BMJ Open

Factors contributing to practitioner choice when declining involvement in legally available care: A scoping protocol

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To cite: Brown J, Goodridge D, Thorpe L, *et al*. Factors contributing to practitioner choice when declining involvement in legally available care: A scoping protocol. *BMJ Open* 2018;**8**:e023901. doi:10.1136/bmjopen-2018-023901

► Prepublication history and additional material for this paper are available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2018-023901).

Received 29 April 2018
Revised 12 July 2018
Accepted 27 July 2018

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ABSTRACT

Introduction As legislation addressing medical treatments continues to evolve, there are several circumstances (eg, abortion, assisted dying) in which health practitioners may choose to not provide legally available care options. It is not always clear what underlies practitioner choice, as some research has suggested non-participation in care provision is not always due to an ethical abstention but may represent other factors. This results in tension between a practitioner's right to refrain from practices deemed morally objectionable by the practitioner, and the care recipient's right to access legally available treatments. The aim of this systematic scoping review is to identify the current knowledge regarding all the factors influencing practitioner's choices when declining involvement in legally available healthcare options.

Methods and analysis Arksey and O'Malley's scoping framework in concert with Levac *et al*'s enhancements will guide the systematic scoping review methodological processes. English language documents from 1 January 1998 to current will be sought using Medline, CINAHL, JSTOR, EMBASE, ProQuest Dissertations and Theses Global, PsychINFO and Sociological Abstracts. MeSH headings, keywords and synonyms will be adjusted using an iterative search process. Theses and dissertations will be included in the search protocol; however, other grey literature will be accessed only as required. Two research team members will screen the abstracts and full articles against inclusion criteria. Article information will be extracted via a data collection tool and undergo thematic analysis. Descriptive summary (visual summary and study contextual information) and a presentation of analytical themes will align findings back to the research question.

Ethics and dissemination Ethics approval is not required. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses checklist will be used to support transparency and guide translation of findings. Findings will be disseminated through professional networks, in peer-reviewed journals and conferences via abstract and presentation.

Strengths and limitations of this study

- This protocol will be used to identify the current knowledge regarding the factors (of both a conscience and non-conscience origin) influencing practitioner's choices when declining involvement in legally available healthcare practices.
- This protocol is based on valid methodological frameworks, and the review will be conducted using an exhaustive, iterative search strategy with both descriptive and analytical theme outcomes.
- This resultant study may be used by healthcare providers, healthcare managers, ethicists and administrators in planning for ethically safe care and by professional associations in the development of practice standards and supports.
- Limitations in the identified project include differing reasons for non-participation based on profession, cultural and practice area influences, selected databases for data procurement and chosen medical subject headings, keywords and synonyms; in addition, the set exclusion criteria may result in the exclusion of studies of other health professional groups.
- Quality of evidence will not be evaluated in this scoping review.

INTRODUCTION

Practitioner's choice in care participation

Healthcare practice and care options evolve and expand as laws change and as health science and technology advances. Additionally, practitioners and care recipients are morally and culturally pluralistic and diverse. Within this diversity, individual practitioners have dual roles, both as providers of healthcare and as members of society. This necessitates reconciliation of professional roles and responsibilities with personal beliefs and values as healthcare practice options and moral diversity is respected. Healthcare practitioners make choices regarding the care they provide. In some instances, healthcare practitioners engage in conscientious objection (CO); when the refusal to provide a service is based on the belief that doing so is against personal conscience.[1] CO can further be operationalised as non-participation in a legally available healthcare practice based on 'a particularly important subset of an agent's ethical or religious beliefs—[or] core moral beliefs'.

