AMERICAN THORACIC SOCIETY DOCUMENTS

An Official American Thoracic Society Policy Statement: Managing Conscientious Objections in Intensive Care Medicine

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Rationale: Intensive care unit (ICU) clinicians sometimes have a conscientious objection (CO) to providing or disclosing information about a legal, professionally accepted, and otherwise available medical service. There is little guidance about how to manage COs in ICUs.

Objectives: To provide clinicians, hospital administrators, and policymakers with recommendations for managing COs in the critical care setting.

Methods: This policy statement was developed by a multidisciplinary expert committee using an iterative process with a diverse working group representing adult medicine, pediatrics, nursing, patient advocacy, bioethics, philosophy, and law.

Main Results: The policy recommendations are based on the dual goals of protecting patients' access to medical services and protecting the moral integrity of clinicians. Conceptually, accommodating COs should be considered a "shield" to protect individual clinicians' moral integrity rather than as a "sword" to impose clinicians' judgments on patients. The committee recommends that: (*1*) COs in ICUs be managed through institutional mechanisms, (*2*) institutions accommodate COs, provided doing so will not impede a patient's or surrogate's timely access to medical services or information or create excessive hardships for other clinicians or the institution, (*3*) a clinician's CO to providing potentially inappropriate or futile medical services should not be considered sufficient justification to forgo the treatment against the objections of the patient or surrogate, and (*4*) institutions promote open moral dialogue and foster a culture that respects diverse values in the critical care setting.

Conclusions: This American Thoracic Society statement provides guidance for clinicians, hospital administrators, and policymakers to address clinicians' COs in the critical care setting.

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Overview

Intensive care unit (ICU) clinicians are sometimes faced with situations in which they have a moral objection to providing or disclosing information about a legal, professionally accepted, and otherwise available medical service. Such objections will be referred to as "conscientious objections" (COs). There is considerable controversy about how to manage COs in general and little guidance about how to do so in the ICU setting. This policy statement was developed to help critical care clinicians, hospital administrators, and policymakers evaluate and manage COs in the ICU setting. This policy statement provides: (*1*) an ethical analysis of COs in ICUs, (*2*) recommendations for management of COs in critical care settings, and (*3*) proposed components of a model institutional policy to manage COs in ICUs.

Accommodating COs can promote valuable goals. Reasons to accommodate

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COs include: (*1*) to protect clinicians' moral integrity, (*2*) to respect clinicians' autonomy, (*3*) to improve the quality of medical care, and (*4*) to identify needed changes in professional norms and practices. However, the accommodation of COs may have negative consequences for patients, colleagues, and institutions. Reasons not to accommodate COs include: (*1*) to honor core professional commitments, (*2*) to protect vulnerable patients, (*3*) to prevent excessive hardships for other clinicians or the institution, and (*4*) to avoid invidious discrimination.

The following four policy recommendations are designed to balance two ethical goals in the management of COs in ICUs: (*1*) to protect patients' access to legal, professionally accepted, and otherwise available medical services; and (*2*) to protect clinicians' moral integrity.

Recommendation 1

COs in ICUs should be managed through institutional mechanisms rather than *ad hoc* by clinicians. Healthcare institutions should develop and implement CO policies that encourage prospective management of foreseeable COs and that provide a clear process to manage unanticipated COs.

Recommendation 2

Institutions should accommodate COs in ICUs if the following criteria are met: (*1*) the accommodation will not impede a patient's or surrogate's timely access to medical services or information, (*2*) the accommodation will not create excessive hardships for other clinicians or the institution, and (*3*) the CO is not based on invidious discrimination.

Recommendation 3

A clinician's CO to providing potentially inappropriate or futile medical services should not be considered sufficient justification to unilaterally forgo the treatment against the objections of the patient or surrogate. Clinicians should instead use a fair process-based mechanism to resolve such disputes. A clinician may use the institutional CO management process to request a personal exemption from providing the medical service.

Recommendation 4

Institutions should promote open moral dialogue, advance measures to minimize moral distress, and generally foster a culture that respects diverse values in the critical care setting.

Introduction

Intensive care unit (ICU) clinicians are sometimes faced with situations in which they have a moral objection to providing or disclosing information about a medical service (1). For example, ICU clinicians may have moral objections to disclosing information about the option of withdrawing nutrition and hydration, offering or providing palliative sedation to unconsciousness, participating in organ donation, or providing advanced life support to patients with a poor prognosis. In a recent survey of ICU clinicians, 27% of respondents reported acting "in a manner contrary to his or her personal and professional beliefs" during the single-day study period (2). In that study, the most common circumstance cited by physicians and nurses was providing treatment perceived to be excessive or overly aggressive.

