Conscientious Objection to Gender-Affirming Surgery: A Cross-Sectional Analysis of Plastic Surgery and Urology Residency Programs

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OBJECTIVE: Medical conscientious objection is a federally protected right of physicians to refuse participation in medically indicated services or research activities that are incompatible with their ethical, moral, or religious beliefs. Individual provider objections to gender-affirming surgery have been documented, however the prevalence of such objections is unknown. Our study aimed to characterize physician objections to gender-affirming surgery in plastic surgery and urology residencies and to assess related institutional policies.

DESIGN, SETTING, PARTICIPANTS: A cross-sectional electronic survey was administered to program leadership of 239 accredited US plastic surgery and urology residencies from February to October 2023. Trainee exposure to gender-affirming surgery, programmatic experience with objections, and presence and content of institutional objection policies were collected. Bivariate analyses were performed to determine associations with objectors.

RESULTS: One-hundred and twenty-four plastic surgery (n = 59) and urology (n = 65) residencies completed the survey, representing a 52% response rate. Most programs included didactic training (n = 107, 86%) and direct clinical exposure (n = 98, 79%) to gender-affirming surgery. Few (n = 24, 19%) endorsed existent objection policies. Sixteen programs (13%) experienced objections to gender-affirming surgery by trainees (n = 15), faculty (n = 6), and staff (n = 1). Neither geographic region, exposure to gender-affirming surgery, nor presence of objection policies significantly contributed to programmatic objections. Programs with formal objection policies reported increased confidence in addressing future objection events (p = 0.017).

CONCLUSIONS: Objection to gender-affirming surgery is a rare, but plausible occurrence amongst plastic surgery and urology trainees. Residency programs should consider anticipatory policies to protect patients and, when feasible, provide reasonable accommodations for objecting trainees. (J Surg Ed 81:1675–1682. © 2024 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights are reserved, including those for text and data mining, AI training, and similar technologies.)

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ABBREVIATIONS: ACGME, Accreditation Council for Graduate Medical Education APD, associate/assistant program director GAS, gender-affirming surgery PD program director

INTRODUCTION

Healthcare providers have a duty to care for their patients, yet there are times when one's personal beliefs may conflict with their professional obligations.[1,2] This concept, formally known as medical conscientious objection, is a right of clinicians to refuse participation in medically indicated services or research activities that are incompatible with their ethical, moral, or religious beliefs.[3-5] In the United States, the first conscience clause was enacted in 1973 in response to the Roe versus Wade decision.[6] Since then, the concept of who can object to providing what kinds of care in medicine has been a legal moving target informed by multiple pieces of legislation, such as the Religious Freedom Restoration Act and Section 1557 of the Affordable Care Act.[7,8] This legislation has sequentially broadened over the past half century to allow healthcare provider objection for *any* reason, except those made on the basis of discrimination.[2,9,10] While commonly discussed in reproductive healthcare, individual reports of medical objection to gender-affirming care have emerged in recent years, paralleling escalating political tensions surrounding these therapies.[2,11,12] Transition-related care has simultaneously become more accessible in many states, thus provider conscientious objection may become more widespread in this context.[13-17]

Limited data exists regarding physician objections to gender-affirming interventions. The current literature comprises 2 relevant case reports of religious-based objections to gender-affirming care by 1 plastic surgery and 1 pediatrics resident. Morrison et al.[11] and Teelin et al.[12] provide management recommendations based on their respective experiences with resident conscientious objection, each stressing the careful balance of medical education, resident autonomy, and – above all – patient care. Morrison et al.[11] further suggest the importance of anticipatory institutional objection policies and procedures. However, there is a lack of national-level data on the frequency and nature of conscientious objection to gender-affirming care, which limits effective policy development.[18]

This study aims to characterize objections to gender-affirming surgery within accredited US plastic surgery and urology residency programs. We also evaluate the availability, content, and role of institutional objection policies.