However, it is not always clear what underlies non-participation, as non-participation in care may not always be due to an underlying ethical abstention. Practitioners may choose non-participation for a variety of factors, such as time commitments, workload, emotional investment.[3–6] Additionally, there is a need to distinguish CO from non-participation precipitated by fears (of legal prosecution, judgement from peers, being viewed as among the least virtuous healthcare providers, of causing death) and from non-participation in care that is precipitated by high emotional burden of care, self-interest, discrimination or prejudice.[3 5 6]

A number of healthcare practice areas bring the dialogue of practitioner choice in care participation forward in the literature; pregnancy termination, reproductive technology, genetic choices, end-of-life care practices, assisted dying, organ/tissue donation, harm-reduction strategies and biomedical research. Within the Canadian context, the legalisation of medical assistance in dying has elicited polarising discussions regarding practitioner choice in care participation, CO in addition to factors influencing practitioner's choices in participation in this end-of-life care option.

There are a number of features to consider when considering practitioner's declining involvement in legally available care. The Canada Health Act (1984) specifies criteria and conditions that provinces must conform to for continuation of federal payments; public administration, comprehensiveness, accessibility, portability and universality.[7] These principles are applied across the lifespan and spectrum of healthcare options, including ethically sensitive areas. Care recipients have the right to fair, timely and equitable access to all legally available healthcare services. When practitioners choose not to participate in legally available options, a tension can arise between a practitioners' right to refrain from morally objectionable practices and the right of the care recipient to access these options. The ability to refuse to participate in legally available healthcare option due to reasons of conscience aligns with The Canadian Charter of Rights and Freedoms that protects the fundamental freedom of conscience and religion.[8] Although guidance is provided in a multitude of documents, there is no definitive solution on how practitioners should provide the care recipient with the best care while preserving an internal sense of moral integrity.[1 9] Additionally, there is little guidance on how care provision should proceed when healthcare practitioners object for reasons other than conscience.

Reflections on CO

CO, as both a theoretical and conceptual construct within various practitioner groups and practice environments, is present in academic and clinical literature.[5 10–18] Positions for and against practitioner choice in participation in legally available medical care may be placed along a continuum.[1] On one end is conscientious absolutism, when a practitioner's declaration of CO is morally binding at all times. On the opposite end of the spectrum are those who assert firm upholding of professional norms and standards, or professionalism. This view requires practitioner's moral or ethical values to be considered secondary to the profession's accepted standards and processes. A compromise approach seeks to balance practitioner's CO with the need to uphold the care recipient's rights to treatment and believes the application of CO must be facilitated within parameters.[1] A number of models are available to guide the application of CO, such as the Lynch approach, Wicclair approach, Cantor and Baum approach and the Magelssen approach.[9] These approaches agree that CO can, and should be, facilitated when non-participation in care is based on conscience, moral or religious rationale, and when non-participation in care does not hinder client access to care.[1 9 19–21] Further, when balancing application of practitioners' CO and care recipients' medical needs, processes that create an undue burden on care recipients cannot be condoned.[9 19–23] Literature suggests practitioners are 'divided about whether they ever have a professional obligation to do things they may personally believe are wrong'([2], p.1280) highlighting the concern of practitioner ambiguity in participation or non-participation in legally available care options. Vagueness in conceptualisation and application of CO results in confusion regarding what care practitioners are obligated to provide when conscientiously objecting to care which patients have legal right of access.[24]

This scoping review will look at factors of both a conscience and non-conscience origin that influence practitioner choice when declining involvement in a legally available healthcare practice. The research team guiding this project determined the research question to be 'What is known regarding the factors influencing practitioner choice when declining involvement in a legally available care option?' This information may be used to summarise current state of the literature, identity gaps in knowledge and policy as well as inform and support future areas of practice.[25] A search of the International Prospective Register of Systematic Reviews[26] does not reveal an ongoing review in this area. This scoping review will be undertaken by a review team of four, including a librarian, one physician and two registered nurses.

