ANESTHESIOLOGY

Conscientious Objection and the Anesthesiologist: An Ethical Dilemma

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ABSTRACT

Conscientious objection is a legally protected right of medical professionals to recuse themselves from patient care activities that conflict with their personal values. Anesthesiology is different from most specialties with respect to conscientious objection in that the focus is to facilitate safe, efficient, and successful performance of procedures by others, rather than to perform the treatment in question. This could give rise to a unique, somewhat indirect ethical tension between the application of conscientious objection and potential infringement upon patient autonomy and well-being. While some situations have clear grounds and precedent for conscientious objection (*e.g.*, abortion, or futile procedures), newer procedures, such as gender-affirming surgery and xenotransplantation, may trigger conscientious objection for complex reasons. This review discusses ethical, legal, and practical aspects of conscientious objection; challenges to anesthesia groups, departments, and healthcare organizations when conscientious objection is invoked by anesthesiologists; and strategies to help mitigate the ethical dilemmas.

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Conscientious objection is a legally protected right in the United States, enabling medical professionals to recuse themselves from activities that they believe conflict with their personal values.[1] The U.S. Department of Health and Human Services (Washington, D.C.) prohibits organizations that receive federal funds from discriminating against healthcare providers who exercise this right.[2] Conscientious objection allows clinicians to act consistent with their personal moral belief system, thereby reducing cognitive dissonance and potentially increasing physician satisfaction with their practice.[3] Many states offer additional protections to the federal laws permitting conscientious objection.[4] Healthcare providers in the United States who make a claim of conscientious objection are currently not required to provide justification.[3] Interestingly, conscientious objection has become more contentious in European countries after recent court rulings requiring providers to prioritize access to health services over their conscience rights.[5]

The American Society of Anesthesiologists (Schaumburg, Illinois) Code of Ethical Conduct does not directly address conscientious objection. Rather, it defers to the Principles of Medical Ethics of the American Medical Association (Chicago, Illinois), which also provide protections for conscientious objection: "A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical care."[6] Based upon this limited statement, anesthesiologists may exercise conscientious objection except in emergencies where the absence of healthcare services would have serious consequences for patients.

Apart from chronic pain therapy and critical care, anesthesiologists typically do not have primary ownership of a patient's care, and they are therefore in a different position with respect to conscientious objection. Rather, anesthesiologists may consider conscientious objection to participation in procedures including, but not limited to, those perceived as futile, abortion, gender- or intersex-affirming surgery, elective sterilization, and transplantation procedures.[7] This could give rise to a unique, somewhat indirect ethical tension between the application of conscientious objection and potential infringement upon patient autonomy and well-being.[8] In this respect, conscientious objection by an anesthesiologist carries different implications than conscientious objection by those performing the procedures, and conscientious objection has received scant attention in residency training programs and the anesthesiology literature, rendering this review a new source of knowledge and discovery consistent with the mission of this Journal.[9,10] This review is also timely and presented specifically to anesthesiologists because of the emerging new procedures they will likely be exposed to in the near future such as gender-affirming surgery,[11–14] the likelihood of increasing use of xenotransplantation,[15] and the re-emergence of discussion

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of abortion in the public sphere since the now 2-yr-old Dobbs decision by the U.S. Supreme Court.[16]

In this review, we describe the sources of conscientious objection, discuss the application of ethical principles on conscientious objection to the practice of anesthesiology, review relevant legal rulings, and discuss practical challenges to anesthesia groups, departments, and healthcare organizations when conscientious objection is invoked by anesthesiologists, as well as suggest management strategies in today's era where personnel shortages and production pressures are increasingly challenging the fundamental nature of anesthesia practice.

Sources of Conscientious Objection

Conscientious objections can be grouped into two broad categories: religious and secular. Many physicians hold strong religious beliefs that serve as their moral compass, and with which certain procedures may be at odds. For example, devout Catholics carry a long-standing tradition that rejects abortion and feticide.[17] Some Muslim physicians may object to examining patients of the opposite sex, and to Muslims receiving xenotransplantation from a pig.[18–20]

While religious objections typically garner the most attention, secular objections may be more ubiquitous. These objections are attempts to balance the principles of beneficence, nonmaleficence, and patient autonomy. They may range from common interventions that some physicians might perceive and object to as futile such as percutaneous endoscopic gastrostomy or tracheostomy in moribund, terminally ill patients, to rare, complex surgery such as a facial transplant, where the main benefits are not medical but cosmetic. When the medical benefit is not readily apparent, some physicians may be reluctant to participate, especially when the procedure carries a high risk of morbidity and mortality, as common with near-end-of-life procedures.[21] Given a perceived imbalance of benefit, harm, and autonomy, anesthesiologists may feel conflicted and recuse themselves accordingly.[22] Additionally, some physicians may be concerned about patient regret after undergoing irreversible procedures such as tubal ligation, abortion, and gender-affirming surgery, and may decline to participate.[23]

Applying Secular Ethical Principles for Conscientious Objection and Anesthesiology

Preserving Nonmaleficence over Autonomy

Primum non nocere or "first, do no harm," attributed to Hippocrates, affirms the commitment of the practitioner to nonmaleficence.[24] While a literal interpretation in the absolute would in fact be detrimental to patient care, a reasonable viewpoint could entail abstaining from procedures in which the risks do not clearly outweigh the benefits. Physicians who recuse themselves from a procedure that they believe would cause significant harm are abiding by this fundamental principle. At the same time, medicine is far from predictable, as Sir William Osler famously stated: "medicine is a science of uncertainty and an art of probability."[25] The moral implications of procedures are not spared from this state of uncertainty.

