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Conscientious objection: a global health perspective

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ABSTRACT

Conscientious objection is a critical topic that has been sparsely discussed from a global health perspective, despite its special relevance to our inherently diverse field. In this Analysis paper, we argue that blanket prohibitions of a specific type of non-discriminatory conscientious objection are unjustified in the global health context. We begin both by introducing a nuanced account of conscience that is grounded in moral psychology and by providing an overview of discriminatory and non-discriminatory forms of objection. Next, we point to the frequently neglected but ubiquitous presence of moral uncertainty, which entails a need for epistemic humility—that is, an attitude that acknowledges the possibility one might be wrong. We build two arguments on moral uncertainty. First, if epistemic humility is necessary when dealing with values in theory (as appears to be the consensus in bioethics), then it will be even more necessary when these values are applied in the real world. Second, the emergence of global health from its colonial past requires special awareness of, and resistance to, moral imperialism. Absolutist attitudes towards disagreement are thus incompatible with global health's dual aims of reducing inequity and emerging from colonialism. Indeed, the possibility of global bioethics (which balances respect for plurality with the goal of collective moral progress) hinges on appropriately acknowledging moral uncertainty when faced with inevitable disagreement. This is incompatible with blanket prohibitions of conscientious objection. As a brief final note, we distinguish conscientious objection from the problem of equitable access to care. We note that conflating the two may actually lead to a less equitable picture on the whole. We conclude by recommending that international consensus documents, such as the Universal Declaration on Bioethics and Human Rights, be amended to include nuanced guidelines regarding conscientious objection that can then be used as a template by regional and national policymaking bodies.

SUMMARY BOX

⇒ Though freedom of conscience is protected by several international human rights frameworks, conscientious objection in healthcare has been sharply contested and some have even called for its universal prohibition.

⇒ Global health is especially vulnerable to occasions for moral disagreement given its inherent pluriversality.

⇒ The authors of this Analysis highlight nuanced accounts of both objection and conscience, and develop two arguments—grounded in moral uncertainty—that show blanket prohibitions of conscientious objection to be incompatible with our current understanding of bioethics, with global health's emergence from its colonial past, and with the respect for pluralism called for by the Universal Declaration on Bioethics and Human Rights (UDBHR).

⇒ Embracing epistemic humility will be more fruitful for the global health community than enforcing moral uniformity. The authors recommend that the UDBHR be amended to explicitly protect freedom of conscience while also contextualising it to healthcare by stipulating conditions that account for professional obligations and public interest.

INTRODUCTION

Freedom of conscience is protected in Article 18 of the United Nations Universal Declaration of Human Rights[1] as well as in the International Charter on Civil and Political Rights.[2] Conscientious objection in healthcare, a concept that gained legislative attention due to conscientious objection in war,[3] is expressly permitted by some medical associations.[4–7] In January of 2024, the Department of Health and Human Services in the USA issued a final ruling protecting conscientious objection.[8] On an international level, the picture is less clear. Conscientious objection is not directly addressed by the Universal Declaration on Bioethics and Human Rights (UDBHR)[9] and it has recently come under heavy criticism in bioethics literature.[10–13] Critics of conscientious objection do not shy away from recommending essentially blanket prohibitions,[3 11 13 14] suggesting that objectors leave medicine entirely,[3 12 15] or asserting that clinicians 'must put patients' interest ahead of their own integrity'.[11]

If moral conflicts are at all present in medicine and medical ethics[16]—at national and subnational levels—they will invariably manifest to a greater extent in global health. Global health is multicultural by nature and

is constantly confronted by some of the most profound inequities seen on this planet. Yet very little about conscientious objection has been published from the perspective of global health practitioners. The aim of this article is thus to present two arguments for conscientious objection that we find relevant in light of global health practice. In good faith, we think that the fundamental concern shared by critics of conscientious objection is that of providing equitable care to all patients. We share this concern. However, there is something deeply contradictory about applying an absolutist attitude to this debate in the name of equity—especially in the global health setting. As Seye Abimbola and Madhukar Pai have noted, our discipline 'was birthed in supremacy, but its mission is to reduce or eliminate inequities globally'.[17] Shedding this history of supremacy has meant, in part, recognising the presence of moral imperialism—that is, the practice of imposing as universal values held by (often economically dominant) cultures.[18] A rejection of moral imperialism is not incompatible with global health's mission to eliminate inequities. In this sense we share the mission, but not the approach, of many critics of conscientious objection.