METHODS

Participant Recruitment

Accredited US residency programs in plastic surgery and urology were eligible for this study. Within plastic surgery, both categorical and independent programs were included. These specialties were selected due to high likelihood of exposure to gender-affirming surgery. Eligible residency programs were identified using the Accreditation Council for Graduate Medical Education (ACGME) website for the 2022-2023 academic year. A 2-pronged e-mail and telephonic recruitment protocol was implemented to enroll a single representative from each program from February to October 2023 (see Supplemental Digital Content 1, which demonstrates the participant recruitment protocol). Eligible participants included program directors (PDs), assistant program directors (APDs), or a PD/APD assigned proxy. A written informed consent was completed by each participant through a separate, nonlinked electronic REDCap survey prior to administration of the research questionnaire. Data were de-identified and stored within the REDCap data management system hosted at our institution.[19] This study was determined to be exempt by our Institutional Review Board (STUDY00004078).

Survey Instrument

A 23-item electronic survey with skip patterns was administered through REDCap to capture program characteristics, trainee exposure to gender-affirming surgery, and programmatic experience with objection and related policies (see Supplemental Digital Content 2, which demonstrates the electronic survey instrument). Of note, each program's specific location (state-of-origin) was intentionally excluded from the research questionnaire to maintain respondent anonymity and limit cross-recognition of responses. Geographic location was instead collected in broad regional aggregates: South (AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV), Northeast (CT, MA, ME, NH, NY, NJ, PA, RI, VT), Midwest (IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI), West (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY).

The survey was developed by multidisciplinary physician specialists in plastic surgery, urology, obstetrics and gynecology, and pediatrics who provide medical and

surgical gender-affirming care. Focus groups were conducted with 5 PDs to establish relevance and understandability of each item. The survey was then piloted, updated, and reviewed for clarity with 8 PDs or APDs until all participants agreed on the structure of the survey.

Statistical Analysis

Descriptive statistics were performed on completed surveys and reported as counts and percentages. Characteristics of programs, policies, and objectors were analyzed via Fisher's exact testing. Program confidence with addressing future incidents of objection to gender-affirming surgery was compared using Wilcoxon rank sum testing. A 2-tailed $p < 0.05$ was considered to be statistically significant. All analyses were performed using R (Version 4.3.2) and RStudio (Version 2023.09.1).

RESULTS

Program Characteristics

A total of 239 ACGME accredited plastic surgery (n = 89) and urology programs (n = 150) were eligible for the study. The survey was completed by 59 plastic surgery and 65 urology programs, representing a 66% and 43% response rate, respectively. The cohort comprised programs from the West (n = 24, 19%), Midwest (n = 36, 29%), South (n = 32, 26%), and Northeast (n = 32, 26%) (Table 1). Region-specific response rates were 65% in the West, 61% in the Midwest, 41% in the South and 50% in the Northeast. Most programs provided both formal didactic training (n = 107, 86%) and direct clinical exposure to gender-affirming surgery (n = 98%, n = 79) (Table 1). Plastic surgery programs were noted to have significantly more didactic (p = 0.001) and clinical exposure (p = 0.002) to gender-affirming surgery than urology programs (Table 1).

Conscientious Objection

Sixteen programs (13%) reported at least 1 incident of objection to gender-affirming surgery (Table 1). The

