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Philip Mongan
Radford University, pmongan@radford.edu

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Radford University

ABSTRACT

Recently, several states have passed legislation allowing conscientious objection for social workers. Due to the potential impact on the profession that these policies carry, it is critical that this issue be explored and discussed within the social work profession. This article examines the arguments for and against conscientious objection, discusses the use of conscientious objection in other professions, and then explores the potential options and consequences for social work. The argument is made that the profession of social work should seek to define itself and its values related to conscientious objection before outside forces make the decision for us.

Key Words: Social Work, Ethics, Conscientious Objection, and Religious Liberty Laws.

Introduction

Over the past several years' battle lines have formed regarding religious freedom and the rights of certain marginalized groups. These included: *Burwell v. Hobby Lobby* (2014), which pitted government mandated contraceptive care versus the deeply held religious beliefs of a closely held company (i.e. a company that does not have a readily available public market for trading shares); *Obergefell v. Hodges* (2015), which resulted in recognition of same-gender marriage; and, *Masterpiece v. Colorado Civil Rights Commission* (2017), which could result in the ability of business to deny services due to deeply held beliefs. Inevitably, the escalation of the social issues surrounding religious liberty and equality has resulted in the recent adoption of religious liberty laws that attempt to protect individuals with closely held religious beliefs from being forced to violate their moral code by providing services to a population that engages in behavior they find immoral or abhorrent. Historically, the social work profession has been on the side of fighting for marriage equality, and ending discrimination based on sexual orientation or gender identity. However, this new battlefield has resulted in the introduction of policies that aim to provide social workers with the right to refuse services to an individual that engages in behaviors that violates deeply held beliefs of the social worker. Such bills in various stages of passage can be found in Tennessee (HB 1840), as well as Mississippi (HB 1523). Other variations of religious liberty laws have been attempted in Georgia (vetoed by the Governor), and North Carolina (signed into law but subsequently repealed). These various policies illustrate is that the fight between religious liberty and equality continues to intensify, and it is the opinion of the author that it is only a matter of time before other states follow suit and introduce similar legislation.

This conflict has put the social work profession in the precarious position of having to take a stance on whether to make clear that social workers will be held accountable for their actions if they refuse service due to a deeply held belief, or to allow their members to exercise their legal rights if they do deny service in a state where it is allowed. Regardless of the decision the profession will ultimately make, the battle lines have been drawn and the profession has little choice but to formulate a position, and

create subsequent policy to support that decision. This paper outlines the arguments supporting and opposing conscientious objection (i.e. refusing service due to a deeply held belief) in social work, and explores the possible routes and outcomes for selecting a course of action. Arguably, the most devastating route would be for the profession to not take a stance on religious liberty and equality, and thereby let society decide the values our profession will uphold.

Conscientious Objection

People are likely most familiar with conscientious objection (CO) in regard to the draft and military service (Chavkin, Leitman, & Polin, 2013). However, that it is beyond the scope of this paper to cover the history of CO with military service. It has only been within the last few decades that CO due to deeply held beliefs of those in non-military professions have become a national debate. Social work has been able to avoid much of that debate by making it clear that it is unethical to discriminate against certain populations, and reinforcing the belief that social workers must, "uphold the profession's values" (Reamer, 2006, p. 37), even if those values conflict with deeply held personal values. It is also important to note that the profession still allows social workers to practice in agencies that *may* deny service based on that agency's deeply held beliefs, or earn degrees from accredited institutions that may have policies antithetical to social work values.

In instances of an inability to resolve differences between personal and professional values, it is not uncommon for professionals to find a new profession. As Strom-Gottfriend (2007) notes:

> When we accept membership in a profession, we also accept the values and standards of that profession as they are put forth through codes of ethics and our professional organizations' credos. The process of professional acculturation helps people decide if they can embrace the values and standards of their chosen fields. Those who find themselves in constant conflict with the core beliefs of the profession must reflect seriously on their suitability for the field they have chosen. (p. 12)

Despite the historical impetus to either accept the values of the profession or be encouraged to find a different line of work, it is still important to examine social work's place among the other professions in regards to conscientious objection. This section explores the role of conscientious objection in law, nursing, medicine, and pharmacy.

Law. One profession that provides some level of discretion in regard to accepting clients is law. As can be seen throughout the *Model Rules of Professional Conduct* (2015), lawyers and firms are provided with opportunities for declining or terminating representation if the client is engaged in "repugnant" behavior, or if the lawyer's ability to provide counsel would be limited due to a conflict in beliefs (Spahn, 2011). The rules also outline a clear differentiation of a lawyer's personal view from those of their clients. For example, Rule 1.2(b) states, "A lawyer's representation of a client, including representation by appointment, does not constitute an endorsement of the client's political, economic, social or moral views or activities".