Beneficence and Justice

Some suggest that physicians who utilize conscientious objection, legal permissibility notwithstanding, are derelict in their commitments to the medical profession. They argue that working as a physician is voluntary, and those unable to provide care to all patients in need must relegate themselves to nonpatient specialties such as radiology, or leave medicine altogether. We disagree, arguing that physicians are moral beings with agency that is actualized in their moral duty as medical professionals.[26] Therefore, one cannot separate a physician's moral identity from their professional one.

Diversity of Beliefs

Ideally, medical communities embrace diversity in general, as well as diversity of thought.[27] Promoting open discussion of contrasting viewpoints, and accommodating those with beliefs that may differ from those of some or even most of their colleagues, enable diversity of thought to flourish, and education for all to be enriched. Rarely is the solution to moral quandaries binary. The individual physician possesses a layered personal and professional moral framework. Societies that support conscientious objection practice a form of ethical humility in which individuals can recognize they may be mistaken about their beliefs and therefore abstain from forcing their beliefs onto others.[28] Daniel Sulmasy stated, "…moral knowledge is imperfect. Even a moral realist will acknowledge that although we might approach certitude regarding certain moral questions, moral reasoning has no empirical method of verification."[28]

Tolerance, as written into the U.S. Constitution,[29] breeds respect and understanding, and is crucial to reduce the risk of groupthink and conformity to majority perspectives. In health care, tolerance permits those who struggle internally with the morality of an intervention the time to ponder their beliefs and avoid engaging in a morally objectionable act they might later regret. Indeed, one can imagine, *e.g.*, the emotional burden of a physician who participates in medical assistance in dying but later sees it as akin to murder.[30]

Criteria for Evaluating a Conscientious Objection

By which criteria should we as a profession evaluate the merit of an individual's conscientious objection? Currently there is no standard. Genuineness and reasonableness of the objection have been posited as criteria, but each has significant flaws that prevent it from being widely adopted.[8,28,31] For example, sincere objections based upon fundamentally immoral beliefs are inconsistent with the code of the medical profession. McConnell illustrates this point with a

thought experiment in which an anesthesiologist refuses to provide analgesia to a patient because he sincerely believes it is wrong to treat patients of other races.[31] Such an objection is clearly illegitimate and violates fundamental ethical principles.[32] Reasonability criteria are limited by the specific thresholds utilized to define reasonability, which are often arbitrary and vary greatly even between philosophers.[31,33,34]

To address these deficiencies, Sulmasy suggested that conscientious objection should be judged based on whether it itself contradicts the principle of tolerance, entails a significant risk of harm for those who do not share the belief, and involves positive or negative actions.[28] Ben-Moshe suggested the objection be judged from the view of an impartial observer, one who could not be swayed by appeals to Scripture but instead by arguments invoking a common moral framework.[8] Under this schema, an objection to abortion on religious grounds would need to be supported by secular arguments as well for it to have merit. McConnell posited that objections should be based on the requirements of objectively good public health care and limit religious objections that would worsen healthcare outcomes.[31] While these criteria are not universally accepted by professional organizations, they nevertheless provide stronger reasoning toward an accepted set of standards for which an objection can be evaluated. Further work must be performed to develop standards, but the challenge in doing so does not constitute a reason to dispose of conscientious objection.

Legal Protections for Conscientious Objection

At least two categories of statutes protect healthcare providers who invoke conscientious objection (see table 1 for a summary of selected federal laws). The first does not specifically mention conscientious objection, but provides protection nonetheless. The federal Religious Freedom Restoration Act of 1993[35] and its 18 or more state clones fall into this group.[36] These laws prohibit governmental actions, laws, and regulations that substantially burden the free exercise of religion unless they both further "a compelling governmental interest" and constitute the "least restrictive means" of doing so. The federal Religious Freedom Restoration Act applies to actions by the federal government, while the state versions apply to the respective state and municipal governments. This group of laws includes Title VII of the federal Civil Rights Act of 1964, which prohibits employers from discriminating against personnel for religiously based objections to performing particular job functions unless doing so would impose an undue hardship.[37]

Religiously based conscientious objection may also be protected on constitutional grounds. Although as interpreted by the U.S. Supreme Court, the Constitution provides less protection to religious rights than does Religious Freedom Restoration Act, 13 or more states construe their own constitutions as providing the same degree of protection as the Religious Freedom Restoration Act.[36]

The second category of statutes, and their associated regulations, explicitly refer to conscientious objection. They may forbid private or governmental discrimination against medical professionals who invoke conscientious objection, whether based on religious, moral, or secular ethical grounds, or who, because of conscientious objection, never received training with respect to certain medical procedures (the latter provision may be particularly important in some states in the post-Dobbs era). Those who illegally discriminate against them are subject to loss of federal funding, civil lawsuits, and additional sanctions. This type of statute may also immunize those who assert conscientious objection from criminal or civil liability.

