

## Ethics Consultation Service

### Conscientious objections by nonclinical team members

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#### I. Case Summary:

An aid-in-dying physician with an office in their prior oncology practice has an office manager who handles all aid-in-dying patients. When this employee is on paid time off, other team members would normally cover the manager's duties. These employees, however, made conscientious objection claims to avoid participating in aid-in-dying care. The regional director created a work-around whereby a corporate staff member without training in the practice would cover for the manager when they were out of the office. These duties would be added to their normal workload.

The physician expressed concern that the work-around 1) places a burden on the other team member in terms of workload and 2) will create barriers to and delays in communication between potential patients and the aid-in-dying provider. **In this consult, the ethics team considered whether administrative and medical-assistant staff in a private physician practice have ethical grounds under a conscientious objection standard to refuse to perform nonclinical duties related to aid-in-dying.**

#### II. Discussion and Analysis:

The team focused on two aspects of the case to answer this question: defining nonclinical participation and weighing the burden of refusals to participate on all stakeholders. In a medical context, conscientious objection refers to the refusal of a health care professional to provide or participate in the delivery of a legal, medically appropriate health care service to a patient due to personal beliefs based on moral or religious grounds. In order to establish whether a claim is valid, therefore, we need to understand what constitutes participation.

The provider is working in a state where medical aid in dying is legal, and medical aid-in-dying services are supported by the organization in which the team member is employed. The organization has formal policies allowing physicians to participate and educates all team members on the state's aid-in-dying law, including through annual compliance training. At a minimum all employees at this practice work for an organization that supports medical aid in dying.

Within the practice, staff involvement in aid in dying remains indirect. It is administrative and nonclinical. Duties include scheduling and rooming patients—duties that are similar for all patients. What goes on during these appointments is indeterminate and protected by provider/physician-patient privilege. Consultations with terminally ill patients are informed discussions during which providers aim to understand the specific concerns and challenges of the patient and to offer resources that might improve the quality of their life. These conversations are about all end-of-life options; they are not exclusively about accessing aid in dying. The purpose of the doctor-patient privilege is to allow full disclosure between patients and health care providers without fear of legal repercussion and safeguarding trust and openness between them. Nonclinical staff is not part of these discussions or their content.

If a physician determines that the patient is eligible to participate and if the patient completes all qualifying criteria, the provider can then provide the patient with a prescription, which the patient may choose (or choose not) to obtain and then self-administer in order to hasten their own death. These are the voluntary and willing acts of participation in medical aid in dying. Nothing in these actions either guarantees or provides a patient with the physical tools to hasten their death.

Employees who decline to participate in routine nonclinical acts, such as scheduling patients who might be considering aid in dying, impose a burden on other stakeholders if they work in an office and institution that provides the option. Refusing to carry out front desk duties impacts: the employee(s) who object(s); the patient; the physician/provider; the other team members; the organization.

While the conscientious objector might feel relief from their own moral distress, their refusal also denies them important opportunities—for example, to learn more fully about end-of-life discussions and about the challenges of those seeking to relieve their own suffering. They deny themselves the opportunity for the humanistic connection that comes with expressing compassion.

Refusal might also impose undue barriers on patients. When other staff have to pick up duties that a designated team member usually carries out, this can lead to delays, and delays can potentially lead to loss of eligibility (such as loss of decisional capacity) or impose a natural death with undesired suffering. Delays impinge on the private provider-patient dialogue and might restrict the free speech of the patient and their provider. Finally, the patient and their family might feel judged by this treatment, which can lead to feelings of shame.

The provider, who is seeking to exercise their clinical expertise and compassion may also feel the burden of judgment. They may find that the privacy of the patient-provider relationship is compromised. Moreover, other employees may feel the stresses of the additional workload and hostility can accrue.

Finally, refusal affects the organization. On the one hand, accommodating the claim would satisfy the organization's responsibility to support their employees. On the other hand, it creates an environment in which the values of the organization are not supported by the actions of the individual team member, which can cause harm to the "brand."

