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A Defense of Institutional Conscience Rights for Secular Hospitals: Philosophical Justifications and Practical Applications

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ABSTRACT
We have previously argued that clinicians should leverage conscience, rather than quasi-objective clinical standards, to justify their refusal to provide aggressive interventions to patients who were likely permanently unconscious. Such a move sidesteps perennial disagreements over concepts such as “futility,” “harm,” and “best interest”; and it is consistent with the growing acknowledgement of value pluralism in healthcare. In this paper, we make similar arguments about the conscience rights of *institutions*. We argue that, like individuals, healthcare *organizations* can leverage conscience claims to justify institution-wide prohibitions on some medical interventions that are legal and within the standard of care. Of course, faith-based healthcare institutions already enjoy institutional conscience protections. We argue that *secular* institutions can also claim conscience protections to refuse some kinds of interventions on the basis of system-level moral commitments.

KEYWORDS
Institutional conscience; conscientious objection; futility; best interests; brain death; vegetative patients

INTRODUCTION

Many clinical conflicts involve questions about the ethicality of providing interventions that patients or surrogates demand, but physicians strongly oppose. Attempts to address conflicts in such cases often focus on whether the intervention is physiologically futile or medically inappropriate, since such treatments generally should not be offered. However, this approach often fails to resolve the dispute, particularly when surrogates and clinicians evaluate questions of futility or inappropriateness differently. Professional medical and clinical ethics guidance about determinations of futility and inappropriateness have anchored professional consensus for the past decade (Bosslet et al. 2015; Kon et al. 2016), but these standards have always been contested, in both the academic literature and in wider public discourses (Burns and Truog 2007; Misak et al. 2014; da Silva Vieira et al. 2021). Furthermore, whatever consensus has been achieved may be giving way to a socio-political surge in deference to patient or surrogate beliefs. Vague, contradictory, and idiosyncratic legislative and judicial guidance in cases involving such conflicts also has contributed to ongoing tension and conflict (Pope 2007, 2011, 2021).

In response to both the perennial disagreements about the meaning of concepts such as “futility,” “harm,” and “best interest,” as well as the growing deference to value pluralism in healthcare that we are currently witnessing, we have previously argued that clinicians should leverage conscience to justify their refusal to provide aggressive interventions to patients who were likely permanently unconscious (Wasserman et al. 2025a). Invoking conscience sidesteps intractable disputes about “objective” clinical standards and instead positions refusal as a matter of one’s own subjective values (Brock 2008; Card 2020; Wasserman et al. 2025a).

In this paper, we make similar arguments about the conscience rights of *institutions*. We argue that, like individuals, healthcare *organizations* can leverage conscience claims to justify a refusal to provide medical interventions that are within the standard of care. Of course, faith-based healthcare institutions already commonly exercise institutional conscience. Our work here aims to show that *secular* institutions

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can also claim conscience protections to refuse some kinds of interventions on the basis of system-level moral commitments.[1]

In what follows, we first describe ongoing, and arguably increasing, deference for value pluralism regarding neurologically devastated patients and how this shift renders concepts like "futility" and "inappropriate care" unable to resolve many clinical ethics conflicts. In contrast, conscience claims, either by individuals or institutions, *can* provide guidance in such situations because they require neither a reliance on "objective" moral values nor agreement between the parties, e.g. about the nature of "benefit" or the metaphysics of "death." The field of bioethics already possesses well worked-out accounts of individual conscience rights, but we need clearer parameters for institutional conscience, especially for secular institutions. We argue both that institutions can have conscience claims and that secular institutions have the same conscience rights that have been well established and reliably defended for religious institutions. We then apply secular institutional conscientious refusal to patients who are likely permanently unconscious and those who are brain dead, both of which reflect areas of intractable disagreement that we contend are best addressed by appeal to conscience. We conclude by discussing the broader implications of our view.

GROUNDWORK: INTRACTABLE CONFLICTS AND EXPANDING PLURALISM

One of the most common moral conflicts in acute care settings concerns patient or surrogate demands for physiologically futile or potentially inappropriate care (FPIC). Clinicians usually should not offer FPIC, but the contested nature of these determinations, combined with socio-political and legal pressure, can make refusing such interventions difficult in practice. According to Lambden et al. (2019, 6), "Across all clinicians, 91.4% reported that they either had, or had possibly, provided futile/PIC to dying patients in the preceding 6 months, with 41.3% reporting that they had provided futile/PIC for at least 6 patients." While intractable ethical conflict may be relatively rare, these kinds of disputes comprise a high proportion of such conflicts.

Resisting surrogate demands for FPIC can generate conflict with patients or families, and often with administrators, risk managers, and other clinical colleagues. Judicial rulings on these issues have been unpredictable because these cases often fundamental disagreements over notions like "best interests" or "quality of life" (Biel and Durrant 2020). Even though courts tend *ultimately* to rule in favor of hospitals, they often mandate treatment over the weeks or months it can take for the judicial process to play out (Pope 2007). The specters of liability and burdensome legal entanglement discourage physicians from holding firm ethical boundaries, even in cases that are not formally in the judicial process. As ethics consultants, we have often encountered physicians who cited their fear of litigation and their previous experiences with lawsuits as reasons for acquiescing to family wishes, even in cases of FPIC and even when they acknowledge that it is ethically problematic (see also, Borhani et al. 2015; Dzeng et al. 2016).