While some statutes identify particular practices to which they apply, they often contain broader protections as well that would apply for conscientious objection. For example, although the Church Amendments to the Public Health Service Act are known mostly for their sections regarding abortions and sterilizations, another provision prohibits any entity receiving a grant or contract for biomedical research under any program administered by the US Department of Health and Human Services from discriminating against healthcare personnel because, based on moral or religious beliefs, they "refused to perform or assist in the performance of any [lawful health service or activity]."[38] The scope of state statutes differs, but some are quite broad. Ohio's statute, for instance, excuses a medical practitioner from participating in any healthcare service that conflicts with the practitioner's "moral, ethical, or religious beliefs or convictions," and even protects the practitioner from being required, against conscience, to participate in the transfer of the patient to a colleague for the requested care. The medical practitioner is protected from criminal, civil, and administrative liability or discrimination. Violators of the law are subject to civil lawsuit for treble damages and other relief.[39]

Conscientious Objection and the Practice of Anesthesia

Below we describe and analyze a selection of procedures most commonly associated with conscientious objection. We chose to highlight well-established procedures, along with newer interventions that may still be experimental, such as xenotransplantation. Naturally, we expect that conscientious objection will arise in the future as medical technology continues to evolve. Far from an exhaustive list, these procedures are recognizable examples of the principled application of conscientious objection in the ethical practice of anesthesiology.

Medical Futility

Perhaps the most common situations leading an anesthesiologist to invoke conscientious objection are procedures lacking medical benefit. Such medically "futile" treatments are

Table 1. Select Federal Legal Protections for Conscientious Objection

Name	Illustrative Provisions
Church Amendments (enacted in the 1970s) to the Public Health Service Act	(1) Prohibits the government from requiring the following: (a) Individuals, against their CO, to perform or assist in an abortion or sterilization (b) An entity: (i) against its own rules based on CO, to provide facilities for such procedures; or (ii) to provide personnel for such procedures against the personnel's CO (2) Prohibits any entity receiving financial assistance under certain HHS-implemented statutes from discriminating against any physician for refusing to participate, against their CO, in an abortion or sterilization procedure (3) Broadly prohibits any entity receiving a grant or contract from the HHS for biomedical research from discriminating against any healthcare personnel for refusing, based on their CO, to perform or assist in "any lawful health service or research activity"
Section 245 (enacted in 1996) to the Public Health Service Act	Prohibits any governmental entity receiving federal financial assistance from discriminating against any healthcare entity on the basis that the entity does the following: (a) Refuses to undergo training for, to provide training for, to perform, or to provide referrals for induced abortions (b) Attends or attended a training program that did not or does not perform, provide training, require training, or provide referrals for induced abortions
Welden Amendment (enacted 2005)	Prohibits discrimination based on a healthcare entity's coverage of, or referral for, abortions
Affordable Care Act (amendments enacted in 2010)	Prohibits discrimination against health plans for the refusal, based on CO, of coverage for abortions or assisted suicide, euthanasia, or mercy killing
Religious Freedom Restoration Act (enacted 1993)	Prohibits federal governmental restrictions on free exercise of religion unless (a) The restriction furthers a compelling government interest; and (b) Is the least restrictive way of doing so

CO, conscientious objection; HHS, US Department of Health and Human Services.

typically requested by patients or, more likely, by their surrogate decision-makers, grounded in their personal values, spiritual or religious beliefs, or simply out of genuine care and compassion. (Of note, it is for this latter reason the term "futile" may not be helpful in doctor–patient communication; to a patient or surrogate, an action-oriented plan, *i.e.*, "doing something," does not seem "futile.") Understandably, these decision-makers lack the experience and education to foresee the neutral, if not harmful, outcome of fulfilling their requests. Interventions that are unlikely to improve a patient's quality of life or even increase longevity often involve considerable perioperative morbidity and mortality, and evidence to support their efficacy may be nonexistent or weak. Examples include a percutaneous gastrostomy in a patient declared dead by neurologic criteria ("brain death"), and end-stage Alzheimer disease or terminal cancer with multiorgan failure, with a Power of Attorney document that calls for hemodialysis. Unfortunately, such medically "futile" procedures are ubiquitous in U.S. health care.[40] At the same time, there may be "gray areas," interventions that may not enjoy universal consensus on their benefit or futility.[41] Ultimately, the principles of nonmaleficence and beneficence clash when anesthesiologists are asked to participate. Conscientious objections are likely secular, although ironically they may stem from religious or spiritual values similar to those of the patients themselves, where the patients lack the knowledge and awareness of the consequences. An excellent summary of religion-based approaches in Catholicism, Judaism, and Islam to near-end-of-life and other futile procedures has been written.[42]

Compared with their surgical colleagues, anesthesiologists are more likely to consider futile those procedures that are unlikely to improve quality of life.[43] Anesthesiologists' vital role in evaluating the safety of an operation creates a unique opportunity to prevent their patients from experiencing harm from futile procedures. Due to the complexities of conscientious objection in these situations, models based upon due process have been developed for mediating disputes between families and physicians.[44] Development of a set of guidelines specific to the institution or organization for handling these challenging cases is advisable, including mechanisms such as dialogue and mediation in cases where physicians invoke conscientious objection.[45]

Abortion

Conscientious objection to abortion is common. Abortion has received large-scale attention after the U.S. Supreme Court Dobbs decision that ruled there was no constitutional right to abortion, thereby returning regulation to the state branches of government.[46] Secular objections to abortion include concerns that the fetus has consciousness and experiences pain akin to an infant shortly after birth.[47] Religion-based objections include Catholicism,[48] which equates abortion with murder where the embryo or even the fertilized ovum is considered a living being, and the anesthesiologist may be precluded from participating.[49] In Jewish law, abortion *may* be considered murder, but may also be permitted in certain extenuating circumstances, *e.g.*, where there is a threat to the life of the mother.[48,50] From the perspective of Jewish law, the anesthesiologist would not be directly culpable for murder but rather indirectly, as an "assistant."[51] Islamic scholars believe that seven stages of development are necessary in order to create a new life, and

these stages vary between 4 and 6 months after conception depending on the interpretation of the Koran.[52] Therefore, some Muslim providers may feel uneasy participating in abortions during later stages of pregnancy.

