



# Professional responsibility, nurses, and conscientious objection: A framework for ethical evaluation

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## Abstract

Conscientious objections (CO) can be disruptive in a variety of ways and may disadvantage patients and colleagues who must step-in to assume care. Nevertheless, nurses have a right and responsibility to object to participation in interventions that would seriously harm their sense of integrity. This is an ethical problem of balancing risks and responsibilities related to patient care. Here we explore the problem and propose a nonlinear framework for exploring the authenticity of a claim of CO from the perspective of the nurse and of those who must evaluate such claims. We synthesized the framework using Rest's Four Component Model of moral reasoning along with tenets of the International Council of Nursing's (ICN) Code of Ethics for Nurses and insights from relevant ethics and nursing ethics literature. The resulting framework facilitates evaluating potential consequences of a given CO for all involved. We propose that the framework can also serve as an aid for nurse educators as they prepare students for practice. Gaining clarity about the sense in which the concept of conscience provides a defensible foundation for objecting to legally, or otherwise ethically, permissible actions, in any given case is critical to arriving at an ethical and reasonable plan of action.

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## Keywords

Conscientious objection, ethical decision making framework, ethical responsibility, international council of nursing's code of ethics, rest's four component model, self-reflection

## Introduction

Nurses have a responsibility to provide for individual and societal healthcare needs. At its core, nursing, like other healthcare professions, has come into existence and persists as a function of an implicit social contract—privileges are accorded to professionals in exchange for services provided.<sup>1</sup> Thus, there are ethical obligations to fulfill professional responsibilities.<sup>2</sup> Healthcare professions “provide services that are crucial in some way to the functioning of individuals and the societies in which they live.”<sup>3(p. 47)</sup> Most have implicit or explicit codes of ethics that are shaped by the profession's scholars and practitioners. Codes of ethics essentially represent a service profession's promises to society about what we take ourselves to be responsible for and in what manner. People, such as healthcare providers, with specialized knowledge and skill are in a powerful position relative to those served. Thus, decisions about how to use that knowledge and skill should not be capricious, arbitrary, or unexamined. Healthcare professions are fiduciary in nature, meaning that there is a responsibility of trust. Essentially, people need to trust that healthcare professions and their members are honest, thoughtful, and competent in their provision of healthcare services.<sup>3-6</sup> People should be able to expect that the professional is working on their behalf and with their best interest at the forefront of decision-making and are not constricting or hiding available choices.

Codes of ethics, such as the International Council of Nurses' (ICN) Code of Ethics for Nurses, permit nurses to refuse to provide care if they have a conscientious objection (CO) in circumstances when their moral integrity could be compromised, or a patient might be harmed. Because these refusals could result in patients being deprived of care to which they would normally be entitled, these claims should be carefully explored relative to the claimant and the likelihood of harm to their moral integrity in acting against their strongly held and justified beliefs. Given the inherent power imbalances between patients and providers, claims of conscience require a process of analysis that lays bare the nuances of a particular situation.

In this article we provide a template derived from descriptive work in cognitive psychology, that is, Rest's<sup>7,8</sup> Four Component Model of moral reasoning, about human processes of moral decision-making. We adapt it to the task of exploring both conscious and subconscious elements of claims of conscience. We also use tenets of the ICN Code of Ethics for Nurses,<sup>9</sup> the American Nurses Association (ANA)<sup>10</sup> position statement on *Risk and Responsibility in Providing Nursing Care*, and insights from ethics literature as a strategy to evaluate the ethical status of possible claims of conscientious objection. The resulting template facilitates evaluating potential consequences of a given conscientious objection for all involved. While our focus is the nursing profession, there is utility in a framework such as this for other service professions. Gaining clarity about the sense in which the concept of conscience provides a defensible foundation for objecting to legally, or otherwise ethically permissible actions in any given case is critical to arriving at an ethical thus reasonable plan of action.