Two brief clarifications before we begin. First, although some of us write as practicing physicians and surgeons, we use the term 'global health' inclusively. Dilemmas of conscientious objection are faced by other professions in healthcare—including, for example, nursing,[19] pharmacy[20] and midwifery.[21] As we hope to make clear below, understanding conscience in terms of moral agency makes our argument applicable to any health profession that delivers care. Second, our argument is narrow in the sense that it is directed against blanket prohibitions of a specific kind of conscientious objection. As we will note below, there are discriminatory forms of objection which are evidently not appropriate. We thus begin by briefly discussing accounts of 'conscience' and 'objection', as these concepts are infrequently appraised yet are critical to the debate.[22] We then contextualise these concepts in global health, and argue that the presence of moral uncertainty implies a need for epistemic humility that is incompatible with blanket prohibitions.

A CLEARER UNDERSTANDING OF CONSCIENCE AND OBJECTION

Philosophy is ineliminable from practical problems in medicine because a shared understanding of key concepts ensures we do not talk past each other.[23 24] Despite its widespread usage, the absence of a uniform understanding of 'conscience'[22] reflects both the complexity of the subject and a relative lack of attention.[25 26] Conscience has been understood to mean anything from a subjective set of beliefs, to self-knowledge, to a moral motivator, to a direct or indirect way of acquiring moral knowledge.[22] When used in the context of conscientious objection debates, conscience is most often characterised as the intuitive 'voice' that tells us the rightness or wrongness of actions (and is therefore a source of moral knowledge).[26] Sometimes this voice is characterised as identifying merely arbitrary likes and dislikes.[12] Such an account is understandably concerning when it comes to objection debates, since this voice is both subjective (ie, inscrutable) and potentially wrong.

In contrast to this common characterisation, Xavier Symons has argued for an understanding of conscience that is grounded in moral psychology. This account views conscience as a faculty that leads persons to relate morality to their own identity.[25 27] It thus helps to explain the difference between, for example, the attitudes 'I know stealing is bad' and 'I should not steal'. In this way, conscience involves a simultaneous commitment to (1) understanding morality and (2) acting with integrity.[26] It is therefore not merely a source of intuitive moral knowledge (ie, a set of religious or moral beliefs).[26] It is instead the mechanism by which a person puts themselves in relation to certain values by way of their commitments. It is more like a source of moral awareness than moral knowledge; but not just a general awareness of the rightness or wrongness of actions, a personal awareness.[26] Conscience is what gives normative language—'ought' language—its prescriptive force to an individual. As Symons explains, it leads persons 'to view morality in relation to their own character and identity and leads them to commit to living up to the requirements of the moral life'.[25] Such a commitment, facilitated by conscience, results in psychological unity, a sense of identity, and a meaningful moral life.

Thus, to respect conscience is to respect the faculty by which individuals navigate the moral landscape with a personal moral identity. Conversely, repeat violations of conscience (ie, 'moral injury') risk jeopardising a person's sense of moral meaning and integrity.[26] The results may be devastating, as shown in studies of military veterans strongly correlating moral injury with risk for suicide, among other harms.[28–30] Among physicians, there is increasing recognition that moral injury plays a significant role in ever-rising rates of burnout and suicidality.[31] These untoward effects follow in two ways from our psychologically-grounded exposition of conscience. First, if conscience generates meaning, then to lose this meaning may leave one feeling, as the philosopher Bernard Williams wrote, that one 'might as well have died'.[32] It insidiously separates people from a sense of meaning. Second, since consciences is conducive to forming identity, and agency is dependent on identity, an injured conscience might also make it harder to exercise moral agency. Stamping out the exercise of conscience might make healthcare providers worse navigators of the complex, value-laden clinical landscape.