These moral objections will be referred to as conscientious objections (COs) and are defined as objections to providing or disclosing information about legal, professionally accepted, and otherwise available medical services based on a clinician's judgment that to do what is requested would be *morally* wrong (3). This American Thoracic Society (ATS) policy statement provides clinicians, hospital administrators, and policymakers with guidelines for evaluating and managing COs. This policy statement does not address objections to providing medical services that are: (*1*) illegal (e.g., objection to performing physician-assisted suicide in states where this is illegal), (*2*) clearly outside accepted medical practice (e.g., objection to prescribing antifungal therapy for a bacterial infection), (*3*) outside the scope of a clinician's professional competence (e.g., objection to intubating a patient without appropriate training and credentials), or (*4*) based on a clinician's self-interest (e.g., an objection to treating a patient with a contagious disease out of a concern for the clinician's own health or an objection to treating a Medicare patient based on a desire to protect the clinician's financial interests). Nor does it address institutional refusals based on moral or religious principles. Throughout this document "clinicians" refers generally to individuals in the ICU who provide care to patients (e.g., physicians, nurses, respiratory therapists, pharmacists, etc., at any level of training), acknowledging that each discipline has unique roles, responsibilities, and challenges.

Methods

This policy statement was developed by a multidisciplinary expert committee using an iterative process. The ATS Ethics and Conflict of Interest (ECOI) Committee first convened an *ad hoc* working group composed of a subset of members of the ATS ECOI committee. The need for additional expertise was evaluated, and national experts were invited to join the working group. The full working group represented a breadth of disciplines, including adult medicine, pediatric medicine, nursing, patient advocacy, bioethics, philosophy, and law.

The working group first reviewed known relevant literature and existing policies of other medical organizations. The content of this policy was then developed through a 3-year iterative discussion-based consensus process consisting of face-to-face meetings, teleconferences, web conferences, and electronic correspondence. A writing committee drafted the policy statement, which was reviewed by the working group members on multiple occasions and revised. The policy statement was further modified and ultimately approved by the full ATS ECOI committee. This statement then underwent a rigorous peer review process, and ultimately review by the ATS Board of Directors.

Ethical Analysis of COs in Intensive Care Medicine

One approach to managing COs is to accommodate clinicians by exempting them from personally providing specific medical services. Accommodating COs may achieve certain valuable goals but also may have negative consequences for patients, colleagues, and institutions. These valuable goals and potential negative consequences are explored below as reasons for and against accommodating COs and are summarized in Table 1.

Reasons to Accommodate COs

To protect clinicians' moral integrity. Accommodating clinicians' COs provides "moral space" in which to practice with

Table 1. Ethically Relevant Considerations in the Analysis of Conscientious Objections in Intensive Care Medicine

Reasons to accommodate COs
Consideration 1: To protect clinicians' moral integrity Accommodating clinicians' COs allows them to protect their moral integrity and to avoid the moral harm associated with acting contrary to moral beliefs.
Consideration 2: To respect clinicians' autonomy Accommodating COs protects clinicians' freedom to refrain from acting in ways that violate their personal beliefs and values.
Consideration 3: To improve the quality of medical care Protecting the moral integrity of critical care clinicians may improve medical quality at the population level.
Consideration 4: To identify needed changes in professional norms and practices The evaluation and accommodation of COs may be one effective way to promote critical reappraisal of the boundaries of accepted medical practice.
Reasons not to accommodate COs
Consideration 5: To honor core professional commitments Clinicians voluntarily commit to promote the patient's best medical interests, not to abandon the patient, and to make reasonable sacrifices for the benefit of their patient's health.
Consideration 6: To protect vulnerable patients Patients receiving critical care are particularly vulnerable due to incapacity, life-threatening illness, lack of choice of clinician, lack of potential to be notified in advance of the clinician's CO, and a severely constrained opportunity to seek out a new clinician.
Consideration 7: To prevent excessive hardships on other clinicians or the institution Accommodating CO can create excessive hardships on other clinicians and healthcare institutions.
Consideration 8: To avoid invidious discrimination Invidious discrimination is prohibited by most healthcare professional codes of ethics and by law.