## Conscience

The concept of conscience remains abstract, and its nature contested. What constitutes a conscience is defined variously depending on the philosophical, theoretical, or theological perspective and reasons for its invocation.<sup>11</sup> Subjective and subconscious elements are inescapably part of what a person takes as their conscience and its directives. Given advances in cognitive science, along with the existence of strongly held religious and moral belief systems of varied origins and dictates, a universal definition of conscience is not possible but, for our purposes, not necessary. What is important about the concept of conscience is that those who have

strongly held convictions about right and wrong can suffer psychological and social harms if pressured to act against these convictions and these harms, in turn, can give rise to physical symptoms. Such disruptions surely count in any risk benefit analysis, but the question remains, “To what extent should they count given power differentials between those who seek care and those who provide it?” The answer to this is “it depends.”

A power differential may also exist between a nurse who is providing care and administrative directives. Such power differentials can contribute to moral conflict and harm the nurse. For example, nurse A opposes participating in any aspect of abortion, but they are assigned to prepare a patient for the procedure, or they are unexpectedly put in a position to participate in the process. If another nurse is available and willing the emergent issue can be resolved. However, if a manager or administrator demands the nurse’s participation then the nurse faces a dilemma. That nurse either has to participate and deal with the potential consequence of loss of their sense of integrity or lose their job. We propose a way to evaluate when and with what provisos declining to participate in an action is ethically permissible and to articulate the responsibilities of those who evaluate a nurse’s conscientious objection, such as a leader or institution. Specifically, the questions asked focus on helping a potential objector be clear about their reasons for objecting and the accuracy of their concerns about their participation causing them harm. In addition, the proposed questions will help leaders to assess their own responsibilities in this matter.

We recognize there are many instances when a nurse may face moral conflict or indecision about how best to act and must engage in a process of ethical decision-making; they may even refer to this as a conscientious objection. For example, a nurse may be charged with caring for more patients than is feasible for optimal or even safe care. Should they refuse the assignment worsening the problem or stay and risk the moral distress associated with not being able to practice well? Frameworks are available to explore these situations. There are commonalities among such frameworks, but modifications are needed depending on the type of problem or conflict in question. Here we focus on the issue of conscientious objection specifically.<sup>12</sup> There is an extensive body of literature addressing ethical decision-making in gray areas of practice<sup>12</sup> available to the interested reader. We also acknowledge that not all conscience-based decisions are objections to participating in an intervention or procedure. Acts of conscience can also stem from a commitment to patients that can be reflected in practitioners’ courage to stand up against existing legal, religious, and medical standards in a way that places patients’ interests ahead of their own.<sup>13</sup>

Since refusals to participate in treatment for legitimate interventions can harm intended recipients in various ways, and forced or pressured participation in such action can harm the objector, claims of conscientious objection should be subject to as rigorous a process of ethical analysis as any other ethical conflict. Laying bare the conscious and subconscious presuppositions and risks and harms to all involved is ethically required to avoid arbitrariness and unwarranted exercises of power that deny legitimate interventions. Additionally, careful ethical decision making facilitates the revelation of alternative courses of action that limit harms. Anticipating and limiting harms for both the objector and patient, where possible, is an ethical obligation of healthcare professional practice also known as the principle of non-maleficence.<sup>4</sup>

## **Salient ethical arguments for non-arbitrariness in nursing conscientious objection**

The modern, pluralistic, democratic state is built on the idea that tolerance of diverse perspectives is foundational for a just society. The paradox is that not everyone within a society is tolerant to the same degree because of cultural, religious, and political influences on the formation of beliefs and the way people think. The notion of tolerance itself requires moral humility, or the belief that one’s own views could be mistaken, which is the reason that ethical arguments exist at all.<sup>14</sup> In healthcare the notion of tolerance for those with a conscientious objection to participating in certain interventions differs among groups. However, healthcare providers have responsibilities to their patients beyond normal expectations, thus tolerant attitudes must be

tempered by patient benefits and harms. Harter<sup>15</sup> argues that conscientious objection may be tolerated for situations where patients are not likely to be unduly harmed, but that tolerance is based on a realistic potential disruption of a provider's sense of integrity.

