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Factors Attributed to Beliefs of Conscientious Objection Towards LGBTQPIA+ Individuals in Healthcare Settings

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Introduction

Conscientious objection (CO) is the refusal to perform a legal role or responsibility because of personal beliefs[1]. The idea of CO originated in the pacifistic beliefs that were in direct conflict with being forced to join the military. In regards to healthcare, though, it has a much broader meaning and can have severe consequences for those involved with the decisions[2].

In healthcare scenarios, many forms of conscientious objection can occur. For example, doctors can cite moral reasons and deny patients their rights to an abortion, contraceptive medications, or other procedures. Another example is seen in a doctor's ability to deny care to LGBTQPIA+ patients, regardless of the care that they would be providing. Furthermore, in some states where physician assisted suicide is legal, physicians may object to providing this end of life care[1].

The American Medical Association (AMA) supports this belief that a doctor should be able to deny care if it opposes their values[3]. While there are a multitude of reasons to conscientiously object to providing care, undeniably these objections come at the expense of the patients. Due to this, one cannot separate the social aspects behind a physician's moral views with the delivery of healthcare, making CO more than solely about one's beliefs. For example, a physician might object to caring for an LGBTQPIA+ person in a rural area, their only care.

It is imperative to have access to healthcare, as LGBTQPIA+ individuals are two times more likely to attempt suicide, 1.5 times more likely to experience anxiety, depression, and suffer from substance dependence[4]. Being informed about a physician's background and prior care is important when LGBTQPIA+ individuals assess their options when obtaining healthcare.

Aims and Objectives

Ultimately, being denied care due to religious or other reasons can cause physical and psychological harm to patients. Therefore, it is important for LGBTQPIA+ and Transgender individuals to search out physicians that will care for all of their health needs. Physicians often don't note specific populations that they choose not to care for, so providing patients with information on what background characteristics are related to permitting conscientious objection can be paramount in their receiving of care..

Aim I: Determine differences in beliefs regarding conscientious objection in unique clinical scenarios for individuals of multiple different backgrounds and identities.

Aim II: Recognize at what level of medical care and in what medical scenarios an individual sees conscientious objection as acceptable or unacceptable.

Methods

An electronic survey was dispersed to US adults utilizing the online survey database Prolific. This survey asked participants information pertaining to their background characteristics and personal beliefs in regards to many topic areas, including but not limited to gender, race, education, and political ideology.

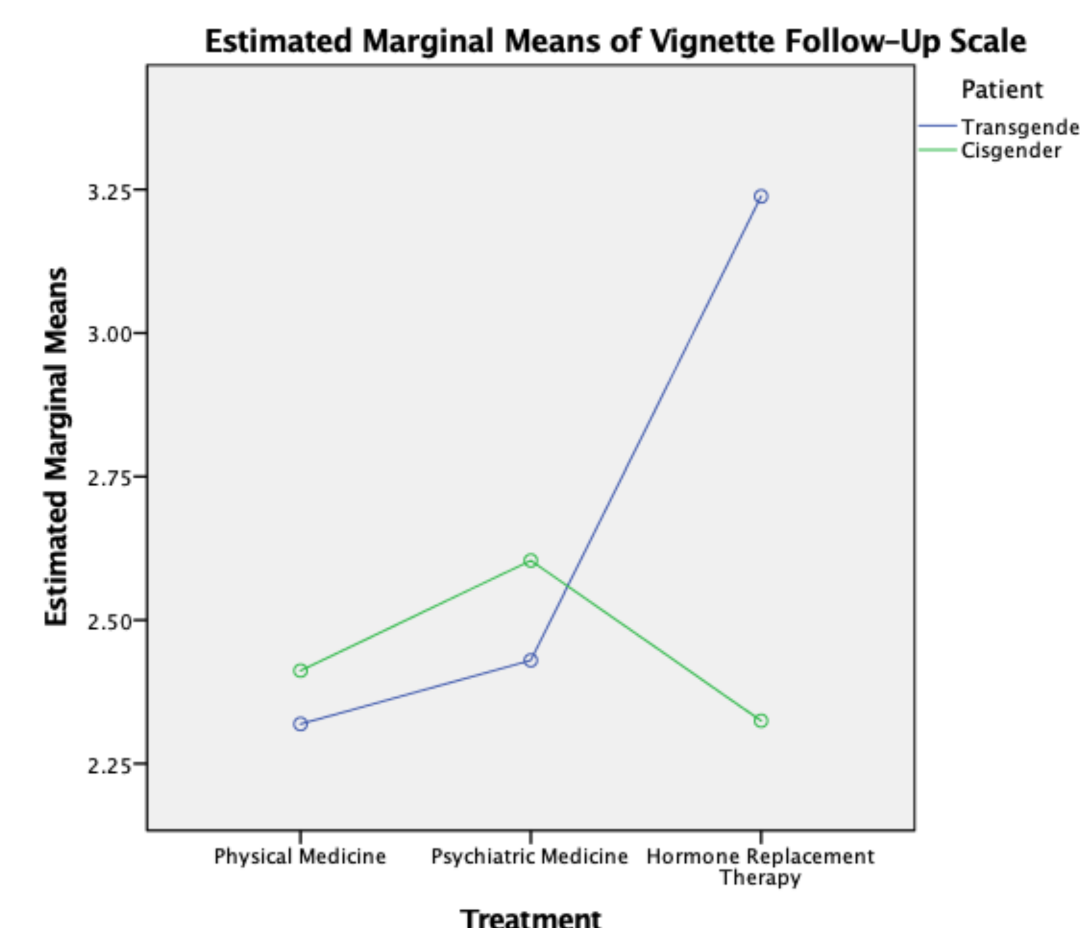
Additionally, subjects were addressed with vignettes of six fabricated patient encounters. These encounters were of cisgender women and transgender women, both in the same scenarios obtaining blood pressure medication, psychiatric medication, or hormone replacement therapy. Subjects were asked their beliefs on conscientious objection of the physician towards these patients in one specific vignette.