Our understanding of 'objection' in the setting of conscience also warrants nuance. To begin with, a conscientious objector does not necessarily do so for reasons that are religious.[26] There are non-religious value commitments that may conflict with providing a service, such as a commitment to a particular way of justly distributing scarce resources. Furthermore, there is widely-accepted

Table 1 Various types of conscientious objection as outlined by Ancell and Sinnott-Armstrong.[33] Note that we have labelled as type 2a and type 2b what the aforementioned authors define as type 3 and type 4, respectively. The examples provided here are illustrative, not definitive. The justifiability of prohibition is based on widespread acceptance (eg, prudential objection) or the analysis provided by Ancell and Sinnott-Armstrong. (1) Real case described in a session on ethics at the American Burn Association in Chicago, 9–12 April 2024. (2) Gonzalez and Trueblood.[79]

Type of objection	Key feature	Example	Prohibition of objection justified?
Prudential	Objection is due to reasons not related to conscience (eg, personal preference, self-interest).	Microsurgeon refuses to perform phalloplasty since she has no experience with this complex procedure and the subsequent postoperative care required.	No
Type 1	Objection is grounded in the nature of the service.	Physician routinely refuses to provide physician-assisted suicide because he believes this runs counter to his calling in the medical profession.	No
Type 2	Objection is grounded in a patient characteristic.	Paediatrician who works in a children's hospital refuses to establish care for a 25-year-old.	Depends: **Type 2a** vs **type 2b**
Type 2a	Objection is grounded in a **justifiable** negative judgement of a patient characteristic.	Following multiple episodes of reconstruction, a burn surgeon refuses to perform surgery and instead recommends local wound care for a patient who has factitious disorder (Munchausen) and keeps inflicting non-lethal chemical burns on themselves (1).	No
Type 2b	Objection is grounded in an **unjustifiable** negative judgement of a patient characteristic (ie, invidious discrimination).	Obstetrician who regularly provides intrauterine insemination refuses to do so because the patient has a same-sex partner (2).	Yes

discretion for clinicians to refuse services for prudential reasons, such as cost or risk.[33 34] Aaron Ancell and Walter Sinnott-Armstrong have distinguished between objections based on a negative judgement of the nature of the service refused (type 1) and those based on patient characteristics (type 2) (see table 1).[33] The core of this distinction comes down to the difference between respecting conscience and protecting patients from discrimination. Type 1 objection would be present in the case of a physician who refuses to perform physician-assisted suicide due to the belief that such killing is immoral; it would be similarly present in the case of a surgeon who refuses to participate in judicial hand amputations due to the punitive nature of the procedure. In contrast, a doctor refusing to perform testing due to a patient's sexual orientation would be engaged in a type 2 objection. Type 2 objections can be further subdivided based on whether such a negative judgement is justifiable or not (ie, whether it represents invidious discrimination). It is sufficient for our purposes to note that invidious discrimination is generally discouraged or even expressly prohibited.[35]

In this paper, we restrict our conception of conscientious objection to type 1 cases. This type has already been alluded to in official guidelines; take, for example, the British Medical Association's statement that it is the 'procedure itself that the conscientious objection refers to, not specific characteristics of the patient'.[7] In following our arguments below, the reader is thus committed only to type 1 objections that react to the nature of the service in question.