A common kind of case in which physician-surrogate disputes about FPIC occur involve treatment for "neurologically devastated" patients, which we define here as those very likely to remain permanently unconscious or those who have been pronounced dead by neurological criteria. Indeed, brain injury has generated significant debate over the last 50 years, and this issue continues to highlight how substantial value pluralism complicates clinical medicine (Lewis and Greer 2017). Given the emerging evidence over the last decade about the routinely underappreciated rehabilitative potential of some brain injured patients (Fins 2015), these cases may seem to be opportunities for reasonable compromise with families. But the evidence in support of guarded optimism should not be applied universally; it does not warrant treatment of all brain injured patients (Wasserman et al. 2025a). While it is right to say that prognoses about the rehabilitative potential of patients with severe brain injury have often been overly grim, there remain indicators that support reliable prognostication of permanent unconsciousness, including diffuse anoxic injury, status myoclonus, no pupillary or corneal reflexes after 72 hours, and a highly malignant EEG after 24 hours (Nolan et al. 2021). Thus, while we should temper dogmatic forms of "clinical nihilism" for brain injured patients, it would be just as dogmatic and incorrect to say that we cannot reliably make prognoses about *any* brain-injured patients, regardless of the etiology of their injury. For some patients, there is virtually no uncertainty about their prognosis: they are not going to make meaningful neurological recovery.

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[1] In this paper, we presume a compromise view of conscientious objection, rejecting conscience absolutism (where all conscience claims must be respected) and incompatibility thesis views (where no conscience claims must be respected) (Wicclair 2011). The precise criteria to constrain conscience claims in compromise views are debated, but commonly include a reasonability criterion (Card 2020). In our previous work, we argued that refusal of tracheostomy for patients who are very likely to remain permanently unconscious are ethically permissible on the grounds of reasonable disagreement about 1) the goals of medicine, 2) the appropriate prognostic thresholds for interventions, and 3) the metaphysics of disability vis-à-vis unconsciousness. In this paper, we extend our analysis to institutional conscientious objections.

Disputes about what is best for patients who are very likely to remain permanently unconscious occur not only at the bedside, but in the ethics literature. Lo (2013, 73) argues that whether to provide life-sustaining treatment for vegetative patients "needs to be assessed according to the goals and values of the patient and cannot be determined unilaterally by physicians." In contrast, a companion guideline to the Five Society Statement reads, "ICU [intensive care unit] interventions should generally be considered inappropriate when there is no reasonable expectation that the patient's neurologic function will improve sufficiently to allow the patient to perceive the benefits of treatment" (Kon et al. 2016). We cannot expect to resolve bedside conflicts about these issues when there is no consensus among physicians and bioethicists about them.

We have noted that ethicists disagree among themselves and clinicians often disagree with patients and surrogates about whether to perform aggressive interventions on patients with permanent unconsciousness. In contrast, there has been a *relatively* stable clinical bright-line for decision making about interventions related to determination of death by neurological criteria, at least for the past five decades. Even where it has sometimes been philosophically contested or where well-known cases have gained media attention, brain death criteria are routinely exercised as connoting death itself in US hospitals (Nair-Collins 2010).[2] In turn, treating patients who have been pronounced dead by neurological criteria is clearly outside the current standard of care. Limited exceptions to this include a "period of accommodation" (usually 24-48 hours) to sustain a patient on organ support so the family can process the death, and a legal mechanism that permits patients or families to "opt out" of determinations of death by neurologic criteria, thereby requiring clinicians to continue treatment, which is currently available only in New Jersey.

There appears, however, to be growing support for allowing patients or families to "opt out" of brain death criteria, which would, in turn, situate continued organ support for patients pronounced dead by neurological criteria *within* the standard of care. A recent statement from the American College of Physicians, for example, includes an appeal for greater deference to families rejecting neurological death (DeCamp and Prager 2023). While it was ultimately struck, a 2023 draft by the Universal Law Commission on the UDDA initially contained a recommendation for the nationwide adoption of exemptions to brain death declaration for patients or families that would *require* hospitals to continue treating brain dead patients (Pope 2023). Court rulings in Montana (In re Callaway 2016), Kansas (Shively v. Wesley Medical Center 2006), and California (Pierce v. Loma Linda University Medical Center 2016) have favored requiring surrogate consent to conduct brain death testing, a necessary precursor to the declaration of death by neurological criteria. Finally, the public has never embraced brain death to the same degree as medicine, and growing skepticism may soon lead to the adoption of a national conscience clause that would require hospitals to continue treating patients who had been declared dead by neurologic criteria. Indeed, one national survey of 1386 informed respondents reports that 41.9% support a conscience clause that would require a hospital to continue treating a patient who had been pronounced dead by neurologic criteria, with 24.4% reporting they would invoke it for themselves and 27.3% for a family member (Ludka et al. 2025). Clearly, even if clinicians can maintain that "brain death is death" among themselves, they do not speak for all members of the public. Conflicts about neurological criteria for determination of death are very likely to intensify.

For many clinicians, extreme deference to patients or families can be morally injurious. For example, continued provision of aggressive interventions for patients who are very likely to remain permanently unconscious causes substantial clinician moral distress (Payne et al. 1996; Montagnino and Ethier 2007; Milliken 2014). In the U.S. there are tens of thousands of neurologically devastated patients who have received aggressive interventions, e.g. tracheostomy or gastronomy tube placement (Giacino et al. 2018). Some clinicians describe such patients as "lying in an open grave" (Crisci 1995) or having a "fate worse than death" (Feinberg and Ferry 1984). One might imagine that widespread obligations to provide organ support for brain dead patients would impose similar moral distress and moral injury. We should not ignore the vulnerabilities of clinicians as moral actors.

