitude for a particular clinical specialty, but who have misgivings about a small segment of that specialty's practice.

Another solution would have physicians inform patients, at the beginning of the physician-patient relationship or another reasonable time, what medical services they are and are not willing to provide.[15 16] This would ostensibly enhance patient autonomy by allowing patients to seek out physicians who will at least accommodate their values. Many patients, however, have limited choices regarding their physicians, either because they live in rural or otherwise remote areas or because of their insurance status. In addition, it is unreasonable to expect patients to anticipate all circumstances that might transpire or the medical interventions they might one day request.[27 35] Therefore, even if physicians make sincere efforts to proactively disclose their relevant objections to patients, conflicts will arise.

Future efforts to resolve problems posed by conscientious refusals should be informed by our findings. The conventional compromise, which permits conscientious refusals so long as physicians make timely referrals to accommodating providers, has been advanced as a way of protecting both physician integrity and patient autonomy. However, the compromise is unproblematic only when physicians can in good conscience make the referral. When they cannot, our data suggest that almost half (43%) of US physicians do not believe the conventional compromise applies. Policies that mandate referrals are therefore likely to be resisted by large portions of the profession. Less contentious, perhaps, would be policies that focus on meeting patients' interest in having increased access to controversial interventions without asking or requiring individual physicians to do what they believe is immoral.[36]

Our study suggests a possible role for healthcare institutions in mediating disputes over controversial medical services. Healthcare institutions have obligations not only to individual patients, but also to their broader communities.[37] Moreover, healthcare institutions have the capacity to anticipate the sorts of conflicts that may emerge between physicians and patients, and to set up systems that minimise both the inconvenience to the patient and the complicity of the medical personnel.[38] Some institutions are committed to providing all legal medical interventions. Others, such as Catholic hospitals, exclude those interventions that are inconsistent with their mission and identity. Either way, healthcare institutions can ask clinicians' to disclose clinically relevant objections, and should have policies and procedures to facilitate referrals, transfers of care, or other accommodations when patients' request interventions to which their physicians object.

There are additional limitations to this study. Although our response rate is consistent with other surveys of this type,[39] there is a possibility that non-respondents differed in ways that biased our findings. Theological pluralism has internal consistency and has been found previously to account for difference in physicians' ethical judgements, but it remains a novel variable and should be considered provisional until further research affirms its validity. In addition, the structure of the questionnaire allowed respondents to imagine clinical scenarios specific to their practice. Future studies would benefit from vignettes that to some extent normalise how respondents think about conscientious refusals. Finally, the cross-sectional design of this study does not permit any causal inferences from statistical associations, nor can we say how physicians in fact behave in any specific instance.

Despite these limitations, this study indicates that physicians are divided about a professional obligation to refer if the physician believes that referral itself is immoral. Given the absence of consensus concerning a requirement to refer, at this time there remains no uncontroversial way to resolve conflicts posed when patients request interventions that their physicians cannot in good conscience provide.

Acknowledgements Thanks to Michael Putman, Jiwon Helen Shin and Robert Stern for their insightful comments on earlier drafts of this manuscript, to Kenneth Rasinski for help with statistical analyses, and to the Mayo Clinic Survey Research Center and the University of Chicago Survey Lab for assistance in designing and implementing the study.

Funding This study is supported by grants from the National Center for Research Resources (NCRR), a component of the National Institutes of Health (NIH), the NIH Roadmap for Medical Research (1 KL2 RR024151, to JCT) and the National Center for Complementary and Alternative Medicine (1 K23 AT002749, to FAC). MPC was supported by funding from the Pritzker School of Medicine's Summer Research Program. RMA was funded by the Mayo Clinic Program in Professionalism and Ethics.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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International Journal of
GYNECOLOGY & OBSTETRICS

Volume 123, Supplement 3 (2013)

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Supplement to

International Journal of Gynecology & Obstetrics

Volume 123, Supplement 3

Conscientious objection to the provision of reproductive healthcare

Guest Editor:

Wendy Chavkin MD, MPH

Publication of this supplement was made possible with support from Ford Foundation and an anonymous donor. We thank all Global Doctors for Choice funders for making the project possible.

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Printed by Henry Ling, Dorchester

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International Journal of
GYNECOLOGY
& OBSTETRICS

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International Journal of Gynecology and Obstetrics

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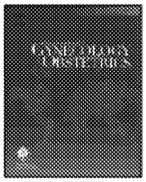

EDITORIAL

Conscientious objection to the provision of reproductive healthcare

Healthcare providers who cite conscientious objection as grounds for refusing to provide components of legal reproductive care highlight the tension between their right to exercise their conscience and women's rights to receive needed care. There are also societal obligations and ramifications at stake, including the responsibility for negotiating balance between all of these competing interests.

Global Doctors for Choice (GDC) is a transnational network of physicians who advocate for reproductive health and rights (http://www.globaldoctorsforchoice.org).

GDC became concerned about the impact of conscience-based refusal on reproductive healthcare as we began to hear increasing reports of harms from many parts of the globe. Therefore, we began to talk with colleagues and colleague organizations, to compile data, and to review policy efforts to resolve the competing interests at play. This supplement presents the result of these efforts.

GDC starts from the premise that both individual conscience and autonomy in reproductive decision making are essential rights. As a physician group, we advocate for the rights of individual physicians to maintain their integrity by honoring their conscience. We simultaneously advocate that physicians maintain the integrity of the profession by according first priority to patient needs and to adherence to the highest standards of evidence-based care. We broaden the frame beyond individual physician and patient to also consider the impact of conscientious objection on other clinicians, on health systems, and on communities.

When we embarked on this investigation, we found legal and ethical analyses but far fewer data regarding health. Thus, we offer a health-focused White Paper [1] as a complement to this previous work and to spur the design of a research agenda. GDC is particularly eager to bring the findings to the attention of members of FIGO, who care about physician and patient rights, about health, and about the consequences for all of the different players and interests involved. We intend this compilation and analysis of health-related information to provide the evidence base to ground our efforts as we move forward creatively together to uphold the rights and health of all.

This supplement also includes commentaries from 3 critical vantage points. Faúndes et al. [2] provide a perspective from this professional medical society and contrast FIGO's clear-cut articulation that "the primary conscientious duty of obstetrician–gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" [3] with the patchy and inconsistent physician behaviors they describe. They call for improved dissemination and education regarding bioethical principles and FIGO positions. Johnson et al. [4] discuss the application of WHO's second edition of *Safe Abortion: Technical and Policy Guidance for Health Systems* [5]. They spell out ways in which adherence to the individual and institutional responsibilities described therein allows individuals to exercise conscience, as it requires them to refer and provide urgently needed care and expects systemic provision of sufficient facilities, providers, equipment, and medications to assure uncompromised access to safe, legal abortion services. Zampas [6] discusses international human rights law and state obligation to harmonize the practice of conscientious objection with women's rights to sexual and reproductive health services. She reports that UN human rights treaty-monitoring bodies have raised concern about the insufficient regulation of the practice of conscientious objection to abortion and consistently recommend that states ensure that the practice is well defined and well regulated in order to avoid limiting women's access to reproductive healthcare. She emphasizes that *women's* conscience must also be fully respected.

This supplement reflects the work of many. We are grateful to Drs Dragoman, Faúndes, Johnson, and Temerman, and to Graciana Alves Duarte, Maria José Duarte Osis, Eszter Kismödi, and Christina Zampas for the cogent commentaries they have authored. We are also very appreciative of their ongoing collaboration.

Further, GDC thanks the following for their contributions to the White Paper: the writing team (Wendy Chavkin, Liddy Leitman, and Kate Polin); the research team (Mohammad Alyafi, Linda Arnade, Teri Bilhartz, Kathleen Morrell, Kate Polin, and Dana Schonberg); and the supplement peer reviewers (Giselle Carino, Alta Charo, Kelly Culwell, Bernard Dickens, Debora Diniz, Monica V. Dragoman, Laurence Finer, Jennifer Friedman, Ana Cristina González Vélez, Lisa H. Harris, Brooke Ronald Johnson, Eszter Kismödi, Anne Lyerly, Alberto Madeiro, Terry McGovern, Howard Minkoff, Joanna Mishtal, Jennifer Moodley, Sara Morello, Charles Ngwena, Andrea Rufino, Siri Suh, Johanna Westeson, Christina Zampas, and Silvia de Zordo).

There are too many barriers to access to reproductive healthcare. Conscience-based refusal of care may be one that we can successfully address.

Conflict of interest

The author has no conflicts of interest.

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International Journal of Gynecology and Obstetrics 123 (2013) S41–S56

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International Journal of Gynecology and Obstetrics

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CONSCIENTIOUS OBJECTION

Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses

Wendy Chavkin[a,b,c,*], Liddy Leitman[a], Kate Polin[a]; for Global Doctors for Choice

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ARTICLE INFO

Keywords:
Abortion
Assisted reproductive technologies
Conscience-based refusal of care
Conscientious commitment
Conscientious objection
Contraception
Policy response
Reproductive health services

ABSTRACT

Background: Global Doctors for Choice—a transnational network of physician advocates for reproductive health and rights—began exploring the phenomenon of conscience-based refusal of reproductive healthcare as a result of increasing reports of harms worldwide. The present White Paper examines the prevalence and impact of such refusal and reviews policy efforts to balance individual conscience, autonomy in reproductive decision making, safeguards for health, and professional medical integrity.
Objectives and search strategy: The White Paper draws on medical, public health, legal, ethical, and social science literature published between 1998 and 2013 in English, French, German, Italian, Portuguese, and Spanish. Estimates of prevalence are difficult to obtain, as there is no consensus about criteria for refuser status and no standardized definition of the practice, and the studies have sampling and other methodologic limitations. The White Paper reviews these data and offers logical frameworks to represent the possible health and health system consequences of conscience-based refusal to provide abortion; assisted reproductive technologies; contraception; treatment in cases of maternal health risk and inevitable pregnancy loss; and prenatal diagnosis. It concludes by categorizing legal, regulatory, and other policy responses to the practice.
Conclusions: Empirical evidence is essential for varied political actors as they respond with policies or regulations to the competing concerns at stake. Further research and training in diverse geopolitical settings are required. With dual commitments toward their own conscience and their obligations to patients' health and rights, providers and professional medical/public health societies must lead attempts to respond to conscience-based refusal and to safeguard reproductive health, medical integrity, and women's lives.
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1. Introduction

How can societies find the proper balance between women's rights to receive the reproductive healthcare they need and healthcare providers' rights to exercise their conscience? Global Doctors for Choice (GDC)—a transnational network of physician advocates for reproductive health and rights (www.globaldoctorsforchoice.org)—began exploring the phenomenon of conscience-based refusal of reproductive healthcare in response to increasing reports of harms worldwide. The present White Paper addresses the varied interests and needs at stake when clinicians claim conscientious objector status when providing certain elements of reproductive healthcare. (While GDC represents physicians, in the present White Paper we use the terms providers or clinicians to also address refusal of care by nurses, midwives, and pharmacists.) As the focus is on health, we examine data on the prevalence of refusal; lay out the potential consequences for the health of patients and the impact on other health providers and health systems; and report on legal, regulatory, and professional responses. Human rights are intertwined with health, and we draw upon human rights frameworks and decisions throughout. We also refer to bedrock bioethical principles that undergird the practice of medicine in general, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care that is urgently needed. Others have underscored the consequences of negotiating conscientious objection in healthcare in terms of secular/religious tension. Our contribution, which complements all of this previous work, is to provide the medical and public health perspectives and the evidence. We focus on the rights of the provider who conscientiously objects, together with that provider's professional obligations; the rights of the women who need healthcare and the consequences of refusal for their health; and the impact on the health system as a whole.

Conscientious objection is the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs [1]. This originated as opposition to mandatory military service but has increasingly been

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raised in a wide variety of contested contexts such as education, capital punishment, driver's license requirements, marriage licenses for same-sex couples, and medicine and healthcare. While health providers have claimed conscientious objection to a variety of medical treatments (e.g. end-of-life palliative care and stem cell treatment), the present White Paper addresses conscientious objection to providing certain components of reproductive healthcare. (The terms conscientious objection and conscience-based refusal of care are used interchangeably throughout.) Refusal to provide this care has affected a wide swath of diagnostic procedures and treatments, including abortion and postabortion care; components of assisted reproductive technologies (ART) relating to embryo manipulation or selection; contraceptive services, including emergency contraception (EC); treatment in cases of unavoidable pregnancy loss or maternal illness during pregnancy; and prenatal diagnosis (PND).