TABLE 1. Respondent Program Characteristics

	Total N = 124	Plastic Surgery N = 59	Urology N = 65	p-Value*
Geographic Location†				0.876
West	24 (19%)	10 (17%)	14 (22%)	
Midwest	36 (29%)	19 (32%)	17 (26%)	
South	32 (26%)	15 (25%)	17 (26%)	
Northeast	32 (26%)	15 (25%)	17 (26%)	
Integrated or Independent				
Integrated		42 (71%)		
Independent		1 (2%)		
Both		16 (27%)		
Didactic Teaching on GAS				**0.001**
Yes	107 (86%)	57 (97%)	50 (77%)	
No	17 (14%)	2 (3%)	15 (23%)	
Clinical Exposure to GAS				**0.002**
Yes	98 (79%)	54 (92%)	44 (68%)	
No	26 (21%)	5 (8%)	21 (32%)	
Any Conscientious Objection Policy				0.514
Yes	24 (19%)	12 (20%)	12 (18%)	
No	59 (48%)	25 (42%)	34 (52%)	
Unsure	41 (33%)	22 (37%)	19 (29%)	
GAS Specific Conscientious Objection Policy				0.650
Yes	5 (4%)	2 (3%)	3 (5%)	
No	76 (61%)	34 (58%)	42 (65%)	
Unsure	43 (35%)	23 (39%)	20 (31%)	
Any Objections to GAS				1.00
Yes	16 (13%)	8 (14%)	8 (12%)	
No	108 (87%)	51 (86%)	57 (88%)	

*p-values represent a comparison between plastic surgery and urology training programs. Fisher's exact test was used.
†Geographic locations are categorized as West: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY; Midwest: IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI; South: AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV; Northeast: CT, MA, ME, NH, NY, NJ, PA, RI, VT.

TABLE 2. Program Characteristics by Objector Status

	Total N = 124	With Objectors N = 16	Without Objectors N = 108	p-Value*
Geographic Location†				0.096
West	24 (19.4%)	4 (25%)	20 (18.5%)	
Midwest	36 (29.0%)	8 (50%)	28 (25.9%)	
South	32 (25.8%)	3 (19%)	29 (26.9%)	
Northeast	32 (25.8%)	1 (6%)	31 (28.7%)	
Didactic Teaching on GAS				1.00
Yes	107 (86.3%)	14 (88%)	93 (86.1%)	
No	17 (13.7%)	2 (13%)	15 (13.9%)	
Clinical Exposure to GAS				1.00
Yes	98 (79.0%)	13 (81%)	85 (78.7%)	
No	26 (21.0%)	3 (19%)	23 (21.3%)	

*p-values represent a comparison between programs with and without objectors. Fisher's exact test was used.
†Geographic locations are categorized as West: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY; Midwest: IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI; South: AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV; Northeast: CT, MA, ME, NH, NY, NJ, PA, RI, VT.

majority of these programs reported objection by trainees (n = 15, 94%), while fewer programs reported objection by faculty (n = 6, 38%) and staff (n = 1, 6%). Neither geographic region, surgical subspecialty, nor degree of didactic or clinical exposure to gender-affirming surgery was associated with programmatic objections (Tables 1 and 2).

Program Policies

Twenty-four programs (19%) endorsed formal institutional or programmatic objection policies, whereas seventy-six 59 (48%) programs declined presence of an objection policy. An additional forty-three programs 41 (33%) were "unsure" of institutional policy status, and thus excluded from further comparative analyses.

Of the 24 programs with an objection policy, only 5 (16%) of specifically addressed gender-affirming surgery (Table 1). All 5 gender-affirming surgery policies allowed providers to refuse participation in gender-affirming operations and 2 allowed for objections to preoperative care. No specific policies explicitly allowed for objections to emergent care of transgender and gender diverse individuals. Of the 16 programs that reported at least 1 objection to gender-affirming surgery, 9 (56%) did not have formal institutional conscientious objection policies (Table 3).

There was no significant difference in rates of objection between programs with institutional policies and those without. However, program leadership expressed increased confidence in addressing future incidents of objection at institutions where a formal objection policy was already in place (p = 0.02) (Fig. 1).

DISCUSSION

This cross-sectional study examines physician objections to gender-affirming surgery amongst accredited U.S. plastic surgery and urology training programs. Most programs reported didactic or clinical exposure to gender-affirming procedures. However, only a fraction had

TABLE 3. Program Characteristics by Conscientious Objection Policy Status

	Total N = 83	Policy N = 24	No Policy N = 59	p-Value*
Didactic Teaching on GAS				0.098
Yes	75 (90%)	24 (100%)	51 (86%)	
No	8 (10%)	0 (0%)	8 (14%)	
Clinical Exposure to GAS				0.748
Yes	69 (83%)	21 (88%)	48 (81%)	
No	14 (17%)	3 (13%)	11 (19%)	
Any Objections to GAS				0.350
Yes	15 (18%)	6 (25%)	9 (15%)	
No	68 (82%)	18 (75%)	50 (85%)	

*p-values represent a comparison between programs with and without any conscientious objection policy. Fisher's exact test was used.