METHODS AND ANALYSIS

Scoping reviews are useful to map key concepts and to examine emerging knowledge when it is unclear what detailed questions are required in the area of study.[27] They are also useful to identify knowledge gaps and report on the available knowledge to inform a practice area or topic.[27] These offer substantive reason to undertake this scoping project in relation to factors contributing to practitioner choice in participation or non-participation in legally available care. This scoping review will use Arksey and O'Malley's framework which identifies the scoping methodological stages of (1) identifying the research question, (2) identifying the relevant studies, (3) study selection,

(4) charting the data and (5) collating, summarising and reporting results.[28] Levac *et al*'s enhancements to the original framework[29] and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist[30] (in the absence of a specific scoping checklist) will be used to support transparency and guide translation of findings. Individual study methodology quality will not be critiqued in this scoping review which is consistent with a number of guidance statements regarding the conduction of scoping reviews.[25 27–29 31]

Patient and public involvement

Patients and public were not involved in the formulation of this scoping review protocol, nor will they be involved in the scoping review itself on commencement. However, subsequent knowledge translation activities to disseminate findings to knowledge users, including advocacy groups and the public, are anticipated.

Eligibility criteria

The search date will be limited from 1 January 1998 to current, and this time line may be adjusted depending on the quantity and quality of search returns to meet the project goal. Final search time frame will be reflected in the final scoping review report. We will include studies published in English. The scoping review will use the following inclusion criteria: (a) includes both physicians and registered nurses, (b) includes discussion of the reasons or factors that precipitate or influence a practitioner choice to decline involvement in a legally available healthcare option. Exclusion criteria will include studies examining students of the two identified profession and other healthcare professional groups. Scoping review inclusion and exclusion criteria may also be determined post-hoc within an iterative, dynamic process, resulting in revisiting and refining the search strategy.[27 32] As such, changes or modifications as a result of the iterative process will be described in the final manuscript.

Search strategy and information sources

The development of the search protocol will be led by the team librarian with the support by all team members. Identified databases will include Medline, CINAHL, JSTOR, PsycINFO, ProQuest Dissertations and Theses Global, EMBASE and Sociological Abstracts. The search will be conducted using the Sampson *et al* evidence-based-practice guideline for the peer review of electronic search strategies.[33] The search strategy will include MeSH, keywords and synonyms as appropriate, for example, Physicians, Nurses, Health Personnel, conscientious objection, conscience, refusal to treat, attitude of health personnel, professional autonomy and objector (online supplementary appendix A). The reference lists of relevant studies will be examined to identify other relevant articles. Theses and dissertations will be included in the search protocol; however, other grey literature will be accessed only as required. Grey literature includes conference proceedings, technical specifications and standards, bibliographies and official documents and reports (ie, preprints, preliminary progress and advanced reports, institutional, technical and statistical reports, market research and commission reports).[34] The final subjected headings, keywords and synonyms will be reflected in the final manuscript.

Study selection

Two researchers will screen all abstracts, and full-text studies for inclusion into the scoping review. Literature research results will be uploaded into Covidence[35] where duplicate entries will be deleted. The scoping review team will meet at the onset of the project to review and use the preset inclusion and exclusion criteria on a selection of articles (minimum 30). Individual team member application of criteria will be cross-checked to support consistent application and enhance reliability. Additional training rounds and revision of selection criteria will be conducted as required. Two team members will then continue to screen remaining titles and abstracts. Individual study authors will be contacted if additional information on methodology or results are required. This will be followed by a full-text article screening by two reviewers against eligibility criteria to determine final inclusion into the scoping review. Should reviewer disagreement on study eligibility occur at this stage, the third reviewer will be asked to determine eligibility.

Data items and data-collection process

A data-collection tool has been developed a priori to extract the study characteristics and findings of the final identified studies (online supplementary appendix B). This tool will be piloted by two reviewers on a sample of included articles and cross-checked for reliability. Any adjustments in the data-collection tool that may be required as part of the iterative process will be highlighted in the final manuscript preparation. Information will be extracted and housed in Excelspreadsheet format and will include study characteristics (year, author, country and journal), study design (objectives, methodology, participant profession and sample size) and findings in relation to the review question.[36]

The following data will be extracted from the included studies: (1) factors precipitating or influencing practitioner choice in declining involvement in care, (2) determination if the factors are related to conscience or for reasons other than conscience and (3) healthcare practice areas precipitating the objection (ie, pregnancy termination, reproductive technology, genetic choices, end-of-life care practices, organ/tissue donation, biomedical research).