Definition of abbreviation: CO = conscientious objection.

moral integrity and thereby enables clinicians to avoid the moral harms associated with acting contrary to one's moral convictions (4, 5). Depending on the depth of one's moral convictions, acting contrary to them can result in a sense of self-betrayal and a loss of self-respect and may be accompanied by emotions ranging from temporary feelings of frustration, sadness, anxiety, or anger to sustained feelings of anguish, guilt, remorse, and self-loathing. A failure to maintain moral integrity can have detrimental effects on the physical, emotional, and spiritual well-being of clinicians, which may contribute to burnout, job dissatisfaction, compassion fatigue, substance abuse, or depression, particularly if there is repeated exposure (2, 6–10).

To respect clinicians' autonomy. Individual autonomy and self-determination are important values in a free society. Accommodating COs protects clinicians' freedom to refrain from acting in ways that violate their moral beliefs and values.

To improve the quality of medical care. Accommodating COs may improve the quality of medical care at the population level (11). Promoting a medical culture that protects clinicians' moral integrity may: (*1*) help to prevent clinicians from becoming "callous" to their patients' moral concerns, (*2*) avoid discouraging ethically sensitive persons from entering critical care disciplines, (*3*) prevent impaired medical team dynamics and problems with staff retention, and (*4*) encourage a culturally and religiously diverse healthcare workforce (4, 11).

To identify needed changes in professional norms and practices. The evaluation and accommodation of COs may be one effective way to promote critical reappraisal of the boundaries of accepted medical practice. Historically, clinicians have spoken out against potentially problematic cultural norms or practices and in so doing have promoted awareness of the need for change. For example, clinicians who objected to the nontreatment of newborns with trisomy 21 and duodenal atresia contributed to changing this previously widely accepted practice. Clinicians who reflect on existing medical norms and object to them may represent the first wave of awareness that an accepted medical norm should be reviewed and potentially revised.

Reasons Not to Accommodate COs

To honor core professional commitments. When clinicians enter practice, they voluntarily accept a set of core professional commitments (12–15). The exercise of conscience should be consistent with these core professional obligations. Clinicians voluntarily commit to act beneficently and to respect patients' rights of self-determination. These commitments are foundational fiduciary duties of the clinician. Clinicians are expected to promote their patients' best medical interests, to not abandon them, and to make reasonable sacrifices for the benefit of their patients' health (14, 16). The most compelling constraint on accommodating COs in medicine is to protect patients from suffering harms that may occur if they do not receive a requested medical service or if they or their surrogates do not receive information in a timely or competent manner. This constraint may be particularly salient in the critical care setting, where patients are being treated for life-threatening illnesses.

To protect vulnerable patients. Critically ill patients are often vulnerable in several ethically relevant ways, which may place greater constraints on the accommodation of COs in ICUs than in other healthcare settings (17, 18). First, due to the severity of their medical illnesses, patients in ICUs frequently lack decision-making capacity (19, 20). Even if they retain decision-making capacity, critically ill patients are likely limited in their ability to advocate for themselves, seek out medical options, and search for another clinician. Second, when admitted to an ICU, patients usually lack a choice of healthcare clinician. Third, due to the severe and unstable nature of many critical illnesses, a transfer of care to another clinician may not be safe or feasible. Several of the main strategies to manage COs in other medical settings are more difficult if not impossible to implement in the critical care setting (e.g., providing prior notice to patients regarding one's COs and referring patients to other clinicians in a timely and safe manner) (21, 22).

To prevent undue excessive hardships on other clinicians or the institution. The degree of hardship a CO places on other clinicians or an institution is an ethically relevant consideration. Healthcare institutions generally have an obligation to ensure that patients in their care receive legal, professionally accepted, and otherwise

available medical services. Therefore, institutions generally must ensure that another clinician is available to provide the medical service. Depending on the institutional context, the accommodation of a clinician with a CO may create significant financial or scheduling hardships for other clinicians or the institution, such as requiring the hiring of additional personnel.

To avoid invidious discrimination. Some objections are based on medically irrelevant characteristics of the patient (e.g., the patient's race, sex, religion, ethnicity, or sexual orientation) rather than on the nature of the medical service. Such objections represent invidious discrimination, are condemned by most health care professionals' codes of ethics (12, 14, 15), are illegal, and should not be accommodated.