Philosophical conflicts over the ethics of treating neurologically devastated patients involve questions about the nature of life itself (Fiester [forthcoming]). On one side, a vitalist perspective holds that all human

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[2] Despite this relative consensus, some ethicists have critiqued the Uniform Declaration of Death Act (UDDA). For example, Veatch and Ross (2016) argue that patients and families should be allowed to decide whether to continue treatment for patients that have been pronounced dead by neurological criteria, but still have ventilator-sustained cardiopulmonary function, because the definition of death is ultimately a philosophical question that the medical profession cannot answer (see also Veatch 1993). Still, these views have been in the minority in both ethics and the law.

life has intrinsic worth in any state or condition (even arguably among patients who have been pronounced dead by neurological criteria). Other kinds of non-vitalist views (mechanistic, materialist, liberal individualist, etc.) hold that nonexistence can be better than existence for some patients (e.g., those who have been pronounced dead by neurological criteria or will remain permanently unconscious). Reasonable pluralism about ethics and justice is an inherent feature of liberal societies and we should acknowledge that it also exists in clinical medicine. In turn, clinical ethics must find better ways to accommodate it, if not because ethicists substantively endorse such views, then at least because social shifts suggest it is pragmatically necessary to reach these kinds of compromises. However, we reject putative solutions to the problem of pluralism that always require clinician deference to patients and families (see Veatch 2009; Fiester 2011). Mandating deference in these kinds of contested cases wrongly obligates clinicians to provide aggressive interventions that may conflict with their deeply held moral commitments. Put another way, inasmuch as there is reasonable and intractable disagreement about the ethicality of such interventions, we are pushed into a space where we should defer to conscience. The question then becomes which entities within healthcare can claim conscience rights.

We have argued elsewhere that individual clinicians should invoke their conscience rights when they refuse to provide aggressive measures that they believe are unethical, but when such interventions do not meet the threshold of futility or inappropriateness, or when there is reasonable disagreement about whether they do (Wasserman et al. 2025a). Invoking conscience obviates the need to achieve elusive consensus about quality of life or the patient's best interests. Instead, it draws upon the deeply held values of the clinician and well-established protections for the exercise of conscience in health care. In the next section, we turn toward conceptual arguments about the nature of conscience and the ontological status of institutions, including secular institutions. These arguments will ground our claims about the legitimacy of deploying institutional conscience to address ethical conflict in cases where professional judgments conflict with the views of surrogates, including, or perhaps especially, in cases of patients who are brain dead or very likely to remain permanently unconscious.

SECULAR AND FAITH-BASED INSTITUTIONAL CONSCIENCE: AN UNTENABLE ASYMMETRY

Before turning to a positive case for institutional conscience per se, we first want to dispense with the notion that only faith-based institutions can have conscience. In practice, Catholic hospitals commonly invoke institutional conscience protections. They systematically refuse to provide a variety of legal and professionally accepted goods and services because of deeply held institutional values rooted in Catholic moral teaching and articulated in the Ethical and Religious Directives for Catholic Health Care Services (United States Conference of Catholic Bishops 2009). But conscience requires only deeply held values, not a religious mythos.

There are two main objections to the notion of conscience for secular institutions, but neither stands up to scrutiny. The first is a kind of religious exceptionalism that suggests protecting institutional conscience is a function of protecting, not deeply held moral commitments per se, but the free exercise of religion more narrowly. Since secular institutions do not work from explicitly religious frameworks, they do not have conscience rights. But this requires defining religion in ways distinct from other kinds of deeply held moral beliefs, which all naturally entail metaphysical commitments. This is at the heart of numerous defenses of conscientious refusal which leverage First Amendment prohibitions on the state defining religion. Consequently, it has historically been impossible to clearly delimit religious and philosophical beliefs in any principled way.

Second, one could argue that secular institutions do not have deeply held values, or that their values are merely contingent on the views of their leaders or compromised by profit motives. However, this seems both empirically false and non-unique as an objection. Healthcare institutions of all kinds are organized around core sets of values, such as the promotion of patient wellbeing and respect for human dignity, even where these can be cashed out in divergent ways across different institutions. For example, Kulesa and Giubilini (2024) identify a fault line between pathocentric vs salutogenic views of medicine that results in different views on the moral permissibility of highly contested services such as abortion, contraception, etc. (see also, Curlin and Tollefsen 2019). On pathocentric views, the goal of medicine is *healing*, understood as treating, preventing, or managing pathologies. On salutogenic views, the goal of medicine is to promote the patient's *best interests,* which can include inducing a pathology to serve some important psychosocial benefit (e.g., preventing pregnancy to focus on one's career). Institutions that adopt a salutogenic view aim at promoting well-being, a core value that drives the delivery of healthcare in those institutions. But while distinct from the pathocentric orientation of many faith-based institutions, this orientation toward medicine nonetheless reflects a reasonable and deeply held value commitment. While no secular healthcare institution has, to our knowledge, ever explicitly or formally invoked an institutional conscientious objection, there are good reasons to think they can do so in ethically supported ways.

Of course, the kinds of corporate documents like mission, vision, and values statements may be contingent on a particular slate of leaders and revised frequently with administrative turnover. But such statements usually point to more stable underlying value commitments, such as those rooted in the basic goals of medicine as conceived by the institution. These are not as transitory as different leadership regimes. As noted above, secular healthcare institutions routinely operate from a commitment to salutogenic goals of medicine. Most operate as non-profits, which entails a stated commitment to a community good. Moreover, while they may compromise their values under financial strain or amidst other conflicts, the same is true of faith-based institutions. What matters is less that they act purely and unwaveringly with regard to their value commitments, and more that they have underlying value commitments to which they aspire.

Ultimately the asymmetry in conscience protections between faith-based and secular institutions is not viable. While this asymmetry argument does not support the notion of institutional conscience per se, it does require one to either endorse conscience protections for all institutions with deeply held values, or reject such institutional protections altogether. In the next section, we argue for the former.

A DEFENSE OF INSTITUTIONAL CONSCIENCE ITSELF

The U.S. has provided federal protection for conscientious objection since the passage of the Church Amendments in 1973. However, it is often assumed that a conscientious objector is an individual person. The notion of institutional conscientious objection permits whole hospitals or health systems to prohibit their employees from providing legal and professionally accepted medical care that conflicts with the institution's core values. As noted above, while it is commonly invoked by faith-based institutions, the very concept of institutional conscience has been the subject of critique (Symons and Chua 2024).

