



Opinions of nurses regarding conscientious objection

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Abstract

Background: In the last decades, there have been important developments in the scientific and technological areas of healthcare. On certain occasions this provokes conflict between the patients' rights and the values of healthcare professionals which brings about, within this clinical relationship, the problem of conscientious objection.

Aims: To learn the opinions that the Nurses of the Madrid Autonomous Community have regarding conscientious objection.

Research design: Cross-cutting descriptive study.

Participants and research context: The nurses of 9 hospitals and 12 Health Centers in the Madrid Autonomous Community. The study was done by means of an auto completed anonymous questionnaire. The variables studied were social-demographical and their opinions about conscientious objections.

Ethical considerations: The study was approved by the Ethical Community of Clinical Research of the University Hospital Príncipe de Asturias. Participants were assured of maximum confidentiality and anonymity.

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Findings: A total of 421 nurses answered the questionnaire. In total, 55.6% of the nurses confirmed they were religious believers, and 64.3% declared having poor knowledge regarding conscientious objection. The matters that caused the greatest objections were voluntary abortions, genetic embryo selection, refusal of blood transfusions, and therapy refusal.

Discussion: Different authors state that the most significant cases of conscientious objections for health professionals are those regarding carrying out or assisting in abortions, euthanasia, the practice of assisted reproduction and, finally, the prescription and dispensing of the morning-after pill. In our study, the most significant cases in which the nurses would declare conscientious objections would be the refusal to accept treatment, the selection of embryos after genetic diagnosis preimplantation, the patient's refusal to receive blood transfusions due to religious reasons and pregnant women's request for voluntary abortions within the first 14 weeks.

Conclusion: Nurses' religious beliefs influence their opinions regarding conscientious objection. The nurses who declare themselves as religious believers object in a higher percentage than those without religious beliefs.

Keywords

Attitudes, bioethics, clinical ethics, conscientious objections, nurse, topic areas

Introduction

In the last decades, there have been important developments in the scientific and technological areas of healthcare. In certain occasions, this provokes conflict between the patients' rights and the values of the health professionals, which brings about within this clinical relationship the problem of conscientious objection.

Professional conscientious objection can be defined as the refusal to comply with professional obligations as stated by law or institutional rule, doing so by claiming moral or conscientious reasons.¹ Conscientious objections should be treated as a collision in rights and also as a conflict regarding values. The conflict between law and morals is ancient, as it was already displayed by Sophocles in his works "Antigone" (442 A.C.).² Locke (1632–1704) emphasized the freedom of individual conscience, but also he warned about the difficulties to balance the laws that regulate the fundamentals of social coexistence, and the respect for personal opinions. In the 19th century, H.D. Thoreau pointed out the need to object to unfair laws that were contrary to each individual's conscience. In more modern times, Gandhi and Martin Luther King carried out this idea to the practice.³ In healthcare areas, the term "conscientious objections" appears for the first time in the "British Vaccination Act" of 1898, as it included a clause for conscientious objections to the mandatory vaccination against smallpox. With the legalization of voluntary abortions during the 1970s in the United States and United Kingdom appeared movements in favor of conscientious objections.³

In 1978, the Spanish Constitution recognizes the right of conscientious objectors to deny entering the obligatory military service.⁴ Later, in 1985, abortion was declared legal and the Constitutional Court recognized the existence of the right to conscientious objections as part of the fundamental liberties in ideological and religious beliefs.⁵ At present, the cases of conscientious objections in the health area have been increased to include contraceptive treatments, assisted reproductions, experimentation with stem cells or life ending.⁶ Therefore, laws concerning sexual health, reproduction, and voluntary abortions as well as different autonomic regulations regarding information given beforehand expressly recognize the rights of the health professionals to their conscientious objections.^{7,8}

The different practice and ethics codes for nurses in force now in Spain also recognize their right to conscientious objection when facing specific practices which could go against their principles and values.⁹

