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Toward a Structured Framework for Conscientious Objection in Spain's Healthcare System

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Abstract

Medical practitioners commonly deal with moral tensions and difficult choices in patient care, prompting increased attention to the concept of conscientious objection (CO). Spain's health system currently offers no formal guidance on what constitutes valid reasons for CO, how it should be properly exercised, or how best to assist professionals who choose to invoke it. A well-defined procedural framework is therefore necessary. This framework must ensure responsible use of CO by clinicians while upholding its moral legitimacy and legal compliance, balancing respect for personal ethical convictions with patients' entitlement to timely healthcare. The suggested approach specifies eligibility criteria for CO (individual reference, specific clinical context, ethical justification, assurance of non-discrimination, professional consistency, attitude of mutual respect, assurance of patient rights and safety) along with a step-by-step procedural pathway (notification and preparation, documentation and confidentiality, evaluation of prerequisites, non-abandonment, transparency, allowance for unforeseen objection, compensatory responsibilities, access to guidance and/or consultative advice, and organizational guarantee of professional substitution). The practical usefulness of this model is shown by applying it to a realistic clinical case scenario.

Keywords: Conscientious objection, Clinical ethics, Decision-making, Professionalism

Introduction

Definition of conscientious objection

Conscientious objection (CO) means declining to carry out certain actions or services due to deeply held ethical or religious beliefs [1]. In healthcare settings, this occurs when a practitioner refuses to perform a required professional task mandated by statute, rules, institutional policies, or judicial decisions, because it clashes with their core personal values, convictions, or principles [2-11]. The objector accepts that the demanded obligation is legitimate and generally binding, yet argues that their individual moral stance should override it in the given circumstance [11].

Unlike other expressions of disagreement, someone exercising CO does not attempt to modify the underlying laws or policies; they merely request to be excused from one particular duty that conflicts with their conscience [5]. In contrast, civil disobedience [7, 12-14] involves

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intentionally breaking a law deemed morally wrong to abolish or reform it. When such resistance challenges an enforceable court ruling, the individual is labeled an "objector" [8]. Essentially, CO is a form of personal dissent, whereas civil disobedience is collective resistance, often within the political domain [7].

Although not everyone agrees that CO is necessary, its practice has become more widely accepted among healthcare staff working in diverse societies in recent decades, where it is regarded as both an ethical entitlement and a protected legal right [4]. Opposing voices maintain that all clinicians have a duty to fulfill the professional and societal expectations of medicine, placing these obligations above private moral views [4, 9, 15-18].

Regulatory framework regarding conscientious objection in Spain

Originally in Spain, conscientious objection was asserted mainly by men facing mandatory military conscription. Its application in the medical field started in 1985 after the legalization of abortion [19, 20]. Over time, the increasing complexity of modern medicine [2] and ongoing scientific developments have prompted consideration of CO in many additional areas, such as withholding or withdrawing aggressive treatments, providing comfort-focused care near death, honoring patients' wishes to forgo life support, and addressing ethical issues involving embryos or stem cells. Consequently, CO is increasingly viewed by Spanish healthcare workers as a justified ethical and legal option, especially following the approval in 2021 of dedicated legislation on euthanasia and physician-assisted dying [21].

Article 16.1 of the Spanish Constitution [22] recognizes freedom of ideology and religion as a basic constitutional right. Constitutional Court Ruling 15/1982 [23] held that CO "exists both explicitly and implicitly in the Spanish constitutional framework," allowing individuals to act in accordance with ethical convictions in both personal and occupational contexts. Another ruling (53/1985) [20] noted that CO does not require separate legislation, as it flows directly from Article 16.1. Subsequent Constitutional Court decisions, however, have limited this interpretation, emphasizing that CO is not a blanket entitlement but only relieves a person from specific legal duties under exceptional conditions [24, 25].

At the statutory level, CO for healthcare personnel is governed by two main national provisions: Public Act 2/2010 on Sexual and Reproductive Health and Voluntary Interruption of Pregnancy [26] and Organic Law 3/2021 regulating Euthanasia [21]. Additionally, several regional authorities—Madrid, Valencia, Extremadura, the Balearic Islands, Murcia, and La Rioja—have included CO clauses in laws related to advance healthcare directives [2, 27] **(Table 1)**.