Some critics have argued that speaking of collective conscience of any kind is bad metaphor. Durland writes (2011, 1659), "a hospital is not a person; it is a physical structure within which providers give medical care. It does not perform procedures or counsel patients. It does not take lunch hours or vacations. And it does not have a conscience." This critique has *prima facie* appeal. It is widely held that for a refusal to represent a true conscience claim an actor must feel significant shame or loss of self-respect if they were to perform the action (Wicclair 2011). This conceptualization of conscience leverages a kind of affective experience that is only characteristic of individuals.[3] To invoke Durland, institutions cannot feel shame, only individuals can. But such a critique misunderstands both the nature of collectivities and the requirements of conscientious objection.

In this section, we offer complementary sociological and philosophical accounts that establish the metaphysical prerequisites of institutional conscience. The first illustrates that collectivities are not reducible to the individuals within them and therefore that institutions have a kind of independent agency that is a prerequisite of making a conscience claim. The second describes how those collectivities can have an attribute rightly called "conscience." Together, these illustrate that conscience protections for individuals within institutions are not sufficient, but rather should extend to institutions themselves.

The Irreducible Nature of Collectivities

The irreducible nature of collectivities is a well-established sociological principle. Put simply: the whole is more than the sum of its parts. Institutions like family, religion, and law represent organized systems that endure and evolve over time and which influence individual behavior. Social systems therefore represent distinct entities with their own dynamics, patterns, and forces that cannot be reduced to the characteristics of individual members within them or understood merely as a coalescence of idiosyncratic individual actions. Of course, individual behaviors and interactions within systems can help shape these social forces through an upward conflation of patterned norms and behaviors. But collectivities are not merely the emergent properties of these individual behaviors because macro level social systems also structure the behaviors of individuals within them. Thus, as Sulmasy (2008) writes,

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[3] For pragmatic reasons, laws or institutional policies establishing conscience protections often do not invoke shame or loss of self-respect as a necessary condition for the exercise of conscience. However, the ethics literature frequently includes such a standard as a moral condition. Accordingly, we illustrate that institutions can meet a sufficient analogue of the shame criterion, but it is worth noting that the legal or practical case for institutional conscience is even easier to make.

"[Healthcare institutions] are not random collections of doctors, nurses, social workers, and other professionals thrown together in a building without a common purpose and identity that transcends each of them. In organizations that qualify as moral agents, the identity of the organization is not exhausted by merely tallying up the identities of the individuals. Organizations have an identity that is much more than the sum of their constituent parts" (see also, Pellegrino 1982).

The reality of social systems and their independence from individual actors is further indicated within modernist bureaucracies, such as health systems, where both values and role functions are abstracted from individual actors and absorbed into a wholly institutional framework. Thus, even where there is individual variance of values and behaviors within an institutional system, and even when those individuals affect and alter the institutional system [a concept sometimes referred to as "structuration" (Giddens 1984)], there remain highly influential, if not dominant, structuring social forces which emanate from the institution itself. While the institution's norms and values may require human beings for their animation, these social actors are often carrying out collective norms and values (Pellegrino 1982; Sulmasy 2008). In this way, collectives have a kind of agency that is similar in key respects to the agency of individuals, but which is not reducible to individual actors themselves. While Pellegrino (1982) and Sulmasy (2008) have anchored claims about collective conscience in healthcare institutions around shared moral values, in the next section we elaborate ontological claims about conscience to advance the notion that institutions are the kinds of entities that can be rightly described as having "conscience" (or something sufficiently similar to justify conscience protections).

Conceptions of Conscience for Institutions

Building on the sociological account of systems, there are numerous philosophical accounts of conscience that can be characteristic of collectivities. Giubilini (2021) argues that conceptions of conscience can be organized into four main categories. These are conscience as: (1) self-knowledge/self-assessment, (2) epistemic function, (3) motivation to act morally, and (4) self-identifying moral commitments and moral integrity. Institutions might be said to possess conscience on any of these accounts.

The view of conscience as *self-knowledge and self-assessment* conceives of conscience as an introspective faculty for assessing moral character and is represented in a wide range of philosophical traditions, from the Greeks to Roman Catholicism to enlightenment thinkers such as Adam Smith or Immanuel Kant. On this view, conscience fosters introspection about one's actions and motivations, and it promotes internal accountability that is independent of external sanctions. These functions of conscience benefit not just individuals, but communities, which suggests that there are also other-regarding reasons to protect conscience rights. Without such protection, professionals might become mere technicians, who are ordered by external demands, rather than oriented to internal value-driven obligations. Like individuals, institutions can also engage in systematic moral self-evaluation. Institutions often conduct self-assessment through mechanisms like internal reviews, ethics committees, and compliance boards. These collective processes may lack the immediate, personal quality of individual conscience, but we can nonetheless speak meaningfully of institutional conscience on this account if we understand it as a collective process that serves similar functions to individual conscience: promoting ethical reflection and ensuring accountability to moral principles. In turn, protecting institutional conscience would matter on this account because it allows organizations to maintain their moral character and engage in genuine ethical deliberation, even when external pressures push mere compliance with rules.

The *epistemic function* view characterizes conscience as providing direct or indirect moral knowledge. The former entails moral intuitions, while the latter reflects laws or social norms. On this view, conscience is an important channel for moral knowledge. Accordingly, conscience protections preserve diverse sources of ethical understanding and they enrich ethical discourse by appealing to various traditions. Institutions can meaningfully be described as embodying conscience on this account as well. While individual conscience often operates through immediate moral intuition or personal revelation, institutional conscience works through the systemic development and preservation of moral knowledge. For example, religious institutions maintain centuries-old traditions of ethical reasoning, while universities cultivate spaces for moral inquiry and debate. Many healthcare institutions develop sophisticated frameworks for addressing bioethical challenges *within* broader moral communities, sometimes within religious traditions, but also within the normative commitments of medicine itself. This institutional form of an epistemically-oriented conscience similarly preserves diverse moral traditions, enables sustained ethical reflection, and provides resources for addressing new moral challenges. Critics might object that this is merely cultural memory or organizational ideology rather than true conscience. However, this objection ignores that profound moral insights often emerge not from individual intuition, but from collective processes of reflection, debate, and tradition-building.