In Spain, numerous authors^{10,11} defend the existence of an overall right to conscientious objection, as this is part of the fundamental rights to freedom of ideological and religious beliefs as per article 16.1 of the Spanish Constitution, which defends their right to refuse to carry out those clinical procedures which represent a violation of their personal beliefs. Nevertheless, other authors state that an overall right to conscientious objection does not exist, what exists is an overall acknowledgment to certain situations, subject to the compliance of certain requirements and would allow the objector to legally not follow a regulation or legal obligation.¹²

Herreros et al.¹³ state that the requirements needed for a morally justified objection would be (1) that the moral belief be acceptable, (2) that the refusal of the regulation comes from genuine moral reasons, and (3) that the actual situation is susceptible to objection.

Studies to learn the opinions of health professionals regarding conscientious objection have been carried out in different countries.^{14–17} In Spain, these types of studies are few. Some studies have been done to learn the opinion of students from medical, nursing, pharmaceutical, and law schools regarding voluntary abortions.^{18,19} Gracia Arenillas²⁰ has studied the experiences of doctors and nurses, in an area of Aragon, regarding conscientious objections. We specifically have not found any answers in any publications regarding the opinions of nurses¹ in the Madrid Autonomous Community in those cases in which conscientious objections is stated. Due to the lack of studies mentioned, the need to know the opinions of the nurses regarding conscientious objections is important to try to identify the confusion and controversy which arise from this matter. This could be a first step to deal with the moral agony and ethical conflicts which appear in the relationship between the nurse and the other health professionals and which, on occasion, can bring about situations of pseudo objection and go against the requisites of conscientious objection.

To carry out this study, we start with the premise that no health professional should be discriminated against because of their beliefs, but without forgetting that the practice of these ideals cannot damage the rights and interests of those legally established to use them. With this study we are trying to learn the possible influence of religious beliefs when stating conscientious objections and the actions the nurses of the Madrid Autonomous Community take when facing cases that could cause them conflicts in their conscience since they are morally important to them.

Population and methods

An observational, descriptive, and cross-cutting study has been carried out in 9 hospitals and 12 health centers of the Madrid Autonomous Community. The study group is formed by a total of 19,228 nurses who work at the Madrid Health Services (SERMAS).²¹ To calculate the sample size, reference has been taken with the assumption of maximum uncertainty with an expected proportion of 50%, which was estimated to be a number of 376 participants with a confidence level of 95% and accuracy of 5%. Taking into consideration a loss percentage of at least 20%, the participation of 452 nurses would be needed.

The centers included in the study were chosen randomly. In order to ensure the representativeness of the sample, a proportional stratified sampling was carried out with this type of sampling to ensure that the sample of nurses has the same distribution as the population of nurses in the Community of Madrid in relation to the variables sex and age. In order to meet the inclusion criteria, the nurses surveyed had to serve the Madrid Health Service (SERMAS) and agree to participate in the study.

The selection of health centers was done by means of a simple random sampling from the 28 public hospitals and 275 health centers of the Madrid Autonomous Community. The nurses of each hospital and health center that complied with the inclusion criteria were chosen by consecutive sampling. The data were obtained between the months of October 2014 and November 2015.

¹The text makes reference to nurses, which includes both the female and masculine gender.

To obtain the data, an ad hoc questionnaire was created which was based on the questionnaires used for the Strickland⁶ and Nordstran⁷ studies.

The questionnaire has 27 items which incorporate relevant aspects regarding religious beliefs, bioethical formation, information regarding conscientious objections, and the opinion which arises when facing 18 interventions which could generate conflicts of conscience (Table 2). The creation and legitimacy of the questionnaire guaranteed its validity and reliability as it was submitted to the following processes:

1. Panel of experts made up of nurses with important experience in clinical bioethics.
2. Pilot studies with a sample of 73 nurses representing the study population.
3. Statistical verification of the reliability of the questionnaire as per Cronbach's alpha with rating of 0.857.