Table 1. Spanish legislation and regulations on CO. From: Guidelines for conscientious objection in Spain: a proposal involving prerequisites and protocolized procedure

Scope	Law/Legislation	Article	Application
National	Spanish Constitution (1978)	Article 16	Establishes a fundamental right: freedom of ideology, religion, and worship.
	Spanish Public Act 2/2010 on Sexual and Reproductive Health and Voluntary Interruption of Pregnancy	Article 19	Applies to voluntary termination of pregnancy.
	Organic Law 3/2021 regulating euthanasia	Article 16	Governs euthanasia and assisted suicide.
	Medical Code of Ethics (2022)	Articles 34–37	Pertains to the practice of medicine.
	Code of Ethics for Nursing (1989)	Article 22	Relates to professional nursing duties.
	Code of Ethics for Pharmacists (2018)	Articles 46–47	Concerns about pharmacists' professional responsibilities.
Regional	Navarra – Regional Act 17 of November 8, 2010, on the rights and obligations of individuals in the healthcare system of the Autonomous Community of Navarra (including the option of conscientious objection in voluntary termination of pregnancy)	Article 75.7	Applies to voluntary termination of pregnancy.
	La Rioja – Act 9 of September 30, 2005, regulating advance directive documentation in healthcare	Article 7.4	Applies to advance directives.
	Valencia – (1) Act 1 of January 28, 2003, on patient rights and information; (2) Decree 168/2004 of September 10,	- Article 17.2 - Article 5.3	Applies to patient rights and advance directives.

2004, regulating advance directives and establishing the Central Registry of Advance Directives		
Madrid – Act 3 of May 23, 2005, governing the exercise of the right to issue advance directives in healthcare and creating the corresponding registry	Article 3.3	Applies to advance directives.
Extremadura – (1) Act 3 of July 8, 2005, on healthcare information and patient autonomy; (2) Decree 31/2007 of October 15, 2007, regulating the structure, organization, and functioning of the Register of Advance Statements of Will in Extremadura and establishing its associated automated data file	- Article 20.2 - Article 13.3	Applies to patient autonomy and advance directives.
Murcia – Decree 80/2005 of July 8, 2005, approving regulations on advance directives and their registration	Article 5	Applies to advance directives.
Balearic Islands – Act 1 of March 3, 2006, on advance directives	Article 6	Applies to advance directives.

Various professional bodies across healthcare fields explicitly endorse the moral validity of CO in their official ethical guidelines. Article 34.2 of the Spanish Medical Ethics Code [6] outlines basic conditions for its use and characterizes CO as "an essential requirement for preserving freedom and autonomy in professional activity." Comparable recognition appears in the Code of Ethics for Nursing [28] and the Code of Ethics for the Pharmaceutical Profession [29]. These codes collectively affirm that CO is an individual right available to every healthcare professional, to be claimed personally and supported by reasoned justification. Importantly, exercising this right must not result in any unfair advantage or disadvantage to the person invoking it.

The purpose of this document

Ethical and legal complexities surrounding conscientious objection (CO) currently make establishing it properly quite demanding. This raises the question of whether dedicated guidelines could offer meaningful support. In the following pages, we first describe the main obstacles professionals face when considering invoking CO and then review key arguments supporting and opposing the development of such guidelines. Next, we provide a clear rationale for these guidelines and present a structured framework with specific recommendations to guide healthcare professionals and institutional authorities in implementing CO effectively while remaining ethically responsible and fully compliant with the law. Lastly, we introduce a real-world clinical case that provides context for CO and demonstrate how applying our proposed guideline to that case illustrates its practical value.

Are guidelines for conscientious objection necessary?

The complexity of the problem

Exercising CO responsibly demands thorough attention to intertwined ethical, clinical, and legal considerations along with their broader consequences. To start with, healthcare workers sometimes cite many different grounds for refusing to participate, but a large portion of these lack a genuine moral basis and therefore cannot be considered ethically valid **(Table 2)**. Some individuals may declare themselves conscientious objectors even though the reasons they provide do not truly stem from a deep moral conflict [8, 19]. Since objections frequently mix rational and irrational elements depending on the circumstances, judging whether they are legitimate proves far from straightforward.