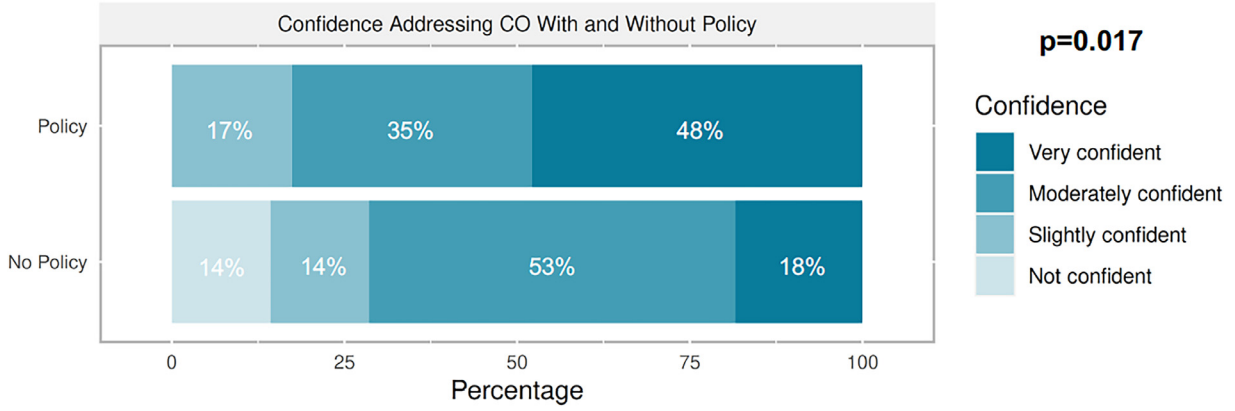

FIGURE 1. Various levels of confidence in addressing future incidents of conscientious objection are depicted after being stratified based on current objection policy status. P-values represent comparison between programs with formal CO policies and programs without formal CO policies. Programs with indeterminate policy status were excluded from analysis.

policies in place to address potential physician objections to these surgeries. Although the rate of objection was low overall, these incidents commonly involved trainees and occurred irrespective of degree of exposure to gender-affirming surgery or policy status, and incidents occurred at programs in all regions of the country. Thus, conscientious objection to gender-affirming care is an important consideration for plastic surgery and urology training programs. Our study also suggests that institutional policies may improve confidence of residency program leadership in managing these situations.

Our findings highlight the evolving landscape of gender-affirming care within plastic surgery and urology residencies over the past decade. A majority of residency programs within our cohort incorporated gender-affirming surgery into their clinical curriculum, far exceeding what has been reported in similar historic studies. Compared to a 2017 study, didactic exposure in plastic surgery and urology grew from 82% to 96.6% and 58% to 76.9%, respectively.[20] Likewise, clinical exposure grew from 66% to 91.5% in plastic surgery and remained stable at 67.7% from 70% in urology.[20]

The current body of literature comprises only 1 case report of resident objection to gender-affirming surgery specifically.[11] Comparatively, sixteen surgical programs in our cohort experienced objections in this context. Three programs reported objection even though they did not report current clinical exposure to gender-affirming surgery, suggesting that even programs without formal clinical exposure to gender-affirming care should recognize that objection may occur with prior, intermittent, or informal exposure. These findings postulate that conscientious objection to gender-affirming surgery is an uncommon, but under-reported issue and residency programs should anticipate objection as a plausible occurrence.[11,12,21-23]