The study variables were social-demographical, knowledge, and attitudes. To obtain all of the data, the investigating team contacted model nurses, Heads of Research Units in hospitals, and Coordinators in health centers which were given verbal and written information regarding the study. Once they accepted that their center would participate in the study, they were given the assigned questionnaires and a collecting procedure was agreed upon.

Ethical considerations

When delivering the questionnaire to the participants, they were first informed of the objectives of the study, they were asked for their agreement to participate, and they were guaranteed maximum confidentiality and anonymity with regard to the data acquired. The study was approved by the Ethical Community of Clinical Research of the University Hospital Príncipe de Asturias.

Statistical analysis

The qualitative variables are described using percentages of absolute and relative frequencies for each category, and associations were looked for using the chi-square test or Fisher's exact test. To know the estimation of the effect as per Prevailing Reasoning (RP or exponent β) of the predictor variable "religious beliefs," the answers from the different interventions in which the nurses would plead conscientious objections were recoded, dichotomizing the categories in order to include them in a model of logistic regression. In the variables of the analysis, a confidence interval for error alpha of 5% is calculated through the statistical program SPSS v. 18.0.

Results

Between both the hospitals and the health centers, 500 questionnaires were distributed of which 421 questionnaires were correctly answered, thus meaning an 84.2% answer rate (Figure 1).

Within the social-demographic characteristics, we found that 82.4% ($n = 347$) were women against the 17.6% ($n = 74$) that were men. The average age of participants was 41.26 years old (95% confidence interval (CI): 40.14–42.39); the youngest nurse was 23 years old and the oldest one was 64 years old. The distribution made by age groups and gender is presented in Table 1.

The majority of the nurses, 70.5% ($n = 297$), work in hospitals, while 29.5% ($n = 124$) work in health centers. The average length of service in this profession is 17.96 years (95% CI: 16.9–19.03), with the shortest time in the profession being 1 year and the longest 42 years.