A third view describes *conscience as motivation,* whereby conscience compels us toward moral behavior. Kant described conscience as an "inner court" that generates guilt or self-approval, thereby spurring action (Kant 1797 [1991]: 160). Conscience-motivated action serves several important social functions including the prevention of moral atrophy in professional settings and pushing against institutional inertia by allowing principled dissent. Institutions do not have the same affective experiences of guilt or moral satisfaction that individuals do (we return to a discussion of conscience as an affective experience below), but they can meaningfully embody conscience as a motivational force. Rather than seeing institutional conscience as requiring emotional responses, we can understand it as operating through collective commitment to moral principles that actively guide organizational behavior. For instance, when a hospital refuses to prioritize profit over patient care, or when a university maintains academic freedom despite political pressure, they demonstrate conscience-motivated institutional action. Critics might object that such choices merely reflect policy compliance or strategic decisions. However, this objection overlooks how institutions can develop genuine moral agency through their mission, culture, and decision-making processes. Even if organizations *often do not* explicate these things sufficiently, it is sufficient for our purposes here that they *can do so.* When properly structured, institutional conscience can motivate ethical behavior in ways that transcend both individual conscience (by achieving consistency and scale beyond what individuals can maintain) and mere rule-following (by actively engaging with moral principles rather than just complying with external standards).

Finally, conscience can be conceived as a kind of *moral integrity,* understood as harmony between one's beliefs and actions which culminate in a sense of one's identity. Here, conscience shapes and preserves an agent's identity, which is defined as much or more by moral beliefs than memories or other psychological attributes (Strohminger and Nichols 2015). The value of conscience as moral integrity not only promotes individual psychological wellbeing, but serves critical social functions. These include enabling authentic ethical agency that encourages more thoughtful approaches to ethical challenges and preventing the kinds of psychological and social dysfunction that can occur when individuals are forced to violate their deeply held moral beliefs. This also fosters social trust by allowing people to defect from prevailing norms without being dismissed from a community and it promotes social progress through dissent. Institutions can embody conscience as moral integrity by maintaining alignment between their stated values and actual practices. Institutions lack the psychological continuity of individuals, but they develop identities that are fundamentally shaped by moral commitments. For example, a humanitarian organization that refuses to compromise its neutrality during military conflicts thereby demonstrates institutional moral integrity. Such integrity over time is made possible by organizational memory, governance structures, and cultural practices that preserve core values even as individual members change. Supporting institutional conscience as moral integrity serves important social functions: it enables organizations to counterbalance troubling societal trends, creates spaces where individuals can align work with values, and provides resilience against moral conformity.

Each of these four conceptions of conscience can be meaningfully conceptualized at the institutional level of scale. These accounts of conscience may sometimes appear fundamentally individualistic because they speak of conscience as dependent on attributes we typically think of as belonging to individuals (e.g., ways of knowing or understanding one's self or the world, motivations and intentions, feeling or affect, etc.). But the analysis above illustrates that the essential nature of conscience on any of the four major accounts is not *fundamentally* reliant on an individual's affective experience (see also, Sulmasy 2008). In fact, there is a sufficient institutional analogue for the affective experiences that accompany shame or loss of self-respect. Inasmuch as shame or loss of self-respect constitute a necessary criterion for the exercise of conscience, in the next section we explicate how institutions can meet this standard.

Can Institutions Experience Shame or Loss of Self Respect?

Institutions act as normative systems that do not reduce to the individuals within them. This is why we can speak meaningfully about institutional conscience on any of the four accounts above. As such, institutions can meet the requirement for conscientious objection, where refusal must be based on deeply held values. But what about the common ethical criterion where providing a good or service over a conscience-based objection must lead to the experience of shame or loss of self-respect (e.g. Durland 2011)? Shame and loss of self-respect may seem to represent fundamentally individual experiences, but they have meaningful institutional analogues.

At the individual level, shame or loss of self-respect result from the perception that one has acted in ways decidedly against one's core values. These appear to be fundamentally individualist constructs because they result in poignant affective experiences. Individuals who violate their conscience *feel* ashamed. But the mere fact that individuals experience feelings associated with shame or loss of self-respect does not mean these phenomena are *essentially* affective. As Sulmasy writes (2008, 137-138), "Emotions are associated with conscience, but conscience is not reducible to those emotions… the act of conscience itself is a meta-moral judgment, not an emotion." Particularly where these are operative for conscientious objection, shame and loss of self-respect are experiences of existential crisis, where one does not merely *feel bad* about their behavior, but rather where they are *fundamentally disoriented from self.*[4] Even if individuals experience this disorientation in sentient terms, what is definitive about shame—and which sets it apart from the bad feelings often associated with it, such as guilt or remorse—is that it reflects an existential reckoning between action and identity.

Additionally, in the context of conscientious objection, the "shame criterion" appears to serve a heuristic purpose, setting a threshold of significance in order for a refusal to be protected as an exercise of conscience. That is, not every preference, and not even every value concession, on the part of an actor constitutes a conscientious objection with its corresponding entitlements. When the criterion requiring shame or loss of self-respect are understood as both existential and heuristic in nature, appropriate institutional analogues become clear. While institutions collectively may not experience the *affective* aspects of shame, they can, collectively experience the very same kind of disorientation toward institutional identities.