Efforts have been made to balance the rights of objecting providers and other health personnel with those of patients. International and regional human rights conventions such as the Convention on the Elimination of All Forms of Discrimination against Women [2], the International Covenant on Civil and Political Rights (ICCPR) [1], the American Convention on Human Rights [3], and the European Convention for the Protection of Human Rights and Fundamental Freedoms [4], as well as UN treaty-monitoring bodies [5,6], have recognized both the right to have access to quality, affordable, and acceptable sexual and reproductive healthcare services and/or the right to freedom of religion, conscience, and thought. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes the right to be free from discrimination based on religion and acknowledges the right to health, especially reproductive health, as a key human right [7]. These instruments negotiate these apparently competing rights by stipulating that individuals have a right to belief but that the freedom to manifest one's religion or beliefs can be limited in order to protect the rights of others.

The ICCPR, a central pillar of human rights that gives legal force to the 1948 UN Universal Declaration of Human Rights, states in Article 18(1) that [1]:

> Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

Article 18(3), however, states that [1]:

> Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

International professional associations such as the World Medical Association (WMA) [8] and FIGO [9]—as well as national medical and nursing societies and groups such as the American Congress of Obstetricians and Gynecologists (ACOG) [10]; Grupo Médico por el Derecho a Decidir/GDC Colombia [11]; and the Royal College of Nursing, Australia [12]—have similarly agreed that the provider's right to conscientiously refuse to provide certain services must be secondary to his or her first duty, which is to the patient. They specify that this right to refuse must be bounded by obligations to ensure that the patient's rights to information and services are not infringed.

Conscience-based refusal of care appears to be widespread in many parts of the world. Although rigorous studies are few, estimates range from 10% of OB/GYNs refusing to provide abortions reported in a UK study [13] to almost 70% of gynecologists who registered as conscientious objectors to abortion with the Italian Ministry of Health [14]. While the impact of the loss of providers may be immediate and most obvious in countries in which maternal death rates from pregnancy, delivery, and illegal abortion are high and represent major public health concerns, consequences at individual and systemic levels have also been reported in resource-rich settings. At the individual level, decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious circumstances, or at otherwise heightened risk, and aggravates inequities in health status. Indeed, too many women, men, and adolescents lack access to essential reproductive healthcare services because they live in countries with restrictive laws, scant health resources, too few providers and slots to train more, and limited infrastructure for healthcare and means to reach care (e.g. roads and transport). The inadequate number of providers is further depleted by the "brain drain" when trained personnel leave their home countries for more comfortable, technically fulfilling, and lucrative careers in wealthier lands [15]. Access to reproductive healthcare is additionally compromised when gynecologists, anesthesiologists, generalists, nurses, midwives, and pharmacists cite conscientious objection as grounds for refusing to provide specific elements of care.

The level of resources allocated by the health system greatly influences the impact caused by the loss of providers due to conscience-based refusal of care. In resource-constrained settings, where there are too few providers for population need, it is logical to assume the following chain of events: further reductions in available personnel lead to greater pressure on those remaining providers; more women present with complications due to decreased access to timely services; and complications require specialized services such as maternal/neonatal intensive care and more highly trained staff, in addition to incurring higher costs. The increased demand for specialized services and staffing burdens and diverts the human and infrastructural resources available for other priority health conditions. However, it is difficult to disentangle the impact of conscientious objection when it is one of many barriers to reproductive healthcare. It is conceptually and pragmatically complicated to sort the contribution to constrained access to reproductive care attributable to conscientious objectors from that due to limited resources, restrictive laws, or other barriers.

What are the criteria for establishing objector status and who is eligible to do so? In the military context, conscientious objector applicants must satisfy numerous procedural requirements and must provide evidence that their beliefs are sincere, deeply held, and consistent [16]. These requirements aim to parse genuine objectors from those who conflate conscientious objection with political or personal opinion. For example, the true conscientious objector to military involvement would refuse to fight in any war, whereas the latter describes someone who disagrees with a particular war but who would be willing to participate in a different, "just" war. Study findings and anecdotal reports from many countries suggest that some clinicians claim conscientious objection for reasons other than deeply held religious or ethical convictions. For example, some physicians in Brazil who described themselves as objectors were, nonetheless, willing to obtain or provide abortions for their immediate family members [17]. A Polish study described clinicians, such as those referred to as the White Coat Underground, who claim conscientious objection status in their public sector jobs but provide the same services in their fee-paying private practices [18]. Other investigations indicate that some claim objector status because they seek to avoid being associated with stigmatized services, rather than because they truly conscientiously object [19].

Moreover, some religiously affiliated healthcare *institutions* claim objector status and compel their employees to refuse to provide legally permissible care [20,21]. The right to conscience is generally understood to belong to an individual, not to an institution, as claims of conscience are considered a way to maintain an individual's moral or religious integrity. Some disagree, however, and argue that a hospital's mission is analogous to a conscience–identity resembling that of an individual, and "warrant[s] substantial deference" [22]. Others dispute this on the grounds that healthcare institutions are licensed by states, often receive public financing, and may be the sole providers of healthcare services in communities. Wicclair and Charo both argue that, since a license bestows certain rights and privileges on an institution [22–24], "[W]hen licensees accept and enjoy these rights and privileges, they incur reciprocal obligations, including obligations to protect patients from harm, promote their health, and respect their autonomy" [22].

There are also disputes as to whether obligations and rights vary if a provider works in the public or private sector. Public sector providers are employees of the state and have obligations to serve the public for the greater good, providing the highest "standard of care," as codified in the laws and policies of the state [22]. The Institute of Medicine in the USA defines standard of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" and identifies safety, effectiveness, patient centeredness, and timeliness as key components [25]. WHO adds the concepts of equitability, accessibility, and efficiency to the list of essential components of quality of care [26]. There are legal precedents limiting the scope of conscientious objection for professionals who operate as state actors [23]. Some argue that such limitations can be extended to those who provide health services in the private sector because, as state licensure grants these professions a monopoly on a public service, the professions have a collective obligation to patients to provide non-discriminatory access to all lawful services [23,27]. However, it is more difficult to identify conscience-based refusal of care in the private sector because clinicians typically have discretion over the services they choose to offer, although the same professional obligations of providing patients with accurate information and referral pertain.

An alternative framing is provided by the concept of *conscientious commitment* to acknowledge those providers whose conscience motivates them to deliver reproductive health services and who place priority on patient care over adherence to religious doctrines or religious self-interest [28,29]. Dickens and Cook articulate that conscientious commitment "inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women's health" [28]. They assert that, because provision of care can be conscience based, full respect for conscience requires accommodation of both objection to participation and commitment to performance of services such that the latter group of providers also have the right to not suffer discrimination on the basis of their convictions [28]. This principle is articulated by FIGO [9]; according to the FIGO "Resolution on Conscientious Objection," "Practitioners have a right to respect for their conscientious convictions in respect both not to undertake and to undertake the delivery of lawful procedures" [30].

We begin the present White Paper with a review of the limited data regarding the prevalence of conscience-based refusal of care and objectors' motivations. Descriptive prevalence data are needed in order to assess the distribution and scope of this phenomenon and it is necessary to understand the concerns of those who refuse in order to design respectful and effective responses. We review the data; point out the methodologic, geographic, and other limitations; and specify some questions requiring further investigation. Next, we explore the consequences of conscientious objection for patients and for health systems. Ideally, we would evaluate empirical evidence on the impact of conscience-based refusal on delay in obtaining care for patients and their families, society, healthcare providers, and health systems. As such research has not been conducted, we schematically delineate the logical sequence of events if care is refused.

We then look at responses to conscience-based refusal of care by transnational bodies, governments, health sector and other employers, and professional associations. These responses include establishment of criteria for obtaining objector status, required disclosure to patients, registration of objector status, mandatory referral to willing providers, and provision of emergency care. We draw upon analyses performed by others to categorize the different models used: legislative, constitutional, case law, regulatory, employment requirements, and professional standards of care. Finally, we provide recommendations for further research and for ways in which medical and public health organizations could contribute to the development and implementation of policies to manage conscientious objection.

The present White Paper draws upon medical, public health, legal, ethical, and social science literature of the past 15 years in English, French, German, Italian, Portuguese, and Spanish available in 2013. It is intended to be a state-of-the-art compendium useful for health and other policymakers negotiating the balance of an individual provider's rights to "conscience" with the systemic obligation to provide care and it will need updating as further evidence and policy experiences accrue. It is intended to highlight the importance of the medical and public health perspectives, employ a human rights framework for provision of reproductive health services, and emphasize the use of scientific evidence in policy deliberations about competing rights and obligations.

2. Review of the evidence

2.1. Methods

We reviewed data regarding the prevalence of conscientious objection and the motivations of objectors in order to assess the distribution and scope of the phenomenon and to have an empirical basis for designing respectful and effective responses. However, estimates of prevalence are difficult to obtain: there is no consensus about criteria for objector status and, thus, no standardized definition of the practice. Moreover, it is difficult to assess whether findings in some studies reflect intention or actual behavior. The few countries that require registration provide the most solid evidence of prevalence.

A systematic review could not be performed because the data are limited in a variety of ways (which we describe), making most of them ineligible for inclusion in such a process. We searched systematically for data from quantitative, qualitative, and ethnographic studies and found that many have non-representative or small samples, low response rates, and other methodologic limitations that limit their generalizability. Indeed, the studies reviewed are not comparable methodologically or topically. The majority focus on conscience-based refusal of abortion-related care and only a few examine refusal of emergency or other contraception, PND, or other elements of care. Some examine provider attitudes and practices related to abortion in general, while others investigate these in terms of the specific circumstances for which people seek the service: for example, financial reasons, sex selection, failed contraception, rape/incest, fetal anomaly, and maternal life endangerment. Some rely on closed-ended electronic or mail surveys, while others employ in-depth interviews. Most focus on physicians; fewer study nurses, midwives, or pharmacists.

These investigations are also limited geographically because more were conducted in higher-income than lower-income countries. Because of both greater resources and more liberalized reproductive health laws and policies, many higher-income countries offer a greater range of legal services and, consequently, more opportunities for objection. Assessment of the impact of conscience-based refusal of care in resource-constrained settings presents additional challenges because high costs and lack of skilled providers may dwarf this and other factors that impede access. Acknowledging that conscientious objection to reproductive healthcare has yet to be rigorously studied, we included all studies we were able to locate within the past 15 years, and present the cross-cutting themes as topics for future systematic investigation.

2.2. Prevalence and attitudes

The sturdiest estimates of prevalence come from a limited sample of those few places that require objectors to register as such or to provide written notification. 70% of OB/GYNs and 50% of anesthesiologists have registered with the Italian Ministry of Health as objectors to abortion [31]. While Norway and Slovenia require some form of registration, neither has reported prevalence data [32–34]. Other estimates of prevalence derive from surveys with varied sampling strategies and response rates. In a random sample of OB/GYN trainees in the UK, almost one-third objected to abortion [35]. 14% of physicians of varied specialties surveyed in Hong Kong reported themselves to be objectors [36]. 17% of licensed Nevada pharmacists surveyed objected to dispensing mifepristone and 8% objected to EC [37]. A report from Austria describes many regions without providers and a report from Portugal indicates that approximately 80% of gynecologists there refuse to perform legal abortions [38–40].

Other studies have investigated opinions about abortion and intention to provide services. A convenience sample of Spanish medical and nursing students indicated that most support access to abortion and intend to provide it [41]. A survey of medical, nursing, and physician assistant students at a US university indicated that more than two-thirds support abortion yet only one-third intend to provide, with the nursing and physician assistant students evincing the strongest interest in doing so [42]. The 8 traditional healers interviewed in South Africa were opposed to abortion [43], and an ethnographic study of Senegalese OB/GYNs, midwives, and nurses reported that one-third thought the highly restrictive law there should permit abortion for rape/incest, although very few were willing to provide services (unpublished data).

Some studies indicate that a subset of providers claim to be conscientious objectors when, in fact, their objection is not absolute. Rather, it reflects opinions about patient characteristics or reasons for seeking a particular service. For example, a stratified random sample of US physicians revealed that half refuse contraception and abortion to adolescents without parental consent, although the law stipulates otherwise [44]. A survey of members of the US professional society of pediatric emergency room physicians indicated that the majority supported prescription of EC to adolescents but only a minority had done so [45]. A study of the postabortion care program in Senegal, intended to reduce morbidity and mortality due to complications from unsafe abortion, found that some providers nonetheless delayed care for women they suspected of having had an induced abortion (unpublished data).

Willingness to provide abortions varies by clinical context and reason for abortion, as demonstrated by a stratified random sample of OB/GYN members of the American Medical Association (AMA) [46]. A survey of family medicine residents in the USA assessing prevalence of moral objection to 14 legally available medical procedures revealed that 52% supported performing abortion for failed contraception [47]. Despite opposition to voluntary abortion, more than three-quarters of OB/GYNs working in public hospitals in the Buenos Aires area from 1998 to 1999 supported abortion for maternal health threat, severe fetal anomaly, and rape/incest [48]. While 10% of a random sample of consultant OB/GYNs in the UK described themselves as objectors, most of this group supported abortion for severe fetal anomaly [13].