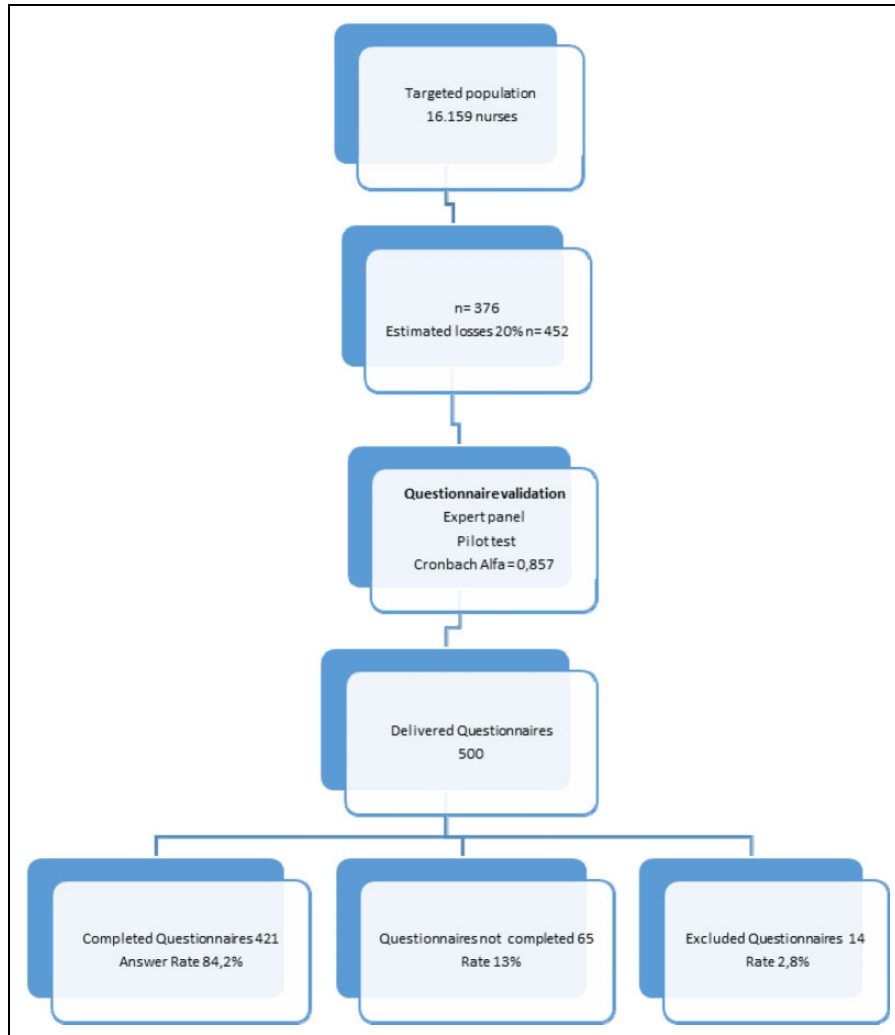


Figure 1. Design and response rates.

As to their religious beliefs, 55.6% ($n = 234$) claim to be believers and 43.5% ($n = 183$) non-believers. The results of the importance of their religion for those nurses who are believers are shown in Table 2.

In total, 47.7% ($n = 201$) of the nurses polled state that they had received studies in bioethics in their undergraduate years. While 31.4% ($n = 132$) state that they have not received any studies in this area. Only 19.7% ($n = 83$) have taken postgraduate studies in bioethics. Nevertheless, 64.3% ($n = 271$) state that they have little or no education regarding conscientious objection and only 8.8% ($n = 37$) of the nurses polled declare to have sufficient or a lot of information in this area. However, a 51.6% ($n = 271$) of nurses understand that the right to conscientious objection in the health area is enough of or a very important problem, against a 18.3% ($n = 77$) that consider it no problem or a small problem.

The cases which bring about a higher conscientious objection for the nurses are voluntary abortions, embryo selections, the refusal by the patient to receive blood transfusions due to religious beliefs, and the refusal to receive treatment (Figure 2).

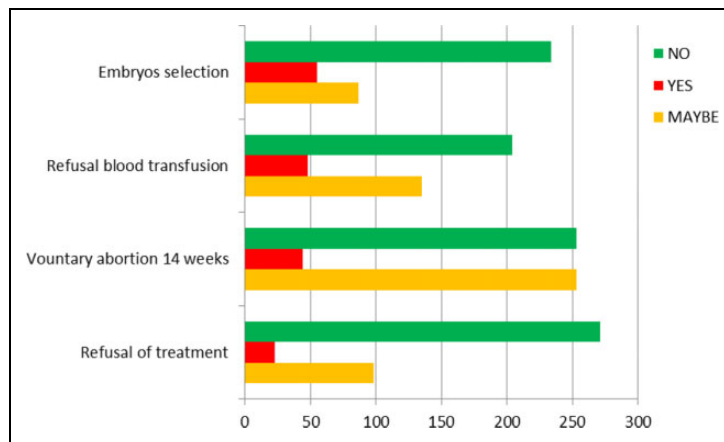
Table 1. Distribution by age groups, sex, and medical center type.

Age	Men			Women			Total
	%	TC	PC	%	TC	PC	
<35 years	9.50	31	9	29.93	96	30	166
35–54 years	3.8	10	6	34.44	104	41	161
55–65 years	3.8	6	10	14.97	38	25	79
NA	0.47	1	1	3.09	11	2	15
Total	17.57	48	26	82.43	249	98	421

TC: tertiary/secondary care; PC: primary care.

Table 2. Religious belief and importance attributed to religion.