Variations in tolerance of particular perspectives have been highlighted contemporarily with the varied responses to COVID-19 and other vaccines.<sup>16,17</sup> The impact of prior influences on beliefs and belief formation is critical to understand when exploring the soundness of a nurse's conscientious objection to participating in certain societally legitimized healthcare practices and actions on behalf of another. Two important questions are "How are we to know whether and when it is ethically permissible to refuse to participate in an action that is requested?" and "If conscientious objection is deemed permissible or necessary to protect the nurse, for what further actions on behalf of the patient and colleagues are we accountable?" Our framework provides a way to explore these questions.

Supportive of the ICN's definition that we rely on for our framework and describe shortly, conscientious objection has been described as refusing to perform a task or service "only if the objector is refusing because she takes acting to be morally wrong or religiously impermissible."<sup>18</sup> They must believe that they are responsible for or at least substantially contributing to the occurrence of the moral wrong. However, these beliefs that justify conscientious objection "cannot be empirical falsehoods, objectionably discriminatory attitudes, or unreasonable normative beliefs."<sup>18(pp. 495-96)</sup> If a refusal does not meet these minimally necessary conditions, then the healthcare provider is abdicating their professional obligation.

Risk to the provider, while not necessarily the priority consideration, counts in the benefit to risk analysis. Besides the obvious need for clinical competence in nursing or other healthcare services, caring appropriately and well for others is also somewhat dependent on one's own subjective sense of integrity. For integrity to be undermined, nurses must act in self-betraying ways. For example, they act against fundamental commitments to themselves and or against what they perceive to be important nursing values. Upholding one's sense of moral integrity in such circumstances both requires understanding the role of one's treasured personal and professional values in ethical decision-making and being open to reflect upon the coherence of these values within the context of a particular situation. A willingness to explore the beliefs and values for their coherence and pertinence to the situation at hand is important.<sup>19</sup> Czarnecki and colleagues<sup>19</sup> qualitative study found that providers, even with similar views on abortion, differed quite widely on what they considered participation in abortion care. Thus, a framework guiding a personal exploration in such cases would help a potential objector to explore more deeply their potential objection and make a decision about participation based on self-reflection of their participation causing harm.

Moreover, research in the various cognitive sciences points to the existence of human patterns of bias which do not represent logical thinking.<sup>20</sup> Cognitive science has shown us that how we think and act are not always, or even mostly, unbiased or well understood. Not surprisingly, cognitive patterns of bias such as confirmation biases (the tendency to accept ideas as true that conform with one's preconceptions) differ among persons. Thus, no one person is going to have the same emotional reactions to a given situation, and emotions can motivate action.<sup>21</sup> However, motivations are not always well considered and that can be the pivotal problem in conscientious objection. Helping healthcare providers to understand this facilitates decision-making that is more authentic in terms of a reflective and self-reflective exploration of why they are reacting in a certain way and whether feared consequences are realistic.

The above discussion supports the need for a decision-making model that facilitates deeper explorations. Such explorations, among other things, have the benefit of providing the sort of clarity that can mitigate moral distress.<sup>22</sup> When one's sense of equilibrium or confidence is disrupted, patient care can also suffer.<sup>23</sup> Indeed a general ethical exception to the rule that the needs or desires of the recipients of healthcare are prioritized is when severe and/or imminent harms are likely to accrue to the provider or others (constraints on the exercise of autonomy). When a provider provides convincing support about the likely harms to themselves by

participating in a legally available intervention, a CO may be permissible with the caveat that alternate resources are made available to the patient.

## Ethical analysis

Many models of ethical analysis exist. None of them are linear or step-by-step processes. This is because of the complexity of most ethical decision-making and the necessarily interactive and recursive nature of data-gathering that is needed to fill in details in a given situation. As new information is gathered, the nuances of an ethical situation or conflict become clearer, and the narrative becomes richer and more detailed. Moreover, what was taken as the initial crux of the problem may evolve into something quite different. For such reasons, and because we did not find any of the existing models a good fit for analyzing whether one is justified in refusing to provide or participate in certain services based on claims of conscience, we synthesized a model capable of exploring the ethical status of claims of conscientious objection.