Other inconsistencies regarding refusal of care derived from the provider's familiarity with a patient, experience of stigmatization, or opportunism. A Brazilian study reported that Brazilian gynecologists were more likely to support abortion for themselves or a family member than for patients [17]. Physicians in Poland and Brazil reported reluctance to perform legally permissible abortions because of a hostile political atmosphere rather than because of conscience-based objection. The authors also noted that conscientious objection in the public sphere allowed doctors to funnel patients to private practices for higher fees [19].

Not surprisingly, higher levels of self-described religiosity were associated with higher levels of disapproval and objection regarding the provision of certain procedures [49]. Additionally, a random sample of UK general practitioners (GPs) [50], a study of Idaho licensed nurses [51], a study of OB/GYNs in a New York hospital [52], and a cross-sectional survey of OB/GYNs and midwives in Sweden [53] found self-reported religiosity to be associated with reluctance to perform abortion. A study of Texas pharmacists found the same association regarding refusal to prescribe EC [54].

Higher acceptance of these contested service components and lower rates of objection were associated with higher levels of training and experience in a survey of medical students and physicians in Cameroon and in a qualitative study of OB/GYN clinicians in Senegal [55,56]. Similar patterns prevailed in a survey of Norwegian medical students [57] and among pharmacists and OB/GYNs in the USA [45].

Clinicians' refusal to provide elements of ART and PND also varied, at times motivated by concerns about their own lack of competence with these procedures. And, while the majority of Danish OB/GYNs and nurses (87%) in a non-random sample supported abortion and ART, 69% opposed selective reduction [49]. A random sample of OB/GYNs from the UK indicated that 18% would not agree to provide a patient with PND [13].

Several studies report institutional-level implications consequent to refusal of care. Physicians and nurse managers in hospitals in Massachusetts said that nurse objection limited the ability to schedule procedures and caused delays for patients [58]. Half of a stratified random sample of US OB/GYNs practicing primarily at religiously affiliated hospitals reported conflicts with the hospital regarding clinical practice; 5% reported these to center on treatment of ectopic pregnancy [59]. 52% of a non-random sample of regional consultant OB/GYNs in the UK said that insufficient numbers of junior doctors are being trained to provide abortions owing to opting out and conscientious objection [35]. A 2011 South African report states that more than half of facilities designated to provide abortion do not do so, partly because of conscientious objection, resulting in the persistence of widespread unsafe abortion, morbidity, and mortality [60]. A non-random sample of Polish physicians reported that institutional, rather than individual, objection was common [19]. Similar observations have been made about Slovakian hospitals [61].

A few investigations have explored clinician attitudes toward regulation of conscience-based refusal of reproductive healthcare. Two studies from the USA indicate that majorities of family medicine physicians in Wisconsin and a random sample of US physicians believe physicians should disclose objector status to patients [44,47]. A survey of UK consultants revealed that half want the authority to include abortion provision in job descriptions for OB/GYN posts, and more than one-third think objectors should be required to state their reasons [35]. Interviews with a purposive sample of Irish physicians revealed mixed opinions about the obligation of objectors to refer to other willing providers, as well as awareness that women traveled abroad for abortions and related services that were denied at home [62].

While the reviewed literature indicates widespread occurrence of conscientious objection to providing some elements of reproductive healthcare, it does not offer a rigorously obtained evidentiary basis from which to map the global landscape. Assessment of the prevalence of conscientious objection requires ascertainment of the number objecting (numerator) and the total count of the relevant population of providers comprising the denominator (e.g. the number of OB/GYNs claiming conscientious objection to providing EC and the total population of OB/GYNs). Registration of objectors, as required by the Italian Ministry of Health, provides such data. Professional societies could also systematically gather data by surveying members on their practices related to conscience-based refusal of care or by including such self-identification on standard mandatory forms. Academic institutions or other research organizations could conduct formal studies or add questions on conscience-based refusal of care to ongoing general surveys of clinicians.

Aside from prevalence, there are a host of key questions. Further research on motivations of objectors is required in order to better understand reasons other than conscience-based objection that may lead to refusal of care. As the studies reviewed indicate, these factors may include desire to avoid stigma, to avoid burdensome administrative processes, and to earn more money by providing services in private practice rather than in public facilities; knowledge gaps in professional training; and lack of access to necessary supplies or equipment. Qualitative studies would best probe these complicated motivations.

What is the impact of conscience-based refusal of care? In the next section, we outline systemic and biologically plausible sequences of events when specified care components are refused. Research is needed to see whether these hold true and have health consequences for women and practical consequences for other clinicians and the health system as a whole. Research could illuminate women's experiences when refused care—their understanding, access to safe and unsafe alternatives, emotional response, and course of action. Investigations on the clinician side could further explore the experiences of those who do provide services after others have refused to do so. Each of these questions is likely to have context-specific answers, so research should take place in varied geopolitical settings, and the contextual nature of the findings must be made clear.

Do clinicians consider conscientious objection to be problematic? What kinds of constraints on provider behavior do clinicians consider appropriate or realistic? When enacted, have such policies or regulations been implemented? Have those implemented effectively met their purported objectives? What mechanisms of regulation do women consider reasonable? Do they perceive conscience-based refusal of care as a significant barrier to reproductive health services? Could enhanced training and updated medical and nursing school curricula devoted to reproductive health address the lack of clinical skills that contributes to refusal of care? Could further education clarify which services are permitted by law, and under which circumstances, and thus reassure clinicians sufficiently such that they provide care? Empirical evidence is essential as varied political actors try to respond to these competing concerns with policies or regulations.

3. Consequences of refusal of reproductive healthcare for women and for health systems

We lay out the potential implications of conscience-based refusal of care for patients and for health systems in 5 areas of reproductive healthcare—abortion and postabortion care, ART, contraception, treatment for maternal health risk and unavoidable pregnancy loss, and PND. Because we lack empirical data to explore the impact of conscience-based refusal of care on patients and health systems, we build logical models delineating plausible consequences if a particular component of care is refused. We provide visual schemata to represent these pathways and we use data and examples of refusal from around the world to ground them.

We attempt to isolate the impact of conscientious objection for each of the 5 reproductive health components, although we recognize the difficulties of identifying the contributions attributable to other barriers to access. These include limited resources, inadequate infrastructure, failure to implement policies, sociocultural practices, and inadequate understanding of the relevant law by providers and patients alike.

We start from the premise that refusal of care leads to fewer clinicians providing specific services, thereby constraining access to these services. We posit that those who continue to provide these contested services may face stigma and/or become overburdened. We specify plausible health outcomes for patients, as well as the consequences of refusal for families, communities, health systems, and providers.

3.1. *Conscience-based refusal of abortion-related services*

The availability of safe and legal abortion services varies greatly by setting. Nearly all countries in the world allow legal abortion in certain cases (e.g. to save the life of the woman, in cases of rape, and in cases of severe fetal anomaly). Few countries prohibit abortion in all circumstances. While some among these allow the criminal law defense of necessity to permit life-saving abortions, Chile, El Salvador, Malta, and Nicaragua restrict even this recourse. Other countries with restrictive laws are not explicit or clear about those circumstances in which abortion is allowed [63].

In many countries, particularly in low-resource areas, access to legal services is compromised by lack of resources for health services, lack of health information, inadequate understanding of the law, and societal stigma associated with abortion [64].

There is substantial evidence that countries that provide greater access to safe, legal abortion services have negligible rates of unsafe abortion [65]. Conversely, nearly all of the world's unsafe abortions occur in restrictive legal settings. Where access to legal abortion services is restricted, women seek services under unsafe circumstances. Approximately 21.6 million of the world's annual 46 million induced abortions are unsafe, with nearly all of these (98%) occurring in resource-limited countries [65,66]. In low-income countries, more than half of abortions performed (56%) are unsafe, compared with 6% in high-income areas [66]. Nearly one-quarter (more than 5 million) of these result in serious medical complications that require hospital-based treatment [67,68]; 47,000 women die each year because of unsafe abortion and an additional unknown number of women experience complications from unsafe abortions but do not seek care [68]. While the international health community has sought to mitigate the high rates of maternal morbidity and mortality caused by unsafe abortion through postabortion care programs [56], the implementation and effectiveness of these have been undermined by conscience-based refusal of care [24,56,69].

We posit that conscience-based refusal of care will have less of an impact at the population level in countries with available safe, legal abortion services than in those where access is restricted. Women living in settings in which legal abortion is widely available and who experience provider refusal will be more likely to find other willing providers offering safe, legal services than women in settings in which abortion is more highly restricted. We ground our model (Fig. 1) in the following examples: (1) in South Africa, widespread conscientious objection limits the numbers of willing providers and, thus, access to safe care, and the number of unsafe abortions has not decreased since the legalization of abortion in

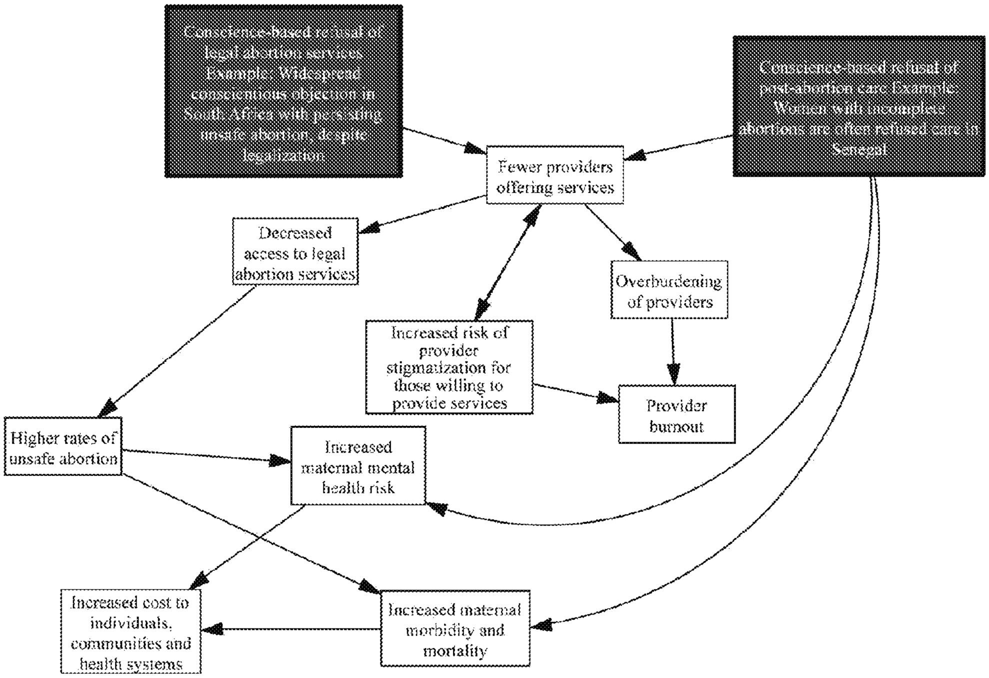

Fig. 1. Consequences of refusal of abortion-related services.

1996 [70,71]; (2) although Senegal's postabortion care program is meant to mitigate the grave consequences of unsafe abortion, conscientious objection is, nevertheless, often invoked when abortion is suspected of being induced rather than spontaneous [56] (unpublished data).

3.2. Conscience-based refusal of components of ART

Infertility is a global public health issue affecting approximately 8%–15% of couples [72,73], or 50–80 million people [74], worldwide. Although the majority of those affected reside in low-resource countries [72,73], the use of ART is much more likely in high-resource countries.

Access to specific ART varies by socioeconomic status and geographic location, between and within countries. In high-resource countries, the cost of treatment varies greatly depending on the healthcare system and the availability of government subsidy [75]. For example, in 2006, the price of a standard in vitro fertilization (IVF) cycle ranged from US$3956 in Japan to $12,513 in the USA [76]. After government subsidization in Australia, the cost of IVF averaged 6% of an individual's annual disposable income; it was 50% without subsidization in the USA [77]. In low-income countries, despite high rates of infertility, there are few resources available for ART, and costs are generally prohibitive for the majority of the population. Because these economic and infrastructural factors drive lack of access to ART in low-income countries, we posit that denial of services owing to conscience-based refusal of care is not a major contributing factor to limited access in these settings. Therefore, for the model (Fig. 2), we primarily examine the consequences of conscientious objection to components of ART in middle- to high-income countries. At times, regulations and policies regarding ART stem from empirically based concerns, grounded in medical evidence, about health outcomes for women and their offspring or health system priorities. Our focus, however, is on those instances in which some physicians practice according to moral or religious beliefs, even when these contradict best medical practices. In some Latin American countries, despite the medical evidence that maternal and fetal outcomes are markedly superior when fewer embryos are implanted, the objection to embryo selection/reduction and cryopreservation promoted by the Catholic Church has reportedly led many physicians to avoid these [78]. Anecdotal reports from Argentina describe ART physicians' avoidance of cryopreservation and embryo selection/reduction following the self-appointment of a lawyer and member of Opus Dei as legal guardian for cryopreserved embryos [78,79]. The only example that illustrates the implications of denial of preimplantation genetic diagnosis (PGD) refers to a legal ban, rather than conscience-based refusal of care. Nonetheless, we use it to describe the potential consequences when such care is denied. In 2004, Italy passed a law banning PGD, cryopreservation, and gamete donation [80]. This ban compelled a couple who were both carriers of the gene for β-thalassemia to wait to undergo amniocentesis and then to have a second-trimester abortion rather than allow the abnormality to be detected prior to implantation [80] (Fig. 2).

