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Conscientious refusal in health care: the Swedish solution

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Abstract

The Swedish solution to the legal handling of professional conscientious refusal in health care is described. No legal right to conscientious refusal for any profession or class of professional tasks exist in Sweden, regardless of the religious or moral background of the objection. The background of this can be found in strong convictions about the importance of public service provision and related civic duties, and ideals about rule of law, equality and non-discrimination. Employee requests to change work tasks are handled case by case within the frames of labour law, ensuring full voluntariness, but also employer privilege regarding the organisations and direction of work, and duties of public institutions to provide services. Two complicating aspects of this solution related to the inclusion of "alternative medical" service providers in a national health service, and professional insistence on conscientious refusal rights to accept legalised assisted dying are discussed. The latter is found to undermine the pragmatic reasons behind recent attempts by pro-life groups to challenge the Swedish solution related to legal abortion in courts.

INTRODUCTION

The discussion of conscientious objection to and refusal to perform provided services within health care has many layers. In this brief note, I will sketch the societal solution to the regulation of this phenomenon that is in place in my own country, Sweden. This solution is, simply put, to provide no legal right to coscientious refusal of individual health professionals. I will also expand slightly around its justificartory background, as I see it, and to some complicating aspects that may be seen to challange it.

THE SWEDISH SOLUTION

There are, of course, boundaries to what may be offered and done within Swedish health care and these are set by relevant legislation in combination with standards set by the health professional communities on acceptable and recommended practice. Among relevant laws are the ones regulating the provision of public health care services and the positive legal rights of citizens and residents to access them on equal conditions. Although some private providers operate with public funding (and must then abide by the same rules as public providers), publicly run institutions still create the lion's share of the provision of health services. Further boundaries are set by financial conditions regarding what is being funded publicly (through taxes and health insurance), and what is being offerred by private providers based on business considerations.

In all of these areas of health care services, it may happen (and do happen) that an employed professional finds reasons to refuse some of the work tasks they are instructed to perform. The employer (through the head of unit, clinic or hospital) may then grant this individual a reassignment of work tasks, or to another part of the organisation. The room for such

accommodation will be restricted by reasons having to do with efficiency of service (e.g. the presence of alternative tasks where the person's competence may come to good use, the availability of suitable replacements, or the cumbersomeness of straighteneing these possibilities out) and the quality of the work environment (will it negatively affect the shared feeling of each pulling one's weight in the clinical team, for instance), and so on. But, of course, sometimes and to some extent such reasons may also provide reasons *for* the employer to accommodate the request of the employee. Accommodations within these frames are done of a case by case and day-to-day basis, governed by the context and exact practical circumstances. All such possibilities of accommodation to employee requests are legally *optional* for the employer, and they are, moreover, *constrained* by the obligation to secure provision and quality of services, including not wasting available resources (for tax payers or owners). Therefore, there is no legal right of emplopyees in this area.

The basic legal options in this area are set by labour law, where one of the most basic tenets is one stating that employers have a right to decide the content and organisation of work (within the realm of what they are legally required to do in other respects). There is, however, no right of employees to have accommodations made, although legal requirements to optimise quality and efficiency of service may sometimes support such steps. If no accommodation is provided by the employer, an employee who insists on being relieved of prescribed work tasks have three options: (1) accepting penalties (such as reduced pay), (2) being discharged due to refusal to do one's duty, or (3) resign before any of 1 or 2 occur and seek alternative emplpyment(which in the health care sector is abundant). This regulation applies to all areas of work, and regardless of the grounds for the employee's request. To the extent that the request can be classified as based on a conscientious objection, this phenomenon will thus be handled within this system on the same premises as any other ground for employee

preferences. These conditions also imply that if an applicant for an employment reveals that he or she, if hired, will insist on having such requests met and the employer finds no reason to do so, this is valid reason for the employer not to hire this person (since he or she will not contribute to efficient service). Again, these conditions apply equally regardless of the ground for the request.