Instead of forcing a lawyer to accept a client regardless of any conflicting personal belief, the onus is placed on each lawyer to assess whether or not they can provide adequate legal counsel. If the lawyer believes the client is engaging in repugnant

behavior, they are provided an outlet for discharging that client. However, as Spahn (2011) notes, that is an unusual occurrence since there is an honor in the profession in representing clients, which are considered outcasts. Put another way, law prides itself on working with clients, even if others may find them repugnant. One only has to examine John Adams defending the British soldiers who perpetrated the Boston Massacre in 1770 to see the historical significance of defending the "bad guy" that is present in the profession.

Nursing. Although conscientious objection in nursing is still highly controversial, and disapproved of by a majority of nurses, it remains an option (Davis, Schrader, & Belcheir, 2012). This is especially true in relation to areas such as reproductive healthcare and palliative care (Lachman, 2014). In part, this is due to the moral distress caused if a nurse is forced to go against a deeply held belief, as well as the consequences that the distress can have on the profession (Beil & Breslin, 2008; Epstein & Delgado, 2010). According to the American Nurses Association *Code of Ethics* (2015) conscientious objection is allowed:

> When nurses are placed in circumstances that exceed moral limits or that violate moral standards in any nursing practice setting, they must express to the appropriate authority their conscientious objection to participating in these situations. When a particular decision or action is morally objectionable to the nurse, whether intrinsically so or because it may jeopardize a specific patient, family, community, or population, or when it may jeopardize nursing practice the nurse is justified in refusing to participate on moral grounds. (p. 21)

As can be seen in the above statement, the idea of conscientious objection is not just tacitly approved in the nursing profession, but laid out specifically in their ethical code. Despite the clarity in the code of ethics, nurses cannot object to treating a patient for reasons that are not clearly morally objectionable, such as to only serve self-interest (Lachman, 2014). That difference between morally objectionable and serving self-interest is important to note since nursing may allow conscientious objection regarding abortion services, but not abortion aftercare (Dickens, 2001). These intricacies demonstrate that nursing has found an option to provide some discretion to those nurses with deep personal beliefs, while still maintaining the values and goals of the profession.

Medicine. Physicians have the longest history of acceptance and application of conscientious objection (Dickens, 2001). This ranges from reproductive healthcare (Shaw & Downie, 2014), to palliative healthcare and capital punishment (Chavkin et al., 2013). According to the American Medical Association *Code of Ethics* (2014) section 10.05(3)(c), a physician may refuse service to a patient if, "A specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs". There is even a strong argument that the Hippocratic Oath supports the use of conscientious objection by physicians (Dickens, 2001).

Despite the medical acceptance of conscientious objection, there are some requirements for physicians who utilize that option. As Dickens (2001) notes, physicians who object to certain treatments should provide a referral to someone who does not have the same objections. Physicians should also make an effort to make their conscientious objections clear at the forefront of treatment, so that patients are aware and can seek treatment elsewhere for issues that the physician may object to. However, despite the rich history of conscientious objection within the medical field, the conditions under

which physicians may conscientiously object (e.g. reasonability requirement, genuine requirement), and requirements for those who do object, is hotly debated (for example see Card, 2014; Dickens, 2001; Kaczor, 2012; Kantymir & Mcleod, 2014; Marsh, 2014).

Pharmacy. Arguably, pharmacist's use of conscientious objection is the most controversial of all the professions discussed in this article. Unlike physicians, there has not been the historic support or tradition of refusal of service in pharmacy (Grady, 2006). Some arguments are even made that pharmacists have an obligation to service patients, and that obligation "override claims of conscience" (Wicclair, 2006, p. 225). As Grady (2006) further discussed, this new integration of conscientious objection has led to conflicting state policies, putting pharmacists in an uncomfortable position of not having a clear policy in which to follow since it may vary from state to state, and from nation to nation. For example, Great Britain allows pharmacists to refuse service for reasons of conscience, as long they provide an appropriate referral to the client (Deans, 2013).

Like most of the other professions discussed in this article, contraceptive medicine is the main issue in which conscientious objection is exercised (Chavkin et al., 2013; Grady, 2006; Shaw & Downie, 2014). The opposing side of the argument on the inclusion of conscientious objection involves – on one side – the ethical standard of respecting autonomy and the dignity and worth of a patient as stated by the American Pharmacists Association *Code of Ethics*:

> A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.