MORAL UNCERTAINTY IN GLOBAL HEALTH AND THE NATURE OF BIOETHICS

Well-intended, reasonable and informed people disagree about many moral issues.[36] This fact has recently promulgated a whole literature on moral uncertainty.[36–40] The occasions for disagreement, and magnitude of uncertainty, will only grow when extrapolated to a global scale. In ethics, the possibility of certitude (whether moral propositions can be true or false in a logical sense) has been a source of contention for over a century. This uncertainty does not necessarily imply moral relativism; it is possible that there is a gap between true facts and our ability to know these facts.[23] Though moral relativism is a non sequitur, what does follow from uncertainty is a need for epistemic humility—that is, an attitude that acknowledges the possibility of being mistaken about what we think we know. So while it is coherent to argue for philosophical positions with rigour in spite of moral uncertainty, epistemic humility prevents such endeavours from lapsing into intellectual hubris.[41]

A recognition of epistemic humility is built into our understanding of bioethics. John McMillan, current editor-in-chief of the Journal of Medical Ethics, has written that epistemic humility is critical to good bioethics[41] and that this entails being open to all perspectives.[42] Daniel Callahan, founder of the Hastings Center, remarked that bioethics 'should take in the full range of human life' and therefore be open to varying perspectives.[43] Jürgen Habermas argued for a requirement for everyone to 'take the perspective of everyone else'.[44] Former presidents of the International Association of Bioethics have stated bioethics should uphold 'free, open and reasoned discussion of issues'.[45 46] Open-mindedness was one of four criteria for reasonableness John Rawls identified in his outline for decision-making in ethics.[47]

Few of the moral issues encountered in global health will espouse unanimous agreement. But that is precisely why they require open-minded argumentation. In an essay dedicated to contextualising medical ethics in global health, Paul Farmer and Nicole Campos asserted that bioethics is 'necessarily contentious'.[48] Likewise, McMillan reminds us that anything worth arguing for philosophically is likely to be controversial.[41] It is this controversy, contention, and uncertainty that makes epistemic humility both prudent and necessary for meaningful progress.

Having sketched the role of epistemic humility in view of moral uncertainty, we now arrive at the core of this first argument. If it is in any way true—all other things being equal ('ceteris paribus,' a favoured aphorism in ethics)—that there is disagreement between reasonable people in theory,[49] then the case for disagreement in practice—where all other things are decidedly not equal—will be much stronger. Problems that manifest in the comfort of an armchair will undoubtedly manifest in under-resourced, over-burdened district hospital wards. Thus, if epistemic humility is necessary when theoretically engaging with values, it will also be necessary when applying values in the real world. We do, obviously, recognise the disanalogy between bioethicists and clinicians in the sense that the latter have other demands (ie, professional obligations, which critics of conscientious objection sometimes cite as a dominant consideration over conscience[12 13 16]). We maintain, however, that we are dealing with the same fundamental problem of moral uncertainty in both cases, and that additional obligations do not obviate this. Though professional obligations are a critical consideration, it does not follow that they automatically supersedes conscience in all cases. Instead, professional obligations considered alongside moral uncertainty might imply that it is appropriate to scrutinise objections for reasonableness and justifiability—as has been argued extensively by Robert Card[50]—especially when the objection runs counter to established professional practice. Subsequent assessments of justifiability might be based on, for example, the consistency of the objection with the internal values of the profession[51] or whether the objection poses a substantial risk for injury or death to others.[52] Many countries or regions that have explicit guidelines on conscientious objection include prohibitions in the case of emergencies and require patients to be referred in a timely manner (table 2, see online supplemental appendix: methods for table).[4 7 53–63] However, adequate justification of conscientious objection in light of professional obligations may entail more explicit pathways and more comprehensive assessments than current legislation tends to require.[22]

Regardless of such specifics, our main point here is that taking the problem of moral uncertainty from a theoretical to a practical realm does not suddenly erase our need to account for it. Calls for a blanket prohibition of (type 1) conscientious objection are therefore unjustified. The need for epistemic humility in practice follows from the need for epistemic humility in theory.

