Acceptable attitudes and the limits of tolerance: Understanding public attitudes to conscientious objection in healthcare

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Abstract

Background. The public's attitudes to conscientious objection (CO) are likely to influence political decisions about CO and trust towards healthcare systems and providers. Few studies examine the public's attitudes in an in-depth way.

Methods. Six hypotheses about public attitudes to CO were devised and a questionnaire designed in order to test them. 1,617 Norwegian citizens completed the online questionnaire.

Results. Support for toleration of CO was strongest in the case of ritual circumcision of infant boys, lower for assisted dying and abortion. Attitudes to the procedure itself negatively predicted attitudes to CO for the procedure. Respondents were more accepting of CO to performing abortion than of CO to referrals for abortion. There was stronger support for CO as an outcome of local pragmatic arrangements than for CO as a statutory right.

Conclusions. Instead of viewing CO as a 'moral safety valve' or minority right which is due also to those with whom we disagree strongly, a portion of the public approaches the issue from the angle of what moral attitudes they deem acceptable to hold. The gap between this approach on the one hand and human rights principles on the other is likely to give rise to tensions in political processes whenever policies for CO are negotiated.

Introduction

Conscientious objection in healthcare – in which a healthcare professional refuses to contribute to legal services for moral or religious reasons – has been debated extensively as a normative issue within academic bioethics. However, there are few studies that examine the public's attitudes and reasoning in an in-depth way. Such explorations would be worthwhile in that the public's attitudes are likely not only to impact attitudes and trust towards healthcare systems and providers, but also to influence political decisions in the field.

Legally, a certain scope for toleration of conscientious objection in healthcare (CO) is often argued to follow from human rights conventions such as the European Convention on Human Rights (ECHR) article 9 and its provision for freedom of conscience, which includes a person's right «in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.»[1]

Ethically, although several argue either that there should be broad toleration of CO or that CO should seldom or never be accepted, there are also many who champion views resembling what has been termed the 'conventional compromise',[2] wherein CO is thought to be morally acceptable if the professional has a serious moral objection, yet is willing to refer the patient to a colleague and the patient is not unduly burdened. Arguably, the conventional compromise comports well with the principles of the ECHR's article 9.[1] Toleration for CO can also be seen as an accommodation for a 'moral minority' which it is reasonable for a liberal democracy to make in order to protect minority rights.[3]

However, in our impression, neither of these frameworks – the freedom of conscience or the minority right framework, respectively – typically get to structure public debates about conscientious objection in practice. Building on extensive observation of recent public debates in Norway and Sweden, we proposed six hypotheses about the public's attitudes and reasoning about CO (Table 1). We then devised questions to test the hypotheses, with the aim of providing a deeper understanding about how the public's views arise.

Table 1. Six hypotheses about public attitudes to conscientious objection in healthcare.

	Hypothesis
H1	Public attitudes to CO varies between the procedures in question

H2	The respondents' moral attitude to the procedure itself predicts the attitude to CO concerning the procedure
H3	The public is more accepting of local, pragmatic arrangements for CO than of CO as a statutory right
H4	The public is more accepting of CO to performing a procedure than of CO to referrals for the same procedure
H5	Public attitudes to CO are influenced by factors that are not usually considered morally relevant, such as the gender and religion of the objector
H6	Public attitudes are influenced by how CO is framed

The Norwegian context

In Norway, abortion is available on request in the first trimester. Health professionals have a statutory right to refrain from performing and assisting with abortion. However, the issue of CO to abortion referrals for general practitioners (GPs) spurred a protracted and heated public debate in 2012-14.[4] The outcome – likely to have been influenced by strong public opposition to CO in this context – was a government circular that made clear that no CO on the part of GPs, neither in the case of abortion referrals nor in any other case, would henceforth be tolerated.[5] A case concerning a GP who was fired for refusing to insert contraceptive intrauterine devices reached the Supreme court, which in autumn 2018 ruled in favour of the GP. The case was, however, decided primarily on labour law and not on human rights.

The issue of CO has also been debated for other procedures, such as ritual circumcision and assisted dying. In Norway, all regional health trusts are required to offer ritual circumcision of infant boys. The law states that professionals' requests to refrain from participating in the procedure should be met as far as possible, as long as access to the procedure is not thereby

restricted. Assisted dying is prohibited by the penal code; in public debates on the issue several have stated that if it were to be allowed, it should have to be accompanied by a CO clause.