Table 2. Examples of grounds stated by health care professionals for exercising CO. From: Guidelines for conscientious objection in Spain: a proposal involving prerequisites and protocolized procedure

Medical intervention related to CO	Justifications cited for refusal and invocation of CO (a)
Treatment of unvaccinated children [30].	Risk of harm to other unvaccinated minors and immunocompromised individuals. Perception among parents of unvaccinated children that care provided may constitute malpractice due to deviation from accepted standards.
Assistance in the dying process (e.g., euthanasia, medically assisted suicide) [31].	Conviction regarding the absolute protection and preservation of human life. Principle of non-maleficence. Possible adverse emotional or psychological consequences (e.g., intensifying fears related to death). Concern about legal liability and societal stigma.

	Challenges in adequately assessing patient decision-making capacity (linked to limited experience, time constraints, or excessive workload) in irreversible situations.
Provision and/or initiation of life-sustaining therapies [32].	Principle of non-maleficence. Commitment to unconditional preservation of life.
Voluntary termination of pregnancy [33-36].	Belief in the need to protect and preserve life from the moment of conception. Principle of non-maleficence. Principle of prudence: when uncertainty exists, avoidance of performing an abortion is preferred. Concern regarding social stigma. Perceived absence of clinical benefit.
Prescription of emergency (post-coital) contraceptives [33, 37].	Belief in safeguarding life beginning at conception.
Elective sterilization procedures [33].	Rejection of reproductive methods is considered inconsistent with “natural” or “appropriate” conception.
Gender transition interventions [33].	Concern over potential future regret following irreversible procedures.
Assisted reproductive technologies.	Perception of negative cultural implications for future generations (e.g., belief that homosexual couples are less suitable parents than heterosexual couples) [33, 36]. Preference for conception methods regarded as “natural” or “appropriate” [38].
Disposal of surplus cryopreserved embryos [36].	Concern about possible misuse (e.g., for research purposes or use by infertile couples).
Refusal to perform abortions within “objecting institutions” [39].	Perceived infringement on patient safety, well-being, and autonomous decision-making.
Force-feeding of prisoners during hunger strikes [36].	Avoidance of practices interpreted as forms of torture. Respect for autonomy and decision-making capacity.
Care provision to individuals of different genders [36].	Invocation of religious exemptions.
Use of life-sustaining interventions in patients beyond defined age thresholds (e.g., 80 years) [36].	The principle of distributive justice emphasizes the appropriate allocation of limited resources.
Inclusion of individuals with disabilities (e.g., children with Down syndrome) on organ transplant waiting lists [36].	Distributive justice considerations regarding fair allocation of scarce resources.
Prescription of medications with potential for misuse (e.g., opioid substitutes that could be diverted to the black market) [40].	Risk of indirect harm to third parties.
Female genital mutilation [38, 41].	Principle of non-maleficence.
Animal experimentation.	Avoidance of actions considered harmful or torturous to sentient beings, particularly when viable alternatives exist [42].
Training involving animals.	Ethical concerns arise from the use of animals in the learning process.

1. [a]: A complete and/or true ethical justification or argument may not always exist

Furthermore, making CO work effectively requires careful handling of the delicate ethical and legal subtleties involved. Among the important questions are: Which particular moral values or principles can properly underpin a claim of CO? Should CO be available only to individual practitioners, or could entire medical groups or institutions also claim it? In what manner should an objection be formally reported to the healthcare organization and explained to the patient? Which aspects of patient care need continued attention once the objection takes effect? And how do laws at the local, regional, and national levels influence the handling of CO? These issues and others form the foundation of any thoughtfully managed conscientious objection.

Because of this inherent complexity, it is vital to establish a clear procedural framework. Such a framework must ensure that healthcare professionals use CO appropriately, confirm its moral soundness and compliance with legal standards, protect individual ethical beliefs, and ensure that patients continue to receive necessary care.

What is a guideline for CO?

In clinical ethics, guidelines consist of suggested recommendations or benchmarks rooted in well-accepted ethical principles. Healthcare teams can refer to them when reaching final decisions about treatment and care [43]. These tools serve as safeguards that help prevent or manage conflicts that often surface during routine clinical work, and they provide practical guidance when needed.

When put into practice, guidelines identify the strongest available approaches for reaching sound judgments, spell out the sequence of actions to be taken, and clearly assign responsibilities to the people involved [44]. A good illustration is the set of guidelines addressing Jehovah's Witnesses who refuse blood products. These clarify the limited circumstances in which transfusions may still be used and outline the specific duties of the doctor, the patient, relatives, lawyers, and other parties [45, 46]. Practitioners are encouraged to consult the recommendations and adapt them to the unique details of each case as they see fit (the guidelines are not compulsory). However, many hospitals and clinics request an explanation whenever a clinical decision substantially departs from the recommended approach [47].