MORAL IMPERIALISM IN GLOBAL HEALTH

There is another reason that epistemic humility is particularly salient to the discussion of conscientious objection in global health. As we already noted, our field was born in supremacy and is attempting to shed its colonial past. Efforts to decolonise global health should involve a sensitivity to moral imperialism.[18] In contrast to being characterised by epistemic humility, the core of moral imperialism consists of a 'deeply-entrenched epistemological arrogance, supported by economic and political power'.[64] Such moral imperialism is, naturally, a cause of epistemic injustice—a kind of injustice that has already been identified in academic global health.[65] Epistemic injustice discredits the knowledge processes of marginalised people and, when it is a result of moral imperialism, compromises their dignity as both moral and epistemic agents. Thus, when some authors call for other countries to follow 'enlightened, progressive secular'[11] Nordic countries in their legislative prohibitions of conscientious objection, we believe we have grounds to urge caution.

The assumption behind a claim such as the one above appears to be that homogeneity on moral issues is possible (on an international level) and therefore desirable. This is necessary for the claim to be extrapolated globally without appearing capricious: it would be inconsistent for one to prohibit conscientious objection in principle, given that two societies might have differing stances on a morally contentious medical issue, if one did not also believe this discrepancy could be practically resolved. This assumption, however, is suspect from a global perspective. It may betray an unwarranted confidence that is, in part, due to skewed representation.[66 67] As one review of the literature on global health ethics between 1977 and 2015 showed, 88% of manuscripts had exclusively high-income country authorship.[68] Calls for absolute prohibition of conscientious objection are thus led by a certitude that is, in fact, incompatible with real-world disparities in representation. In contrast to absolute attitudes, such disparities ought to lead us to epistemic humility, especially in the context of global

Table 2 Examples of countries/regions with professional bodies that specify policies for conscientious objection in healthcare. References: Argentina[63]; Australia[61]; Canada[60]; Colombia[62]; Europe[59]; Japan[57]; Mexico[54]; New Zealand[56]; South Africa[58]; USA[4 8 53]; UK[7]; Venezuela[55]

Country	Professional organisation	Summary of policy	Specific restrictions in the setting of emergencies?	Specific referral mandate?
Argentina	Senate and House of Representatives of Argentina	Establishes a right to conscientious objection, including in healthcare, while safeguarding the rights of third parties and the public interest. Requires a formal written request with clear evidence of the objector's convictions and creates a consultative council to provide guidance on disputes and policy related to conscientious objection.	Yes	Yes
Australia	Australian Medical Association	Clinicians may refuse to provide or participate in medical treatment or procedures based on conscientious objection, but they have an ethical obligation to minimise disruption to patient care.	Yes	No referral mandate, though it is noted that clinicians should ensure patient access to care is not impeded.
Canada	College of Physicians and Surgeons of Alberta	Clinicians must communicate promptly about any treatments or procedures that they decline to provide. They cannot withhold information about the existence of a procedure or treatment. They must not promote their own moral or religious beliefs when interacting with a patient.	No specific mention of emergency situations.	Yes
Colombia	Senate of the Republic of Colombia (Article 18)	Recognises a right to conscientious objection (including healthcare) while ensuring that obligations to third parties are met. Requires the submission of a formal written declaration of objection.	Yes	Yes
Europe	Parliamentary Assembly of the Council of Europe (Resolution 1763)	Affirms the right to conscientious objection alongside the responsibility of the state to ensure that patients be enabled to access lawful medical care in a timely manner.	Yes	Yes
Japan	Medical Practitioners' Act (Article 19, Act No. 201 of 1948)	No medical practitioner may refuse any request for medical examination or treatment without legitimate grounds (duty to rescue act).	No specific mention of emergency situations.	No
Mexico	Mexico's Supreme Court of Justice	Conscientious objection is not absolute due to the concurrence of legal rights worthy of special protection.	Yes, refusal or postponement of the service must not involve risk to health or aggravation of that risk.	No
New Zealand	Health Practitioners Competence Assurance Act 2003	Clinicians must communicate promptly regarding conscientious objection and provide information regarding the closest provider that offers the service requested.	No, there is no specific mention of emergency situations.	Yes
South Africa	National Department of Health, Republic of South Africa	Public sector facilities are obliged to ensure that clients have access to the services to which they are legally entitled.	Yes	Yes