Methods

The study was performed as part of the NOBAS (Norwegian Bioethics Attitude Survey) project which examines public attitudes to bioethics issues. In February 2017, electronic questionnaires were distributed via email by the firm Respons Analyse to their web-based, nationally representative panel of Norwegian adults. Members of the web panel are invited to respond to surveys and in return have a chance to win gift cards. Participation was voluntary. The study was evaluated by the Data Protection Official at the Norwegian Centre for Research Data (ref. 51786). In total, 18,978 respondents were invited to participate; we received 1,617 completed questionnaires (response rate 8.5 %).

The questionnaire was designed with the aim of testing the six hypotheses (Table 1) and refined through discussion among the authors. Four lay persons also tested and gave feedback on the questionnaire.

Translated introductions and questions are given in Box 1. In order to examine whether respondents would be affected by the way the issues were framed, two variations of the introduction to the survey were constructed and the respondents were randomized to receive one of these. Introduction 1 contained keywords that were meant to portray CO in a positive light (eg, 'freedom of conscience', 'human right', 'tolerance'). Introduction 2 represented CO in a more negative light (eg, 'refuse to perform certain duties', 'unconditional right to conscientious objection'). All respondents then received the first set of questions. The second

set of questions was prefaced by a brief case in which three factors were randomized: whether the CO was to performing abortion or to referring for abortion; and the gender and religious affiliation of the objecting doctor. In addition, the analyses make use of two questions on attitudes towards abortion and assisted dying and of demographic information.

Box 1. Questionnaire on conscientious objection.

Introduction version 1: "Freedom of conscience is the right to act according to your own conscience. Freedom of conscience is considered a fundamental human right. To what extent should society display tolerance? Should workers have the right to refrain from certain tasks at work due to conscience?"

Introduction version 2: "Occasionally, workers refuse to perform certain duties due to their conscience. Where should the society set the limit? Should workers have an unconditional right to conscientious objection to certain tasks?"

Respondents were randomized to receive either version 1 or 2.

First set of questions:

Q1. In general, healthcare professionals should be able to refrain from tasks for reasons of conscience, through local agreements that ensure the patient help from a colleague.
Q2. In general, healthcare professionals should have a statutory right to refrain from tasks for reasons of conscience.
Q3. Doctors should be able to refrain from performing ritual circumcision of infant boys.
Q4. If assisted dying is legalized in Norway, doctors should be able to refrain from performing this.

Second set of questions:
Introduction: A **[gender]** doctor wants to refrain from **[procedure]**. **[Religious affiliation]**

Variables: Gender: female/male. Procedure: performing abortion/referring for abortion. Religious affiliation: The doctor is Muslim/The doctor is Christian/(no information given)

Q5. The doctor's wish to refrain should be respected, as long as it can be facilitated in practice and the patient is ensured help from a colleague.
Q6. Doctors should have a statutory right to conscientious objection in such cases.

Response alternatives for all questions: Fully disagree, somewhat disagree, neither agree nor disagree, somewhat agree, fully agree.

Several results are given as the average number on a 5-point Likert-scale, where 1 corresponds to fully disagree, 2=somewhat disagree, 3=neither agree nor disagree,

4=somewhat agree, 5=fully agree. Data were analyzed in IBM SPSS Statistics 24 with descriptive statistics and MANOVA (multivariate analyses of variance). Data were weighted to improve the match with the national average on demographic characteristics. Analyses were performed on weighted data. A table detailing the demographic composition of the respondents is available as an online appendix.

Authors' normative preconceptions

For the sake of transparency, we state that all authors of this paper favour views on CO somewhat in line with 'the conventional compromise' introduced above.

Results

Attitudes to conscientious objection

Support for toleration of CO varied according to the procedure in question (Table 2). In order from highest to lowest support, majorities accepted CO in the cases of ritual circumcision, assisted dying, and performing abortion – the latter, however, only through local arrangements and not as a statutory right. In the case of abortion, support for CO to referrals was lower than to abortion provision.

A majority rejected a general, statutory right to CO (Q2; Table 2), whereas a general practice of accepting CO by local arrangements received somewhat stronger support (Q1).

Table 2. Attitudes to conscientious objection. Mean Likert scores and percentage who agree fully or somewhat.