Synthesis

Data will be collated and presented in two formats: a descriptive numerical summary of the scoping review process and a presentation of themes. Descriptive summary will include a visual flow chart outlining the decision making processes, including primary screening

results, determination of eligibility and final study inclusion number. It will also include characteristics of the included studies (year of publication, country, study methodology, professional group represented and research participant numbers). This information will provide contextual information for the presentation of themes.

Presentation of themes will occur after extracted data has undergone thematic analysis.[37] The thematic analysis approach includes text coding, development of descriptive themes and further generation of analytical themes.[36] Descriptive themes typically remain closely aligned to the primary studies, whereas analytical themes will facilitate interpretation of the data to produce explanations and constructs.[36] Depending on the volume of the data generated, computer software-facilitated coding (ie, NVivio[38]) may be used to facilitate this process. Thematic results will be presented in a diagrammatical map of the data which will align the findings to the project goal and objectives as outlined in step 1 of the Arksey and O'Malley framework.[28]

Strengths and limitations

The goal of this scoping project is an enhanced understanding of the factors (conscience and non-conscience in origin) influencing practitioner choice of non-participation in a legally available healthcare practice. Practitioners have the right to conscientiously object, and care recipients have the right to access to legally available care. Negotiating the practice realities of ethically sensitive healthcare areas requires attention to both the healthcare provider's and the care recipient's needs. As non-participation in care provision and CO is not unique to a specific healthcare area, or to a professional practice group, reviewing this information from a variety of healthcare practices and from two of the largest healthcare provider groups will enrich the understanding of the factors influencing a practitioner choice in the participation in legally available care. This enriched understanding of the current literature will subsequently highlight literature gaps and may inform future areas of study and exploration.

There may be a number of limitations in the identified project. Motivations for non-participation in care provision may differ depending on practice areas and professional groups, within individual cultural contexts and within healthcare practice areas. Utilisation of identified databases may result in the exlusion of studies exclusivly indexed in other databases. Inconsistencies and ambiguity in terminology within the academic literature of this field may result in some studies inadvertently being excluded. To mitigate this, careful consideration, revisiting and adjusting of the medical subject headings, keywords and synonyms will occur through the iterative process of study identification. Questions regarding operationalisation of terms and study findings will be mitigated by connecting with study primary authors for clarification. Finally, the inclusion of registered nurses and physicians may result in inadvertent exclusion of studies of other health professional groups.

ETHICS AND DISSEMINATION

The PRISMA checklist will be used to support transparency and guide translation and dissemination of the findings. A presentation of the scoping findings will include both descriptive and thematic presentation of findings. Discussion will include the implications of the findings in relation to clinical practice for healthcare providers, for healthcare managers and administrators in healthcare planning and for professional associations in the development of practice standards. Results will be shared with a wide variety of knowledge users, including advocacy groups, general public, professional associations, employers, health ethicists, legal consultants and healthcare practitioners. It is anticipated that results will be shared locally, provincially, nationally and internationally via posters and individual presentations to both academic and clinical knowledge users as well as through peer-reviewed journals.

The thematic findings of this scoping review will not only assist in understanding the factors that influence practitioners' involvement in legally available care and the application of CO, but may be used to inform the development of practice supports required for ethically safe care participation. As there may be unintended consequences after non-participation in care provision to the practitioner, the care recipient and the healthcare delivery system, an enhanced understanding of the rationale precipitating non-participation may assist in mitigating the unintended consequences. Healthcare and client options for care will continue to evolve and as new practices emerge, an enhanced understanding of non-participation in care provision and its multifaceted impacts will be crucial to guide practice and facilitate care that is appropriate for the care provider and the care recipient.

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Contributors JB is the guarantor, leads the study and was responsible for initial development of all components of the protocol. JB, DG and LT participated in refinement of the research question. MC developed and refined the search strategies, inclusion and exclusion criteria in collaboration with JB and DG and LT. All authors approved the final manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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