Making the case for guidelines in CO

When facing situations involving CO, an organized, transparent procedure proves especially useful. It allows clinicians to respect their own deeply held personal convictions without interfering with the overall provision of medical services [15, 48], while also taking full account of the complicated clinical, ethical, and legal factors described earlier. Guidelines provide a reliable framework that helps professionals navigate challenging scenarios in which they may have had little prior preparation or hands-on experience.

That said, relying on guidelines is not without drawbacks. First, broad recommendations can be hard to apply accurately to every unique patient situation, since the medical details and applicable legal rules often vary from place to place. If applied too rigidly, they risk creating unintended problems such as excessive confidence in the rules, reliance on easily recalled examples, or jumping to conclusions too quickly — all of which can interfere with the fair use of CO in specific instances. Second, guidelines may not develop sufficient depth or strength if conscientious objection claims remain uncommon in everyday practice. For instance, many organizations might struggle to produce meaningful CO guidelines because they lack sufficient real-world cases to draw reliable data from. Third, the sharing and regular revision of guidelines can vary widely across institutions, which may reduce their overall usefulness unless there is genuine, organization-wide dedication to the process. Clinical Ethics Committees, which exist in most Spanish healthcare facilities, could play an important leadership role here. Finally, although CO guidelines support decisions grounded in ethics, they do not automatically shield users from legal liability. Additional laws and institutional policies are still needed to address the purely legal aspects of these situations.

Even with these potential shortcomings, we are convinced that creating a well-designed set of guidelines is both achievable and worthwhile. When properly constructed, such guidelines can help safeguard healthcare workers' personal moral values while also maintaining, balancing, and supporting the established standards of quality healthcare delivery — particularly when Clinical Ethics Committees actively contribute, as they do in the majority of healthcare settings throughout Spain.

Guidelines for the appropriate use of conscientious objection in Spain

Spain's healthcare system currently lacks official guidelines on valid reasons for conscientious objection (CO), the proper application of CO, or practical steps to assist healthcare professionals who wish to invoke CO in specific situations. Since no established method currently exists to balance these conflicting interests, we introduce a new evaluative and procedural framework. This framework is intended to support Spanish healthcare professionals who seek to exercise conscientious objection in a specific clinical scenario.

Our proposal consists of a series of recommendations aimed at harmonizing existing Spanish regulations with potentially competing ethical and societal principles — specifically, the protection of professionals' personal freedom and the guarantee of fair and equitable healthcare delivery. The recommendations presented below **(Table 3)** are designed to ensure that any use of CO remains both ethically justified and legally compliant.

Table 3. Guideline for CO: eligibility prerequisites and procedural process. From: Guidelines for conscientious objection in Spain: a proposal involving prerequisites and protocolized procedure

Eligibility prerequisites	Notes/explanation
1) Individual reference	Conscientious objection is a personal matter; collective or group-based CO is not permitted.
2) Specific clinical context	Each instance of CO is assessed independently; prior CO does not obligate future decisions, as each clinical scenario is distinct.
3) Ethical justification	Both the normative ethical principles and the objecting professional's moral reasoning must be valid. CO should reflect a genuine exercise of personal moral freedom.
4) Assurance of non-discrimination	Objection cannot stem from bias or prejudice; the refusal must target the act itself, not the individual receiving care.
5) Professional consistency	CO must be consistently applicable to analogous ethical dilemmas regardless of geographic, physical, or professional circumstances.
6) Attitude of mutual respect	Respect must be maintained toward patients, colleagues, and institutional authorities, including both objecting and non-objecting professionals.
7) Assurance of patient rights and safety	The patient's access to safe, high-quality healthcare must not be compromised.
Procedural process	Description
1) Notification and preparation	CO declarations should be submitted well in advance to allow proper planning and arrangements.
2) Documentation and confidentiality	Requests for CO must be formally documented (e.g., in writing) and handled in accordance with privacy standards, and shared only when necessary to protect the rights of the professional, the institution, and the patient.
3) Evaluation of prerequisites	A careful assessment of all eligibility criteria must be conducted to determine if CO is appropriate.
4) Non-abandonment	Professionals must continue to provide care for medical interventions not covered by CO.
5) Transparency	The medical professional must disclose their CO status to the patient involved.
6) Allowance for unforeseen objection	Spontaneous CO may be acceptable in urgent situations; in such cases, a formal CO submission can be made afterward.
7) Compensatory responsibilities	Professionals excused from certain duties due to CO should compensate by performing alternative responsibilities to prevent personal or institutional gain.
8) Access to guidance and/or consultative advice	Professionals considering CO must have access to support from professional associations or Clinical Ethics Committees (CECs).
9) Organizational guarantees of professional substitution	Patients must be assured that another qualified professional will deliver the required service within a reasonable timeframe and to the same quality standard.