Beliefs, n (%)	Importance religion/CO, n (%)
Believers 234 (55.6%)	Little/not important 78 (33.3%)
	Important 76 (32.4%)
	A lot/very important 80 (34.2%)
Non-believers 183 (43.5%)	

**Figure 2.** Cases in which the nurses would mostly declare conscientious objections.

The rest of the suppositions are presented in Table 3.

There is a relevant correlation ($p < 0.001$) between the age of the nurses and their workplace. In total, 77.9% of the nurses younger than 40 work in hospitals, while only 22.1% do so in health centers. To the contrary, in the age group of over 40, 62.8% work in health centers while only 37.2% do so in hospitals. No other relevant differences have been found in the areas of primary care and specialized care.

As to the subject of religious beliefs, 55.6% ($n = 234$) have declared to be believers against 43.5% ($n = 183$) who don't. The results of the importance given to religion with regard to conscientious objection are presented in Table 4.

As to studies in bioethics, it seems that younger nurses have a more complete education in this area ($p = 0.012$). In total, 11.7% of the nurses under 40 years of age have taken postgraduate courses against the 6.4% of the nurses over 40.

Table 3. Cases and declarations of conscientious objection.

Case study	YES CO	NO CO	Maybe	NA
	n (%)	n (%)	CO n (%)	n (%)
1. Dispensation of the morning-after pill	39 (9.3)	317 (75.3)	57 (13.5)	6 (1.4)
2. Voluntary abortion within the first 14 weeks of pregnancy as per the mother's request	44 (10.5)	253 (60.1)	105 (24.9)	17 (4)
3. Voluntary abortion due to grave illness of the mother	22 (5.2)	344 (81.7)	22 (5.2)	1 (0.2)
4. Voluntary abortion due to malformations of the fetus	43 (10.2)	333 (79.1)	35 (8.3)	1 (0.2)
5. Voluntary abortion in cases in which the pregnant woman was raped	46 (10.9)	338 (80.3)	30 (7.1)	7 (1.7)
6. Voluntary sterilization	24 (5.7)	347 (84.2)	24 (5.7)	8 (1.9)
7. Assisted human reproduction	37 (8.8)	329 (78.1)	39 (9.3)	11 (2.6)
8. Embryo selection after DGP	55 (13.1)	234 (55.6)	87 (20.7)	43 (10.2)
9. Participation/collaboration in preparing documents for previous instructions	30 (7.1)	313 (74.3)	49 (11.6)	27 (6.4)
10. Completing previous instructions with regard to palliative measures	30 (7.15)	344 (81.7)	29 (6.9)	16 (3.8)
11. Carrying out previous instructions regarding removing life-supporting systems	27 (6.4)	315 (74.8)	61 (14.5)	16 (3.8)
12. Patient's refusal of proposed medical treatment	23 (5.5)	271 (64.4)	98 (23.3)	26 (6.2)
13. Patient's refusal of blood transfusion due to religious beliefs	48 (11.4)	204 (48.5)	135 (32.1)	29 (6.9)
14. Limited life support systems	25 (5.9)	278 (66)	93 (22.1)	20 (4.8)
15. Treatment refusal	140 (33.3)	140 (33.3)	109 (25.9)	26 (6.2)
16. Palliative sedation	39 (9.3)	345 (81.9)	19 (4.5)	8 (1.9)
17. Participation in the removal of organs from a deceased donor	37 (8.8)	345 (81.9)	27 (6.4)	9 (2.1)
18. Participation in the removal of organs from a live donor	30 (7.1)	306 (72.7)	64 (15.2)	14 (3.3)

CO: Conscientious Objection; DGP: Diagnosis Preimplantation.

There appear to be no significant differences regarding the age of the nurses and the importance given to the subject of conscientious objections. Neither does it appear when taking into account the age and the importance given to religion with regard to conscientious objections.