3.3. Conscience-based refusal of contraceptive services

The availability of the range of contraceptive methods varies by setting, as does prevalence of use [81]. In general, contraceptive use is correlated with level of income. In 2011, 61.3% of women aged 15–49 years, married or in a union, in middle-upper-income countries were using modern methods, compared with 25% in the lowest-resource countries [81,82]. Within countries, access to and use of methods also vary. For example, according to the 2003 Demographic and Health Survey of Kenya (a cross-sectional study of a nationally representative sample), women in the richest quintile were reported to have significantly higher odds for using long-term contraceptive methods (intrauterine device, sterilization, implants) than women in the poorest quintile [82].

The legal status of particular contraceptive methods also varies by setting. In Honduras, Congress passed a bill banning EC, which has not yet been enacted into law [83]. Even when contraception is legal, lack of basic resources allocated by government programs may compromise availability of particular methods. High manufacturing

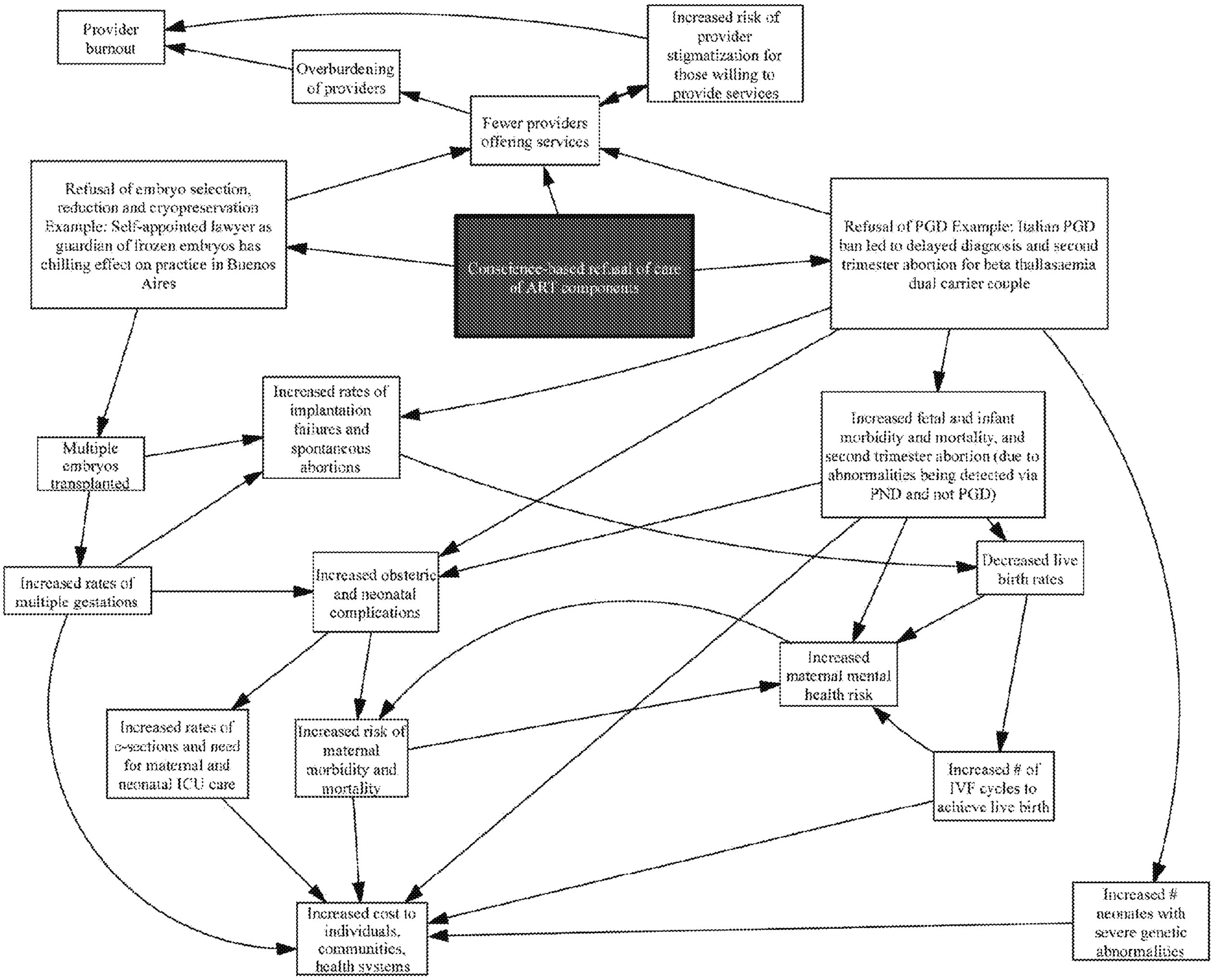

Fig. 2. Consequences of refusal of components of assisted reproductive technologies.

costs or steep prices can also undermine access [84]. In other cases, individual health providers opt not to provide contraception to all or to certain groups of women. Some providers refuse to provide specific methods such as EC or sterilization. In Poland, there is widespread refusal to provide contraceptive services (J. Mishtal, personal communication, April 2012). In Oklahoma, a rape victim was denied EC by a doctor [85], and in Germany a rape victim was denied EC by 2 Catholic hospitals in 2012 [86]. In Fig. 3, we delineate potential implications of conscience-based refusal of contraceptive services.

3.4. Conscience-based refusal of care in cases of risk to maternal health and unavoidable pregnancy loss

In some circumstances, pregnancy can exacerbate a serious maternal illness or maternal illness may require treatment hazardous to a fetus. In these cases, women require access to life-saving treatment, which may include abortion. Yet women have been denied appropriate treatment. Women seeking completion of inevitable pregnancy loss due to ectopic pregnancy or spontaneous abortion have also been denied necessary care.

It is beyond the scope of the present White Paper to define the full range of conditions that may be exacerbated by pregnancy and jeopardize the health of the pregnant woman. However, the incidence of ectopic pregnancy ranges from 1% to 16% [87–90], and 10%–20% of all clinically recognized pregnancies end in spontaneous abortion [90]. Often, refusal of care in circumstances of maternal health risk occurs in the context of highly restrictive abortion laws. We refer to 3 cases from around the world (Fig. 4) to highlight this phenomenon in our model. In Ireland in 2012, Savita Halappanavar, 31, presented at a Galway hospital with ruptured membranes early in the second trimester. She was refused completion of the inevitable spontaneous abortion, developed sepsis, and subsequently died [91]. Z's daughter, a young Polish woman, was diagnosed with ulcerative colitis while she was pregnant [92]. She was repeatedly denied medical treatment; physicians stated that they would not conduct procedures or tests that might result in fetal harm or termination of the pregnancy [92]. She developed sepsis, experienced fetal demise, and died. The only example that illustrates the implications of denial of treatment for ectopic pregnancy derives from legal bans, rather than from an example of conscience-based refusal of care. In El Salvador, a total prohibition on abortion has led to physician refusal to treat ectopic pregnancy [93]; in Nicaragua, the abortion ban results in delay of treatment for ectopic pregnancies, despite law and medical guidelines mandating the contrary [94] (Fig. 4).

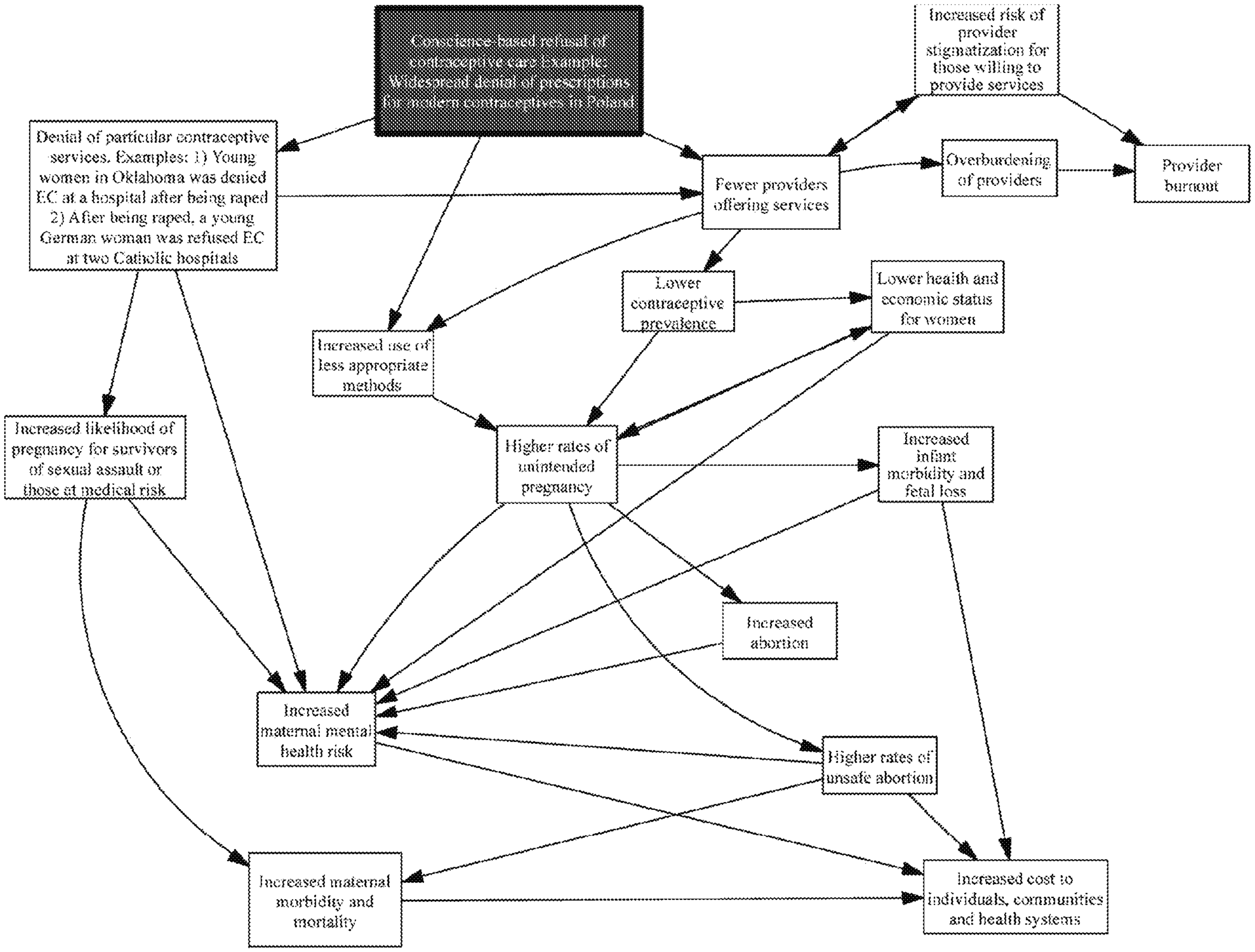

Fig. 3. Consequences of refusal of contraceptive services.

3.5. Conscience-based refusal of PND

The availability of PND varies greatly by setting—with those in middle-upper-income countries having access to testing for a variety of genetic conditions and structural anomalies, and fewer having access to a more limited series of testing in low-income countries. Access to PND provides women with information so that they can make decisions and/or preparations when severe or lethal fetal anomalies are detected. Outcomes for affected neonates vary by country resource level; PND enables physicians to plan for the level of care needed during delivery and in the neonatal period. With PND, families are also afforded the time to secure the necessary emotional and financial resources to prepare for the birth of a child with special needs [95,96]. In settings in which there are fewer resources available for PND, conscientious objection further restricts women's access to services. Figure 5 presents pathways and implications of provider conscience-based refusal to provide PND services. Because most data on access to PND are from high-resource countries, we must project what would happen in lower-income countries. We use the example of *R.R.*, a Polish woman who was repeatedly refused diagnostic tests to assess fetal status after ultrasound detection of a nuchal hygroma [97] (Fig. 5).