### **III. Conclusion and Recommendations:**

*In light of the fact that the team member is performing their standard role and is not required to discuss medical aid in dying with the patient or the patient's loved ones and, given the nature of patient consultations and their protected status, it is reasonable to assert that the team member is not participating in providing medical assistance in dying. Therefore, objection or refusal to participate on moral or religious grounds may not be justified and moreover may negatively impact multiple stakeholders.*

*Importantly, this recommendation may not fully apply, depending on the state. Nonclinical staff would potentially be covered under federal Title VII prohibitions against religious discrimination (See Appendix A2.3). If the employee wants to avoid what they deem to be participation, the employer should accommodate unless accommodation would be unduly burdensome.*

Often it is a misperception or lack of education about the process of aid in dying that causes moral distress and angst for a team member. Education can relieve the team member of feelings of complicity or any notion of having played an active role in providing aid in dying to patients, which might violate their moral or religious belief system. The ethics team therefore recommends that practices that provide aid in dying should consider taking the following precautions:

- Team members should be given the opportunity to express their discomfort with aid in dying.
- Education about aid in dying should be provided. This should be patient centered and include
  - details about consultations—for example, that they involve detailed discussions about alternatives to medical aid in dying at end of life, such as hospice, and determining decisional capacity.
  - information about how other safeguards in the law are met.
  - discussion about the risks of conscience-based refusal including perpetuating a lack of understanding about the nature of the process, creating additional stigma, increasing barriers to accessing care, and conveying potentially discriminatory messages to patients and their loved ones.
- A clear definition of participation for the relevant service or practice should be established and all staff should be aware of it and why it is in place.
- A strong and fair policy that addresses conscience-based objection should also be in place. The policy should support both the team member (in valid situations) and the patient. It should not compromise or create burdens to patients wishing to seek their legal right to health care.

The team would advise against:

- Requiring participation even of nonclinical staff, given that Title VII allows refusal.
- Allowing team members to refuse to perform in a nonclinical role (e.g., scheduling appointments and rooming patients) without clarification and review by the employer of the laws on conscience-based refusal in the jurisdiction of practice, particularly for non-religious reasons.
- Failing to convene a non-threatening, patient-centered discussion of the issues involved in refusal.

#### **IV. Confidentiality**

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## **APPENDICES**

### **APPENDIX A: Existing Law on Conscientious Objection and Conscientious Objection Claims for Nonclinical Duties**

#### **Appendix A1: Existing Laws, Challenges, and Proposals**

Law on conscientious objection by health care team members in the context of medical aid in dying varies across different jurisdictions.

##### **1. Federal Statutes in the United States:**

- Federal statutes protect [health care provider conscience](#) rights and prohibit recipients of certain federal funds from discriminating against health care providers who refuse to participate in services based on moral objections or religious beliefs.
- In institutions receiving federal funds, health care providers who refuse to participate in services based on moral objections or religious beliefs [are protected against discrimination and have official avenues](#) to complain if they feel that right is violated.

##### **2. State-Level Conscience Clauses:**

- Most states in the U.S. have "conscience clauses" that describe the right of physicians and other health care providers to refuse to provide services such as abortion, tubal ligation, or medical aid in dying.
- These clauses [recognize the right of health care professionals to conscientiously object](#) to certain procedures or treatments based on their personal beliefs.

##### **3. Challenges and Controversies:**

- The balance between respecting health care providers' conscientious objections and ensuring patient access to legal and medically appropriate services is a complex issue.
  - Some argue that conscientious refusal should not override patients' wishes, especially when it comes to end-of-life decisions like medical aid in dying.
  - Others advocate for clearer guidelines and mechanisms to address conscientious objections while safeguarding patient rights.
4. **Proposed Principles for a Principled System:** The legal landscape regarding conscientious objection in health care is multifaceted, and striking the right balance between individual beliefs and patient care remains an ongoing challenge.
- A principled system would:
    - Protect refusers less and providers more, with carve-outs tailored to distinct levels of authority (employer and government).
    - Require clear disclosures for conscience exemptions from workplace policies.
    - [Mitigate punishments](#) for supplying clinically reasonable care, even for providers who conscientiously object.