	CO by local arrangement (Q1)	CO by law (Q2)	CO to ritual circumcision (Q3)	CO to assisted dying (Q4)	CO to abortion provision, by local arrangement (Q5)	CO to abortion provision, by law (Q6)	CO to abortion referral, by local arrangement (Q5)	CO to abortion referral, by law (Q6)

Mean Likert score	2.95	2.58	4.23	3.86	3.38	2.75	3.11	2.56
Agree fully or somewh at	44.6%	32.0%	79.8%	69.1%	59.6%	36.5%	51.9%	31.5%

The respondent's attitude to a given procedure was related to the attitude towards CO to the same procedure. These correlations were moderately strong (Table 3). The more positive the respondent was to abortion rights and legalisation of assisted dying, the more negative they were to CO to the same procedure, and vice versa: Respondents who were critical of abortion rights and assisted dying were more likely to endorse CO for the same. To illustrate, of respondents who fully disagreed that assisted dying should be legalized, 87% fully agreed that CO to assisted dying should be respected, whereas of respondents who fully agreed with legalization of assisted dying, only 33% fully agreed to toleration of CO for the same.

Table 3. Correlations between attitudes towards abortion/assisted dying and attitudes towards CO for the same procedures.

	Attitude towards abortion ('in the first 12 weeks of pregnancy abortion should be available on request')	Attitude towards assisted dying ('assisted dying should be allowed for patients who are dying')
Q4: Attitude towards CO for assisted dying	-.186*	-.299*
Q5: Attitude towards CO for abortion	-.267*	-.155*

* = $p<0.01$

Effect of framing

Receiving either introduction 1 or 2 had no significant effects on responses, except on Q2 where there was a small difference in the opposite direction of what was expected (mean Likert 2.48 for introduction 1, 2.66 for introduction 2; $p<0.05$).

Influence of physician characteristics

The influence of the objecting physician's gender and religious affiliation was examined by MANOVA and only two borderline significant differences ($p<0.1$) were found: Tolerance of CO through local arrangement (yet not by law) was higher in the case of a male doctor than a female (mean Likert 3.15 vs. 2.93) and in the case of a Christian than a Muslim doctor (3.40 vs. 3.16).

Discussion

The results confirmed four of our six hypotheses (H1-4; Table 1), whereas one was disconfirmed (H6) and one inconclusive (H5). In this section we explore potential implications of these findings, taking each hypothesis in turn.

Acceptable attitudes and the limits of tolerance (H1&2)

Attitudes to CO do vary according to the procedure (H1): Support was lowest in the case of abortion, higher for assisted dying and highest for ritual circumcision of infant boys. Furthermore, attitudes to the procedure itself predict attitudes to CO to the procedure (H2). Our data show this for abortion and assisted dying. For ritual circumcision we do not have data on attitudes, but our interpretation of the public debate is that there is considerable opposition to the procedure among the Norwegian public, with several calling for an outright ban. In a 2012 survey among medical students, 55% disagreed with the present policy of

offering ritual circumcision in public hospitals.[6] In a 2015 survey, 56% of Norwegian doctors would be unwilling to participate in the procedure.[7]

Our interpretation is that CO to abortion receives relatively low support (only 36.5% agree that toleration as per the present law should be a statutory right) because abortion is regarded by a large majority as an important right. Within a women's rights framework, tolerance for CO to abortion might be perceived as a threat to established rights. Assisted dying is only a hypothetic future right without the same ideological connotations; thus, CO is here likely to be seen as more acceptable. On the other hand, CO to ritual circumcision receives large support because many oppose the procedure and think that it should not be performed at all. Moreover, the religious justification for the procedure is likely to meet little sympathy in an increasingly secular society such as Norway. The justification for the CO, in contrast to the procedure itself, has a partly secular ethical, partly professional basis (eg, autonomy, nonmaleficence, lack of medical indication).

Apparently, then, significant segments of the public consider CO in terms neither of an ECHR framework nor a minority rights framework. In both of these frameworks, *one's own opinion of the procedure itself* is of little normative significance. Rather, the core questions are two: (i) Whether the objector's moral reasoning conforms to some standard of rationality and substantiates the experience of an *important moral conflict*, wherein a moral tenet core to the objector's moral or religious worldview is threatened. In this perspective, life-and-death issues arguably have a particular moral gravity;[8] and in that case, CO to assisted dying and abortion would be morally more important to tolerate than CO to ritual circumcision. Even if one rejects the moral gravity of life-and-death issues, there is no reason to think that CO to assisted dying and abortion is morally *less* important than CO to circumcision from an

objector's perspective. (ii) Whether it is practically feasible to facilitate the refusal in practice, without undue burdens for others. The ECHR §9 spells out this requirement by stating that freedom of conscience shall be 'subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others'.