Data was collected over a 2 month time period. It was then subject to ANOVA to determine similarities and differences amongst participants' backgrounds and their beliefs of conscientious objection by physicians.

Results

Results of a two-way analysis of variance (ANOVA) indicated a significant main effect of vignette treatment (F [2] = 4.58, p = .009, partial η^2 = .03) and a marginally significant main effect of vignette patient (F[1] = 3.83, p = .051, partial η^2 = .01) on acceptance of conscientious objection. However, the interaction between the vignette treatment and vignette patient conditions also was significant (F [2] = 9.97, p < .001, partial η^2 = .06), suggesting a nuanced effect of the manipulations. A probe of the interaction suggested that acceptance of conscientious objection was relatively equal across conditions, except for participants who read the vignette of a transgender patient seeking hormone replacement therapy, which produced significantly higher acceptance of conscientious objection relative to the other conditions (see figure below).

Three-way interactions also were examined between vignette treatment conditions, vignette patient conditions, and demographics of participants, including sex (female; male), race (White; Persons of Color), sexual orientation (heterosexual; lesbian/gay/bisexual+), political ideology (liberal; neutral; conservative), education (less than bachelors; bachelors or above), and type of hometown (rural; suburban; urban). None of the three-way interactions were significant, indicating there were no substantial differences in the pattern of results across demographic constructs. Thus, the two-way interaction between vignette treatment and patient conditions best represented the data.



Conclusions

Subjects were significantly more permissive with physician conscientious objection towards transgender women receiving hormone replacement therapy among all background characteristics and demographics. This finding informs us that there is differing levels of permissiveness of conscientious objection towards transgender women in regards to different modalities of care. Importantly, it supports the idea that transgender people will likely not experience conscientious objection for care other than HRT.

Additionally, there were no statistically significant differences seen between non-HRT therapies. This is seen in Figure 1, where conscientious objection is very low towards both cisgender and transgender patients receiving blood pressure medications and psychiatric medications. This finding supports the idea that transgender individuals may experience the same level of conscientious objection as a cisgender person.

This data provides information that the main reasons people permit conscientious objection is in relation to HRT. There was no substantial differences in the pattern of results across demographic constructs, indicating no additional benefit of searching for a physician of a specific background.

Limitations of the study are that the people surveyed were not physicians. A majority were not healthcare workers. This is important, as there could be major differences among the physician-community when comparing conscientious objection to the general public.

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