Table 2. Policy Recommendations for Managing Conscientious Objections in Intensive Care Medicine

Recommendation 1: COs in ICUs should be managed through institutional mechanisms rather than *ad hoc* by clinicians. Healthcare institutions should develop and implement CO policies that encourage prospective management of foreseeable COs and that provide a clear process to manage unanticipated COs.
Recommendation 2: Institutions should accommodate COs in the ICU if the following criteria are met: a. the accommodation will not impede a patient's or surrogate's timely access to medical services or information; b. the accommodation will not create excessive hardships for other clinicians or the institution; c. the CO is not based on invidious discrimination.
Recommendation 3: A clinician's CO to providing potentially inappropriate or futile medical services should not be considered sufficient justification to unilaterally forgo the treatment against the objections of the patient or surrogate. Clinicians should instead use a fair process-based mechanism to resolve such disputes. A clinician may use the institutional CO management process to request a personal exemption from providing the medical service.
Recommendation 4: Institutions should promote open moral dialogue, advance measures to minimize moral distress, and generally foster a culture that respects diverse values in the critical care setting.

Definition of abbreviations: CO = conscientious objection; ICU = intensive care unit.

Recommendations

The following four recommendations are designed to balance two ethical goals in the management of COs in ICUs: (*1*) to protect patients' access to legal, professionally accepted, and otherwise available medical services; and (*2*) to protect clinicians' moral integrity (summarized in Table 2). An additional discussion of these recommendations can be found in Appendix 2 in the online supplement, "Paradigmatic Cases: Application of Ethical Analysis and Recommendations" (*see* Table 3 and the online supplement).

Recommendation 1:

COs in ICUs should be managed through institutional mechanisms rather than *ad hoc* by clinicians. Healthcare institutions should develop and implement CO policies that encourage prospective management of foreseeable COs and that provide a clear process to manage unanticipated COs.

Institutional policies to manage clinicians' COs are preferable to *ad hoc* strategies by clinicians. Institutional mechanisms can help to strike a balance between the two goals cited above and promote key elements of procedural fairness, including transparency, legitimacy, consistency, and the opportunity for appeal and review. Institutional management strategies can use existing resources (e.g., the institutional ethics committee [23, 24]) and can be tailored to the capabilities of the individual institution.

There are several potential criticisms of institutional management. Compared with *ad hoc* management by clinicians, institutional management strategies: (*1*) potentially have a higher administrative burden, (*2*) might constrain clinician autonomy, and (*3*) may require more time for resolution. However, these possible disadvantages are outweighed by the importance of maintaining procedural fairness and the need to protect particularly vulnerable patients. Key components of a model institutional CO policy are presented below.

Recommendation 2:

Institutions should accommodate COs in ICUs if the following criteria are met: (*1*) the accommodation will not impede a patient's or surrogate's timely access to medical services or information, (*2*) the accommodation will not create excessive hardships for other clinicians or the institution, and (*3*) the CO is not based on invidious discrimination.

This recommendation is justified by the core professional obligation to avoid causing harm to patients and to act to promote their best medical interests. The preservation of a clinician's moral integrity generally cannot come at the expense of a patient's physical safety or access to clinically indicated and professionally accepted medical services. The recommendation is further justified by the particular vulnerability of patients in ICUs. In life-threatening situations, refusing to provide a medical service or information without securing an alternative clinician runs a high risk of leading to significant harm to the patient. Generally, the accommodation of a CO should be considered only if another clinician is available to provide the medical service or information in a timely and competent manner. Some patient inconveniences or a minimal increase in the risk of harm may be acceptable to achieve the goal of preserving clinician moral integrity. Examples of potentially acceptable patient harms may include the inconvenience of a brief delay required to identify an alternate clinician or the risk of psychological harm from a clinician expressing moral disagreement with a patient's values.

Accommodation of a CO may be denied if it would result in excessive hardships for other clinicians who would be asked to provide the medical service.

Table 3. Paradigmatic Cases Explored in Appendix 2

In Appendix 2 (*see* online supplement), the policy recommendations for management of COs are applied to 6 paradigmatic cases. These cases highlight the wide range of circumstances that may surround COs in critical care settings.

Case 1: A CO to providing an emergent life-saving medical service
A 25-yr-old woman is admitted to the ICU shortly after midnight with acute septic shock after a first trimester pregnancy termination. The attending ICU physician refuses to care for women whose critical illness is the result of an abortion, based on his religious beliefs.