Sociologists have used the term "anomie" to refer to a collective state of normlessness that emerges when social systems become existentially unstable. Compelling an institution to offer interventions that violate its core values can create precisely this kind of collective disorientation from an institutional identity (what we might think of as a form of institutional shame). We might call this "institutional anomie," which, as used here, describes a situation in which the core identity of an institution would be disrupted by some kind of intrusion (internal or external) that was significant enough to create a sense of normlessness about the core values upon which the integrity of the institutional identity depends.

Anomie represents significant existential disruption to a social system and it can have dramatic consequences. Durkheim (1951[1979]) described how widespread disruption to social norms explained variance in suicide rates in 19th Century Europe. Faith-based healthcare institutions worry about what being forced to provide interventions they consider morally objectionable might do to their collective religious identity, something that motivates not only their various objections to some kinds of procedures, but also, we should remember, motivates such institutions to provide healthcare in the first place (e.g., Brown 2006). The consequences of institutional anomie can result in similar disruptions to secular institutions, including patterns of moral injury, burnout, and compassion fatigue (see Vaccaro et al. 2021). Insofar as they are also value-oriented organizations, secular healthcare institutions have a right to defend their collective moral identity from institutional anomie and its consequences. In the next section, we apply the concept of institutional conscience to two kinds of cases involving neurologically devastated patients.

EXERCISING INSTITUTIONAL CONSCIENCE IN TWO CONTESTED SPACES

One prerequisite for invoking a conscientious objection is that the requested medical good or service must be legal and within the standard of care. (If a requested good is *outside* of the standard of care, or is illegal, then those are sufficient reasons to refuse without invoking conscience.) In the case of patients very likely to remain permanently unconscious from severe anoxic brain injury, providing life-sustaining treatment falls within the current standard of care. Yet many physicians retain strong moral objections to it. Consider the following case:

> BN was an 83-year-old male patient who suffered a cardiac arrest at a residential elder care facility. Chest compressions were initiated nearly immediately, but BN was not ultimately resuscitated until he had arrived at hospital emergency department approximately 17 minutes following initial arrest. Neurological testing performed two weeks apart in the ICU shows reactive pupils, but no purposeful eye tracking and no purposeful body movements. On the 7th day of admission, the patient began having intermittent seizure activity. The attending physician conveyed to the family that the patient has overwhelmingly low odds of recovering consciousness, given the duration of the

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[4] Of course, the terminological debate is not important. If someone were to insist that shame is fundamentally an emotion, it would simply mean we need a different word for the existential dissonance that can characterize both individuals and institutions.

> anoxic injury, along with other indicators, including seizure activity. Still, the family insisted that the patient continue receiving life-sustaining treatment, noting that BN was a devout Christian who believed deeply that God should be the only one who decided when she died. Given the patient's neurological status, grim odds of recovering consciousness, and other frailties, the attending physician wanted to use the institution's nonbeneficial care policy to unilaterally withhold life-sustaining treatment (e.g., tracheostomy, placement of feeding tube). However, the multidisciplinary review required by the policy determined that the life-sustaining treatments were not physiologically futile nor medically inappropriate merely because the patient was very unlikely to recover consciousness.

A physician who attempts to refuse life-sustaining treatment for patients like BN because it is outside the standard of care faces difficulties in justifying their refusal. Life-sustaining treatment would not be futile in this case because it is very likely to achieve its physiological goals. Moreover, it may not be medically inappropriate because there are not clear countervailing ethical considerations (e.g., that it would cause more suffering than benefit or that it is merely serving to prolong the patient's dying process). Instead, the only grounds on which to suggest it might be inappropriate would draw on contested views about the nature of life and whether being "alive" in any meaningful sense requires consciousness. But we generally leave such determinations to the discretion of patients or families (except in cases of futility or clear inappropriateness).

As noted in our previous paper (Wasserman et al. 2025a), this is a space where the refusal of a physician to offer the intervention is better justified as a conscientious refusal. There, we argued that individual physicians can ethically exercise conscientious refusals of aggressive interventions on patients who are likely permanently unconscious based on their deeply held values. For example, a physician may be deeply committed to the reasonable belief that life without consciousness is undignified or inconsistent with the proper goals of medicine, and that providing those interventions therefore render them complicit in an immoral activity. Anyone who has spent some time in a modern healthcare setting is familiar with hearing the rhetorical question from staff when treating these patients, "What are we really accomplishing here?" At our institution, the moral distress of clinicians is apparent when they make statements such as "This is not why I wanted to become a doctor" or "This does not feel like good medicine."

The case above satisfies the criteria for exercising an individual conscientious objection: 1) the physician is acting out of a deeply held value and, 2) would experience shame or loss of self-respect if they were to provide the intervention. Moreover, the objection is not invidiously discriminatory or at least there is reasonable disagreement about this (see Wasserman et al. 2025a). Thus, the exercise of conscience is ethically permissible.

But the same conditions apply at the institutional level as well. This is particularly true if the institution as a whole endorses (or were to) particular ideas about human dignity and/or the appropriate goals of medicine. That is, if an institutional mission and its corresponding values entail a focus on health restoration, function maintenance, experiential capacity as a prerequisite for having "health" itself, or other kinds of salutogenic goals, then the prolonging of the life of a patient in a permanently unconscious state might easily conflict with those institutional values. In turn, the institution could legitimately enact wholesale prohibitions on aggressive interventions, in the same way that faith-based institutions do for interventions that conflict with their ways of conceptualizing human dignity or the appropriate goals of medicine (e.g., pathocentric goals).

The recognition and deployment of institutional conscience will become even more important if current trends continue toward greater deference to pluralism in healthcare generally, and around brain death, in particular. For example, if revisions to the UDDA or corresponding state laws eventually include exemptions for families to refuse brain death testing or declaration, then the mechanism of institutional conscientious objection will become an especially important protection for some healthcare institutions with deeply held moral objections to providing organ support to these patients.