Rest's<sup>7,8</sup> Four Component Model of moral decision making, as derived from accumulated research in cognitive psychology, provides a helpful way to structure in-depth inquiry. Insights from nursing's codes of ethics along with other ethics literature provide the questions that need to be explored. We rely on the ICN Code of Ethics for Nurses<sup>9</sup> for current purposes both because of its broad scope and the fact that it represents the input of nurses from many different countries. Addressed in the ICN's code is the issue of nurse CO. Additionally the American Nurses Association (ANA)<sup>10</sup> position statement on *Risk and Responsibility in Providing Nursing Care* offers important additional insights. It expands upon and provides more specificity to ideas in the ICN Code about how a particular claim of conscientious objection can be explored.

Ethical decision-making in everyday nursing and healthcare practice is rightly anchored in a combination of the goals and perspectives of the particular profession. We recognize that contemporarily there are debates about professionalism as applied to nursing and other healthcare groups and who is really served by professionalization, but for current purposes we accept that certain groups are accepted as professions and have a degree of autonomy over their practices.<sup>24</sup> In the case of more complex conflicts requiring a team approach to resolution, healthcare goals more generally serve as the focus. That is, there is a person or persons at the center of the problem and the focus is on providing the best for them while taking into consideration what is possible and who else may be at risk. Here we describe Rest's four components, highlighting in what ways they are pertinent to the task of structuring our ethical inquiry into the status of claims of conscientious objection.

### (H2) Rest's four component model

What is important about the Rest model is that it is based on extensive research findings about the moral thinking processes of human beings and includes both affective and cognitive aspects. Rest<sup>7</sup> questioned "(W) hat do we have to assume went on inside the head of a person who acts morally?"<sup>7</sup> His answer is that we have to consider:

*(1) How does the person interpret the situation and how does he or she view any possible action as affecting people's welfare; (2) how does the person figure out what the morally ideal course of action would be; (3) how does he or she decide what to do; and (4) does the person implement what he or she intends to do.*<sup>7(p. 29)</sup>

These questions correspond to the substance of the four components of his model of moral action: moral sensitivity, moral judgment, moral motivation, and moral character. The components are non-hierarchical and interactive with each other. A failure in any one of them results in a failure of moral/ethical decision-making.<sup>7,8</sup> (As defended elsewhere we use the terms moral and ethical interchangeably).<sup>25,26</sup> It is also important to recognize that Rest is not postulating that there is an identifiable right action that is predetermined

as it might be if one were using a particular moral theory. Rather the model lays out the likely interacting thinking processes activated when a person has an intention to act morally in a particular situation. While Rest's research is about the cognitive components of moral action in general, we relate each component to ethical decision-making in nursing and to nursing's ethical responsibilities as outlined in the nursing, nursing ethics and clinical ethics literature<sup>27</sup> and as supported in the ICN code of ethics.

*Moral sensitivity.* This process involves recognition by the agent that there are ethical aspects of a situation. Further, the person can understand who is involved and how proposed actions are likely to impact them now and in the future.<sup>28</sup> The agent can appreciate "that something (they) might do or is doing can affect the welfare of someone else either directly or indirectly (by violating a general practice or commonly held social standard) (*parentheses as in the original*)."<sup>7(p. 29)</sup> Rest asks "(h)ow does the person interpret the situation and how does he or she view any possible action as affecting people's welfare?"<sup>9(p. 9)</sup> Nurses are responsible and accountable for their actions. Their actions are to be focused on fulfilling nursing's goals and perspectives "to promote health, to prevent illness, to restore health, and to alleviate suffering and promote a dignified death."<sup>9(p. 2)</sup> In doing so, nurses respect human rights, including the patients' right of choice,<sup>9</sup> even if they disagree.

A critical aspect of this component for evaluating a conscientious objection request is about how the nurse understands their professional responsibilities. Are they able to articulate to others their duties to the patient and the ways in which a conscientious objection will affect the patient, coworkers, and other stakeholders? The willingness and ability to reflect on one's responses and their origins in beliefs and values, which are inevitably rooted in one's historically developed life influences, is an important aspect of this process. The potential objector should be able to explain why they are reacting as they are and consider whether the reaction is still reasonable currently or is it an artifact of earlier beliefs they can no longer defend. A way to do this is to ask themselves whether there are comparable circumstances where they might be willing to participate. Trying to understand the perspectives of other stakeholders is also important.