While physicians are ethically bound to uphold the medical pillars of beneficence and nonmaleficence – a duty to do good *and* do no harm, residency programs also have an obligation to be aware of the diverse beliefs of their trainees.[2,24,25] Resident physicians are uniquely vulnerable within the hierarchy of medical education and warrant additional consideration when conscientious objections arise.[12,25-27] Nearly all programs with objection to gender-affirming surgery in our cohort experienced resident-based refusals, compared to a fraction of faculty refusals. This data may represent a true finding or may reflect a sampling bias due to our focus on program directors. Surgical trainees inherently have less clinical autonomy than faculty members and are surmised to encounter procedures that conflict with their beliefs more frequently. Resident objectors may also feel pressured to compromise their beliefs to avoid academic consequences.[12,25-27] As such, institutional policies that provide *reasonable* accommodations to sincere resident objections *without* repercussion are thought to reinforce clinician autonomy and prevent the systematic exclusion of physicians with certain belief systems. Such accommodations must balance physician autonomy, the responsibilities of a training program to create culturally and surgically competent physicians, and patients' rights to timely, equitable healthcare.[2,11,12] Further, gender-affirming surgery is a portion of both plastic surgery and urology training competencies for boards examinations and must be considered.[20,28,29] Thinking through these responsibilities preemptively, which at times can appear competing, is essential.

The impact of objections on transgender and gender diverse patients has yet to be explored. However, objections are generally known to disproportionately affect vulnerable patient populations and, in some cases, serve as a pretext for discrimination.[21-23,30,31] Gender-

affirming care has also faced a rise in criticism and prohibitive legislation in recent years, despite evidence of medical necessity, immense psychosocial benefit, and low rates of regret.[32-37] Objections to gender-affirming interventions may consequentially exacerbate the prejudice that many transgender and gender diverse persons already encounter.[30,31] In response, institutions are poised to implement policies that prohibit refusal of time-sensitive, medically necessary care *and* discrimination on the basis of gender identity and/or sexuality. Although the benefit of such policies on transgender and gender diverse persons is unknown, these stipulations are thought to proactively protect patients, rather than harm them.[11,12] This data sets forth a need for subsequent investigations of patient perspectives towards objection and related institutional policies.

Limitations

This study is primarily limited by the cross-sectional design, targeted evaluation of program directors, and use of a nonvalidated survey instrument. These factors may introduce sampling, recall, and social desirability biases. Consider that our survey may have disproportionately captured resident objections and excluded nonacademic faculty and staff objections, which may account for the higher proportion of trainee objectors. Objection events may also be underreported in cases where program leadership was unaware of the objection. Furthermore, our survey did not capture the quantity of objection events at each institution or the timing or reasoning of each objection. We also excluded the specific state each program was located in to protect the anonymity of participating residency programs, which limited our ability to correlate objection events and policy status with state-specific legislative bans on transgender care. Our data on the availability and/or content of objection policies is also dependent on program leadership familiarity with specific institutional guidelines and procedures. The paucity of institutions with a conscientious objection policy limited the ability to identify robust associations with policy implementation. Differences between responders and nonresponders may have also impacted our findings.

Of note, 3 programs reported objection to gender-affirming care, despite also reporting that residents did not have current clinical exposure to such care. While this may represent a true finding in cases where objectors have previous, intermittent, or informal exposure to this care, it may also reflect insufficient effort on the part of the survey respondents.[38,39] Still, the overall objection rate remained stable (12.9% to 13.3%) if programs *without* clinical exposure to gender-affirming surgery were excluded.

CONCLUSION

Many accredited residency training programs in plastic surgery and urology engage in didactic and clinical training related to gender-affirming surgery, yet few are aware of official policies to address provider objection to these services. While the prevalence of conscientious objection is low in this cohort, these incidents *do* occur and commonly involve resident objectors. Residency programs may benefit from anticipatory objection policies to maintain provider autonomy and ensure equitable, timely, and nondiscriminatory access to care for transgender and gender diverse patients.

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SUPPLEMENTARY INFORMATION

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.jsurg.2024.08.022.