Discussion

Different authors state that the most significant cases of conscientious objections for health professionals are those regarding carrying out or assisting in abortions, euthanasia, the practice of assisted reproduction and, finally, the prescription and dispensing of the morning-after pill.^{6,22} Other more concise studies show that the most frequent cases of conscientious objections within the health profession are the morning-after pill (8.8%), abortion (6.5%), limitation of therapeutic efforts (6.2%), and taking away life-supporting systems (5.7%).²⁰

In our study, the most significant cases in which the nurses from Madrid would declare conscientious objections would be the refusal to accept treatment (33.3%), the selection of embryos after genetic diagnosis preimplantation (18.1%), the patient's refusal to receive blood transfusions due to religious reasons (11.4%), and pregnant women's request for voluntary abortions within the first 14 weeks of pregnancy (10.5%). In these cases, many of the nurses have doubts regarding conscientious objections, causing high numbers of "Maybe" in the study.

The influence of religious beliefs regarding conscientious objections is very relevant. Different studies show that when the religious beliefs of the nurses affect their ethical values, they tend to consider their right

Table 4. Religious beliefs and declarations of conscientious objections with regard to certain treatments.

Treatments	Believers			Non-believers			p	RP
	Objection			Objection				
	Yes n (%)	Maybe n (%)	No n (%)	Yes n (%)	Maybe n (%)	No n (%)		
1. Dispensation of the morning-after pill	32 (13.8)	45 (9.4)	153 (65.9)	6 (3.3)	12 (6.6)	162 (88.5)	<0.001	4.843
2. Voluntary abortion within first 14 weeks	38 (16.4)	74 (31.9)	112 (48.3)	6 (3.3)	30 (16.4)	139 (76)	<0.001	6.122
3. Voluntary abortion due to grave illness of the mother	37 (15.9)	20 (8.6)	171 (73.4)	8 (4.4)	2 (1.1)	171 (93.4)	<0.001	3.980
4. Voluntary abortion due to fetus malformation	36 (15.5)	30 (12.9)	161 (69.1)	7 (3.8)	4 (2.2)	170 (2.9)	<0.001	4.620
5. Voluntary abortion due to rape	38 (16.2)	27 (11.5)	164 (70.1)	7 (3.8)	3 (1.6)	172 (94)	<0.001	4.810
6. Voluntary sterilization	36 (15.4)	15 (6.4)	177 (75.6)	5 (2.7)	9 (4.9)	168 (91.8)	<0.001	5.848
7. Assisted human reproduction	29 (12.7)	22 (9.6)	173 (75.5)	7 (3.8)	17 (9.3)	154 (84.2)	0.017	3.189
8. Embryo selection after DGP	42 (18.1)	51 (22)	113 (48.7)	12 (6.6)	36 (19.7)	119 (65)	0.001	2.958
9. Participate/collaborate in preparing the document II.PP	24 (10.3)	35 (15.1)	155 (66.8)	6 (3.3)	14 (7.7)	155 (84.8)	<0.001	3.597
10. Complying with II.PP regarding palliative measures	23 (9.9)	22 (9.5)	175 (75.4)	7 (3.8)	7 (3.8)	166 (90.7)	0.001	2.870
11. Complying with II.PP regarding removal of life support systems	20 (8.6)	45 (19.4)	154 (66.4)	7 (3.8)	16 (8.7)	158 (86.3)	<0.001	2.709
12. Patient's refusal to proposed medical treatment	16 (6.9)	64 (27.7)	135 (58.4)	7 (3.8)	33 (18)	134 (73.2)	0.019	2.134
13. Refusal of blood transfusion due to religious beliefs	27 (11.6)	82 (35.3)	108 (46.6)	21 (11.7)	51 (26.3)	95 (52.8)	0.489	1.104
14. Limitations to life support systems	14 (6)	63 (27.2)	143 (61.1)	11 (6.1)	30 (16.6)	132 (73.3)	0.061	1.115
15. Treatment refusal	68 (29.4)	64 (27.7)	83 (35.9)	56 (3.1)	45 (25)	70 (38.9)	0.232	1.233
16. Palliative sedation	31 (13.7)	11 (4.8)	180 (79.2)	8 (4.4)	8 (4.4)	162 (90)	0.012	3.121
17. Participation in the removal of organs from deceased donor	27 (11.6)	18 (7.7)	182 (78.1)	10 (5.5)	9 (5)	160 (88.4)	0.050	2.196
18. Participation in removal of organs from live donor	22 (9.6)	40 (17.4)	160 (69.6)	8 (4.4)	23 (12.8)	144 (80)	0.084	2.296