Most abortions in the United States occur in the office setting; as of 2020, less than 50% of abortions require surgical care *via* a suction procedure in the first trimester.[53] After the Dobbs decision, state legal landscapes have been rapidly changing.[54] After the State of Georgia's 22-week ban on abortions in 2020, roughly two thirds of anesthesia providers had little to no previous knowledge of the ban and thereafter were concerned about accidentally participating in what could now be considered a felony.[55] A study of U.S. Southeastern anesthesiologist providers found that most were willing to assist in surgical abortions in which maternal or fetal health was the primary indication *versus* social or financial stressors.[56] Thus anesthesiologists have relatively limited exposure to surgical abortions during a viable pregnancy. Despite this, it would be prudent for anesthesiologists to be educated on the legal and ethical issues to be better equipped to handle emergency procedures involving the termination of a pregnancy, and to anticipate the need to find a suitable replacement if they have a conscientious objection in a nonemergent case.

Gender-affirming Care

These interventions (as well as their medical analogues) are under considerable scrutiny in secular and religious ethical circles, as children are considered a vulnerable population, especially regarding procedures that are not universally accepted as standard of care. People identifying as transgender are estimated to make up 0.5% of the adult population and 1.4% of adolescents between 13 and 17 yr old.[57] These estimates are controversial due to the broad range of terms used to denote transgender individuals and recent increasing acceptance of these identities.[58] Ninety-two percent of pediatric anesthesiologists agreed that learning about transgender health care was relevant to their clinical practice.[59] Similar to abortion care, the laws outlining access to gender-affirming surgeries vary dramatically between states, and the political landscape is undergoing rapid change; 15 states have passed legislation restricting access. Many Western European countries are limiting access to permanent gender-affirming procedures.[60]

Anesthesiologists may cite conscientious objection to recuse themselves from participating in gender-affirming surgeries due to a variety of concerns, including fear of patient regret, or a sense that gender is determined at conception and not subject to change. Religious objections are considered under "Sterilization Procedures."

Sterilization Procedures

Vasectomy usually is performed under local anesthesia, but general or regional anesthesia is required for female sterilization, and some anesthesiologists may invoke conscientious objection. Up to 47% of married couples in the United States have undergone some form of sterilization. Secular arguments against sterilization may include patient regret, particularly in nulliparous premenopausal women, and performance of the procedure outside the postpartum period. Religious objections include prohibitions against castration in Judaism, against contraception by the Catholic Church, and against sterilization in Islam.[61,62] If not performed within days after delivery, the complication rate for tubal ligation significantly increases.[63] In the case of cesarean delivery, a new set of incisions must be made that could have been avoided if the ligation was performed with the access gained from the first incision. In practice, for an elective or nonemergent cesarean section, the anesthesiologist with objections to concurrent tubal ligation should attempt to find a replacement before scheduling.

Xenotransplantation

Xenotransplantation is a rapidly evolving new technology that utilizes chimeric organs created from the integration of a patient's stem cells into the blastocyst of a host animal.[64] The resulting animal's organ can be transplanted without immunosuppression.[64] This has potential to reduce the need for human donors and alleviate the global organ shortage.[65] Notwithstanding medical considerations such as risk of viral transmission, tumorigenesis, and rejection, the ethics of xenotransplantation have been hotly debated.[65] Physicians may object that it could propagate unfair organ distribution to the wealthy or promote animal mistreatment.[66] Pigs are prohibited to Muslims for consumption and medicinal purposes, and organ transplantation from pigs is likely to raise similar concerns.[20] Although porcine-derived materials after sufficient transformation are considered permissible by certain Muslim scholars, this distinction is often not known by most Muslims.[20] Egypt's Al-Azhar, its most influential religious institution, prohibited xenotransplantation of pig kidneys in nonemergent scenarios.[67] However, other religious institutions, most notably the Vatican, have supported animal transplants.[68] Jewish law imposes no restrictions on the receipt of pig organs.[69]

Prisoners

Prisoners have a unique relationship with the healthcare system. The U.S. Supreme Court ruled they have an Eighth Amendment right to receive medical care.[70] They are considered a vulnerable population, with more than half suffering from a chronic medical condition.[71]

Some healthcare providers may take exception to providing medical services to those convicted of particularly heinous crimes such as murder, rape, or sex crimes against children. In accordance with the American Medical Association Code of Medical Ethics, anesthesiologists are

free to recuse themselves from participating in procedures involving certain prisoners provided they give a timely referral to a willing practitioner. We suggest that a better approach might be to simply not inquire about the reason for incarceration. This information is never available in the medical record and could only be gleaned by word of mouth, through notoriety of the crime, or by online searching.[72]