4. Policy responses to manage conscience-based refusal of reproductive healthcare

Here, we review various policy interventions related to conscience-based refusal of care. Initially, we look at the context established by human rights standards or human rights bodies wherein freedom of conscience is enshrined. The UN Committee on Economic, Social and Cultural Rights (CESCR); the UN Committee on the Elimination of Discrimination against Women (CEDAW); and the UN Human Rights Committee have commented on the need to balance providers' rights to conscience with women's rights to have access to legal health services [98–104]. CEDAW asserts that "it is discriminatory for a country to refuse to legally provide for the performance of certain reproductive health services for women" and that, if healthcare providers refuse to provide services on the basis of conscientious objection, "measures should be introduced to ensure that women are referred to alternative health providers" [99]. CESCR has called on Poland to take measures to ensure that women enjoy their rights to sexual and reproductive health, including by "enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection" [104].

The international medical and public health communities, including FIGO in its Ethical Guidelines on Conscientious Objection (2005) [9] and WHO in its updated Safe Abortion Guidelines (2012) [105], have agreed on principles related to the management of

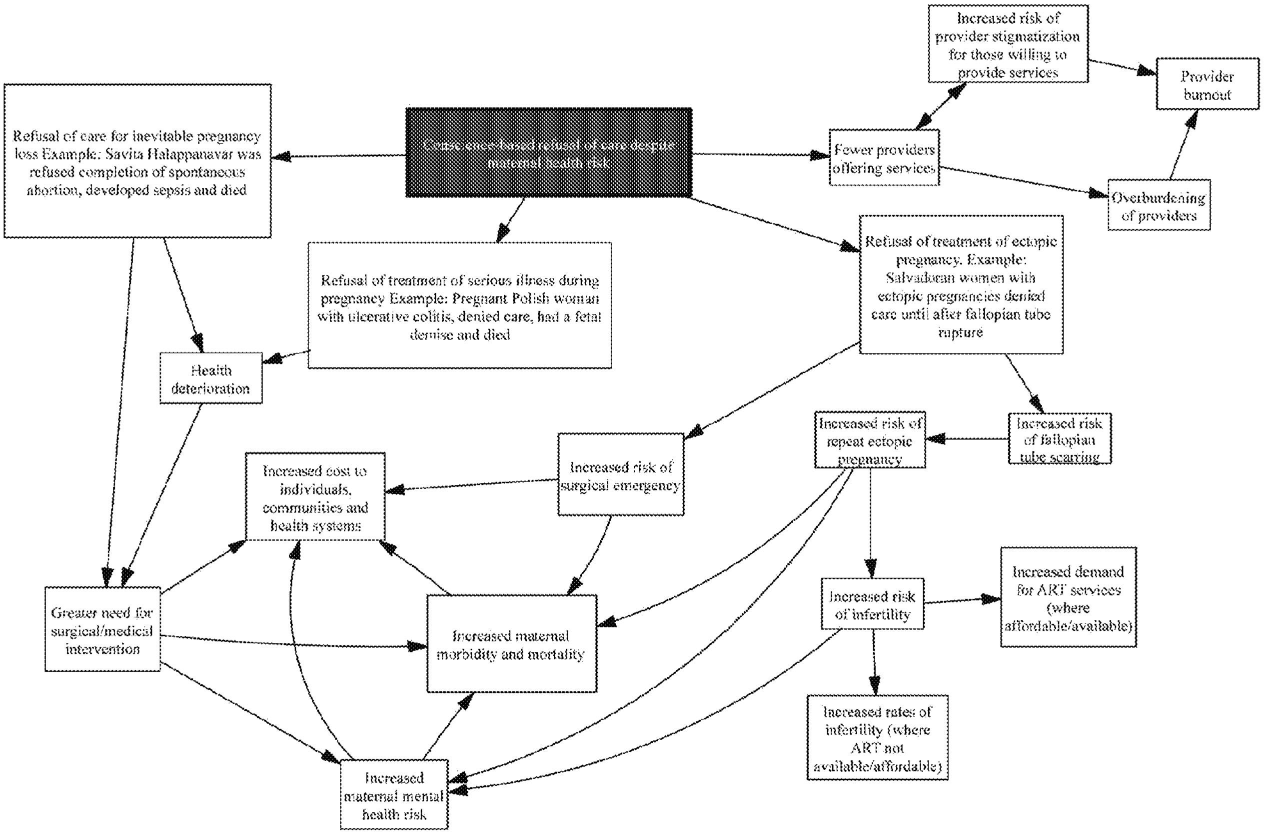

Fig. 4. Consequences of refusal of care in cases of risk to maternal health and unavoidable pregnancy loss.

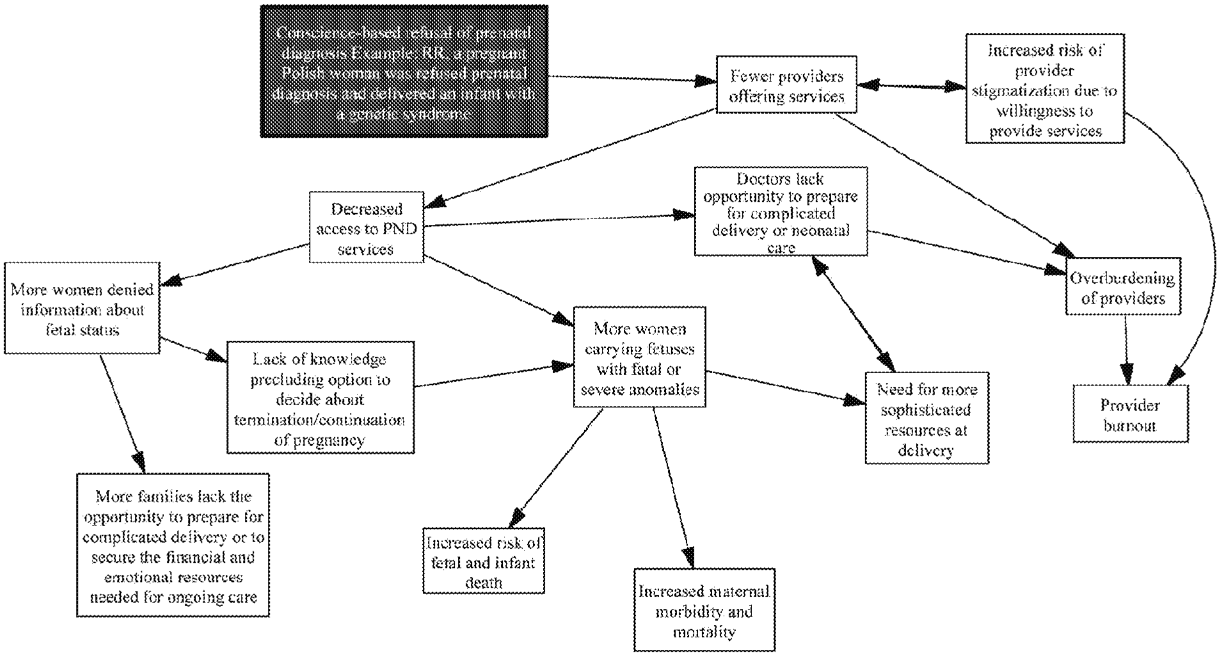

Fig. 5. Consequences of refusal of prenatal diagnosis.

conscientious objection to reproductive healthcare provision. While these are non-binding recommendations, they do assert professional standards of care. These include the following:

- Providers have a right to conscientious objection and not to suffer discrimination on the basis of their beliefs.
- The primary conscientious duty of healthcare providers is to

treat, or provide benefit and prevent harm to patients; conscientious objection is secondary to this primary duty.

Moreover, the following safeguards must be in place in order to ensure access to services without discrimination or undue delays:

- Providers have a professional duty to follow scientifically and professionally determined definitions of reproductive health services, and not to misrepresent them on the basis of personal beliefs.
- Patients have the right to be referred to practitioners who do not object for procedures medically indicated for their care.
- Healthcare providers must provide patients with timely access to medical services, including giving information about the medically indicated options of procedures for care, including those that providers object to on grounds of conscience.
- Providers must provide timely care to their patients when referral to other providers is not possible and delay would jeopardize patients' health.
- In emergency situations, providers must provide the medically indicated care, regardless of their own personal objections.

These statements support both sides of the tension: the right of patients to have access to appropriate medical care and the right of providers to object, for reasons of conscience, to providing particular forms of care. They underscore the professional obligation of healthcare providers to ensure timely access to care, through provision of accurate information, referral, and emergency care. At the transnational level, human rights consensus documents have asserted that institutions and individuals are similarly bound by their obligations to operate according to the bedrock principles that underpin the practice of medicine, such as the obligations to provide patients with accurate information, to provide care conforming to the highest possible standards, and to provide care in emergency situations.

At the country level, however, there is no agreement as to whether institutions can claim objector status. For example, Spain [106], Colombia [107], and South Africa [108] have laws stating that refusal to perform abortions is always an individual, not an institutional, decision. Conversely, Argentinian law [109,110] gives private institutions the ability to object and requires private health centers to register as conscientious objectors with local health authorities. In Uruguay, the Ethical Code does not require the institution employing a conscientious objector to provide referral services, although a newly proposed bill would require such referral [111,112]. In the USA, the question of institutional rights and obligations is hotly debated and the situation is complicated and unresolved. Currently, federal law forbids agencies receiving federal funding from discriminating against any healthcare entity that refuses to provide abortion services [113]. Yet other federal law requires institutions providing services for low-income people to maintain an adequate network of providers and to guarantee that individuals receive services without additional out-of-pocket cost [114].

International and regional human rights bodies, governments, courts, and health professional associations have developed various responses to address conscience-based refusal of care. These responses differ as to whose rights they protect: the rights of a woman to have access to legal services or the rights of a provider to object based on reasons of conscience. They might also have different emphases or targets. Some focus on ensuring an adequate number of providers for a certain service, some concentrate on ensuring that women receive timely referrals to non-objecting practitioners, and some seek to establish criteria for designation as an objector. For example, Norway established a comprehensive regulatory and oversight framework on conscientious objection to abortion, which includes ensuring the availability of providers [33,115]. In Colombia, the Constitutional Court affirmed that conscientious objection must be grounded in true religious conviction, rather than in a personal judgment of "rightness" [116].

Some of these responses are legally binding through national constitutional provisions, legislation, or case law. The European Court of Human Rights (ECHR), whose rulings are legally binding for member nations, clarified the obligation of states to organize the practice of conscience-based refusal of care to ensure that patients have access to legal services, specifically to abortion [97]. Professional associations and employers have developed other interventions, including job requirements and non-binding recommendations. In Germany, for example, a Bavarian High Administrative Court decision [117], upheld by the Federal Administrative Court [118], ruled that it was permissible for a municipality to include ability and willingness to perform abortions as a job criterion. In Norway, employers can refuse to hire objectors and employment advertisements may require performance of abortion as a condition for employment [112]. In Sweden, Bulgaria, Czech Republic, Finland, and Iceland, healthcare providers are not legally permitted to conscientiously object to providing abortion services [38]. Some require referral to non-objecting providers. For example, in the recent *P. and S. v. Poland* case, the ECHR emphasized the need for referrals to be put in writing and included in patients' medical records [119]. In Argentina [110] and France [120], legislation requires doctors who conscientiously object to refer patients to non-objecting practitioners. Similar laws exist in Victoria, Australia [121], Colombia [116,122,123], Italy [124], and Norway [115]. Professional and medical associations around the world recommend that objectors refer patients to non-objecting colleagues. ACOG in the USA [125] and El Sindicato Médico in Uruguay [126] recommend that objectors refer patients to other practitioners. The British Medical Association (BMA) specifies that practitioners cannot claim exemption from giving advice or performing preparatory steps (including referral) where the request for an abortion meets legal requirements [127]. The WMA asserts that, if a physician must refuse a certain service on the basis of conscience, s/he may do so after ensuring the continuity of medical care by a qualified colleague [128]. FIGO maintains that patients are entitled to referral to practitioners who do not object [9].

Pharmacists' associations in the USA and UK have made similar recommendations. The American Society of Health-System Pharmacists asserts that pharmacists and other pharmacy employees have the right not to participate in therapies they consider to be morally objectionable but they must make referrals in an objective manner [129]; the AMA guidelines state that patients have the right to receive an immediate referral to another dispensing pharmacy if a pharmacist invokes conscientious objection [130]. In the UK, pharmacists must also have in place the means to make a referral to another relevant professional within an appropriate time frame [131].