Case 2: A CO resulting from inadequate medical team communication
A 64-yr-old woman with end-stage cancer presents with acute and progressive respiratory failure. The team anticipates that she will require intubation and mechanical ventilation within the next 24 h. Her bedside nurse feels morally uncomfortable with the prospect of intubating her and feels the team should offer comfort care instead.

Case 3: A CO based on a clinician's belief that a family-requested treatment is inappropriate or futile
An 8-mo-old boy who has been in the ICU on mechanical ventilation for 3 mo with complex multiorgan medical problems and chronic respiratory failure has just been placed on ECMO 3 d ago for an acute decompensation. The bedside ECMO specialist claims a CO and requests that ECMO be discontinued, stating that everyone knows survival is highly unlikely and that this is a poor use of resources in a futile situation.

Case 4: A CO to requested withdrawal of life support
A 45-yr-old man remains comatose 12 d after an intracranial hemorrhage from a ruptured aneurism. The family requests the withdrawal of the ventilator to allow the man to die. A valid advanced directive supports the family's request. The physician tells the family that he has a CO to the withdrawal of life support and that the family will have to wait 2 d until another physician takes over.

Case 5: Moral distress that results from a perception of powerlessness
A 70-yr-old woman who suffered a large right middle cerebral artery stroke has been in the ICU for 1 wk on mechanical ventilation and has now developed sepsis from ventilator-associated pneumonia. The physician strongly recommends to the family a palliative treatment plan. The family disagrees but ultimately acquiesces after the physician firmly restates his recommendation. The physician asks the RT to extubate the patient as part of the palliative treatment plan. The RT is hesitant to extubate after witnessing the reluctance by the family but, due to a sense of powerlessness, says nothing and proceeds with extubation. The patient dies several hours later. The RT is very distressed that night, cannot sleep, and calls in "sick" to work the next day.

Case 6: A CO to disclosing a professionally accepted medical option
A 15-yr-old boy has suffered a severe anoxic brain injury after a suicide attempt but after 3 d has not progressed to brain death. The family elects to withdraw life-sustaining therapies. The institution strongly supports DCDD, but the physician is morally opposed to DCDD and refuses to contact the organ recovery organization.

Definition of abbreviations: CO = conscientious objection; DCDD = donation after circulatory determination of death; ECMO = extracorporeal life support; ICU = intensive care unit; RT = respiratory therapist.

Accommodation may also be denied if it would create an excessive hardship for the institution; "there are limits on the burdens that institutions are obligated to accept to accommodate an individual clinician's conscientious objections" (4). Requiring accommodations to be made regardless of the hardship it creates would severely constrain the liberty of other clinicians, would be extremely difficult to implement in practice, and could threaten the economic viability of healthcare institutions. Nevertheless, some hardship should be accepted by clinicians and institutions to accommodate COs (25, 26). When accommodation is not feasible, efforts to find a way to accommodate the CO at the earliest possible time that will not impose excessive hardships on other clinicians or the institution should continue.

There is no consensus on the amount of burden to patients or the degree of hardship to clinicians and institutions that is acceptable. Moreover, such determinations are context dependent. Accordingly, a case-by-case fair process approach is recommended. Difficult cases may require arbitration by a multidisciplinary, multimember institutional body representing a breadth of views (e.g., hospital ethics committee) to promote fairness and reduce the risk of arbitrariness.

Finally, objections based on invidious discrimination are impermissible. Invidious discrimination is contrary to widely shared conceptions of justice, equality, dignity, and respect (*see* the section on Reasons Not to Accommodate COs) (4, 12, 14, 15).

Recommendation 3:

A clinician's CO to providing potentially inappropriate or futile medical services should not be considered sufficient justification to unilaterally forgo the treatment against the objections of the patient or surrogate. Clinicians should instead use a fair process-based mechanism to resolve such disputes. A clinician may use the institutional CO management process to request a personal exemption from providing the medical service.

There is ongoing debate within medical professions and society about whether it is permissible for clinicians to refuse to provide life support requested by a patient or surrogate in the setting of far-advanced disease when the treatment could extend the patient's life to some degree. In these circumstances, clinicians occasionally refuse (against the patient's or surrogates' wishes) to provide treatments they judge to be inappropriate or futile, claiming that providing the treatment would violate their moral integrity.