As an example, a graduate student of one of the authors, who had been unequivocally anti-abortion as an undergraduate student returned to the same university for graduate nursing studies evidencing a changed perspective. Based on several years of practice with disadvantaged women, her presentation to the class on Ethical Issues in Women's Health described a range of ethical issues commonly faced. Signature among these was that for many women everyday choices were constricted by their culture, partners and/or economic circumstances. It is possible that she had been previously influenced by polarized ideas about abortion that tended to shift the focus of debates away from the needs and concerns of women seeking abortion. She realized that for many of the women served by the clinic, circumstances limited their choices in all aspects of their lives. As a Roman Catholic she did not approve of abortion per se but was able to accept the perspective of her patients and came to understand why, barring radical changes in their social conditions, for some women, abortion seemed the only feasible option. An implication of moral sensitivity is one's ability to go beyond immediate or unreflected-upon reactions to explore the situation and its meaning for the person making a request.

A further implication of this component concerns the nurse's ability to anticipate in what ways their sense of integrity is likely to be affected by participating. They should be able to articulate their concerns and explore whether there might be ways to mitigate those effects so that they can continue to provide care. While Rest argues that these processes are interactive and non-hierarchical, nursing scholars have noted the importance of developing nurse ethical sensitivity in that most, if not all nursing actions, have ethical implications in terms of an intentional focus on providing a good for the patient versus being distracted by other pressures such as pressures to complete tasks efficiently or uncritically following protocols that do not serve the patient well.<sup>29</sup>



*Moral judgment.* The potential moral agent brings to bear knowledge and seeks more information, including applicable resources to determine what ought to be done in a particular situation. One or more options are evaluated.<sup>7,28</sup> “(I)n seeking the morally ideal course of action, the person tries to integrate the various considerations—person A’s needs, person B’s needs, personal needs, expectations founded on previous promises or roles.”<sup>7(p. 31)</sup> It is the process of a person deciding what are possible ways to proceed so as to provide the most ethically supported actions.<sup>7</sup> Besides accessing and using prior knowledge in exploring the situation, further understanding is sought when knowledge is incomplete. An important facet of this process for current purposes is acknowledging what one does not know and seeking more information or accessing relevant resources. This component somewhat resembles clinical judgment, where the nuances of a situation are uncovered and brought to scrutiny.

*Moral motivation.* This process involves the agent prioritizing the most morally appropriate action even in the face of alternate pressures or influences.<sup>28</sup> It is about what incentivizes a person to make a particular choice about action. As Rest noted, “research (and common sense) have clearly demonstrated that what people think they ought to do for moral reasons is not necessarily what they decide to do.”<sup>7(p. 33)</sup> Moral motivation in healthcare settings ideally prioritizes ethical actions over personal preferences. In nursing and healthcare, we expect providers to act in a way that brings about a good for another. That is the ostensible reason for the existence of the different healthcare professions. However, people may become conflicted about the role of different values such as “careers, emotional relationships, religious ideology, aesthetic values... and moral beliefs.”<sup>7(p. 33)</sup> Given the availability of other possible options, one must make a determination about which action can and should actually be undertaken. Motivation to act requires a commitment to do the right thing despite competing values and the possible reproach of others.

*Implementation or moral character.*<sup>7</sup> This process refers to the agent’s possession of the required strength of character and the “social and psychological skills necessary to carry out the chosen action.”<sup>28(p. 386)</sup> According to Rest,<sup>7</sup> moral character is about persevering to implement the chosen action. The process involves considering what actions should be taken to maximize benefits and minimize harms. Considerations include how to address barriers to enacting the nurse’s considered decision. The decision might be to follow through with a morally defensible conscientious objection or to ensure a patient’s request is realized despite the nurse’s qualms. These might include legal and/or administrative sanctions and possibly the disapproval of one’s colleagues. Additionally, plans for others to account for and address the patient’s needs and rights need to be undertaken. Finally, the nurse must have thought carefully about the possible consequences to self and others of their actions. For example, will colleagues have to assume responsibility for the patient or procedure and if so, what concessions is the conscientious objector willing to undertake to relieve any additional burdens? Included in this process is the identification of resources that will help them to maintain their sense of integrity and moral agency.