Precedent for Staffing Changes in Anesthesiology Due to Conscientious Objection

Conscientious objection is not without parallels that can be useful for establishing a framework for management of conscientious objection in an anesthesia department or group. One example was staffing models for anesthesiology during the recent pandemic that were designed to minimize exposure to the virus.[73] Some anesthesiologists were assigned to or volunteered for the care of COVID-19 patients, with considerable risks to these physicians; in some institutions, like ours (S.R.), it was optional for anesthesiologists above the age of 55 yr to care for COVID-19 patients. At-risk individuals under 55 yr were granted exemptions on a case-by-case basis. This extreme scenario demonstrated the ability of anesthesiology departments to rapidly adapt their schedules to changing conditions while maximizing the quality of patient care.[74]

Practical Management of Conscientious Objection by an Anesthesiology Department, Group, or Residency Program

Transparency between Clinicians and Employers

How should anesthesiologists go about implementing conscientious objection while minimizing impact to patient care? Advance notice is ideal. Anesthesiologists should inform leadership of any known conscientious objection as early as possible, preferably upon hire. Of course, some practitioners may change their belief system, or not be aware of potential conflicts and conscientious objection until encountering a procedure for the first time. Medicine is constantly evolving, and new procedures may arise that trigger conscientious objection. In these situations, we recommend that clinicians attempt to alert their department or group of their objection in a timely manner, as was done by Ejiogu regarding conscientious objection to intersex surgeries.[7]

Anesthesiology residents are vulnerable because of their position in the hierarchy. We suggest that residency programs normalize the conversation regarding conscientious objection early on in training, analogously as they do for other pressures faced during residency, to minimize stigma and fear of retaliation and ensure candid responses. If postponed until the time when conscientious objection arises for a procedure, these may not be simple or easy discussions. Sensitivity is required, and care should be taken that the existing power differential is not used to coerce the resident to go against their beliefs. Residency programs are in fact required by the Accreditation Council for Graduate Medical Education (Chicago, Illinois) to provide a positive culture accepting diverse views.[75] Moreover, violation of federal and state laws could result in civil or even criminal legal consequences to medical organizations for failure to protect trainees or physician employees if they are compelled to act not in accordance with their beliefs. Therefore, these conversations need to be had despite whatever competing tensions may exist within an organization, including production pressure or concerns about adequate staffing. Openness and early discussions are key; one of the authors (S.R.) declined to participate in certain procedures as a resident due to conscientious objection for religious reasons at a time when diversity was less widely accepted than it is today and encountered no difficulties, in large part because of such early and open discussion of the issue and willingness of the faculty to be flexible with scheduling.

Conscientious objection is naturally suited to areas where there is a concentration of diverse providers available for patients. Large hospitals or groups of anesthesia providers are more likely to have scheduling flexibility and willing providers to substitute for the minority with a conscientious objection. However, in some settings, the relative lack of providers causes each objecting anesthesiologist to have a much greater impact on access to timely care. Given the shortage of anesthesiologists in the United States and the large number of those recently retired, rural and even some urban facilities may also face difficulties in hiring enough staff for their needs if conscientious objection is widespread.[76,77]

Emergency Cases and On-call *versus* Elective

For emergencies, an anesthesiologist with conscientious objection must provide their services to the patient irrespective of an objection; the only alternative is to find another provider for the procedure, which is typically not difficult in larger groups. Similarly, if the on-call anesthesiologist has a conscientious objection and delaying the procedure would cause significant harm to the patient, then they must provide their services irrespective of their objection. Barring these cases, anesthesiologists have an American Medical Association–sanctioned and legal right to conscientious objection so long as the reason for refusal is nondiscriminatory, informed consent is upheld, the operation is nonemergent, and a referral to other providers is given. Elective cases are an ideal time for conscientious objection to be exercised as they are usually scheduled well in advance, and the objecting anesthesiologist can refer the patient to another provider if needed. Communication should occur between surgeons and anesthesiologists to ensure that scheduling conflicts due to conscientious objection are minimized. We also suggest the creation of local guidelines on conscientious objection within organizations to serve as a positive, helpful resource to anesthesiologists across the spectrum of beliefs and personal values. Such guidelines would be of

Table 2. Recommendations for Implementation of Conscientious Objection

Anesthesiologists should give advance notice of CO before or upon hire, or upon realizing they have concerns about CO.
Organizations or departments should create local guidelines on proper usage of CO.
CO should not be permitted in emergent cases, unless a suitable alternative anesthesiologist is immediately available.
There are special considerations for anesthesiology residency programs. We suggest that residency programs normalize the conversation regarding CO early on in training, analogously as they do for other pressures faced during residency.

CO, conscientious objection.

great use in cases where the merits and detriments of conscientious objection in a complex situation are less clear.

Conclusions and Summary

Conscience claims can be religious or secular in nature with various lines of reasoning offered for the objection. Conscientious objection preserves the integrity of the physician as a moral agent in the face of a personally controversial procedure and promotes tolerance within the medical community to opposing viewpoints. It offers a more reasonable alternative for anesthesiologists to participating in procedures unwillingly with possible emotional effects afterward or leaving the profession altogether. Legitimate conscientious objection is legally protected in the United States and is not inconsistent with the American Society of Anesthesiologists' Code of Ethical Conduct. We recommend the following to support successful implementation of conscientious objection (table 2). There should be formal and informal adjustments as needed within departments of anesthesiology for conscientious objection, as well as timely communication between the practitioners themselves to allow for flexibility in cases of conscientious objection. We recommend that residency programs provide readily open channels for trainees to state any conscientious objection needs without fear of stigma or retaliation. The creation of a set of local guidelines on conscientious objection within organizations could serve as a positive, supportive resource for anesthesiologists across the spectrum of beliefs and personal values.