On the other side, some pharmacists argue that not only should pharmacists be allowed to object to delivery of some contraceptive medications, but that, "…a pharmacist is obligated to refuse to dispense contraception" (Kinney III, 2012, p. 675). While that may appear to be an extreme view to some, it provides a clear illustration of a deeply held belief. It would not be hard to imagine the potential for moral distress if that pharmacist was forced to dispense medication that they believed was morally reprehensible.

Arguments against Conscientious Objection

If the social work profession is going to adopt the stance in which conscientious objection is not allowed, which would sharply contrast social work from the other professions discussed, it is imperative that arguments against its inclusion are well constructed and defensible. This section lays out two of those arguments, which include limited availability of social workers, and professional growth. The section also explores the values argument, and posits that this argument is less defensible despite its historic popularity in defense of denial of conscientious objection to social workers. While the two arguments discussed are not exhaustive, they provide a defensible base for its exclusion.

The first argument against conscientious objection surrounds the limited availability of social workers and the subsequent negative impact on client access. Unlike previous professions discussed, there are frequently few social work options for clients under normal circumstances. This mismatch would almost certainly lead to even fewer clients receiving services if social workers exercised conscientious objection options. Unlike law, which has an almost universal professional honor in working with clients viewed as deplorable by society, social work does not possess that badge of honor

across the profession. Without that extra motivation to see those clients, it is unlikely some clients would be provided with services.

The limited availability of social workers would be further exasperated due to billing restrictions with some payer sources. For example, if a payer source requires a licensed clinical social worker in order to bill for services, the permission to conscientiously object to certain clients would burden agencies that may not have an abundance of licensed social workers in which to transfer those clients. If the agency did not possess another appropriately licensed social worker willing to see those clients, the next logical question would be whether the extra cost – since the insurance would be unbillable – would be the responsibility of the agency or directly billed to the client. With the possibility of clients or agencies being forced to cover the costs associated with an individual social worker refusing to see a subset of clients, it is no longer is a decision that only impacts the conscientious objector.

A second reason for denying social workers the ability to refuse service to clients due to deeply held beliefs relates to the personal and professional growth of each social worker. In order to learn to work with clients who come from different backgrounds, a social worker needs to be exposed to cultures that may challenge deeply held beliefs. If a social worker is allowed to operate in a personally selected silo of clients, it is unlikely that the social worker would be required to work through those challenges, which would inevitably stunt growth as a professional (Strom-Gottfried, 2007). For example, a social worker that engages with and works with a client previously convicted of a sexual crime may come to the realization that despite previous behavior, everyone has dignity and worth. This realization may not occur if one always opted out of working with this 'class' of client. Additionally, a social worker who choices not to work with a same-gender couple may become stunted in professional and personal growth as it relates to the diversity of couples.

The values argument. Arguably, the most popular argument that is used to justify the exclusion of a conscientious objection option for social work is the values argument. This argument is based on the premise that the very foundation of the social work profession lies in the values that have shaped the profession (Levy, 1976). Therefore, to exclude any client or subgroup of client would inherently violate the values of our profession, such as social justice and the dignity and worth of a person (National Association of Social Workers, 2007). This section will lie out the argument for why using professional values to exclude a conscientious objection option may be undesirable, as it is less defensible than the previous arguments.

The formal introduction of core values to the NASW *Code of Ethics* did not occur until the 1999 code was released (Reamer, 2006), and have since become a major piece of social work education (Croxton & Jayaratne, 1999). However, that is not to say that values have not played an integral role in defining the profession. After Flexner's (1915) scathing presentation on why social work was not a profession, social work spent the next several decades attempting to define itself in a way that would justify its inclusion as a bon-a-fide profession (for examples see Bartlett, 1958; Brieland, 1977; Gordon, 1962, Gordon, 1965a; Gordon, 1965b; NASW 1958). Throughout this process, values emerged as a cornerstone of social work practice (Boehm, 1958; Brieland, 1977; Gordon, 1965). Therefore, an argument is frequently made that due to the historical significance of values in the social work profession – and because refusing service violates one or more of those

values – practitioners cannot conscientiously object to serving clients due to a deeply held belief. However, that argument proves difficult to defend due to its assumptions that other professions, which do allow conscientious objection, are not based in similar values. An argument can also be made that conscientious objection could be achieved without the social worker directly refusing to serve specific clients, which would eliminate the appearance of direct discrimination by the individual worker. Much in the same way it is the responsibility of physicians to openly disclose objections before treatment.