Some jurisdictions mandate registration of objectors or require objectors to provide advance written notice to employers or government bodies. In Spain, for example, the law requires that conscientious objection must be expressed in advance and in written form to the health institution and the government [106]. Italian law also requires healthcare personnel to declare their conscientious objection to abortion to the medical director of the hospital or nursing home in which they are employed and to the provincial medical officer no later than 1 month after date of commencement of employment [124]. Victoria, Australia [118]; Colombia [123]; Norway [115]; Madagascar [132]; and Argentina [109] have similar laws. In Norway, the administrative head of a health institution must inform the county municipality of the number of different categories of health personnel who are exempted on grounds of conscience [115]. Argentinian law [109] gives private institutions the ability to object, requiring these institutions to register as conscientious objectors with local health authorities and to guarantee care by referring women to other centers. Argentinian law also states that an individual objector cannot provide services in a private health center that s/he objects to the provision of in the public health system [110]. Regulation in Canada requires pharmacists to ensure that employers know about their conscientious objector status and to prearrange access to an alternative source for treatment, medication, or procedure [133]. The Code of Ethics for nurses in Australia also requires disclosure to employers [134]. In Northern Ireland, a guidance document by the Department of Health, Social Services and Public Safety asserts that an objecting provider "should have in place arrangements with practice colleagues, another GP practice, or a Health Social Care Trust to whom the woman can be referred" for advice or assessment for termination of pregnancy [135].

Other measures require disclosure to patients about providers' status as objectors. For example, the law in the state of Victoria, Australia, requires objectors to inform the woman and refer her to a willing provider [121]. In Argentina, the Technical Guide for Comprehensive Legal Abortion Care 2010 [109] requires that all women be informed of the conscientious objections of medical, treating, and/or support staff at first visit. Portugal's medical ethical guidelines encourage doctors to communicate their objection to patients [136].

The right to receive information in healthcare, including reproductive health information, is enshrined in international law. For example, the ECHR determined that denial of services essential to making an informed decision regarding abortion can constitute a violation of the right to be free from inhuman and degrading treatment [97]. At the national level, laws have mandated disclosure of health information to patients. For example, according to the South African abortion law, providers, including objectors, must ensure that pregnant women are aware of their legal rights to abortion [108]. In Spain, women are entitled to receive information about their pregnancies (including prenatal testing results) from all providers, including those registered as objectors [106]. In the UK, objectors are legally required to disclose their conscientious objector status to patients, to tell them they have the right to see another doctor, and to provide them with sufficient information to enable them to exercise that right [137–139].

Professional guidelines have also addressed disclosure of health information. In Argentina, any delaying tactics, provision of false information, or reluctance to carry out treatment by health professionals and authorities of hospitals is subject to administrative, civil, and/or criminal actions [109]. FIGO asserts that the ethical responsibility of OB/GYNs to prevent harm requires them to provide patients with timely access to medical services, including giving them information about the medically indicated options for their care [9].

Some require the provision of services in cases of emergency. For example, legislation in Victoria, Australia [121]; Mexico City [140]; Slovenia [141]; and the UK [138] stipulates that physicians may not refuse to provide services in cases of emergency and when urgent termination is required. US case law determined that a private hospital with a tradition of providing emergency care was still obliged to treat anyone relying on it even after its merger with a Catholic institution. This sets the standard for continuity of access after mergers of 2 hospitals with conflicting philosophies [142]. Also, ACOG urges clinicians to provide medically indicated care in emergency situations [125]. In Argentina, technical guidelines from the Ministry of Health stipulate that institutions must provide termination of pregnancy through another provider at the institution within 5 days or immediately if the situation is urgent [109]. In the UK, medical standards also prohibit conscience-based refusal of care in cases of emergency for nurses and midwives [143].

Other measures address the required provision of services when referral to an alternative provider is not possible. In Norway, for example, a doctor is not legally allowed to refuse care unless a patient has such reasonable access [115]. FIGO recommends that "practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well being, such as by patients experiencing unwanted pregnancy" [9].

Some interventions obligate the state to ensure services. In Colombia, for example, the health system is responsible for providing an adequate number of providers, and institutions must provide services even if individuals conscientiously object [107]. The law on voluntary sterilization and vasectomies in Argentina obligates health centers to ensure the immediate availability of alternative services when a provider has objected [144]. In Spain, the government will pay for transportation to an alternative willing public health facility [106]. Italian law requires healthcare institutions to ensure that women have access to abortion; regional healthcare entities are obliged to supervise and ensure such access, which may include transferring healthcare personnel [125]. In Mexico City, the public health code was amended to reinforce the duty of healthcare facilities to make abortion accessible, including their responsibility to limit the scope of conscientious objection [140].

Some measures specify which service providers are eligible to refuse and when they are allowed to do so. In the UK, for example, auxiliary staff are not entitled to conscientiously object [145,146]. According to the BMA guidelines, refusal to participate in paperwork or administration connected with abortion procedures lies outside the terms of the conscientious objection clause [127]. In Spain, only health professionals directly involved in termination of pregnancy have the right to object, and they must provide care to the woman before and after termination of pregnancy [106]. Similarly, doctors in Italy are legally required to assist before and after an abortion procedure even if they opt out of the procedure itself [124]. Also, medical guidelines in Argentina encourage practitioners to aid before and after legal abortion procedures even if they are invoking conscientious objection to participation in the procedure itself [109]. During the Bush administration, the US Department of Health and Human Services extended regulatory "conscience protections" to any individual peripherally participating in a health service [147]. This regulation was contested vigorously and retracted almost fully in February 2011 [148,149].

In Table 1, we lay out some benefits and limitations of policy responses to conscientious objection in order to provide varied actors with a menu of possibilities. As criteria are developed for invoking refusal, it is essential to address the questions of who is eligible to object, and to the provision of which services. We have added the categories of "data" and "standardization" as parameters in the table in recognition of the scant evidence available and the resulting inability to methodically assess the scope and efficacy of interventions. Selection of the various options delineated below will be influenced by the specific sociopolitical and economic context.

5. Conclusion

Refusal to provide certain components of reproductive healthcare because of moral or religious objection is widespread and seems to be increasing globally. Because lack of access to reproductive healthcare is a recognized route toward adverse health outcomes and inequalities, exacerbation of this through further depletion of clinicians constitutes a grave global health and rights concern. The limited evidence available indicates that objection occurs least when the law, public discourse, provider custom, and clinical experience all normalize the provision of the full range of reproductive healthcare services and promote women's autonomy. While data on both the prevalence of conscience-based refusal of

Table 1
Benefits and limitations of policy interventions

Option	Health system needs	Timely access to care	Balancing rights and obligations	Developing criteria for refusers	Standardization	Data needs
Referral to willing and accessible providers	Enables system planning for service delivery	Expedites patients' access to services	Upholds patients' rights to health-related information; providers' obligations to provide information and make refusal transparent; individual conscience	Establishes obligations of those claiming objector status while acknowledging legitimacy of objection	Policies and procedures for disclosure and referral standardized throughout health system	Provides indirect data on patients' encounters with refusal
Registration of objectors/written notice to employers	Informs on prevalence of objection, enabling system planning for service delivery	Leads to more timely access to care for women who can avoid seeking care from known objectors	Acknowledges provider right to object while informing patients. Requirement of formal documentation acknowledges health system stake in such knowledge	Delineates the specific instances in which objection is permitted, and by whom; formal notification of employers makes explicit the criteria for designation as an objector	Ensures that requirements for designation as objector are standardized throughout the health system	Registries provide data on prevalence by type of provider as well as component of care refused
Required disclosure of objector status to patients	Enables women to avoid unproductive visits to objectors and delayed care, promoting smoother functioning of system	Women go directly to willing provider	Acknowledges provider right to object while upholding patients' rights to autonomy and health-related information	Defines obligations of objectors	Standardizes information provided to patients	N/A
Required information to patients about available health options	Informed patients are better able to make decisions and to locate the services that they need	Facilitates patient access to appropriate care	Upholds patients' rights to obtain health-related information; underscores providers' obligations to provide accurate information and to inform about legally available options; asserts health system's commitment to science and to patients' rights	Limits scope of objection by specifying components of care individuals obligated to provide	Standardizes information to patients about health system's range of available services	N/A
Mandated provision of services in urgent situations or when no alternative exists	Facilitates planning for provision of emergency care and for associated policies, procedures, and oversight; ensures that medical sequelae of denial or delay of care are minimized	Provides critical care in a timely fashion	Obligations of the provider to operate in the best interests of patients and to provide appropriate care take precedence over the individual clinician's right to object	Sets limits on the scope of refusal to protect patients in emergency situations	Ensures that objectors adhere to contractual obligations to provide essential and/or life-saving care	Contributes to the ability to track urgent cases and to plan service provision needs
Willingness to provide and proficiency as criteria for employment	Underscores employers' needs to ensure sufficient number of providers to meet demand for specific services	Staff competency and willingness enable ready and timely access to appropriate care	Health systems' needs to employ proficient and willing providers to respond to the health needs of the community trump provider rights to object; providers free to adhere to conscience by choosing other employment	Limits objection because only those willing and trained are eligible for employment	Standardizes such requirements in job postings throughout health system	Tracks the number of proficient and willing candidates seeking employment
Medical certification contingent upon proficiency in specific services	Improves health system-level planning for service delivery by assuring that providers are proficient in needed services	Availability of trained providers facilitates timely access to care	Establishes that objectors have the right to choose other specialties, but not to refuse essential components of a specialty; ensures patient rights to receive appropriate services from providers designated as specialists; defines and safeguards professional standards	Clarifies that specialist objectors must be trained and ready to provide care in emergency situations or when other options not available	Specialty certification guarantees mastery of a set of skills and compliance with explicit obligations	Tracks number of providers certified and, therefore, proficient, thus facilitating planning
Medical society guidelines delineating expected standards of care	Recommends that priority go to patient receipt of care and to prevention of shortages of willing and qualified providers; guidelines may lack mechanisms for implementation	Recommends policies and procedures to ensure timely access to care but may lack force	Delineates the rights and obligations of providers and the rights of patients	Suggests criteria for designation as objector and associated obligations	Asserts standards of care	N/A

care and the consequences for women's health and health system function are inadequate, they indicate that refusal is unevenly distributed; that it may have the most severe impact in those parts of the world least able to sustain further personnel shortages; and that it also affects women in more privileged circumstances.

The present White Paper has laid out the available data and outlined research questions for further management of conscience-based refusal of care. It presents logical chains of consequences when refusal compromises access to specific components of reproductive healthcare and categorizes efforts to balance the claims of objectors with the claims of both those seeking healthcare and the systems obligated to provide these services. We highlight the claims of those whose conscience compels them to provide such care, despite hardship. As our emphasis is on medicine and science, we close by considering ways for medical professional and public health societies to develop and implement policies to manage conscientious objection.

One recommendation is to standardize a definition of the practice and to develop eligibility criteria for designation as an objector. Such designation would have accompanying obligations, such as disclosure to employers and patients, and duties to refer, to impart accurate information, and to provide urgently needed care. Importantly, professional organizational voices can uphold conformity with standards of care as the priority professional commitment of clinicians, thus eliminating refusal as an option for the care of ectopic pregnancy, inevitable spontaneous abortion, rape, and maternal illness. In sum, medical and public health professional organizations can establish a clinical standard of care for conscientious objection, to which clinicians could be held accountable by patients, medical societies, and health and legal systems.

There are additional avenues for professional organizations to explore in upholding standards. Clinical specialty boards might condition certification upon demonstration of proficiency in specific services. Clinical educators could ensure that trainees and members are educated about relevant laws and clinical protocols/procedures. Health systems may consider willingness to provide needed services and proficiency as criteria for employment. These last are noteworthy because they also move us from locating the issue at the individual level to consideration of obligations at the professional and health system levels.

These issues are neither simple nor one-sided. Conscience and integrity are critically important to individuals. Societies have the complicated task of honoring the rights of dissenters while also limiting their impact on other individuals and on communities. Although conscientious objection is only one of many barriers to reproductive healthcare, it is one that medical societies are well positioned to address because providers are at the nexus of health and rights concerns. They have the unique vantage point of caring simultaneously about their own conscience and about their obligations to patients' health and rights and to the highest standards of evidence-based care. The present White Paper has disentangled the range of implications for women's health and rights, health systems, and objecting and committed providers. Thus, it equips clinicians and their professional organizations to contribute a distinct medical voice, complementary to those of lawyers, ethicists, and others. We urge medical and public health societies to assert leadership in forging policies to balance these competing interests and to safeguard reproductive health, medical integrity, and women's lives.

Acknowledgments

Ford Foundation and an anonymous donor supported the publication of the supplement. We thank all GDC funders for making the project possible.

Conflict of interest

The authors have no conflicts of interest.

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Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

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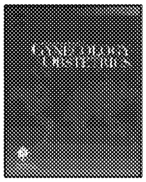

CONSCIENTIOUS OBJECTION

Conscientious objection or fear of social stigma and unawareness of ethical obligations

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ARTICLE INFO

Keywords:
Conscientious objection
Ethical principles
Legal abortion

ABSTRACT

Conscientious objection is a legitimate right of physicians to reject the practice of actions that violate their ethical or moral principles. The application of that principle is being used in many countries as a justification to deny safe abortion care to women who have the legal right to have access to safe termination of pregnancy. The problem is that, often, this concept is abused by physicians who camouflage under the guise of conscientious objection their fear of experiencing discrimination and social stigma if they perform legal abortions. These colleagues seem to ignore the ethical principle that the primary conscientious duty of OB/GYNs is—at all times—to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty. One of the jobs of the FIGO Working Group for the Prevention of Unsafe Abortion is to change this paradigm and make our colleagues proud of providing legal abortion services that protect women's life and health, and concerned about disrespecting the human rights of women and professional ethical principles.