The present study indicates that many citizens evaluate the objector's attitude not primarily as to whether it is indicative of an important moral conflict from the perspective of the objector, but whether it is a moral attitude that they themselves find it *acceptable* for a healthcare professional to hold. If, as with many respondents in the case of ritual circumcision, they find the objector's moral attitude acceptable, they appear likely to accept CO, without necessarily taking into account or giving weight to other considerations, such as the feasibility of toleration in practice. If, however, they find the moral attitude problematic or unacceptable, as with many respondents in the case of abortion, they are likely to reject CO, not necessarily being swayed by the contention that toleration is feasible in practice without burdens for patients (as was often claimed in Norwegian debate to be the case for abortion providers). The adjudged acceptability of attitudes, then, appears to underlie the limits of the public's tolerance of conscientious objectors. Yet according to the reasoning of proponents of CO in the academic literature and implicit in the ECHR, this is not how it ought to be. The topic of conscientious objection requires a level of abstraction and empathetic thinking. It is not about what you think of procedure X, but whether you ought to *tolerate refusals to participate* in X.

The demand that one distinguish one's view of the acceptability of attitudes from the issue of toleration of CO is also shared by many who argue against accommodation for CO[9] or who

reject a legal right while admitting the possibility of accommodation as a 'moral courtesy'.[10] LaFollette claims that both proponents and opponents of a moral right to CO tend to conflate the issue of a right to exemption with the question of what the professional ought to do.[10] Our findings suggest that this is at least true of a proportion of the respondents. One significant reason for allowing CO is to address the presumed disadvantages of belonging to a minority.[3] Many respondents appear not to have taken into account or given weight to this point, and their position would lead to the opposite: only those who belong to the majority will be accommodated.

In sum, instead of viewing conscientious refusals as a 'moral safety valve' or minority right which is due also to those with whom we disagree strongly, a portion of the public approaches the issue from the angle of *what attitudes they deem acceptable to hold*. The gap between this approach on the one hand and human rights principles on the other is likely to give rise to tensions in political processes whenever policies for CO are negotiated.

Statutory rights vs. pragmatic arrangements (H3)

The results confirm that the public is more accepting of local, pragmatic arrangements for CO than of CO as a statutory right (H3). Some might argue that a statutory right to have one's CO tolerated would tip the power balance too far in the direction of the objector, so that verdicts would not be sufficiently sensitive to important contextual factors such as whether patient, employer or colleague interests would be harmed by the way CO is carried out in practice. Another scenario is that accommodating a high number of objectors might threaten the service and thus reduce patient access.[11] A policy of local, pragmatic arrangements, on the other hand, would mean that factors such as those mentioned could be taken into account, thus potentially providing stronger protection of patient and public interests. On the flip side,

without a statutory right the objector would be at the mercy of the goodwill of managers and colleagues.

Performance vs. referral (H4)

The results on abortion also confirm that respondents are more accepting of CO to *performing* a procedure than of CO to *referrals* for the same procedure. Three potential interpretations are, first, that some respondents perceive the moral significance of referring to abortion as lower than that of performing abortion. This issue has been debated extensively within academic bioethics.[12 13] Second, that some respondents deem that in practice, refusals to refer will have greater negative consequences for patients than would refusals to perform. In Norway, although the patient is allowed to approach the hospital gynaecological departments (where all abortions are performed) directly, traditionally the GP is the gatekeeper to specialist services including abortion. That one or a few out of the many doctors in the hospital department refuse to partake in abortion might be thought to impact patients less than that the patient's own GP refuses to partake in the process. The third interpretation is that respondents are influenced by current Norwegian law and regulations, which make provision for conscientious refusals to perform abortion, but not refusals to refer. Future studies should investigate whether the findings hold also in other cases than abortion.

Influence of gender and religion (H5)

In general, public support for CO might not be forthcoming if a policy of toleration is thought to benefit a special interest group only, such as a particular religious group. A 2017 survey of the Norwegian public showed that 27% of respondents harbour negative attitudes towards Muslims, including that one of five would not want Muslim neighbours or friends.[14] Our results indicating higher degree of toleration when the doctor was male, or Christian as

opposed to Muslim, were only borderline significant. We therefore regard this test of the hypothesis that public attitudes to CO are influenced by factors not usually considered morally relevant (H5) as inconclusive.