Moreover, it is not difficult to imagine the level of institutional anomie that could arise from a hospital culture, already stressed from what many view as excessive deference to family demands, who are now being asked to provide interventions for patients that have been declared dead. This care can continue for days, months, or even years. One can imagine not only individual reactions from physicians with conflicting values, ("This is not why I wanted to become a doctor"), but also from institutions themselves ("This is contrary to our mission to promote wellness and dignity").

Indeed, we do not have to imagine such a scenario at all; we have seen the moral distress and moral injury that occurs in such cases:

> In October, 2019, a 16-year-old boy named Titus Cromer was transferred to Beaumont Hospital – Royal Oak with a severe brain injury (Shamus 2020). Testing later confirmed brain death and the hospital

> sought to remove his ventilator. The boy's mother objected and ultimately appealed to the court, which issued a temporary restraining order mandating that the current interventions, including mechanical ventilation, should continue until a full hearing. Following numerous adjournments which delayed the hearing date by nearly 3-months, a mutual agreement between the family and hospital saw Cromer transferred to a rehabilitative facility, where he experienced cardiac failure four days later (Shamus 2020). During his hospitalization, staff reported significant moral distress about continuing to provide aggressive interventions given his neurological status. In the months and years since, the case is commonly cited by healthcare teams within our system as evidence that use of the institutions non-beneficial care policy will fail in the face of resistant families and sympathetic judges.[5]

Conscience, at both the individual and institutional levels, may be the only counterpoint to this kind of insurgent medical pluralism. An appeal to harm (material, as opposed to dignitary), for example, does not provide sufficient justification for a refusal of aggressive interventions. After all, as with permanently unconscious patients, patients who are dead by neurological criteria have no conscious awareness through which to experience (material) harm. Clinicians do not feel moral distress when treating neurologically devastated patients because they believe they are experiencing pain or suffering. Rather, it is practicing medicine in a way that is morally complicit in indignity (Wasserman and Navin 2022).

Instead, these institutional conscientious objections can appeal to their core collective values in the same way that faith-based institutions commonly do. Just as the value of life without consciousness is currently contested, pluralism about the definition of death may soon become broadly legitimized in ways that would allow patients and families to require hospitals to continue treatment for patients pronounced dead by neurological criteria. Amidst such pluralism, conscience claims present a stronger standard for protecting the moral commitments of some secular institutions. No judge would think of compelling a Catholic institution to provide treatments that violate its view of human dignity, even when those treatments are legal, within the standard of care, and requested by patients or families. The same respect and legal protection should also be extended to the core values of secular institutions.

There are numerous objections that have been raised to the legitimacy of conscientious objection in these kinds of cases. In brief, it has been suggested that refusal of aggressive interventions for neurologically devastated patients does not resemble typical kinds of conscience claims (e.g., abortions) (Antommaria 2025) or that because it would result in the death of a patient, it should be viewed as especially harmful and therefore impermissible (or at least viewed with significant suspicion) (Eberl 2025; Fleck 2025). Finally, some have worried that such refusals violate the people/procedure distinction (Mansoori 2025). Many of these objections would apply to the exercise of institutional conscience as well, but we have already addressed them (see Wasserman et al. 2025b).[6]

However, there are at least two additional objections uniquely aimed at *institutional* conscience. The first is that society gives hospitals many financial and legal privileges and, in turn, hospitals must provide legal and professionally accepted medical goods and services (Giubilini et al. 2025; Rhodes and Danziger 2018). This critique could be leveraged against individual providers as well, who often received public funds and whose practices are secured by a social contract under which they are provided protected practice spaces (Cruess and Cruess 2004; Symons and Chua 2024). Additionally, Symons and Chua (2024) argue that there is no expectation to provide all legal and professionally accepted services in exchange for state support. Indeed, faith-based institutions, which commonly exercise institutional conscientious objection, have been transparent with the state about medical goods as services they will not provide. The state is able and willing to tolerate reasonable variances based on institutional value commitments. Moreover,

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[5] Information about the patient and his medical condition were reported publicly in the press, as cited. Information about the reactions and outcomes for the staff are our own first-hand experiences as clinical ethics consultants.

[6] In brief, merely because conscientious objection looks different in this case does not present any principled reason for its impermissibility; the important question is whether it meets the ethical prerequisites for the exercise of conscience. Additionally, the notion that such refusals are impermissible because they may result in the death of the patient (or their organ cessation) relies on a harms analysis that presumes a kind of "death exceptionalism." But reasonable physicians or institutions can and do disagree with the idea that death is an ultimate or special kind of harm. Therefore, to suggest that a refusal is impermissible merely because it results in the death of a patient implicitly relies on reasonably contested underlying values and it is in precisely in spaces of such reasonable disagreement that conscience should be decisive (see Wasserman, Brummett, Navin, and Menkes 2025b). Finally, we have elaborated how such refusals do not violate the reasonable interpretation of the people/procedure distinction where conscience-based refusals should not be based on objections to *protected* classes of people, organized around characteristics that are clinically irrelevant, not the unreasonably broad interpretation where "class of people" is defined as any group that can be named as such. As such, we have argued that refusals of interventions of the sort discussed here do not constitute invidious discrimination of the sort that should be prohibited (see Wasserman et al. 2025a).

if it were not, it would need to apply this standard equally across faith-based and secular institutions.

Other critics of institutional conscience also worry about increased risk of conscience monopolies, where accepted goods or services are simply not available because all accessible providers have refused. Symons and Chua (2024) note that this objection begs the question by assuming that it harms patients to deny them contested services such as abortion or emergency contraception. Similarly, regarding neurologically devastated patients, this would assume particular conceptions of dignity, harm, etc., around which there is legitimate, intractable disagreement in the first place. Inasmuch as there are reasonable disagreements about what human dignity is, and what it requires of us, different conceptions of it can supply a moral basis for the exercise of conscience at both the individual and institutional levels. Finally, if the state believes there is an obligation to provide these contested services, then the state could establish clinics that provide them. Like individuals, institutions that exercise conscientious objections certainly have an obligation to give notice of the medical goods and services they do not provide (Reis-Dennis and Brummett 2022), but it is not clear why such institutions are obligated to provide these services in lieu of other means by which they could be provided.