These four processes provide the outline for considering aspects of reflective thinking that should take place related to a proposed, or before an actual, conscientious objection. The objection may be to participate in an intervention, or care for a person who is receiving an intervention for which one has qualms based on strongly held beliefs. While Rest’s framework describes the cognitive processes that underly a person’s decision to act to provide a good, healthcare professionals have additional ethical responsibility to prioritize the good of the patient over their own preferences, values, and beliefs unless the harm to them outweighs the benefit to the person in question.

Next, we provide support for our interpretation of how Rest’s framework can descriptively frame a model for evaluating the merits of a conscientious objection. We review pertinent tenets of the ICN’s code of ethics and their guidance about nurses’ professional obligation toward patients including in circumstances where a nurse has qualms about participating in an intervention, acting on physician orders, or responding to patient and family requests.

## (H2) The ICN code of ethics for nurses

The ICN Code of Ethics for Nurses provides guidance to nurses<sup>9</sup> internationally by articulating nurses' values, accountabilities, and responsibilities. The ICN recognizes that nurses' main priority is to patients which includes respect for their human rights. The Code states: "Nurses' primary professional responsibility is to people requiring nursing care and services now or in the future, whether individuals, families, communities or populations."<sup>9(p. 7)</sup> This responsibility includes a respect for human rights including those that pertain to life, choice, dignity, and respect regardless of "age, colour, culture, ethnicity, disability or illness, gender, sexual orientation, nationality, politics, language, race, religious or spiritual beliefs, legal, economic or social status."<sup>9(p. 2)</sup>

In the ICN Code conscientious objection is defined as,

*(R)efusing to participate in required action or seeking exemption from participation in classes of interventions (e.g., abortion, gender reassignment surgery, organ transplantation) that threaten a person's sense of moral integrity. It also includes refusal to participate in an action or intervention perceived to be inappropriate for a specific patient or it ignores the patient's wishes.*<sup>9(p. 24)</sup>

While recognizing that nurses' sense of integrity may be seriously threatened by participating in actions that contravene their strongly held moral convictions, they are expected to recognize their professional accountability. Nurses are to "assure continuity of care for the patient when exercising conscientious objection."<sup>9(p. 14)</sup> Self-reflection is also an important part of decision-making regarding conscientious objection, particularly with respect to human rights. An ethically justified conscientious objection cannot be capricious or reflect discrimination. Nurse educators and other leaders are also encouraged to help students and nurses develop skills of self-reflection and "teach frameworks and processes of conscientious objection."<sup>9(p. 14)</sup>

## (H2) American nurses association position statement "risk and responsibility in providing nursing care"

In the US, particular guidance exists related to nurses' responsibilities and conscientious objection. While this is promulgated from the ANA, the position statement<sup>10</sup> is in accord with the ICN definition and offers helpful specific guidance for the conditions of permissible objections. Elaborating on aspects of the *ANA Code of Ethics for Nurses with Interpretive Statements*<sup>22</sup> an emphasis is placed on reflection and accountability.

Conscience-based refusals to participate exclude personal preference, prejudice, bias, convenience, or arbitrariness. Acts of conscientious objection may be acts of moral courage and may not insulate nurses from formal or informal consequences. Such refusal should be made known as soon as possible, in advance and in time for alternate arrangements to be made for patient care.<sup>25(p. 21)</sup>

While not solely addressing acts of conscientious objection, the position statement provides the conditions for participation in situations that invoke a moral obligation for the nurse to participate. It is important to note that all of the following criteria must be met:

1. The patient is at significant risk of harm, loss, or damage if the nurse does not assist.
2. The nurse's intervention or care is directly relevant to preventing harm.
3. The nurse's care will probably prevent harm, loss, or damage to the patient.
4. The benefit the patient will gain outweighs any harm the nurse might incur and does not present more than an acceptable risk to the nurse.<sup>10</sup>



However, the moral obligation is tempered when the potential harm to the nurse outweighs the moral obligation. "Accepting personal risk exceeding the limits of duty is not morally obligatory; it is a moral option."<sup>10(p. 4)</sup>