Continued

Table 2 Continued

Country	Professional organisation	Summary of policy	Specific restrictions in the setting of emergencies?	Specific referral mandate?
USA	American Medical Association Code of Medical Ethics (1) US Department of Health and Human Services (2)	(1) Clinicians may choose whom to serve, with whom to associate and the environment in which to provide medical care. (2) Federal statutes protect clinicians' conscience rights and prohibit recipients of certain federal funds from discriminating against clinicians who conscientiously object.	Yes	No
UK	British Medical Association, Core Ethics Guidance	Conscientious objection is permitted provided it does not discriminate against characteristics of the patient. It is prohibited in emergency settings.	Yes	Yes
Venezuela	Constitution of the Bolivarian Republic of Venezuela	All individuals have the right to freedom of conscience and to express those practices unless constituting a criminal offence. Conscientious objection may not be invoked to prevent others from complying with the law or exercising their rights.	No	No

health's emergence from supremacy. As Abimbola and Pai powerfully note: 'respect and humility are vaccines against supremacy'.[17]

A further point is that epistemic humility is the only way to heed the UDBHR's exhortation to balance collective ethical progress with respect for pluralism.[69] This balance is embodied by global bioethics, an endeavour that aims to avoid both extremes of moral imperialism and relativism (a representation of how this might work is illustrated in figure 1).[64 70] Under this paradigm, geographical origin is morally irrelevant (contra moral imperialism) but collective moral progress possible (contra moral relativism).[67] Conscientious objection is thus a case study for the broader possibility of global bioethics, since it turns specifically on moral disagreement. Approaches to moral disagreement that are characterised by humility and respect will likely help foster persuasion as opposed to coercion.[71] Persuasion is more likely to engender change driven by the force of argument, not arguments of force.[64] Change driven by persuasion is 'more influential, firmer and longer lasting' than change driven by coercion—it is thus clearly preferable despite being less rapid.[72]

A FINAL DISTINCTION

Finally, we want to note that in the global health context, the ethical challenge of conscientious objection will be easily conflated with the ethical challenge of unjust access to scarce healthcare resources. This is understandable but ought to be avoided. As we stated at the outset, the concern for equitable patient care is one that we share with objectors to conscientious objection.

It is of course true that if clinicians in already resource-poor settings refuse to provide certain services, access to those specific resources might be stymied further. The most recent WHO data indicate a median density of 1.1 physicians and 7.5 nurses or midwives per 10 000 population in low-income countries.[73] These clinicians also tend to be concentrated in urban areas, placing rural patients at a further disadvantage.[15] For this reason, critics of conscientious objection have pointed out that even one objecting clinician has a disproportionate impact on

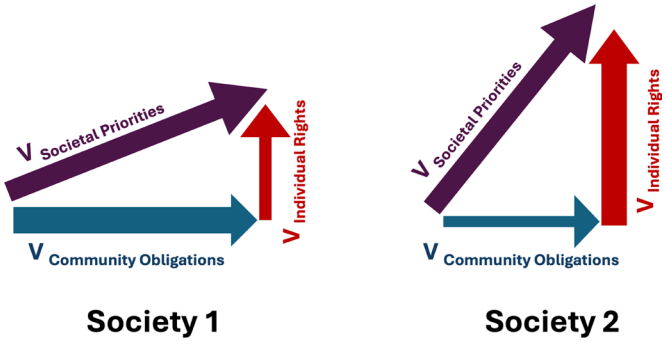

Figure 1 The possibility of global bioethics hinges on reconciling different value priorities with an objective project of collective ethical progress. In this figure we use differences in prioritisation of communitarian and individualistic societies (prioritisations that do not necessarily exclude each other—see reference #[71]) to illustrate how such an endeavour might be possible. Each value-vector (blue and red) has a magnitude and a direction, the sum of which (purple) reflects general priorities for that society. It is the business of ethics to identify the relevant value-vectors, as well as the direction and weight they carry in a given argument. Although magnitudes and directions ascribed by societies may differ, these differences are intelligible to us because we ultimately rely on the same laws of reason (analogous to the laws of physics in our example of vectors). We credit the vector analogy to a talk given by Julian Savulescu at the Oxford Uehiro Centre for Practical Ethics on 10 June 2023.