If an argument is made that social workers cannot deny service due to the values of the profession, the assumption is that our values are somehow different and play a more integral role in service delivery than the other professions that allow conscientious objection. In reality, this assumption is false. For example, medicine heavily values autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2012). As another example, the first provision in the nursing code of ethics states, "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person" (American Nurses Association, 2015, p. 1). As can be seen, both nursing and medicine value nearly the same principles that social work does, and yet only social work does not allow conscientious objection. Besides sharing common values, these professions also share a duty to treat (Sweifach, 2011), with the primary difference being that the non-social work professions accept that if a practitioner is faced with a client that challenges a deeply held belief, it may elicit moral distress and not be in the best interest of the client or provider to engage in treatment if the conflict cannot be resolved (Davis et al., 2012; Zuzelo, 2007).

Another reason that the value argument should not be used is that it is dependent on the assumption that there must be a direct refusal of service between the social worker and the client if conscientious objection is permitted. Put in a different light, this is also the argument that is frequently given to say that denial of services equates to discrimination. However, as with other professions that allow denial of service, there is a method for allowing practitioners to not violate deeply held beliefs without that worker having to directly refuse seeing the client, or being accused of being discriminatory against them. As Kaczor (2012) notes, "conscience protections do not empower individuals to subordinate others to their preferences, since denial …does not necessarily mean that the doctor's preferences will be realized" (p. 61). An argument can also be made that refusal of service by a provider does not mean that the entire profession of that provider objects to that treatment (Kaczor, 2012). Therefore, as long as appropriate referral options are available, the need of the patient is still met.

Conscientious objection could also occur at the agency level, before assignment to a practitioner, in order to minimize the effects of the worker refusing to provide service. There can be little doubt that a client being told by their social worker that they cannot see them due to deeply held beliefs would be traumatizing. However, there are policy responses available, which simultaneously allow conscientious objection as well as minimizing negative consequences from that option (Chavkin et al., 2013). One of those options is the registration with the state board and/or requiring providing notice to employers of conscientious objection. This option would allow clients to select appropriate social workers, as well as provide employers with information in which to appropriately assign clients. Another option is to forbid conscientious objection in cases

or agencies where there is not another worker available to see the client. Since that limit would be known by the agency and provider before a client is seen, the social worker would know beforehand that conscientious objection was not an option. Either of these policy responses provides the agency options that minimize the potential negative effects of conscientious objection.

Arguments for Conscientious Objection

It is important to also provide an unbiased discussion of the reasons for adopting conscientious objection. The argument that supports the inclusion of conscientious objection is that it supports the wellbeing of the professional. Being able to refuse service due to a deeply held moral or religious belief provides protection from moral distress (Davis et al., 2012; Zuzelo, 2007), and supports the liberty of the practitioner (Savulescu, 2006). Moral distress can be defined as a violation of moral integrity, which leads to various negative emotions, such as helplessness, anger, and frustration (Davis et al., 2012). Repeated instances of moral distress can lead to burnout, and therefore directly impact the delivery of service. Other professions allow this type of refusal of service and yet have long histories of fighting for values such as justice, autonomy, and dignity and worth of the client. The difference is that they apply those principles not only to the clients, but also to the practitioners. Stated differently, in order to respect values such as justice and worth with clients, one must also respect professionals who serve those clients.

The second argument for conscientious objection is that it helps support the wellbeing of the profession. Many professions, including social work, struggle with not having enough practitioners to serve the population (Chavkin et al., 2013). Therefore, when a group of practitioners experience repeated examples of moral distress, they may leave the profession; thereby, further compounding the problem. In addition social work already provides exceptions for social workers practicing in private agencies to exclude certain clients or treatments due to religious beliefs. Hence, it could be argued that the profession could increase the number of professionals if they equally applied those exceptions to the profession as a whole by incorporating conscientious objection.

The Three Possible Paths

Ultimately, the profession of social work has three possible options for conscientious objection. We can either eliminate it as being an option for social work let state governments and courts decide the outcome for us, or we can incorporate it into the profession with the appropriate policy responses in order to minimize its negative impact on clients. This section explores those three options, as well as possible outcomes for each of the choices. In addition to that discussion, several of the policy responses that could be included with the final option are also provided in order to illustrate how a comprehensive conscientious objection policy could look for the social work profession.

The first option for the profession is to take a strong stance against conscientious objection, and explicate that social workers will not be allowed to use it, even if states make such options legal. Mississippi House Bill 1523 or Tennessee House Bill 1840 (both signed into law) are both examples of state policies that make it legal for counselors to refuse service for deeply held beliefs.