Another important objection centers on the tension between access and conscience. That is, we should worry that the exercise of conscience inappropriately limits access to a good or service that, after all, and by definition, falls within the standard of care and is commonly accepted. As Berlinger (2008, 35) writes, "Conscientious objection in health care always affects someone else's health or access to care because the refusal interrupts the delivery of health services. Therefore, conscientious objection in health care always has a social dimension and cannot be framed solely as an issue of individual rights or beliefs." Objections related to access are also magnified when we move from the individual to the institutional level because they constrain a whole set of providers. However, while the availability of a commonly accepted good or service certainly acts as a constraint on the exercise of conscience, it does not preclude it altogether. Indeed, the AMA (2025) notes that "physicians have *stronger* obligations to patients…when the patient is not reasonably able to access needed treatment from another qualified physician" (italics added), but it stops short of saying this obviates conscience rights altogether. Thus, arguments from accessibility will have to be considered when organizations enact institutional conscientious objections. But this only means that the strength of an institution's conscience claims will have to be weighed in the context of the wider availability of the kinds of interventions refused. Moreover, the existence of access-driven constraints does not mean that institutions cannot exercise conscience, but may instead mean that hospitals that invoke conscience have a stronger obligation to refer patients or to otherwise promote their access to interventions the institution refuses to provide.

Finally, as with other critiques of secular institutional conscience, concerns about conscience monopolies apply equally well to faith-based institutions, where, as noted above, conscience rights have been nonetheless supported. While arguments about impermissible access constraints may ultimately win out in a pragmatic analysis about whether any given institution, operating within a particular social and community context, *should* exercise a conscientious refusal, this does not mean they are not (or should not) be able to do so *by virtue of the fact that they are institutions.*

Finally, one might worry about bad faith exercises of conscience by institutions, where, for example, they might launder concerns that are really about financial costs or other considerations through post hoc rationalizations that invoke a language of conscience. This is a legitimate worry, but the objection is non-unique; all conscience claims, individual or institutional, could be corrupt in this way, and discriminating between genuine and disingenuous claims is always difficult. Thus, unless we want to eliminate all conscience rights, we inevitably will have to tolerate high degrees of epistemic uncertainty, though that certainly does not mean we cannot subject them to interrogation (and we should).

CONCLUSION: FURTHER IMPLICATIONS OF SECULAR LEGITIMATING INSTITUTIONAL CONSCIENCE

Above, we make a case that institutional conscience is a legitimate construct, not merely a metaphor for a fundamentally individual phenomenon. But although it is under-developed and under-utilized within the secular context, the right to institutional conscience is widely recognized and legally protected for faith-based institutions. U.S. Catholic hospitals, for example, operate under the Ethical and Religious Directives, which prohibit abortive, sterilizing, or contraceptive goods or services (United States Conference of Catholic Bishops 2009). These treatments are generally within the standard of care, but refused by entire Catholic health systems on the grounds that they violate the view of human dignity endorsed by the institution. These healthcare systems do not justify their refusals by objectivist claims over debatable constructs about what is medically appropriate or in the patient's best interest. Instead, they point to the fact that certain treatments undermine the core values of the institution.

Of course, we have only applied the concept of institutional conscience to two kinds of neurologically devastated patients, but the implications of our arguments may extend further into various other kinds of cases. If so, institutions may be able to engage in wholesale refusal of other kinds of professionally accepted goods or services. Put another way, legitimating secular institutional conscience may have implications of any number of kinds of interventions that are not considered here (e.g., performing CPR for a dying patient when the family demands it). However, this is not an objection to our arguments per se. The consequences of legitimating institutional conscientious objection may indeed be problematic, particularly in terms of access to widely accepted kinds of medical care. But such considerations act as a constraint on the exercise of conscience and so different kinds of situations each need to be evaluated on their merits and within their own practice contexts. Finally, merely because we do not like the implications of an argument does not weaken the argument itself. Instead, it calls for rigorously working through its nuances and identifying ways to render practices both coherent and functional. Indeed, it is perfectly coherent to accept that it is permissible in principle for institutions to exercise collective conscience and still think there are countervailing pragmatic reasons for them not to do so (e.g., because the consequences would be especially bad). However, in the case of profoundly neurologically devastated patients, we believe that it is plausible that institutions could collectively exercise wholesale conscientious refusals of aggressive interventions in ways that protect their missions and values and mitigate institutional anomie and moral distress.

Ultimately, the argument for institutional conscience is at least as defensible for secular institutions as it is for religious ones. Put another way, the only coherent way to reject the legitimacy of secular institutional conscience is to reject institutional conscience altogether, something which seems untenable given the expanding value pluralism of the contemporary social landscape generally, and within the health landscape, in particular. Indeed, scholars defending the institutional conscience claims of faith-based institutions have recognized that the same justifications apply to secular organizations. While defending Catholic institutional conscience, for example, Bedford (2012, 413) notes, "arguments in support of the concept do not see institutional conscience as a solely religious phenomenon."

The expansion of patient choices related to abortion following *Roe v. Wade* were immediately met with accommodations for physicians *and institutions* who had moral objections (as exemplified in the Church Amendments 1973). Similarly, the movement toward deference about treatment choices for patients who are likely permanently unconscious and the growing pluralism about the definition of death, will require corresponding recognition of the conscience rights of both clinicians and institutions. Both are moral stakeholders for whom aggressive interventions might conflict with deeply held values. Justifying the refusal to provide aggressive treatment for patients who have a negligible chance of ever again experiencing the world around them with contested notions of best interests or medical futility have proven unreliable. Instead, institutions should leverage their core values as a stronger justification for refusing aggressive interventions in these cases.

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