Eligibility prerequisites for CO

For CO to be considered appropriate, all of the following conditions must be met and carried out as described.

To be performed by the requesting professional and/or governing institution:

1) Individual reference: CO must be claimed and exercised on a strictly personal basis [7, 49], not as a collective action (such as civil disobedience). Group-based objection in healthcare settings is not acceptable [6, 11, 29], since genuine CO reflects deeply personal moral reasoning that remains free from external pressure, peer influence, workplace obligations, or institutional politics [50]. In certain cases, private facilities that uphold particular institutional values may choose not to provide a given medical service. In such situations, the institution refrains from offering that procedure to its patients [4].

2) Specific clinical context: CO must be limited to a clearly defined clinical situation and should not automatically extend to previous or future cases. The objection begins and ends with the particular scenario in question. Moreover, healthcare professionals should make decisions about CO without being swayed by choices they have made in earlier situations [2, 11]. The professional remains free to withdraw their objector status at any time once the specific situation no longer creates a genuine internal moral conflict.

3) Ethical justification: CO must stem directly from the professional's deeply held personal convictions, thereby upholding the ethical principle of autonomy through the free exercise of individual conscience. In addition, the values challenged by the required action must be central to the professional's moral framework [11, 14]. For instance, CO cannot be accepted if the requested

procedure is illegal, falls outside the scope of accepted medical practice, or if the clinician lacks the necessary competence. Similarly, objections driven by laziness, convenience, or self-interest are not valid [6, 11, 18, 29]. To help determine true ethical validity, some experts recommend that a formal committee review the stated reasons in each case [48] to confirm the presence of a real moral dilemma and to rule out any hidden secondary gains [11, 17]. Others suggest that professional associations should conduct structured evaluations to assist clinicians in distinguishing legitimate CO from situations where no authentic moral conflict actually exists [14].

4) Assurance of non-discrimination: CO cannot be invoked if the underlying motivation involves discrimination or prejudice [6, 29]. For example, it is unacceptable to refuse care based on a patient's ethnicity, race, religion, or personal beliefs [51]. Instead, any objection must arise solely from a genuine ethical conflict related to the specific procedure itself, independent of the patient's personal characteristics or other unrelated factors.

5) Professional consistency: The use of CO must demonstrate consistency in principles and behavior across different settings [7]. For instance, a professional cannot refuse to act for patients in the public system while willingly carrying out the same for private patients [14]. Because CO arises from internal moral convictions rather than external conditions, it should apply uniformly across all care settings.

To be performed by the requesting professional and by the governing institution of the professional:

6) Attitude of mutual respect: During the entire CO process, every party involved must treat one another with respect. Clinicians should continue to show respect for patients, colleagues, and institutional authorities, as well as for their respective values and choices. In particular, the objecting professional must avoid imposing personal beliefs on others or passing judgment on their decisions [29, 52]. At the same time, the objecting professional must also receive respect from colleagues and must not face psychological, professional, or other forms of retaliation for exercising CO [48, 53]. Likewise, when most members of a team object, it is equally important to protect non-objecting staff from discrimination or harm.

7) Assurance of patient rights and safety: Patients' rights to make informed choices and to request and receive appropriate care must always be upheld, whether or not the attending professional is exercising CO [4, 10, 54]. Even when objecting, physicians are obligated to inform the patient about the requested procedure and explain how they can obtain it elsewhere [4, 55]. Professionals may decline to participate, but they must not obstruct or delay the patient's access to care [4]. In short, if invoking CO would directly or indirectly place the patient at risk of abandonment, neglect, or harm — for example, when no suitable replacement professional can be arranged — then the objection cannot be permitted [15, 33]. Provided the requested service meets accepted standards of medical quality and safety (a basic requirement for any treatment), the risk of compromising patient care or established standards can be effectively prevented.