DGP: Diagnosis Preimplantation; IIPP: Previous Instructions/ Advance Directives; RP: proportion of reason due to the assumption of religious beliefs.

to conscientious objections more important than the patients' healthcare rights.^{16,23} In total, 55.6% of the nurses of our study declare themselves religious believers, this number being smaller than that of the general population; according to data from the Center for Sociological Investigations (CIS), the percentage of religious believers in the Madrid Autonomous Region is 66.7%.²⁴ Strickland¹⁴ in his study of medical students in the United Kingdom states that religion is an important matter for 46% of those polled. In the study carried out by Gracia Arnillas,²⁰ 75.3% of doctors and nurses state that they are religious believers against 24.7% who declare to be agnostic or atheist and within the group of believers 22.5% also declare to practice their religious beliefs. In our study, within the group of nurses who declare to be believers, 34.20% state that religion for them is important or very important (Table 2).

Of the 18 possible cases of conscientious objections given, a significant difference is found in 13 of them between those nurses who declare themselves as believers and those who don't. The case in which the largest difference is seen between the nurses who are believers against those who are non-believers is that of voluntary abortion within the first 14 weeks of pregnancy, as the nurses with religious beliefs would object 6.12 times more than those who are non-believers (RP = 6.122; $p < 0.001$), followed by voluntary sterilization (RP = 5.848; $p < 0.001$), and the dispensing of the morning-after pill (PDD) (RP = 4.843; $p < 0.001$). Significant differences are also found in other cases of voluntary abortions, such as in the case where pregnancy has occurred due to rape, nurses who are believers would object 4.81 times more than those who are non-believers (RP = 4.810; $p < 0.001$); in the assumption of fetus malformation, this difference would be 4.62 (RP = 4.620; $p < 0.001$) and in the case of voluntary abortion due to critical illness of the mother it would be 3.98 (RP = 3.980; $p < 0.001$). The cases of conscientious objections to the morning-after pill can be due to the fact that it is considered an abortion although authors such as García Calvente and Lomas Hernández²⁵ state that the morning-after pill should not be considered as such as there is no evidence that it interferes in the fertilization of the egg. On the other hand, those cases in which there are smaller differences between nurses with religious beliefs and those non-believers are refusal to blood transfusions due to religious beliefs (RP = 1.104; $p < 0.489$), in limiting life support (RP = 1.115; $p < 0.061$) and in refusing treatment (RP = 1.233; $p < 0.232$). The rest of the differences are shown in Table 4.

The correlation between conscientious objections and religious beliefs brings about two questions, the first being if it is justified that, under a reference of personal values and beliefs, health professionals can go against the rights to treatment of patients within the healthcare system and second how to fit within a healthcare system conscientious objections without hindering said health treatment.²⁶

With regard to education in bioethics, 31.4% of the nurses polled declare to have not received studies in this subject, 47.7% declare to have taken these studies during their pre-graduate courses, and only 19.7% have taken postgraduate studies in bioethics. There is a significant correlation between age and studies ($p < 0.001$); 43.6% of the nurses over 40 years of age state that they have not received any education regarding bioethics, while only 20.8% of those whose ages are below 40 declare to not have received any studies with regard to this subject. We can also find a relation ($p < 0,001$) between the courses taken in bioethics and the seniority in their workplace, that is, 11.7% of the nurses with less than 20 years of experience have taken long-term courses or masters against 7.2% of the nurses who have a seniority of more than 20 years. These data contrast with those presented by Zabala Blanco et al.²⁷ in which 64.4% of doctors and nurses polled stated having no education regarding bioethics, with only those professionals with a seniority of more than 20 years having a more complete education in this area.