rural patients seeking care in the global south.[15] This inequity in access to medical services is clearly unjust, and a sensitivity to this injustice—from our standpoint in the conscientious objection debate—might involve enacting the kind of legislation described above in our discussion of professional obligations. In other words, it might warrant additional scrutiny for reasonableness and justifiability. However, our point in making the express a priori distinction between conscientious objection and unequal access to care is precisely to prevent one injustice (inequity) from justifying another (the blanket suppression of conscience). In an ideal world with no want for resources, conscientious objection would nonetheless remain a problem that must be contended with due to moral uncertainty.

Furthermore, there are normative factors other than conscientious objection (to say nothing of systemic factors such as infrastructure, funding, and equipment) that affect access to scarce healthcare resources. The pattern and currency of the distributive justice model that is employed,[74] questions of cost-effectiveness (to an extent unavoidable when dealing with scarce resources),[75] or even patient-specific values, are all examples of normative factors that might affect access to care. Yet this causal link to access does not automatically trump all other considerations.

Again, our point here is simply to expressly distinguish the two issues, since conflating them will only obfuscate things without helping us with either. In fact, blunting the conscience of clinicians and homogenising value priorities might lead to a less equitable picture on the whole. Values typically associated with Western industrialised countries are derived from only 12% of the world's population.[76] The degree to which some of these values are prioritised may not be shared by patients in many low- and middle-income countries. These patients, in turn, are heavily reliant on trust in their healthcare providers; a trust that is greatly aided by having values in common. Trust is demonstrably a determinant of health,[77] so a trust deficit consequent from moral imperialism plausibly acts as a barrier to care in the global health context. As a second example, if we are right about the role of conscience in generating meaning and identity, sacrificing conscience might deprive healthcare workforces of the moral agency needed to successfully advocate for their patients. And that would simply substitute one injustice for another.[27]

CONCLUSION

Conscientious objection is an important but underdiscussed challenge in global health. In the face of moral uncertainty, it is imperative that our community advocate for epistemic humility rather than enforce a specific kind of moral uniformity.

We have grounded the arguments presented here in the moral psychology of conscience and in the rocky, uncertain, and resource-deprived realities faced by global health practitioners. Indeed, those who have engaged in medical or humanitarian work in low-resource settings will resonate with Dostoevsky's observation that 'love in action is a harsh and terrible thing compared with love in dreams'.[78] In our experience, it is precisely the moral fibre of clinicians that makes them good caregivers of—and partners to—the poor in spite of the under-resourced, high-stress environments they work in. The enemy of good patient care in these settings is not that clinicians care too much, but too little. Blanket prohibitions of conscientious objection would, by snuffing out conscience, strip the medical profession of the collective moral backbone that gives it life when very little else is left.

None of what we have argued is compatible with a carte blanche right to object to anything and everything. This should be evident from our discussion of different types of objection and the potential need to assess objections for reasonableness and justifiability.[50] Our claim in this paper has been modest and narrow: that blanket prohibitions of type 1 objections are unjustified in the context of global health—a field that aims to simultaneously shed its colonial past while eliminating inequities. Self-assured, absolutist approaches to conscientious objection are counterproductive to both aims. Mutual respect and an appropriate sense of humility are better and more realistic assumptions upon which to build global health practices.[17]

In light of our discussion, we recommend that international policymaking bodies adopt nuanced guidelines for conscientious objection that balance a recognition of moral uncertainty with the presence of professional obligations. The UDBHR ought to be amended to protect freedom of conscience—thus aligning it with the Universal Declaration of Human Rights—yet also contextualise it to healthcare by describing, for example, emergency and referral scenarios. Such guidelines may then serve as useful templates for other regional and national policymaking bodies. These actions would help promote the balance of ethical progress with respect for pluralism already extolled by the UDBHR.

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