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1. The concept of conscientious objection

Conscientious objection is a legitimate right of physicians to reject the practice of actions that violate their ethical or moral principles. It allows them, for example, to reject participation in the process of interrogation of suspects, which may include procedures reaching the limits of torture. In the context of providing legal abortion care, the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health states that [1]:

> Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination.

The application of that principle is being used in several countries in Latin America and other parts of the world as a justification to deny safe abortion care to women who have the legal right to have access to safe termination of pregnancy.

2. Inappropriate utilization of conscientious objection to deny legal abortion services

Latin America is a region with very restrictive abortion laws and it includes most of the few countries in the world where abortion is not permitted in any circumstances: Chile, Honduras, El Salvador, and more recently Dominican Republic and Nicaragua (all of which are relatively small countries) [2]. In most other countries in Latin America, abortion is considered a crime but is not punished in certain circumstances: for example, when performed to preserve women's life and/or health; in cases of rape or incest; and in the presence of very severe fetal defects incompatible with extrauterine life.

Abortion is permitted in broad circumstances in Cuba, Mexico City, Colombia, and more recently Uruguay up to 12 weeks of pregnancy [2–5]. The problem is that most women who meet the requirements for obtaining a permissible abortion do not receive the care they need in public hospitals—instead, resorting to clandestine abortions, which can be unsafe. In recent years, there have been efforts from private organizations and governments to make abortion accessible to women who meet the legal conditions, following International Conference on Population and Development recommendations [6]. The main obstacle to the provision of services is unwillingness of physicians claiming conscientious objection to providing abortion care.

The problem is that, often, the concept of conscientious objection is abused by physicians in at least 2 different ways:

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(1) By not respecting their obligation to give priority to the needs of the women for whose care they are responsible. In the words of the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health: "The primary conscientious duty of obstetrician–gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty" [1].

(2) By camouflaging under the guise of conscientious objection their fear of experiencing discrimination if they perform legal abortions.

A previous study surveyed 3337 members of the Brazilian Federation of Gynecology and Obstetrics Societies who responded to an anonymous questionnaire inquiring under which circumstances abortion should be permitted by law. Almost 85% agreed that women who become pregnant after rape should have the legal right to obtain a safe termination of pregnancy. Only 50%, however, were willing to perform such an abortion or prescribe abortifacient drugs [7].

A subsequent qualitative study of 30 OB/GYNs from the state of Sao Paulo showed that the reasons for refusing to perform legal abortion derived mostly from personal convictions and religious principles [8]. Religious justification is usually accepted without argument. Some study participants, however, expressed their doubt that the religious rationale was always genuine because they suspected that the main reason for unwillingness to perform abortion was the fear of social stigma [9].

Physicians know that refusal to perform pregnancy termination while alleging conscientious objection will have no consequences such as complaints or disciplinary action against them. By contrast, they fear negative legal or social consequences if they do perform terminations and prefer to avoid these. The concept that "the primary conscientious duty of obstetrician–gynecologists is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" is rarely taken into account [1]. It is much easier to use conscientious objection to hide the real reason, which is that it is simply more comfortable to deny the service that the woman needs than to fulfill their professional and ethical obligation of providing safe abortion services according to the country's law.

It is disappointing to observe that many of our colleagues, at least in the Latin American region, appear to fear being stigmatized for carrying out a legal procedure that would avert the serious complications that could occur if the procedure were performed unsafely and clandestinely but are not afraid of being stigmatized for avoiding their ethical duty "to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible" [1].

3. How to promote proper balance between conscientious objection and ethical obligations to patients

It appears that those of us who occupy positions of leadership in the professional organizations of gynecologists and obstetricians have not done our job sufficiently in terms of promoting and normalizing these ethical principles among our colleagues. It appears that they are unaware that our "… primary conscientious duty … is at all times to … provide benefit and prevent harm to the patients" under our care [1].

We have often been in meetings with honest and sensitive colleagues who, in general, promote and defend women's sexual and reproductive rights, but who nevertheless find excuses—under the guise of conscientious objection—for not providing abortion services within the limits of the local law.

One explanation for this situation is the incorrect idea that facilitating access to safe and legal abortion services promotes abortions. Many obstetricians, accustomed to work protecting the life and health of the fetuses of women who want to have children, feel uncomfortable with the notion of increasing the number of abortions. This indicates that we have failed to disseminate the evidence of the statistically significant inverse relationship between the proportion of women living in countries with liberal abortion laws and the induced abortion rate among the same women. These data show unequivocally that giving broader access to safe legal abortion does not lead to increased rates of abortion [9].

In other words, rather than solely criticizing the behavior of the many colleagues who hide their fear of stigma under the guise of conscientious objection, we should work to disseminate some basic ethical principles clearly stated by the FIGO Committee on the Ethical Aspects of Human Reproduction and Women's Health. We should also disseminate the evidence that making legal abortion more broadly available does not increase the abortion rate but does reduce maternal mortality and morbidity.

The FIGO Working Group for the Prevention of Unsafe Abortion promotes the prevention of unintended pregnancy as a primary strategy and then asserts that, if unintended pregnancy has occurred and the abortion is inevitable, safe abortion services should be available within the limits of the law [10]. Although some progress has occurred in Latin America—namely, in Brazil, Colombia, Argentina, and Uruguay—there is still strong resistance from many of our colleagues, and the number of women with legal rights to abortion who lack access to services is much greater than the number of women who receive appropriate care. The situation is not much different in Africa and many countries in Asia, indicating that we have to seek stronger commitments from national OB/GYN societies, who are all bound to follow the FIGO ethical guidelines described above.

The FIGO Working Group for the Prevention of Unsafe Abortion will need the support of the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health to change this paradigm and make our colleagues proud of providing legal abortion services that protect women's life and health, and concerned about disrespecting the human rights of women and professional ethical principles. That is our task for the immediate future.

Conflict of interest

The authors have no conflicts of interest.

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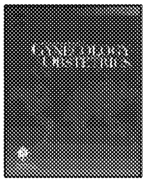

CONSCIENTIOUS OBJECTION

Conscientious objection to provision of legal abortion care

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ARTICLE INFO

Keywords:
Abortion
Conscientious objection
Human rights
Maternal health
Women's health

ABSTRACT

Despite advances in scientific evidence, technologies, and human rights rationale for providing safe abortion, a broad range of cultural, regulatory, and health system barriers that deter access to abortion continues to exist in many countries. When conscientious objection to provision of abortion becomes one of these barriers, it can create risks to women's health and the enjoyment of their human rights. To eliminate this barrier, states should implement regulations for healthcare providers on how to invoke conscientious objection without jeopardizing women's access to safe, legal abortion services, especially with regard to timely referral for care and in emergency cases when referral is not possible. In addition, states should take all necessary measures to ensure that all women and adolescents have the means to prevent unintended pregnancies and to obtain safe abortion.

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1. Introduction

Over the past 2 decades, the scientific evidence, technologies, and human rights rationale for providing safe abortion care have advanced considerably. Despite these advances, however, a broad range of cultural, regulatory, and health system barriers that deter access to abortion continues to exist in many countries, and the numbers and proportion of unsafe abortions continue to increase, especially in low- and middle-income countries [1]. When conscientious objection to provision of abortion becomes one of these barriers, it can create risks to women's health and their human rights.

In view of the continuing need for evidence- and human rights-based recommendations for providing safe abortion care, WHO published the second edition of *Safe Abortion: Technical and Policy Guidance for Health Systems* in June 2012 [2]. In addition to providing recommendations for clinical care and service delivery, the document highlights a number of regulatory and policy barriers, including conscientious objection, and provides guidance to eliminate them. If implemented at country level, the WHO guidance provides a comprehensive framework that can have a substantive public health impact on reducing preventable abortion-related deaths and disability.

2. What is conscientious objection to provision of abortion?

Conscientious objection means that healthcare professionals or institutions exempt themselves from providing or participating in abortion care on religious and/or moral or philosophical grounds. While other regulatory and health system barriers also hinder women's right to obtain abortion services, conscientious objection is unique because of the tension existing between protecting, respecting, and fulfilling women's rights and health service providers' right to exercise their moral conscience. Although the right to freedom of thought, conscience, and religion is protected by international human rights law, the law stipulates that freedom to manifest one's religion or beliefs may be subject to limitations to protect the fundamental human rights of others [3]. Therefore, laws and regulations should not entitle health service providers or institutions to impede women's access to legal health services [4].

Health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of healthcare professionals does not prevent women and adolescents from obtaining access to services to which they are entitled under the applicable legislation [2]. Based on available health evidence and human rights standards, the WHO safe abortion guidance stipulates that healthcare professionals who claim conscientious objection must refer women to a willing and trained service provider in the same or another easily accessible healthcare facility, in accordance with national law. Where referral is not possible, the healthcare professional who objects must provide safe abortion to save the woman's life and to prevent damage to her health. Furthermore, women who present with complications from an abortion, including illegal or unsafe abortion, must be treated urgently and respectfully, in the same way as any other emergency patient, without punitive, prejudiced, or biased behaviors [2]. Adherence to the individual

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and institutional responsibilities outlined in the WHO guidance allows for the exercise of moral conscience without compromising women's and adolescents' access to safe, legal abortion services if sufficient facilities, service providers, necessary equipment, and drugs are made available.

3. Conscientious objection as a barrier to abortion care

In theory, conscientious objection need not be a barrier to women seeking abortion. However, not all claims to conscientious objection reflect a genuine concern about compromising an individual provider's moral integrity; rather, they may represent reluctance to provide certain sexual and reproductive health services such as abortion, discriminatory attitudes, or other motivations stemming from self-interest [5]. In practice, individual or institutional refusal to provide timely referral and emergency care interferes with women's access to services and may increase health risks. In addition to limiting women's access to lawful services in general, abuse of conscientious objection can result in inequities in access, creating disproportionate risks for poor women, young women, ethnic minorities, and other particularly vulnerable groups of women who have fewer alternatives for obtaining services. Women's access to health services is jeopardized not only by providers' refusal of care but also by governments' failure to ensure adequate numbers and distribution of providers and facilities to offer abortion services.

In contexts in which conscientious objection risks harming women's health and their human rights, it is likely to coexist with a broad range of other regulatory and health system barriers, which may be intended to discourage and limit women's access to legal abortion. For example, lack of public information about safe abortion, poorly defined or narrowly interpreted legal grounds for abortion, requirements for third-party authorizations to receive abortion, mandatory waiting periods, requirements for medically unnecessary tests or procedures, restrictions on public funding and private insurance coverage, and requirements for the provision of misleading or inaccurate information may all be intended to discourage women from having an abortion [2,6]. In addition, unregulated conscientious objection opens the door for disingenuous claims of moral conscience for refusing care and compromises accountability for ensuring timely access to care. When combined, these and other barriers may exacerbate inequities to access and delays in seeking services, or serve as a deterrent to seeking legal services altogether, potentially increasing the likelihood of unsafe abortion.

Any barrier, including abuse of conscientious objection, potentially causes delays in gaining access to a needed health service. Legal abortion using WHO-recommended methods and practice is one of the safest of all medical procedures that women undergo. However, although the risk of mortality from safe abortion is low, the risk increases for each additional week of gestation. A study on legal abortion in the USA from 1988 to 1997 found that the overall risk of death from abortion was 0.7 per 100,000 legal abortions [7], with gestational age at time of abortion the greatest risk factor for abortion-related death. The mortality rate for abortions at a gestational age of 8 or fewer weeks was 0.1, but for abortions at 21 or more weeks the rate was 8.9, which was comparable to mortality associated with childbirth in the USA, between 1998 and 2005 [8].

Because conscientious objection is just one of a potentially large number of interconnected barriers to safe abortion services, it is difficult to evaluate the direct impact on access of disingenuous claims of conscientious objection, of conscientious objection without referral, and of refusal to treat emergencies. Indeed, the extent to which conscientious objection to abortion directly results in pregnancy-related mortality and morbidity is unknown and merits further investigation.

4. Policy, health system, and service delivery interventions to protect women's health and their human rights

UN treaty-monitoring bodies, and regional and national courts have increasingly called upon states to provide comprehensive sexual and reproductive health information and services to women and adolescents, to eliminate regulatory and administrative barriers that impede women's access to safe abortion services, and to provide treatment for abortion complications [9–33]. This requires states to train and equip health service providers, along with other measures to ensure that such abortion is safe and accessible [34]. Human rights bodies have also called upon states to ensure that the exercise of conscientious objection does not prevent individuals from obtaining services to which they are legally entitled [17,18,26,35,36]. When laws, policies, and programs do not take into consideration the multiple challenges inherent in implementing conscientious objection to abortion care, women's health and their human rights can be compromised. Specifically, there should be regulations for health service providers on how to invoke conscientious objection without jeopardizing women's access to safe, legal abortion services, especially with regard to referral and in emergency cases when referral is not possible.