Procedural process

To ensure conscientious objection (CO) is carried out properly, the steps described below must be followed in the indicated order.

To be performed by the requesting professional and approved by the governing institution of the professional through internal institutional processes:

1) Notification and preparation: Professionals seeking CO should give timely prior notice so that all parties can make the necessary arrangements and avoid last-minute complications [5]. The formal request must be addressed to the director of the department or hospital unit, who is then responsible for planning and organizing care for any patients who may be affected by the objection [6, 10, 18].

2) Documentation and confidentiality: The request for CO must be submitted in written form to the head of the service where the clinician works [7] and to the appropriate professional association(s) when mandated [6]. The institution and its administrative bodies are required to keep the objector's status strictly confidential, revealing it only when necessary to make suitable arrangements [29].

3) Evaluation of prerequisites: The healthcare professional requesting CO, together with the relevant supervisory or institutional authorities, must conduct a careful assessment of the application by examining all the prerequisites outlined earlier [18].

4) Non-abandonment: The clinician must continue to perform every other duty — both those preceding and following the contested act — that falls outside the scope of the CO, as ongoing patient care demands [4, 18, 26, 53].

5) Transparency: To maintain confidence and the doctor-patient relationship, the professional is obligated to openly inform the patient (and, if relevant, the patient's

family) of their position as a conscientious objector [6] and to reassure them that another equally qualified colleague will provide care at the same level of quality [4, 10, 32].

6) Allowance for unforeseen objection: In rare and urgent circumstances, CO may be permitted even without the usual advance notice or preparation time, but only as an exception evaluated on a case-by-case basis [6, 56]. A notable case in Spain concerned emergency doctors who declined to treat undocumented patients on the basis that these individuals were not covered by the same healthcare entitlements granted to legal residents [12]. Even in such situations, the objection must still be formally documented afterward to satisfy the required procedures [57].

7) Compensatory responsibilities: Any clinician exempted from specific tasks through CO remains obligated to fulfill alternative professional duties in compensation [8]. In essence, claiming CO must never confer any personal benefit or advantage on the objector, whether primary or secondary [6, 29].

8) Access to guidance and/or consultative advice: Should any uncertainty or difficulty emerge regarding the CO request or its execution, the professional should promptly seek advice and support from their professional association(s) and/or the institution's Clinical Ethics Committee (CEC), whenever such resources exist [6, 28].

To be performed by the governing institution of the profession:

9) Organizational guarantee of professional substitution: To maintain seamless continuity of care [2, 58], the department and the broader institution must take all practical steps to arrange for competent replacement professionals who can assume the objecting clinician's responsibilities without causing any disadvantage or harm to the patient [7, 54]. This same commitment to equivalent standards of care applies if the patient has to be transferred to a different facility for ongoing treatment [7, 54].

Application of the guideline to a clinical scenario

Clinical scenario

Pedro, a 58-year-old man, was diagnosed with amyotrophic lateral sclerosis (ALS) seven years ago. This progressive and irreversible neurological disorder has left him heavily dependent on others for basic daily activities. Three weeks ago, he was admitted to the intensive care unit of his local hospital due to respiratory failure that required life-sustaining measures, including endotracheal intubation and invasive mechanical ventilation. This was his fourth such admission in the past six months. A few days ago, after consenting to a tracheostomy, he was moved to the pulmonary medicine ward for long-term ventilator support. Shortly afterward, Pedro asked to have the invasive mechanical ventilation and all other forms of life support withdrawn, explaining that he no longer wished to remain "connected to a machine" or rely on a ventilator. He also requested euthanasia. Pedro had spoken with his wife and sons about his wishes, and they accepted his decision. His psychiatrist confirmed that he retained full decision-making capacity. However, Pedro's attending physician strongly opposes the request because she considers the preservation of life to be an absolute moral principle. This creates a serious ethical conflict for her, and she is now considering conscientious objection (CO) to avoid participating in the patient's request. The question is how she and her supervisors should handle this situation.