No framing effects (H6)

Our final hypothesis, disconfirmed in the study, was that even subtle framing of the issue of CO would influence attitudes. Thus, introduction 1 attempted to frame CO positively, with the use of keywords such as 'tolerance', whereas introduction 2 attempted to put CO in a more negative light, as a refusal 'to perform certain duties'. The intention was to induce alternative interpretative frameworks on the subsequent questions: either CO as a provision for a moral minority, justified by tolerance; or of CO as 'special pleading' for groups at odds with certain accepted societal values. Only one significant effect was detected, in the opposite direction of expectations, likely to be a spurious finding. Two possible interpretations of our failure to demonstrate framing effects are, first, that the public is not significantly susceptible to framing on this issue; or alternatively, that the framing we applied was just too subtle to elucidate significant effects. Conceivably, respondents could have had a settled view of the issue prior to the survey and thus be less susceptible to the framing.

Limitations

The low response rate means that a non-response bias cannot be ruled out. This is, however, less of a problem for the relationship between different attitudes, which is what we have mainly been studying here. The weighing of the data to represent the national average on demographic parameters and the fact that reported attitudes to abortion and assisted dying comport well with previous studies, count against a significant non-response bias.

The study was performed in a Norwegian context. We would welcome similar studies from other countries and studies with qualitative designs.

Conclusion

The study has characterized attitudes towards CO among the Norwegian public. Significantly, a portion of the public appears to approach the issue by distinguishing moral attitudes they deem it acceptable or unacceptable for a healthcare professional to hold. For these respondents, the limits they place on tolerance follow mainly from their own moral evaluation of the medical procedures in question, instead of viewing CO as a minority right which is due also to those with whom we disagree strongly.

Contributors

MM conceived of the idea. All authors contributed to the design of the questionnaire. MS performed the statistical analyses. AHB, AEL and MM wrote the first draft. All authors contributed to the revision of the article and approved the final version. AHB and AEL contributed equally to the article.

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Conflicts of interest

Dr. Magelssen serves as leader of the medico-ethical council of one of the funders of the NOBAS project, the organization Menneskeverd; he receives an annual remuneration. Dr. Supphellen is a board member of the organization Menneskeverd.

References

1. Adenitire JO. The BMA's guidance on conscientious objection may be contrary to human rights law. *Journal of Medical Ethics* 2017;43:260-263.

2. Brock DW. Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics* 2008;29(3):187-200.

3. Maclure J, Taylor C. *Secularism and freedom of conscience.* Harvard University Press 2011.

4. Nordberg EM, Skirbekk H, Magelssen M. Conscientious objection to referrals for abortion: pragmatic solution or threat to women's rights? *BMC Medical Ethics* 2014;15:15.

5. Magelssen M. How details matter morally in the debate on conscientious objection. The case of Norway. In: Frewer A, Bergemann L, Jäger C. (eds.) *Jahrbuch Ethik in der Klinik 9*. Würzburg: Königshausen & Neumann 2016:343-50.

6. Nordstrand S, Nordstrand M, Nortvedt P, et al. Medical students' attitudes towards conscientious objection: a survey. *Journal of Medical Ethics* 2014;40(9):609.

7. Bringedal B, Isaksson Rø K, Magelssen M, et al. Between professional values, social regulations and patient preferences: medical doctors' perceptions of ethical dilemmas. *Journal of Medical Ethics* 2017;44(4):239-43.

8. Myskja B, Magelssen M. Conscientious objection to intentional killing: an argument for toleration. *BMC Medical Ethics* 2018;19:82

9. Giubilini A. The Paradox of Conscientious Objection and the Anemic Concept of 'Conscience': Downplaying the Role of Moral Integrity in Health Care. *Kennedy Institute of Ethics Journal* 2014;24(2):159-85. doi:10.1353/ken.2014.0011

10. Lafollette H. My Conscience May Be My Guide, but You May Not Need to Honor It. *Cambridge quarterly of healthcare ethics* 2017;26(1):44-58. doi: 10.1017/S0963180116000256

11. Minerva F. Conscientious objection in Italy. *Journal of Medical Ethics* 2015;41(2):170-73.

12. Cowley C. Conscientious objection in healthcare and the duty to refer. *Journal of medical ethics* 2017;43:207-212.

13. Chervenak FA, McCullough LB. The ethics of direct and indirect referral for termination of pregnancy. *American Journal of Obstetrics and Gynecology* 2008;199(3):232.

14. Hoffmann C, Moe V. Holdninger til jøder og muslimer i Norge 2017. Oslo: Senter for studier av holocaust og livssynsminoriteter, 2017.