Competing Interests

S. H. Resnicoff reports work for the Academic Engagement Network, Carolina Academic Press (Durham, North Carolina), and Tikva Foundation (New York, New York). The other authors declare no competing interests.

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References

1. Fry-Bowers EK: A matter of conscience: Examining the law and policy of conscientious objection in health care. Policy Polit Nurs Pract 2020; 21:120–6
2. HHS: Conscience and religious nondiscrimination. US Department of Health and Human Services. Updated January 10, 2023. Available at: https://www.hhs.gov/conscience/conscience-protections/index.html. Accessed June 26, 2024.
3. McConnell D, Card RF: Public reason in justifications of conscientious objection in health care. Bioethics 2019; 33:625–32
4. Valero MJ: Freedom of conscience of healthcare professionals and conscientious objection in the European Court of Human Rights. Religions 2022; 13:558
5. Zaami S, Rinaldi R, Montanari Vergallo G: The highly complex issue of conscientious objection to abortion: Can the recent European Court of Human Rights ruling Grimmark v. Sweden redefine the notions of care before freedom of conscience? Eur J Contracept Reprod Health Care 2021; 26:349–55
6. American Society of Anesthesiologists: Guidelines for the ethical practice of anesthesiology. Updated October 15, 2023. Available at: https://www.asahq.org/standards-and-practice-parameters/guidelines-for-the-ethical-practice-of-anesthesiology. Accessed June 26, 2024.
7. Ejiogu NI: Conscientious objection, intersex surgeries, and a call for perioperative justice. Anesth Analg 2020; 131:1626–8
8. Ben-Moshe N: The truth behind conscientious objection in medicine. J Med Ethics 2019; 45:404–10
9. Anesthesiology. About the journal. Updated 2024. Available at: https://pubs.asahq.org/anesthesiology. Accessed June 26, 2024.
10. Pence MJ, Pla RA, Heinz E, Douglas R, Shaykhinurov E, Jacobs B: Identifying relevant topics for inclusion in an ethics curriculum for anesthesiology trainees: A survey of practitioners in the field. Camb Q Healthc Ethics 2024:1–7
11. Akhavan AA, Pang JH, Morrison SD, Satterwhite T: Gender affirming facial surgery-anatomy and procedures for facial masculinization. Oral Maxillofac Surg Clin North Am 2024; 36:221–36
12. Gottlieb L, Cripps C: An update on gender-affirming phallus construction using the radial forearm free-flap. Neurourol Urodyn 2023; 42:963–72
13. Nolan IT, Shepard E, Swanson M, Morrison SD, Hazen A: Techniques and applications of lower extremity feminization and masculinization. Transgend Health 2023; 8:45–55
14. Michael GM, Morrison SD, Nolan IT, et al.: Role of allogeneic placental tissues in penile inversion vaginoplasty. Transl Androl Urol 2024; 13:736–47
15. Vadori M, Cozzi E: Current challenges in xenotransplantation. Curr Opin Organ Transplant 2024; 29:205–11