In addition to providing guidance for regulating providers' conscientious objection to legal abortion, the WHO safe abortion document highlights a number of health system interventions that can facilitate equitable access to and availability of safe abortion [2]. As a first step, the provision and use of effective contraception can reduce the likelihood of unintended pregnancy and, thus, women's need for recourse to abortion. As a remedy to shortages of willing providers of legal abortion care, states should consider improving access through training mid-level providers and offering abortion services at the primary-care level and through outpatient services. Abortion care can be safely provided by any properly trained healthcare provider, including nurses, midwives, clinical officers, physician assistants, family welfare visitors, and others who are trained to provide basic clinical procedures related to reproductive health. Abortion care provided at the primary-care level and through outpatient services in higher-level settings can be done safely and minimizes costs while maximizing the convenience and timeliness of care for the woman. Allowing home use of misoprostol following provision of mifepristone at the healthcare facility can further improve the privacy, convenience, and acceptability of services, without compromising safety. Financing mechanisms can facilitate equitable access to good-quality services and, to the extent possible, abortion services should be mandated for coverage under insurance plans.

Governments have many options for facilitating good access to safe, legal abortion. Ultimately, to mitigate the potential impacts of conscientious objection, well-trained and equipped healthcare providers and affordable services should be readily available and within reach of the entire population. This is essential for ensuring access to safe abortion and should be both a public health and a human rights priority.

Conflict of interest

The authors have no conflicts of interest. B.R.J., M.V.D., and M.T. are staff members of WHO. The authors alone are responsible for the views expressed in the present article, which do not necessarily represent the decisions, policy, or views of WHO.

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International Journal of Gynecology and Obstetrics 123 (2013) S63–S65

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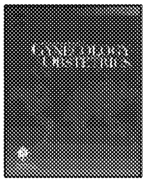
International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo



CONSCIENTIOUS OBJECTION

Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings

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ARTICLE INFO

Keywords:
Abortion
Conscientious objection
Human rights
International law
Reproductive health

ABSTRACT

The practice of conscientious objection by healthcare workers is growing across the globe. It is most common in reproductive healthcare settings because of the religious or moral values placed on beliefs as to when life begins. It is often invoked in the context of abortion and contraceptive services, including the provision of information related to such services. Few states adequately regulate the practice, leading to denial of access to lawful reproductive healthcare services and violations of fundamental human rights. International ethical, health, and human rights standards have recently attempted to address these challenges by harmonizing the practice of conscientious objection with women's right to sexual and reproductive health services. FIGO ethical standards have had an important role in influencing human rights development in this area. They consider regulation of the unfettered use of conscientious objection essential to the realization of sexual and reproductive rights. Under international human rights law, states have a positive obligation to act in this regard. While ethical and human rights standards regarding this issue are growing, they do not yet exhaustively cover all the situations in which women's health and human rights are in jeopardy because of the practice. The present article sets forth existing ethical and human rights standards on the issue and illustrates the need for further development and clarity on balancing these rights and interests.

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1. Introduction

Ethical, health, and human rights standards have attempted to harmonize the practice of conscientious objection with women's right to sexual and reproductive health services. They consider regulation of the unfettered use of conscientious objection essential to the realization of sexual and reproductive rights. Under international human rights law, states have a positive obligation to act in this regard. These standards and recommendations should be universally adopted and applied. While ethical and human rights standards on this issue are growing, they do not yet exhaustively cover all the situations in which women's health and human rights are in jeopardy because of the practice. The present article sets forth existing ethical and human rights standards on the issue and illustrates the need for further development and clarity on balancing these rights and interests.

The practice of conscientious objection by healthcare workers is growing across the globe. It is most common in reproductive healthcare settings because of the religious or moral values placed on beliefs as to when life begins. It is often invoked in the context of abortion and contraceptive services, including the provision of information related to such services. Frequently, such invocation is not transparent and women are neither directly told of providers' beliefs nor referred to another provider. Instead, they are subjected to attempts to sway them away from undergoing abortion. While OB/GYNs may most often be the healthcare workers claiming conscientious objection, pharmacists, nurses, anesthesiologists, and cleaning staff have been reported to refuse to fill their job duties in connection to acts they consider objectionable. In addition, public healthcare institutions are informally refusing to provide certain reproductive health services, often owing to beliefs of individual hospital administrators [1].

The practice arises in countries with relatively liberal abortion laws, such as the USA, Slovakia, and South Africa, as well as in countries with more restrictive laws, such as most Latin American and certain African countries [2,3]. The implications for women's health and lives can be grave in both contexts and urgent questions arise as to how to effectively reconcile respect for the practice of conscientious objection with the right of women to have access to lawful reproductive healthcare services.

Ethical standards in this area can provide some answers. In fact, ethical standards have not only helped shape the development of national law but also recently influenced the development of international human rights law in this area. While these are welcome developments, many gaps remain both in ethics and in law.

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2. International human rights law

The right to access to reproductive healthcare is grounded in numerous human rights, including the rights to life, to health, to non-discrimination, to privacy, and to be free from inhuman and degrading treatment, as explicitly articulated by UN and regional human rights bodies. Such rights place obligations on states to ensure transparent access to legally entitled reproductive health services and to remove barriers limiting women's access to such services [4,5]. Such barriers include conscientious objection. UN bodies monitoring state compliance with international human rights treaties have raised concern about the insufficient regulation by states of the practice of conscientious objection to abortion. They have consistently recommended that states ensure that the practice is well defined and well regulated in order to avoid limiting women's access to reproductive healthcare. They encourage, for example, implementing a mechanism for timely and systematic referrals, and ensuring that the practice of conscientious objection is an individual, personal decision and not that of an institution as a whole [1,6–8].

The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health issued a groundbreaking report in 2011 on the negative impact that the criminalization of abortion has had on women's health and lives, and specifically articulated state obligations to remove barriers—including some laws and practices on conscientious objection—that interfere with individual decision making on abortion. The report notes that such laws and their use create barriers to access by permitting healthcare providers and ancillary personnel to refuse to provide abortion services, information about procedures, and referrals to alternative facilities and providers. These and other laws make safe abortions unavailable, especially to poor, displaced, and young women. The report notes that such restrictive regimes serve to reinforce the stigma of abortion being an objectionable practice. The Rapporteur recommended that, in order to fulfill their obligations under the right to health, states should "[E]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider" [9].

Conscientious objection is grounded in the right to freedom of religion, conscience, and thought—recognized in many international and regional human rights treaties, as well as in national constitutions. Under international and regional human rights law, the freedom to manifest one's religion or beliefs can be limited for the protection of the rights of others, including reproductive rights [8,10–12].

The Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights (one of the major UN human rights treaties), has recognized that religious attitudes can limit women's rights and called on states to "… ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law and to equal enjoyment of all Covenant rights" [13].

Two recent decisions of the European Court of Human Rights shed light on the meaning of such limitations in the context of conscientious objection to abortion-related reproductive health services. In these separate cases against Poland, an adolescent and a woman have complained that access to lawful abortion and prenatal diagnostic services was hindered, in part, by the unregulated practice of conscientious objection. While Poland has one of the most restrictive abortion laws in Europe, the law does allow for abortion in cases of threat to a pregnant woman's health or life, and in cases of rape and cases of fetal abnormality. It also entitles women to receive genetic prenatal examinations in this context. In *R.R. v. Poland* (2011), the applicant was repeatedly denied prenatal genetic testing after her doctor discovered fetal abnormalities during a sonogram [14]. The exam results would have informed *R.R.*'s decision on whether to terminate her pregnancy, yet doctors, hospitals, and administrators repeatedly denied her information and diagnostic tests until the pregnancy was too advanced for abortion to be a legal option [14]. In a case decided a year later, *P. and S. v. Poland* (2012), a 14-year-old who became pregnant as a result of rape faced numerous barriers and delays in obtaining a lawful abortion, including coercive and biased counseling by a priest; divulgence of confidential information about her pregnancy to the press and others; removal from the custody of her mother, who supported her decision to undergo an abortion; and the unregulated practice of conscientious objection [15]. The procedure eventually took place but in a clandestine-like manner and without proper postabortion care [15].

In both cases, the Court found violations of Articles 3 (right to be free from inhuman and degrading treatment) and 8 (right to private life) of the European Convention on Human Rights for obstructing access to lawful reproductive healthcare information and services [16]. With regard to conscientious objection, it held that the Convention does not protect every act motivated or inspired by religion: "… States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation" [14,15].

It also noted problems with lack of implementation and respect for the existing law governing this practice, and specified that reconciliation of conscientious objection with the patient's interests makes it mandatory for such refusals to be made in writing and included in the patient's medical record, mandating that the objecting doctor refer the patient to another physician competent and willing to carry out the same service [15].

These cases are groundbreaking for numerous reasons, but for the purposes of the present article I will focus on 2 reasons. First, it is the first time any international or regional human rights body in *an individual complaint* has articulated states' *positive* obligations to regulate the practice of conscientious objection in relation to abortion and to prenatal diagnostic services. These cases required an international human rights tribunal to take a look at abuse of the practice in a specific situation and the experiences of the women subject to the practice. The Court's finding in the case related to prenatal diagnostic care is groundbreaking because it is the first time a human rights body has addressed objection to providing information to a patient about her health. While the Court's judgments provide minimal guidance, it is developing its standards in this area.

The second reason is that, for the first time, the Court directly relied on FIGO's ethical standards/guidelines and resolution on the issue of conscientious objection to support its decision [14,17].

3. Ethical and health standards

The FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health submitted an amicus brief in the case of *R.R. v. Poland*, presenting its resolution and ethical guidelines on conscientious objection to the Court [18]. In articulating state obligations to regulate the practice, the Court directly relied on the information provided by FIGO to support its judgment, citing the material provided in FIGO's amicus brief as a source of relevant law and practice [14]. FIGO's ethical guidelines and resolution on the subject have, thus, directly influenced the emerging human rights standards regarding conscientious objection to reproductive health services. This is a rare example of how ethical standards can shape the development of international human rights law and reflects the critical importance that ethical standards can have in protecting and promoting human rights.

In fact, FIGO has the most comprehensive ethical guidelines on conscientious objection of any international medical professional organization. The ethical guidelines note that any conscientious objection to treating a patient is secondary to the primary duty—which is to treat, provide benefit, and do no harm, and includes provision of accurate information and referral/obligatory provision of care when referral is not possible or need is urgent [17]. A resolution mirroring these guidelines was adopted a year later by the FIGO General Assembly [19]. The resolution also recognized the duty of practitioners as professionals to abide by scientifically and professionally determined definitions of reproductive health services and not to mischaracterize them on the basis of personal beliefs [18].

WHO has also recognized that, as a barrier to lawful abortion services, conscientious objection can impede women from reaching the services for which they are eligible, potentially contributing to unsafe abortion. In its recent edition of guidelines on safe abortion, WHO notes that health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation. It recommends the establishment of national standards and guidelines facilitating access to and provision of safe abortion care, including the management of conscientious objection [18,20,21].

While these health and ethical standards provide some guidance for regulating the practice of conscientious objection and have an important role in influencing the development of the nascent human rights standards on the topic, many issues that arise in this context are not fully addressed by international legal, health, or ethical standards.

4. Conclusion

International ethical and health bodies, and international and regional human rights mechanisms are well positioned to fill in the gaps in guidance. Such standards can help in the development of national laws and regulations on the subject and can be used to hold states accountable when associated violations of human rights occur. The standards should cover the numerous systemic and individual barriers leading to denial of services. Such guidance should clearly establish that only individuals, not institutions, can have a conscience and that only those involved in the direct provision of services should be allowed to invoke conscientious objection. Medical students, for example, cannot object to learning to perform a service that they may need to provide in case of emergency. They should also establish under which circumstances individuals can and cannot object. For example, the practice should be prohibited when a patient's life or physical/mental health is in danger. In addition, the types of services for which objection is impermissible should be specified, such as providing referrals, information, and diagnostic services. Standards should also clearly articulate state obligations to guarantee that the practice of conscientious objection does not hinder the availability and accessibility of providers, including by employing sufficient staff who are available and willing to deliver services competently; by ensuring oversight and monitoring of the practice; and by holding to account those in violation [1,6,12,22].

Moreover, as in all circumstances, healthcare systems should be transparent, and services should respect women's dignity and autonomy in decision making. In other words, *women's* conscience should be fully respected [23].

Conflict of interest

The author has no conflicts of interest.

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