In the scenario described, Pedro's request for euthanasia creates a moral dilemma for the attending physician, leading her to consider CO. The framework we propose can help both the clinician and the administrative team assess whether the objection is legitimate and determine the most appropriate course of action. The application of the framework is outlined below:

Eligibility prerequisites of the CO request

Although most of the prerequisites appeared to be met through the pulmonologist's written request, the institution must independently verify each one:

1) Individual reference: In this clinical scenario, the moral and ethical conflict was experienced and expressed by the physician as an individual matter only, not as part of any collective stance.

2) Specific clinical context: The CO applied strictly to the particular situation involving the patient's request for euthanasia or medically assisted suicide.

3) Ethical justification: The physician based her objection on the principle of non-maleficence, grounded in her firm belief that preserving life is an inviolable moral value. This reason was considered valid because it did not arise from motives of convenience, personal ease, or any other unacceptable factors.

4) Assurance of non-discrimination: The doctor did not refuse to provide any other aspects of medical care for Pedro beyond the specific procedures that conflicted with her ethical convictions, nor did she oppose other

qualified practitioners stepping in to deliver the requested service.

5) Professional consistency: The case description did not contain sufficient information to confirm this prerequisite. Therefore, the objecting physician must supply evidence demonstrating consistency in her moral stance, which the governing institution will then verify independently, or the institution itself must carry out this verification.

6) Attitude of mutual respect: Neither the requesting physician, the substitute practitioner, nor the patient expressed any value judgments regarding the medical procedure in question or the invocation of CO.

7) Assurance of patient rights and safety: The institution must verify that Pedro can access the requested service through a qualified substitute professional within a reasonable period, given that the request aligns with accepted standards of clinical practice.

Procedural process of the CO request

The pulmonologist who wished to object and her department head carried out the required procedural steps in the following manner:

1) Notification and preparation: In this situation, the pulmonologist quickly reached out to her department head to formally request CO after thoroughly considering Pedro's request for euthanasia and concluding that she had reached a point of deep moral conflict.

2) Documentation and confidentiality: The clinician submitted a formal written application for CO to the department head. This document was handled with strict confidentiality, and only the minimum necessary details were shared with those directly involved in the case to safeguard everyone's privacy.

3) Evaluation of eligibility prerequisites: The department head reviewed the request with the pulmonologist to confirm that the eligibility conditions had been met. As mentioned earlier, the institution flagged two items as still pending: 1) evidence of consistency in the physician's moral stance across different professional situations and 2) confirmation that a qualified substitute could perform the requested procedure within a reasonable period.

4) Non-abandonment: The department head verified that the pulmonologist would continue providing all other aspects of care to Pedro except for the specific act covered by the CO, while simultaneously arranging for another suitable professional to handle the requested service within an agreed-upon timeframe.

5) Transparency: The objecting pulmonologist personally informed Pedro that she was exercising conscientious objection and explained that another equally qualified colleague would be assigned to carry out the requested procedure.

6) Professional substitution: Both the department head and the institution confirmed their commitment to offering the patient a competent alternative provider for the requested service. Should no suitable replacement be found, the CO would be withdrawn.

7) Allowance for unforeseen objection: This condition was not relevant here because the pulmonologist had given ample advance notice, and the requested act was not an emergency.

8) Compensatory responsibilities: The objecting clinician and the institution agreed that, once the CO took effect, she would be assigned other appropriate clinical duties in place of the objected-to service.

9) Consultation: The department head assured the pulmonologist that she could seek advice at any time from her professional association or from the hospital's Clinical Ethics Committee regarding any questions related to this case or the use of CO.

Therefore, in this clinical scenario, all procedural requirements were fulfilled except for two eligibility prerequisites (Professional Consistency and Assurance of Patient Rights and Safety), which must be fully addressed before the physician can lawfully abstain from participating in euthanasia under the protection of CO.

Conclusion

Healthcare professionals sometimes turn to conscientious objection (CO) when their personal ethical beliefs clash with a specific medical request. When properly invoked, CO should not cause harm or disadvantage to any of the parties involved — the clinician, the healthcare institution, or the patient. We strongly endorse the development of clear guidelines to help medical staff and institutions manage the complex ethical, legal, and clinical issues surrounding CO. Since Spain's healthcare system currently has no such guidelines in place, we present a comprehensive set of recommendations to enable the practical and responsible use of CO in the Spanish context. Our proposed framework, which includes eligibility prerequisites (to be fulfilled by the individual professional) and a structured procedural process (to be managed by the governing institution), provides a reliable way to ensure that CO is applied in a

manner that is both legally compliant and ethically sound.

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