16. Brindis CD, Laitner MH, Clayton EW, et al.: Societal implications of the Dobbs v Jackson Women's Health Organization decision. Lancet 2024; 403:2751–4
17. Kluth W: Abortion from the Catholic perspective. Wien Med Wochenschr 1992; (2-3):X–XII
18. Card RF: Is there no alternative? Conscientious objection by medical students. J Med Ethics 2012; 38:602–4
19. Mohd Zailani MF, Hamdan MN, Mohd Yusof AN: Human-pig chimeric organ in organ transplantation from Islamic bioethics perspectives. Asian Bioeth Rev 2023; 15:181–8
20. Bokek-Cohen Y, Gonen LD, Tarabeih M: The Muslim patient and medical treatments based on porcine ingredients. BMC Med Ethics 2023; 24:89
21. Cavaliere A, Rega U, Grimaldi S, et al.: Long-term outcomes and future challenges in face transplantation. J Plast Reconstr Aesthet Surg 2024; 92:87–103
22. Baumrucker SJ, VandeKieft G, Smith ER, et al.: Ethics roundtable: Advance directives, autonomy, and gastrostomy placement. Am J Hosp Palliat Care 2023; 40:1285–91
23. Barbee H, Hassan B, Liang F: Postoperative regret among transgender and gender-diverse recipients of gender-affirming surgery. JAMA Surg 2024; 159:125–6
24. Shmerling R: First, do no harm. Harvard Health Blog. Harvard Health. June 20, 2020. Available at: https://www.health.harvard.edu/blog/first-do-no-harm-201510138421. Accessed June 26, 2024.
25. Meldolesi E, van Soest J, Dinapoli N, et al.: Medicine is a science of uncertainty and an art of probability (Sir W. Osler). Radiother Oncol 2015; 114:132–4
26. Stahl RY, Emanuel EJ: Physicians, not conscripts - Conscientious objection in health care. N Engl J Med 2017; 376:1380–5
27. Stanford FC: The importance of diversity and inclusion in the healthcare workforce. J Natl Med Assoc 2020; 112:247–9
28. Sulmasy DP: What is conscience and why is respect for it so important? Theor Med Bioeth 2008; 29:135–49
29. National Archives of the United States: The Bill of Rights: A Transcription, America's Founding Documents, National Archives. Available at: https://www.archives.gov/founding-docs/bill-of-rights-transcript. Accessed June 26, 2024.
30. Shenouda J, Haslam J: Is medical assistance in dying just medically-administered death? Br J Hosp Med (Lond) 2023; 84:1–3
31. McConnell D: Conscientious objection in health care: Pinning down the reasonability view. J Med Philos 2020; 46:37–57
32. Eberl JT: Protecting reasonable conscientious refusals in health care. Theor Med Bioeth 2019; 40:565–81
33. Card RF: In defence of medical tribunals and the reasonability standard for conscientious objection in medicine. J Med Ethics 2016; 42:73–5
34. Cowley C: Conscientious objection and healthcare in the UK: Why tribunals are not the answer. J Med Ethics 2016; 42:69–72
35. The Government of the United States: 42 U.S.C. ch 21B Section 2000bb, U.S.C. Title 42 - THE PUBLIC HEALTH AND WELFARE. Available at: https://www.govinfo.gov/content/pkg/USCODE-2019-title42/pdf/USCODE-2019-title42.pdf. Accessed June 26, 2024.
36. Eilperin J: 31 states have heightened religious freedom protections. Washington Post. March 1, 2014. Available at: https://www.washingtonpost.com/news/the-fix/wp/2014/03/01/where-in-the-u-s-are-there-heightened-protections-for-religious-freedom. Accessed June 26, 2024.
37. The Supreme Court of the United States: Groff v. DeJoy, 600 U.S. 447 2023. Groff v. DeJoy:: 600 U.S. (2023) Justia US Supreme Court Center. Available at: https://www.supremecourt.gov/opinions/22pdf/22-174_k536.pdf. Accessed June 26, 2024.
38. Health and Human Services Department: 45 CFR Part 88. 45 CFR §88 Protecting Statutory Conscience Rights In Health Care; Delegations Of Authority. Available at: https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority. Accessed June 26, 2024.
39. 134th General Assembly of the House of Representatives of Ohio: R.C. Section 4743.10. Section 4743.10 - Ohio Revised Code | Ohio Laws. Available at: https://codes.ohio.gov/ohio-revised-code/section-4743.10#:~:text=(1)%20%22Health%20care%20service,psychological%20therapy%20or%20counseling%3B%20research%3B. Accessed June 26, 2024.
40. Kwok AC, Semel ME, Lipsitz SR, et al.: The intensity and variation of surgical care at the end of life: A retrospective cohort study. Lancet 2011; 378:1408–13
41. Misak CJ, White DB, Truog RD: Medical futility: A new look at an old problem. Chest 2014; 146:1667–72
42. Clarfield AM, Gordon M, Markwell H, Alibhai SM: Ethical issues in end-of-life geriatric care: The approach of three monotheistic religions-Judaism, Catholicism, and Islam. J Am Geriatr Soc 2003; 51:1149–54
43. Tesoro R, Suppan M, Dupuis A, Escher M, Haller G: Futility of end-of-life and emergency surgery in extreme high-risk patients: Anesthetists' versus surgeons' perspective. Braz J Anesthesiol 2022; 72:434–6
44. Wilkinson DJ, Savulescu J: Knowing when to stop: Futility in the ICU. Curr Opin Anaesthesiol 2011; 24:160–5
45. Lewis-Newby M, Wicclair M, Pope T, et al.; ATS Ethics and Conflict of Interest Committee: An official American Thoracic Society policy statement: Managing conscientious objections in intensive care medicine. Am J Respir Crit Care Med 2015; 191:219–27
46. Kim JH, Gunderson A, Lane EA, Bauer NM: State courts, state legislatures, and setting abortion policy. J Health Polit Policy Law 2023; 48:569–92