In general, a CO only provides sufficient justification for the clinician to seek a personal exemption from providing the medical service. Importantly, a CO *alone* does not carry enough moral weight to justify withholding or withdrawing life-prolonging therapies against patient or surrogate requests. A CO should be used as a shield to protect clinicians from the moral harm that may arise from acting contrary to their moral beliefs rather than as a sword to impose their values and override the choices of patients and surrogates. Allowing clinicians to unilaterally make life or death decisions based on individual COs violates respect for persons and goes beyond the authority society has granted to medical professionals.

When a clinician seeks to forgo a medical service against the wishes of the patient or surrogate based on a judgment that it is inappropriate or futile, the first step is to

Table 4. Summary of Components of Institutional Management Strategies

Component 1: Advance identification and notification of anticipated COs Institutional mechanisms should promote prospective identification and notification of potential COs by clinicians.
Component 2: Timely evaluation of COs The institution should implement a clear mechanism for a timely impartial third-party evaluation of COs.
Component 3: Disclosure of medical options and provision of uninterrupted medical care The institution should identify mechanisms to ensure the disclosure and the uninterrupted provision of all legal, professionally accepted, and otherwise available medical options.
Component 4: Protocol to facilitate transfer of care A transfer of care is the optimal mechanism for accommodating COs. The institution should prospectively identify mechanisms for the safe and timely transfer of care of the patient.
Component 5: Process for appeals The institution should delineate a mechanism for the timely and transparent evaluation of appeals from patients, surrogates, and clinicians.
Component 6: Consequences for clinicians who refuse to provide a medical service when a CO cannot be accommodated Clinicians who refuse to provide a legal, professionally accepted, and otherwise available medical service without a formal CO accommodation may be subject to any applicable institutional or legal consequences.
Component 7: Periodic review of CO cases The institution should establish a mechanism for the routine periodic retrospective review of COs.

Definition of abbreviation: CO = conscientious objection.

thoroughly evaluate the case using a fair dispute resolution process. These cases often arise in situations for which there is lack of consensus about what constitutes accepted medical practice. Therefore, attention to procedural fairness to evaluate the case takes on added importance. The use of existing institutional resolution mechanisms and process-based approaches is recommended (such as those described by the American Medical Association [27], the Society for Critical Care Medicine [28], and the American Thoracic Society [upcoming publication]). If the requested medical service is determined through a fair institutional resolution mechanism (e.g., ethics committee review) to be outside the boundaries of accepted medical practice, then there is no obligation to provide it. If the requested medical service is determined to be within the boundaries of accepted medical practice, then the institution should ensure that the patient receives the requested treatment. In this case, if a clinician continues to have a CO to providing the requested service, one possible resolution is to seek a personal exemption from providing the medical service through the institutional CO management process (*see* algorithm in Figure 1).

Finally, clinicians may disagree with current professional norms and believe they should be changed. In such situations, clinicians should be encouraged to work at the policy level to change existing norms of practice. Attempts to alter social policy should not occur via *ad hoc* bedside decision making because of the lack of procedural fairness and the risk to patients.

Recommendation 4:
Institutions should promote open moral dialogue, advance measures to minimize moral distress, and generally foster a culture that respects diverse values in the critical care setting.

A wide variety of situations can give rise to moral distress. There are some situations in which clinicians cannot be relieved from providing a medical service to which they have a CO. Additionally, some clinicians with COs may choose not to request accommodation due to perceived conflicting obligations to the patient, other clinicians, and/or the institution. Some clinicians may experience moral objections that do not rise to the level of requesting accommodation of a CO. Finally, some clinicians may feel powerless to speak out or request accommodation for a CO.

Without appropriate avenues for resolution, moral distress can have negative consequences for clinicians, patients, and healthcare quality in general (2, 11, 29, 30). Just as it is important for institutions to protect clinicians from risks of physical harm encountered in the clinical setting, it is also important for institutions to protect clinicians by preventing or eliminating conditions that give rise to moral distress (31).

To reduce moral distress and improve the quality of medical care, institutions should promote moral reflection and discourse among ICU clinicians. This may allay or lessen some instances of moral distress through the following mechanisms: (*1*) moral discourse alone may resolve some situations of moral distress through the identification of misunderstandings or misinterpretations, (*2*) establishing a culture that encourages open moral dialogue may help to alleviate the sense of powerlessness that can give rise to moral distress, (*3*) clinicians may be more likely to support colleagues with moral objections, and (*4*) open moral discourse may aid in the assessment of the appropriateness of various therapies and may help clinicians identify professional standards that need to be revised. Creating a culture of open moral discourse and mutual support for colleagues with COs may be achieved through formal mechanisms (educational offerings, multidisciplinary conferences, ethics rounds, etc.) and informal means. Support groups or individual counseling may also help to minimize the impact of moral distress on a clinician's overall moral well-being (6, 9, 10).