If the complete refusal option were used, the likely outcome would be a social worker exercising one's legal right to refuse service, and subsequently having their

license suspended, or being forced to undergo additional training or supervision. This would lead to that social worker having legal standing in which to pursue litigation against the state board. Since, "professional organizations' positions are not legally binding" there is a real possibility the lawsuit could be lost, and the profession forced to adopt a position they had previously taken a strong stance against (Grady, 2006, p. 329). One only has to look at settlement and fallout of the Brooker lawsuit against the University of Missouri – due to punishment over the student's stance on same-gender adoption – or *Ward v. Polite et al.* (2012), in which the 6th Circuit court overturned the expulsion of the student, in order to see the possible fallout from legal action. In regards to *Ward v. Polite et al.* (2012), which settled out of court, the 6th Circuit did state that there was not an issue with the educational institution having a policy that does not allow transfers based on value differences between the counselor and client. However, the court also stated that the profession "adheres to an ethics code that permits values-based referrals in general" (p. 3). This interpretation of the NASW *Code of Ethics* by the court may prove increasingly important if litigation is pursued due to consequences from utilizing state supported conscientious objection. Ultimately, if the profession decides to take a strong stance against conscientious objection, social work must also prepare for the litigation that will certainly follow, and accept the possibility of being forced to adopt a position the vast majority of social workers do not agree with (Sweifach, 2011).

The second option is to let the state governments and courts decide the viability of conscientious objection for the profession. In many ways, this would be similar to exceptions provided to for-profit agencies that maintain the religious freedom to not serve certain clients. With this option, social work could maintain a public stance against conscientious objection while still providing exceptions to workers in states that provide religious liberty protections. At first blush this option may appear to provide a win-win situation for the profession, since social work would avoid taking any hard stances either way. However, the down side with this choice is that it depends on a minority of states adopting religious liberty laws, and the positive outcomes of any potential Supreme Court case that may arise due to conflicting state policies. Another negative consequence with this option is that it takes the ability to define the profession out of the hands of social workers, and puts it in the hands of states and courts. With the previous hundred years of intense debate and discussion involving how social work is defined, it would be counterproductive to now let other entities define our values for us.

The third option is to follow in the footsteps of other professions in order to allow social workers the option to conscientiously object. This option does not inherently mean that conscientious objection need be incorporated carte blanche, and indeed no profession allows refusal of service to rise to that level. It would be reasonable to include limits to objection, as well as to incorporate either – or both – the reasonability requirement and genuineness requirement. The reasonability and genuineness requirements are two examples of how a profession could put the onus on the practitioner to support their conscientious objection to serving a particular client. With this approach, any refusal of service must be supported and meet a certain level before it would be considered valid (Marsh, 2014). The reasonability requirement states that an objection must be deemed reasonable by an outside committee in order to be valid (Card, 2011). The genuineness requirement is essentially the same, except that the practitioner must demonstrate to a committee that their conscientious objection is genuine (Myers & Woods, 2007). Marsh

(2014) defined genuine as, "…a deep feature of their person and not a cover up for questionable biases or prejudices" (p. 313).

The other importance limits on conscientious objection would be the exceptions in which refusal of service would not be allowed. The primary exclusion, which is also present in current religious liberty policies, is that a practitioner cannot refuse emergency treatment. For example, Mississippi HB 1523 does not allow conscientious objection for emergency treatment, which would include clients actively presenting as a risk to themselves or others. Another limit that could be placed on conscientious objection is that it could be excluded from use when there is not the possibility of referral to another practitioner due to competency requirements, billing requirements, or case load restrictions. An example of this can be found in the 2004 Michigan *Conscientious Objector Policy Act*, which would not have allowed employment termination based solely on conscientious objection, but did allow employers to terminate a worker – provided a 60 day notice was given – if their refusal of service interfered with 10% or more of the hours of duty per week (Grady, 2006).

The final policy consideration that could be incorporated with conscientious objection is the requirement to register or commit in writing the objections to the state board or employer. As was previously mentioned this would provide employers with the knowledge to appropriately assign clients. In regards to private practice, a state listing by the board would provide clients with information to appropriately select a social worker. In addition to providing clients and employers with that knowledge, this policy consideration could also serve to partially meet the genuineness and reasonability requirements, as it would require social workers to publically state their conscientious objection. This public declaration would leave little doubt to an outside committee that serving those clients would indeed violate a deeply held belief of the social worker.

Conclusion

In conclusion, social work has been put in a precarious position of needing to respond to various state policies allowing social workers to conscientiously object to serving clients that may violate a deeply held belief of theirs. Therefore, in order to bring that discussion to the forefront, this article explored conscientious objection as it applies to various professions, discussed the arguments for and against conscientious objection, and discussed the various routes that the profession could take. Ultimately, it would be a mistake for the social work profession to sit back and allow others to define our values and practice without first engaging in that dialog ourselves.

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