Conscientious objection is an important matter for 51.6% of the nurses of this study. In the questionnaire carried out by Gracia Arenillas,²⁰ even though not directly asked regarding the importance of conscientious objections, it is stated that it is a subject in which 51.7% of the doctors and nurses polled have thought about and 23.5% declare to have thought about it in various occasions. It is worth noting that in this study 10.6% of the doctors and nurses declare that they had not stated a conscientious objection as they thought they had no right to do so, and this situation suggests a lack of knowledge of the Ethics Codes, since both the Spanish Medical Ethics Code and the Nurses Ethics Code inform of this right.^{9,28}

The importance that nurses believe conscientious objections have can be related by the ethical conflict caused by moral distress. Moral distress, with regard to nursing, can be defined as the concern or intense uneasiness that the nurses feel when carrying out actions as per external rules when in his or her conscience they know that action is not correct. In this sense, conscientious objections reduce the possibility of moral distress as it allows the health professional to decide on the correct form of treatment in accordance with their principle and values.²⁹ One of the questions that most worry nurses is carrying out unnecessary tests or treatments,^{30,31} which is directly related to the patients' right to refuse treatment, understanding these as

fruitless treatments since what they only do is prolong a clinical situation with no reasonable expectations of improvement of the patients' health,³² and in our study, this is the case in which most nurses would object to, 33.3% would do so specifically, and 25.9% would think about doing so.

Finally, we would like to point out that another significant finding in this study was the negative reaction of the nurses when a patient refuses a blood transfusion because of religious beliefs, even if the percentage of the objectors is clear, 11.4%, we found that 32.1% of the nurses polled were in doubt as to which option they would take. In other studies, the percentage of the objectors in this matter is smaller (2.3%).¹⁹ These results could be related to the formation received by health professionals to save lives and we would be seeing here what could be called "emotional objection" in which the health professionals acknowledge and accept the patients' right to refuse treatment, but cannot continue assisting the patient due to the anguish brought about by a situation they wish to avoid.³³

The refusal of medical treatments due to religious beliefs or others is a delicate situation and requires a clinical, ethical, and legal study of each case. Therefore, when a patient refuses treatment, the health professionals can declare and justify their conscientious objection and can withdraw from the case always understanding that there would be other professionals who would take charge of said case, since the enforced treatment or the desertion of the patient as well as an unjustified delay in assisting him would be unacceptable.³³

The fact that the study was carried out in the Madrid Autonomous Community can be considered a limitation of the study and therefore cannot be used to generalize all Spanish nurses. Nevertheless, it demonstrates an important reality of what is happening in Madrid and therefore its projection in other Autonomous Communities.

Conclusion

Considering the results obtained, we can conclude saying: First, the cases in which the possibilities of conscientious objections most arise for the nurses of the Madrid Autonomous Community are refusal of treatment, embryo selection for genetic diagnosis preimplantation, unwillingness to receive medical treatments such as blood transfusions, and voluntary abortions within the first 14 weeks of pregnancy. Second, information regarding conscientious objection received by the nurses during their graduate and postgraduate formation has been little or very little. Third, education in bioethics and information regarding conscientious objection of the nurses in general is poor. However, it appears that in the newer graduates this situation is improving. Fourth, conscientious objection is regarded by more than half of the nurses polled in the study to be an important or very important problem. Finally, there is a correlation between religious beliefs and conscientious objection. Those nurses with strong religious beliefs would object in a larger proportion than those with little or no beliefs. The most important differences when stating a conscientious objection between nurses with religious beliefs and those without would be in the cases of voluntary abortions.

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