Key Components of Institutional Strategies to Manage COs in Intensive Care Medicine

Below are seven proposed components of a model institutional CO policy to manage clinicians' COs at the institutional level (Table 4).

Advance Identification and Notification of Anticipated COs

Ideally, clinicians' potential COs should be prospectively identified and disclosed to the institution. Proactive management of COs can facilitate a more timely evaluation and resolution process, thereby potentially minimizing both the risk of harm to patients and the risk that clinicians may be obligated to act against their moral beliefs.

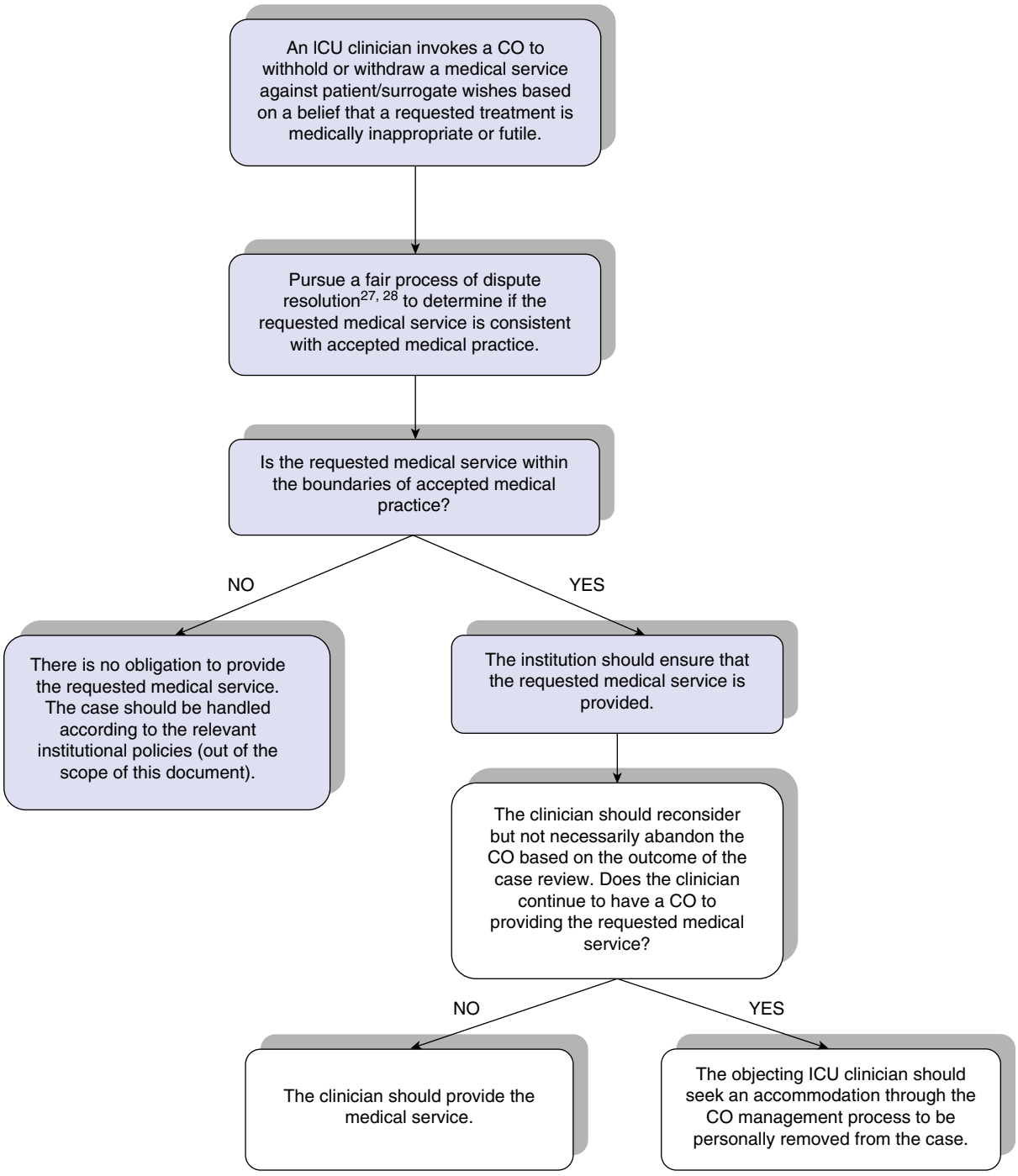

Figure 1. An approach to managing conscientious objections (CO) based on a clinician's belief that a requested medical service is medically inappropriate or futile. ICU = intensive care unit.