### *(H1) Tying it together: A framework for the ethical evaluation of a nurse's conscientious objection*

This synthesized framework, summarized in Table One, addresses the question of how individual nurses, nurse leaders, and those charged with regulating practice can evaluate the ethical status of actual or proposed conscientious objections. Questions to be explored include:

1. How does the nurse understand their professional responsibility and its limits?
2. What does it mean to say a conviction is held strongly enough that the likely harms to the objector outweigh the likely good for the patient?
3. What strategies and resources are available to assist in exploring a particular situation where the nurse is considering a conscientious objection?
4. What are the nurse's and institution's responsibilities to ensure that a patient has their needs met in spite of the conscientious objection?
5. What institutional or leadership support is available for nurses with respect to conscientious objection?

Table 1 provides guidance related to the process of decision-making and evaluation of a proposed or actual conscientious objection. While it provides guidance it does not guarantee the right answer. Its purpose is to facilitate exploration of essential information and prompt reflection to allow clarity about the situation. To understand why the conscientious objection is being asserted, whether it has been sufficiently defended, and in what ways the needs of the patient and nurse are considered. It does place an ethical responsibility on both the nurse and the institution or evaluator. Rest's components provide structure, and insights from the ICN Nurses Code of Ethics,<sup>9</sup> the ANA position statement on Risk and Responsibility,<sup>10</sup> and pertinent ethics literature to provide substantive questions to explore. We have synthesized the questions based on our combined expertise and grasp of the literature in addition to the articles and books referenced throughout.<sup>3,11,17,26,27</sup> This is not an exhaustive list, as questions are explored in any given case more questions may be raised as a result of the necessarily recursive nature of ethical decision-making in general. Thus, there is also inevitably some overlap among the questions asked related to the particular component due to the interactive nature of thinking processes.

## **Summary**

In this manuscript we provided a model for consideration of claims of conscience as a reason to object to, or refuse to participate in actions, or withhold information to which people have a right. The framework, while not linear in its application, nevertheless provides questions to be considered in undertaking or evaluating a proposed or actual conscientious objection. It is particularly appropriate to use in the case of a nurse who is objecting because of their beliefs and values. We provided a framework that captures how a nurse expressing a conscientious objection should explore the ramifications of their conscientious objection for themselves, patients, and colleagues. Additionally, the framework provides guidance for: those charged with evaluating a conscientious objection or potential conscientious objection, educating nurses, or providing institutional leadership. We propose that the framework can also serve as an aid for nurse educators as they prepare students for practice. Ultimately, the framework challenges us to consider and try to balance the harms and benefits for a patient who requests an intervention for which the nurse is objecting, against harms to the nurse if their sense of integrity is shaken by a perceived violation of conscience. Additionally, it accounts for the burdens that could accrue to colleagues who may have to assume additional duties as a result of the conscientious objection. Like other ethical decision making in healthcare, the goal is to balance risks and benefits to all involved. However, is

**Table 1.** Framework for *The Ethical Evaluation of a Nurse's Conscientious Objection*.

Rest's component	Questions for the conscientious objector	Questions for the conscientious objection evaluator (Institution/Leader/Regulator)
<b>Moral sensitivity</b> Recognition by the agent of the ethical aspects of a situation. Questions specifically explored: 1,2,4	Do I understand my professional ethical priority is a patient's needs? Have I reflected on my biases, values, prejudices re. Patient characteristics? (e.g., race, class, gender, age, SES etc.) Have I engaged in perspective-taking re: effects on patient and colleagues? What alternatives can I suggest that facilitate patient choice? What do I mean by my sense of integrity and its possible disruption? How will I defend my reasons for conscientious objection? Have I acted this way in comparable situations? If not, what is the distinction? Do I know what potential legal or practical consequences exist?	Does the institution recognize its responsibilities to: patient, nurse, and other? What is the ethical issue at hand? What other ethical issues are at stake? Who is involved and who is most likely affected? What alternatives can be suggested by the organization that facilitate patient choice? What is our responsibility to support nurses' self-reflection on their values, beliefs, biases? Has the nurse expressed similar conscientious objections in the past? Is this current conscientious objection consistent? Does the conscientious objection reflect known/common religious beliefs? What strategies can help the nurse in reflecting? (On-line exercises, ethics consult, counseling, role play patient or colleagues) What way might this conscientious objection affect the institution, profession, other stakeholders? What policies, codes, standards provide clarity about institutional/legal rules? How can administrators/leaders anticipate situations where a conscientious objection might occur and develop policies or educational activities? (e.g., abortion, embryo selection, blood transfusion, pain management at end-of-life, medical assistance in dying, futility, available resources.) Is the organization willing to be accountable and accept consequences if the conscientious objection is denied?