47. Mellor DJ, Diesch TJ, Gunn AJ, Bennet L: The importance of "awareness" for understanding fetal pain. Brain Res Rev 2005; 49:455–71
48. Nelson L: Provider conscientious refusal of abortion, obstetrical emergencies, and criminal homicide law. Am J Bioeth 2018; 18:43–50
49. Minerva F: Conscientious objection, complicity in wrongdoing, and a not-so-moderate approach. Camb Q Healthc Ethics 2017; 26:109–19
50. Khorfan R, Padela AI: The bioethical concept of life for life in Judaism, Catholicism, and Islam: Abortion when the mother's life is in danger. J IMA 2010; 42:99–105
51. Abraham A-S: Nishmat Avraham, 1st edition. Brooklyn, NY, Mesorah Publications, 2000
52. Bhashti AS: Islamic attitude towards abortion and sterilization. Birthright 1972; 7:49–51
53. Diamant JM, Basheer: What the data says about abortion in the U.S. Pew Research Center. March 24, 2024. Available at: https://www.pewresearch.org/short-reads/2024/03/25/what-the-data-says-about-abortion-in-the-us/. Accessed June 26, 2024.
54. National Constitution Center: Dobbs v. Jackson Women's Health Organization (2022), Supreme Court Case, Dobbs v. Jackson Women's Health Organization | Constitution Center. Available at: https://constitutioncenter.org/the-constitution/supreme-court-case-library/dobbs-v-jackson-womens-health-organization. Accessed June 26, 2024.
55. Reeves JA, Goedken P, Cwiak C, Hall K: "I'm not going to jail for this," an analysis of anesthesia providers' responses to Georgia's 22-week abortion ban [01I]. Obstet Gynecol 2020; 135:91S–2S
56. Reeves JA, Goedken P, Hall KS, Lee SC, Cwiak CA: Anesthesia providers' perspectives on abortion provision: Deductive findings from a qualitative study. Int J Obstet Anesth 2022; 49:103239
57. Jody HF, Andrew, O'Neill, Kathryn: How Many Adults and Youth Identify as Transgender in the United States?, Williams Institute of the UCLA School of Law, June 2022. How Many Adults and Youth Identify as Transgender in the United States? - Williams Institute. Available at: https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/. Accessed June 26, 2024.
58. Nolan IT, Kuhner CJ, Dy GW: Demographic and temporal trends in transgender identities and gender confirming surgery. Transl Androl Urol 2019; 8:184–90
59. Roque RA, O'Reilly-Shah V, Lorello GR, Adams T, Cladis F: Transgender patient care: A prospective survey of pediatric anesthesiologist attitudes and knowledge. Can J Anaesth 2021; 68:1723–6
60. Davis E: European countries restrict trans health care for minors, US News and World Report. July 12, 2023. Why European Countries Are Rethinking Gender-Affirming Care for Minors | Best Countries | U.S. News. Available at: https://www.usnews.com/news/best-countries/articles/2023-07-12/why-european-countries-are-rethinking-gender-affirming-care-for-minors. Accessed June 26, 2024.
61. Ohn Mar S, Ali O, Sandheep S, Husayni Z, Zuhri M: Attitudes towards vasectomy and its acceptance as a method of contraception among clinical-year medical students in a Malaysian private medical college. Singapore Med J 2019; 60:97–103
62. Dardir AM, Ahmed W: Islam and birth planning: An interview with the Grand Mufti of Egypt. Popul Sci 1981; 2:1–5
63. Chi IC, Gates D, Thapa S: Performing tubal sterilizations during women's postpartum hospitalization: A review of the United States and international experiences. Obstet Gynecol Surv 1992; 47:71–9
64. Wu J, Platero-Luengo A, Sakurai M, et al.: Interspecies chimerism with mammalian pluripotent stem cells. Cell 2017; 168:473–86.e15
65. Loike JD, Kadish A: Ethical rejections of xenotransplantation? The potential and challenges of using human-pig chimeras to create organs for transplantation. EMBO Rep 2018; 19:e46337
66. Rollin BE: Ethical and societal issues occasioned by xenotransplantation. Animals (Basel) 2020; 10:1695
67. Mansour T: Egypt's Azhar issues fatwa allowing pigs' kidneys to be transplanted to humans. The New Arab. October 26, 2021. Available at: https://www.newarab.com/news/azhar-issues-fatwa-allowing-transplant-pigs-kidneys. Accessed June 26, 2024.
68. Bosch X: Vatican approves use of animal transplants "to benefit humans." Nature 2001; 413:445–445
69. Loike JD, Krupka RM: The Jewish perspectives on xenotransplantation. Rambam Maimonides Med J 2023; 14:e0024
70. Pazzanese C: Supreme Court may halt health care guarantees for inmates. Harvard Gazette. March 2, 2023. Available at: https://news.harvard.edu/gazette/story/2023/03/supreme-court-may-halt-health-care-guarantees-for-inmates/. Accessed June 26, 2024.
71. Maruschak LM, Bronson J, Alper M: Medical problems reported by prisoners: Survey of prison inmates, 2016. US Department of Justice. June 2, 2021. Available at: https://bjs.ojp.gov/library/publications/medical-problems-reported-prisoners-survey-prison-inmates-2016. Accessed June 26, 2024.
72. McLeod KE, Butler A, Young JT, et al.: Global prison health care governance and health equity: A critical lack of evidence. Am J Public Health 2020; 110:303–8
73. Cook TM: Risk to health from COVID-19 for anaesthetists and intensivists - A narrative review. Anaesthesia 2020; 75:1494–508

74. Ramachandran S, Slinchenkova K, Leff J, et al.: The impact of the COVID-19 surge response on motivation among anesthesiology residents and fellows: A discussion of findings from semi-structured interviews at Montefiore Medical Center and educational takeaways. Health Psychol Res 2023; 11:74137
75. ACGME: Common program requirements. July 1, 2023. Available at: https://www.acgme.org/programs-and-institutions/programs/common-program-requirements/. Accessed June 26, 2024.
76. Menezes J, Zahalka C: Anesthesiologist shortage in the United States: A call for action. J Med Surg Public Health 2024; 2:100048
77. Newitt P: Behind the anesthesia shortage plaguing ASCs, Becker's ASC review. December 15, 2023. Available at: https://www.beckersasc.com/anesthesia/behind-the-anesthesia-shortage-plaguing-ascs.html#:~:text=ASCs%20in%20many%20markets%20are,%2C%20principal%20at%20Ventura%2C%20Calif. Accessed June 26, 2024.