REASONS AND RECENT CHALLENGES

The official Swedish position is that this system guarantees equal treatment, and also meets standards of the freedom of conscience, at the same time as it secures the effiency and quality of public and private services. Nobody is forced to take up any employment, and everyone is free to resign on whatever ground they may find. Therefore, no one is prevented from acting on their moral, religious or personal beliefs, whatever they happen to be. Constraints on having one's personal desires regarding one's work situation met are equal for all, regulated by universal standards that are set out in the various legal boundaries of health care provision. Recently, there have been a few legal cases where midwives backed up by prolife activist organisations have attempted to challenge this system in court in relation to legal abortion, but so far these attempts have failed, although it is likely that the final word will not be heard until the cases have been judged by the European Court of Human Rights.[1]

My own reading of the justificatory background to the Swedish solution in this area is created by the combination of two things: First, deeply entrenched and widely shared views on the importance of public service provision, and of related civic duties to take part in the promotion and not to prevent the production of public goods. Second, strong ideals about the

[1] See [1] for more details.

rule of law, equality before the law and non-discrimination. Together, these theoretical blocks of values and ideology invalidate any notion of a guaranteed employee right: the idea of granting special privilege to some particular group of professionals, types of moral or religious ideas, or specific areas of service is undermined by the second type of consideration. The idea of providing a right to conscientious refusal to employees across all professions and services would escape that objection, but instead be undermined by the first type of considerations. In recent work, myself and Morten Nielsen have used a similar combination of considerations to challenge all types of claims to a legal right to conscientious refusal [1].

Besides the cases of the recent legal challenges by a few midwifes mentioned, this system works very well, as a health professional that objects to some particular practice or area of service can easily avoid it in a number of ways through his or her choice of employment. As an illustration, one of the midwives that have sued a county government for refusing her a right to conscientious refusal to participate in legal abortion provision have used the common and free work market of the nordic countries to obtain employment in Norway, where she is granted exemption from particpation in abortion related services and now recides [2].

COMPLICATIONS AND PROBLEMS

I will end this brief note by setting out two aspects which, unlike the mentioned attempts related to legal abortion, may be seen to present more difficult intellectual problems for the Swedish solution.

One of these is a recent motion accepted by the Swedish Medical Association's general council (against the recommendation of the board) that the association should work for a legal right to conscientious refusal to refer patients to clincics that (besides standard treatment)

provide "alternative medical" procedures but are accepted as providers within the public system, *regardless of the exact content of the referral*. This is a surprising move by the association, as it has before been a strong supporter of the Swedish solution. Even more so, as the reason for insisting on this right to conscientiously refuse is apparently not that there is something inherently unethical about referring to such clinics (as long as the intended procedure is within the realm of professional responsibility and clinical guidelines), but to make a political statement against the inclusion of such clinics among public health care service providers. This change of stance of the association inserts a wedge into the otherwise perfect symmetry of the position that there should be no legal right to conscientiously (or otherwise) refuse any type of task included in the duties defined by a health professional's employer, be it about the performance of abortion, the observation of equal treatment standards to male and female patients, or patients of differing ethnic origin, or routines of referral to clinics based on patient request and political decisions to include a clinic as a public health care service provider. This wedge opens the floor for equal treatment arguments to the accept all kind of other claims to conscientiuous refusal, such as those pursued by the mentioned midwifes and pro-life groups related to legal abortion.

The second aspect relates to how the Swedish solution may impede reforms with regard to the introduction of contested practices, such as euthanasia or physician assisted suicide. None of these practices are currently professionally accepted practice in Sweden. The former is banned in criminal law, while the latter is illegal through legislation around health professional duties and malpractice. Nevertheless, especially PAS is debated from time to time, and a recurrent statement from professional organisations on these occassions is that such a procedure could be accepted only on the conditions that professionals are guaranteed a conscientious refusal right in the relevant regulation or guidelines. However, the Swedish solution to conscientious

refusal provides no room for this, so the matter usually stalls rather quickly, as the professional community "owns" the question about what is to count as accepted practice and malpractice. Unless the recent move by the Swedish medical association related in the preceeding paragraph develops into a comprehensive change of stance, the Swedish solution to conscientious refusal is thus likely to block any advancement in the assisted dying area for the foreseeable future. Interestingly, this may be a strong pragmatic reason for pro-life organisations and activists, which usually strongly oppose legalised assisted dying, to abandon the current campaign for a legal right to conscientiously refusal related to legal abortion, as this inserts a wedgeinto the Swedish solution that may pave the way for legalised assisted dying.

CONCLUSION

Despite the mentioned problems, the Swedish solution to the legal handling of conscientious refusal serves both the public interest and the interests of health care professions well. It sets a clear, symmetrical standard that is easy for all stakeholdrs to relate to and imposes a minimum of disturbance to what has to be seen as the paramount consideration: the secure and efficient provision of public health care services, respect for indivudal liberty and preservation of voluntariness regarding labour, and the strict observance of basic principles of rule of law, equal treatment and non-discrimination. Pro-life organisations that have lately tried to question this solution regarding legal abortion have strong pragmatic reasons to consider abolishing such moves pondering the risk of thus paving the way for legalisation of assisted dying.

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