*(continued)*

Table 1. (continued)

Rest's component	Questions for the conscientious objector	Questions for the conscientious objection evaluator (Institution/Leader/Regulator)
<b>Moral judgment</b> Uses existing knowledge, seeks needed information and resources, determines options. Questions specifically explored: 3,4,5	<p>How do I reconcile my values, core beliefs, values with the priority of patient expressed desires?</p> <p>Who is the most important focus and who else has interests?</p> <p>What are the likely harms or goods? Can harms to all be minimized?</p> <p>What do I know about such situations and how they may be managed?</p> <p>What do I not know?</p> <p>Who can fill the knowledge gap?</p> <p>How do I access more information?</p> <p>What courses of action are possible?</p>	<p>How can the interests of all stakeholders' be considered and addressed?</p> <p>Can we anticipate and minimize harms (e.g., with flexible staffing, discussions with staff)?</p> <p>Do staff feel: free to discuss their concerns, supported in exploring current beliefs, free to articulate rationale for conscientious objection?</p> <p>What institutional resources are available to support ethical decision making?</p> <p>Can a clinical ethicist be brought in for support?</p> <p>What other professionals may need to be brought in for support? (e.g., Chaplaincy, counseling).</p> <p>Are there emerging patterns re. conscientious objections for nurses and allied professionals?</p>
<b>Moral motivation</b> Determining the most morally appropriate choice. Overcoming obstacles. Questions specifically explored: 2,4,5	<p>What am I choosing to do and why?</p> <p>How will my sense of integrity be affected?</p> <p>Are there ways to lessen effects?</p> <p>How might my career, emotional relationships, religious and/or ethical ideology be impacted?</p> <p>How will my choice impact others and what repercussions are likely?</p> <p>How will I manage my choice so that the patient, colleagues, and I suffer the least harm?</p> <p>How will continuity of care be ensured?</p>	<p>How is the practice environment having an impact on the nurse's moral motivation?</p> <p>Are colleagues supporting/not supporting the nurse's conscientious objection?</p> <p>Are staffing and the morale of the practice environment being impacted?</p>
<b>Moral character</b> Possession of the required strength of character and the "social and psychological skills necessary to carry out the chosen action." <sup>25(p. 386)</sup> Questions specifically explored: 2,3,4,5	<p>What actions will I take to maximize benefits and minimize harms to myself, patients, and colleagues?</p> <p>What strategies will help me overcome barriers to ethical action?</p> <p>How will patient needs be accounted for by others?</p> <p>Am I prepared to accept known consequences of exercising a conscientious objection?</p> <p>What burdens will accrue to other nurses?</p> <p>How can I offset burdens incurred by others when I exercise my conscientious objection?</p> <p>How will I persevere to implement my chosen action?</p> <p>Will I modify the action (self-regulate) as consequences arise?</p>	<p>What can the institution do to support the ethical decision making of nurses who choose conscientious objection?</p> <p>How might the institution remove barriers to conscientious objection?</p> <p>What education can be offered to nurses that helps them develop the moral character necessary for conscientious objection?</p> <p>What resources are available to support the nurse who chooses conscientious objection?</p>

often difficult to gauge what is needed to achieve a balance. Using a framework such as we propose allows nuances of a situation to be uncovered, strategies to reduce harm to be identified, and the interests of all involved to be considered. While this framework was developed for nurses by nurses with ethics expertise, we believe it could be used to guide the practice of other healthcare professionals.

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