## Appendix A2: Conscientious Objection and Nonclinical Duties

1. **Conscientious Objection:**
  - Conscientious objection allows health care providers to decline participation in certain procedures or treatments based on their personal beliefs.
  - It is generally accepted that health care professionals have the right to conscientiously object to participating in procedures that conflict with their moral or religious convictions.
2. **Balancing Rights:**
  - Patient Autonomy: Patients have the right to make informed decisions about their own medical care, including end-of-life choices.
  - Provider Conscience: Health care providers also have rights to their own beliefs and conscience.
3. **Legal Protections:**
  - Varies by Jurisdiction: Legal protections for conscientious objection vary by country, state, and institution.
  - Scope of Protection: Some laws protect health care providers from participating in procedures like medical aid in dying while others may not.
  - Reasonable Accommodation: In some cases, health care institutions are required to make reasonable accommodations for conscientious objectors while ensuring patient care.
4. **Scheduling/Rooming a Patient:**
  - Scheduling/Rooming Decision: Refusing to assist with scheduling or rooming a patient in preparation for the consultation visit based solely on their consideration of medical aid in dying is not justifiable.

- **Legal Implications:** Whether this refusal is legally protected depends on local laws and institutional policies.
- 5. **Ethical Considerations:**
  - **Patient-centered Care:** Ethical health care prioritizes patient well-being and autonomy.
  - **Open Communication:** Health care providers should engage in open conversations with patients about their preferences and options.
  - **Referral:** If a provider conscientiously objects, they should consider referring the patient to another colleague who can provide the necessary care.

While conscientious objection is a valid right, it must be balanced with patient autonomy and access to appropriate care and a clear understanding of the process of medical aid in dying. Legal protections and institutional policies play a crucial role in determining the boundaries of conscientious objection in health care settings.

## **Appendix B: Recommendations for Conscientious Objection Policies**

A comprehensive policy for a health care organization regarding conscientious objection should address the rights and responsibilities of both health care providers and patients. Here are key components that such a policy should include:

1. **Definition and Scope:**
  - Clearly define what constitutes conscientious objection within the organization.
  - Specify the scope of the policy, including which procedures or services it applies to (e.g., abortion, sterilization).
2. **Provider Rights and Obligations:**
  - **Provider Notification:** Outline the process for providers to declare their conscientious objection. Providers should promptly inform their supervisors or relevant parties.
  - **Alternative Arrangements:** Describe how the organization will handle situations where a provider objects to a specific procedure. This may involve referring the patient to another provider or ensuring timely access to care.
  - **Balancing Patient Needs:** Emphasize the importance of balancing provider rights with patient needs. Providers should prioritize patient well-being while respecting their own beliefs.
3. **Patient Rights and Access:**
  - **Informed Consent:** Ensure that patients receive clear information about their options, including any procedures the provider objects to. Informed consent remains essential.
  - **Timely Access:** Guarantee timely access to necessary medical services, even if a provider objects. Patients should not face undue delays due to conscientious objections.
  - **Referral Process:** Detail the process for referring patients to other providers who can perform the requested procedure.

4. **Non-Discrimination:**
  - Patient Non-Discrimination: Prohibit discrimination against patients based on their choices or beliefs.
  - Provider Non-Discrimination: Ensure that providers who conscientiously object are not discriminated against in employment or advancement.
5. **Emergency Situations:**
  - Address how conscientious objection applies in emergency scenarios. Providers may need to set aside objections to save a patient's life.
6. **Documentation and Reporting:**
  - Provider Declarations: Require providers to document their conscientious objection formally.
  - Incident Reporting: Establish a system for reporting incidents related to conscientious objection, ensuring transparency and accountability.
7. **Training and Education:**
  - Provider Education: Offer training on conscientious objection, ethical dilemmas, and patient-centered care.
  - Patient Education: Educate patients about their rights and the organization's policies.
8. **Review and Updates:**
  - Regularly review the policy to ensure its effectiveness and alignment with legal and ethical standards.
  - Involve relevant stakeholders in policy updates.

A well-crafted conscientious objection policy balances the rights of providers with the needs of patients, fostering a respectful and compassionate health care environment.