Timely Evaluation of COs

A clear mechanism should be in place for an impartial third party to evaluate clinicians' COs in a timely manner. The evaluation may include an assessment of the facts of the case, the nature of the objection, the impact of the CO on patient care, the feasibility of accommodation, and other options for resolution. A third party could include the ICU director, an administrator, or an ethics committee (23, 24) (especially for more complex cases). The advantage of the efficiency of a single individual must be weighed against the plurality of view represented in a larger committee, and both approaches should be paired with a timely appeals process (*see below*).

Disclosure of Medical Options and Provision of Uninterrupted Medical Care

The institution should delineate mechanisms to ensure the disclosure and the

uninterrupted provision of all legal, professionally accepted, and otherwise available medical options. Ideally, if it can be accomplished in a timely fashion, another clinician would assume the medical care of the patient, inform the patient (or surrogates) of the range of medical options, or arrange the transfer of care. However, depending on the clinical situation, the clinician with a CO may be required to disclose or provide the medical service until care can be transferred. In the case of prospective evaluations of COs, clarification of expectations and arrangements should be made in advance to minimize disruptions in patient care.

Protocol to Facilitate Transfer of Care

Generally, a transfer of care is the optimal mechanism to ensure the patient's well-being while accommodating the clinician's CO. A transfer may be within the unit, to a different unit within the institution, or outside the institution. To optimally meet the needs of both the patient and the clinician, the transfer of care should be made in a timely manner. A transfer may be nearly immediate if another clinician is available. However, in some clinical situations, a transfer of care might take a number of days, which may or may not satisfy the timeliness requirement. Ideally, the mechanism to facilitate the transfer of care is arranged in advance. The transfer of care may be arranged by a third party (e.g., administrator or ICU director), if available. However, if another clinician is not available to arrange the transfer, the clinician with the CO may be required to do so. It is impermissible to interfere with or obstruct a transfer of care.

Process for Appeals

A mechanism for appeals should exist for both patients or surrogates and clinicians. A multimember institutional body representing a breadth of views (e.g., an institutional ethics committee [23, 24]) is appropriate for this purpose. As with other aspects of this process, the mechanism for appeals should be timely and transparent.

Consequences for Clinicians Who Refuse to Provide a Medical Service When a CO Cannot Be Accommodated

Situations may arise in which a clinician's CO cannot be accommodated, but the clinician nonetheless refuses to provide the medical service. In these circumstances the clinician may be subject to the institutional or legal consequences that apply to clinicians who refuse to provide a legal, professionally accepted, and otherwise available medical service.

Periodic Review of CO Cases

A mechanism for the periodic retrospective review of cases of CO should be a component of an institutional policy. A regular review process will help to achieve efficient and consistent management of cases and may identify areas for improvement in institutional practices.

Conclusions

As in other areas of medicine, COs arise in the provision of critical care medicine. Patients requiring critical care therapies are particularly vulnerable. As such, COs in ICUs should be evaluated carefully. Generally, this policy is consistent with those of other organizations (21, 22), but it provides more explicit guidance for the evaluation and management of COs in critical care settings.

Protecting the moral integrity of clinicians should be considered an important goal in critical care medicine. This may be achieved by accommodating clinicians' COs and by fostering a culture that promotes open moral dialogue. In addition, respecting critical care clinicians' consciences may also improve the overall quality of medical care in ICUs. Accordingly, clinicians' COs should be accommodated unless: (*1*) a patient or surrogate is denied timely access to legal, professionally accepted, and otherwise available medical services or information; or (*2*) the accommodation creates excessive hardships for other clinicians or the institution.

Institutional CO management strategies hold the most promise for protecting patients' access to legal, professionally accepted, and otherwise available medical services while protecting critical care clinicians from undue pressure to act against their consciences. ■

This Policy Statement was prepared by an *ad hoc* subcommittee of the ATS Ethics and Conflict of Interest Committee.

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