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The right of health care workers to conscientious objection

Summary

During the past few years, the problem of healthcare workers' conscientious objection became the subject of scientific and socio-political interest. This interest is affirmed by a dynamic increase in the number of scientific publications, the statements of various expert groups, international regulations, legislative initiatives and also the rulings of courts and tribunals (in particular the judgment of the Constitutional Tribunal of 7th October 2015, Ref. No. K 12/14). Despite various articles and individual monographs on selected aspects of conscientious objection being published in Polish, there is no analyzing this issue in a systematic, comprehensive and interdisciplinary manner.

The main problem undertaken in this study is the limitation of conscientious objection in medical practice taking into consideration medical providers' freedom of conscience and the rights of patients (consumers). The aim of the work is explaining the normative content of the right to conscientious objection and examining current Polish legal norms regarding objection of conscience from the perspective of its constitutionality, necessity and legitimacy. It also proposes an internally coherent model of interpretation of these laws and identifies a way to mitigate conflicts of values and norms associated with it. The author is convinced that majority of limitations of healthcare workers' conscientious objection is unnecessary and this was also confirmed by judgment of the Constitutional Tribunal of 7th October 2015. The main thesis of this work states that the essence of the problem of conscientious objection in medical practice does not lie in the regulations of the conscience clause but in the scope of duties imposed on the medical personnel that go beyond the necessity of protecting the patients' health and life, and may even be considered improper from the perspective of individual's beliefs as well as the perspective of inner goals of medicine and medical ethics.

The work applies methods typical for the legal sciences, especially the dogmatic-legal method, but also to a certain extent the legal-comparative method and the historical-legal method. In the analysis of norms, reference was made to the linguistic, systemic and

teleological interpretations. The basic source of law includes acts regulating the area of freedom of conscience, and those on providing health services. The research focuses on universally binding law and the judgments of general jurisdiction courts, the internal corporate rules expressing deontological norms (soft law) and acts containing religious and moral norms, particularly including those of the Catholic Church, which in varying degrees shape the attitudes and decisions of individuals and sometimes cause the conscientious objection.

Based on the stated problem and established research objectives, the work is divided into five chapters. The first is an attempt to place the subject matter in the reality of medical practice and (to the extent possible) describe the situations when conscientious objection is claimed and reasoning behind its occurrence. The description of procedures that can be the source of conscientious objection is dictated by a context broader than the national perspective, with the assumption that some, currently absent (or infrequent) problems in our country, may in the future become a part of a heated social debate and lead to the necessity of developing appropriate regulations. Conscientious objection in medical practice relates to a series of actions associated with the beginning of human life (abortion, prenatal diagnosis, some methods of fertility regulation and assisted procreation) as well as its end stages (euthanasia, medically assisted suicide, criteria of brain death, participating in death penalty executions) but also to such situations as ending persistent therapy, blood transfusion, transplantation and the use of selected drugs and vaccines. The conscientious objection can be enforced by non-religious and religious (e.g. Christian, Jewish, Muslim or Buddhist) members of the medical staff. Apart from moral doubts, cognitive doubts may also occur as a result of stipulations to the correctness of certain standards and guidelines applied in the medical practice such as the criteria of brain death. The analysis of situations in which the conscientious objection occurs, leads to the conclusion that the problem rarely applies to activities directly connected with the patients' health or life protection. In majority of the cases it pertains to the refusal of violating the principle of respect for human life and the principle of nonmaleficence. There is no need to refer to religion in order to understand the motives behind the objection of conscience as it usually stems from universal moral values and norms. Thus, many of the limitations of the conscientious objection in the medical practice raise doubts both from the formal principle of necessity and the constitutional values, which should be the material basis for introducing such limitations.

The second chapter shows legal basis of the right to conscientious objection. It stems from the freedom of conscience, which is constitutive to every human being and is directly

rooted in the dignity of every human person. Freedom of conscience is manifested in an inner dimension (*forum internum*), where individual convictions are shaped and in an external one (*forum externum*) where a person conducts according to his/her convictions. Restriction of freedom of conscience, including conscientious objection, is only permitted in exceptional cases, based on the principle of legality and proportionality, when it is necessary to protect the common good, or the fundamental rights and freedoms of others, and sometimes it takes the form of the so-called conscience clauses. Regulations in the context of conscientious objection should also include other constitutional principles: equality, non-discrimination and the ideological impartiality of public authorities.

The third chapter analyzes the most important premises limiting conscientious objection, which in the context of medical practice include the necessity to protect human life and health. They are protected as personal rights, and simultaneously are the source of patients' rights and obligations of health care workers. However, it is necessary to preserve the principle of proportionality in the protection of the beneficiaries' rights and the limitations of freedoms of healthcare providers, especially in the context of activities other than those directly connected with patients' health and life protection. The inadequate premises limiting the freedom of conscience in the context of medical practice include the right to privacy and other unspecified regulations based on the broadly understood concept of procreation autonomy. This is due to the fact that they are rarely associated with the protection of human health and life, and do not constitute a sufficient material basis for limiting the freedom of consciousness in medical practice.

The fourth chapter is devoted to a discussion of the legislative restrictions on conscientious objection contained in the conscience clauses. With regard to the medical sector employees, the rules governing conscientious objection are found in article 39 of the Act on the Professions of Doctor and Dentist from 5th December 1996 and in the Act on the Occupation of Nurses and Midwives from 15th July 2011. A lot of controversy was raised by article 39 of the first Act, which through the prism of the principle of proportionality, was deemed partially unconstitutional by the judgment of the Constitutional Tribunal of 7th October 2015. The ruling of the Constitutional Tribunal resolved some of the doctrinal disputes and reminded the primary character of freedom of conscience in relation to legislative restrictions. However, it did not resolve the problem relating to the providing information about morally controversial procedures nor the issue of restricting the freedom of conscience of other health care workers. This chapter also touches the issue of institutional conscientious objection.

The fifth chapter contains analysis of various postulates for legislative changes in the healthcare workers' objection of conscience, including the modification of the information obligation and the introduction of conscience clause to acts regulating medical professions other than the doctors', nurses' and midwifes'. Some of the propositions, put forward for consideration are inconsistent with the Constitution (e.g. the elimination of the conscience clause) or only partially resolve this problem by moving its various aspects to other areas of the health care system. Among the more interesting postulates is the proposal to separately contract and finance procedures that do not involve the saving or protection of the human health and life.

In the light of the quoted literature and jurisprudence, as well as on the basis of available data and survey results, it must be concluded that the essence of the problem of conscientious objection in medical practice does not lie in the content or the form of the conscience clause, but in the purview obligations imposed on the medical staff. These obligations go not only beyond the necessity of protecting the patients' health and life (which already raises doubt as to its legitimacy), but are also associated with activities that directly or indirectly violate it. They may therefore be inconsistent not only with the individuals' convictions but also with the internal goals of medicine and the principles of medical ethics. Such a situation is possible due to a broad, imprecise and inconsistent definition of health benefits and disregarding medical axiology and teleology in the process of establishing guaranteed services. A postulate should therefore be made to limit the scope of guaranteed health benefits so that they do not harm the human beings' health and life (except for situations where such an activity is necessary based on the principle of proportionality). Inclusion of axiology and teleology of medicine in the process of establishing the scope of guaranteed medical services would lead to a situation where the scientific and political debate on the conscientious clause in medical practice, would become significantly reduced.