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



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| Keywords: | conscientious objection, MEDICAL ETHICS, refusal to treat, abstention, choice, health |
| | |

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

Janine Brown, RN, MSN (Corresponding Author)
Ph.D Student, Health Sciences Graduate Program, College of Medicine, University of Saskatchewan and Faculty of Nursing, University of Regina 306-664-7395
111-116 Research Drive, Saskatoon, Saskatchewan, S7N 3R3
jma401@mail.usask.ca

Donna Goodridge, RN, Ph.D.
Professor, College of Medicine, University of Saskatchewan
donna.goodridge@usask.ca

Lilian Thorpe, MD, Ph.D, FRCP
Professor, Departments of Community Health & Epidemiology and Psychiatry, University of Saskatchewan
lilian.thorpe@usask.ca

Mary Chipanshi MLS, AHIP
Nursing Liaison Librarian
University of Regina Library
Mary.chipanshi@uregina.ca

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## ABSTRACT

**Introduction:** As legislation addressing medical treatments continues to evolve, there are several circumstances (e.g. abortion, assisted dying) in which health practitioners may choose to not provide legally available treatments. This results in tension between a practitioner's right to refrain from practices morally objectionable to the practitioner, and the care recipient's right to access legally available treatments. It is not always clear what underlies practitioner choice, as some research has suggested that non-participation is not always due to an ethical abstention but may represent other factors. The aim of this systematic scoping review is to identify the current knowledge regarding 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 January 1, 1998 to current will be sought utilizing MEDLINE, CINAHL, JSTOR, EMBASE, ProQuest Dissertations and Theses Global, PsychINFO and Sociological Abstracts. MeSH headings, key words and synonyms will be adjusted utilizing 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 PRISMA-P checklist will be utilized to support transparency of findings and guide translation of findings. Findings will be disseminated in peer reviewed journals and conferences via abstract and presentation.

**Keywords: conscientious objection, medical ethics, refusal to treat, abstention, health, choice**

**STRENGTHS AND LIMITATIONS:**

- This article outlines protocol to be utilized to identify the current knowledge regarding the factors influencing practitioner's choices when declining involvement in legally available healthcare practices.
- This protocol highlights the utilization of Arksey and O'Malley's framework in concert with Levac, Colquhoun and O'Brien et al.'s enhancements and the PRISMA-P checklist (in absence of a specific scoping checklist) in the scoping project and which will support transparency of findings and guide translation of findings.
- This scoping review will assist in understanding the factors that influence practitioners' involvement in legally available care and may be used by healthcare providers, healthcare managers and administrators in planning practice supports for ethically safe care participation and by professional associations in the development of practice standards.
- Limitations in the identified project include differing reasons for non-participation based on profession, cultural influences and practice area, selected data bases for data procurement and chosen medical subject headings, key words and synonyms, as well as the set exclusion criteria may result in the exclusion of studies of other health professional groups.

## 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 and 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 operationalized 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."[1, p.4] In some situations, practitioners may find their understanding and application of ethical principles differs from that of the patient or the healthcare delivery system, or the practitioners' moral and ethical beliefs are in conflict with the care that the care recipients request or are available.[2]

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 legalization of assisted dying has elicited polarizing discussions regarding practitioner choice in care participation, CO and the factors influencing practitioner's choices in participation in this end of life care option.

### Conscientious Objection

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.[3] 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, 3-7] Further, there is general agreement, in the balance of practitioner's' and care recipient's needs that processes that create an undue burden on care recipients cannot be condoned.[3-7,14] Literature suggests practitioners are "divided about whether they ever have a professional obligation to do things they may personally believe are wrong"[2 p1280] highlighting the concern of practitioner ambiguity in participation or non-participation in legally available care options.

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. Vagueness in conceptualization and application of CO results in confusion regarding what practitioners are "obligated or permitted to do when they conscientiously object to providing healthcare services to which patients have a legal right of access."[8 p.iii] It is also 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.[9-12] Additionally, there is a need to

distinguish CO from non-participation precipitated by fears (of legal prosecution, judgment 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.[9,11-12]

**Practitioner Choice in Care Participation: The Canadian Context**

There are a number of factors 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.[13] These principles are applied across the lifespan and spectrum of healthcare options, including potentially ethically sensitive areas. Individuals have the right to fair, timely and equitable access to all legally available healthcare services. 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.[15] Guidance is provided in a multitude of documents, but a 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.[1,3]

The project objective will support the overall scoping review goal which is to identify the current knowledge regarding the factors contributing to practitioner choice in declining involvement in legally available healthcare practices. This information may be utilized to summarize current state of the literature, identity gaps in knowledge and policy as well as inform and support future areas of practice.[16] This scoping project 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 unclear what detailed questions are required in the area of study.[17] They are also useful to identify knowledge gaps, and report on the available knowledge to inform a practice area or topic.[17] 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 utilize 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, summarizing and reporting results.[18] Levac, Colquhoun and O'Brien et al.'s enhancements to the original framework[19] and the PRISMA-P checklist[21] (in absence of a specific scoping checklist) will be utilized to support transparency of findings and guide translation of findings. Individual study methodology quality will not be critiqued in this scoping review. This is consistent with a number of guidance statements regarding the conduction of scoping reviews.[16-20]

**Identification of Research Question and Objectives**

This scoping review will determine the range, depth and characteristics of the known literature regarding factors influencing 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?" The specific objective of this scoping review is: to identify factors influencing practitioner choices in declining involvement in a legally available healthcare procedure

A review of the International Prospective Register of Systematic Reviews demonstrates a lack of work in this area.

**Identification of Relevant Studies**

The development of the search protocol will be led by the team librarian with the support by all team members. The search date will be limited from January 1, 1998 to current and this timeline may be adjusted depending on the quantity and quality of search returns to meet the project goal and objectives. Final search time frame will be reflected in the final scoping review report. Identified databases will include MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), JSTOR, PsycINFO, ProQuest Dissertations and Theses Global, EMBASE and Sociological Abstracts. The search will be conducted utilizing the Sampson et al. evidence based-practice guideline for the peer review of electronic search strategies.[22] The search strategy will include Medical Subject Headings (MeSH), key words and synonyms as appropriate e.g. Physicians, Nurses, Health Personnel, conscientious objection, conscience, refusal to treat, attitude of health personnel, professional autonomy, and objector (Appendix A). The final subjected headings, key words and synonyms will be reflected in the final manuscript.

Theses and dissertations will be included in the search protocol; however, other grey literature will be accessed only as required. Additional grey literature may include conference proceedings, technical specifications and standards, bibliographies and official documents and reports (i.e. preprints, preliminary progress and advanced reports, institutional, technical and statistical reports, market research and commission reports).[23] The reference lists of relevant studies will be examined to identify other relevant articles. For this scoping review, we will include studies published in English.

**Study Selection**

The scoping review objective 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 involve: studies examining students of the two identified profession; other healthcare professional

group; opinion piece commentaries; editorials; and theoretical or philosophical examinations of conscience and CO. 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.[17,24] As such, changes or modifications to the inclusion and exclusion criteria as a result of the iterative process will be described in the final manuscript.

Literature research results will be uploaded into Covidence™[25] where duplicate entries will be deleted. The scoping review team will meet at the onset of the project to review the above pre-set inclusion and exclusion criteria and to utilize inclusion and exclusion criteria on a selection of articles (minimum 30). Individual team member application of inclusion and exclusion criteria will be cross-checked to support consistent application of inclusion and exclusion criteria and to enhance reliability. As required, additional inclusion and exclusion criteria and training rounds will be conducted. Two team members will continue to screen titles and abstracts to determine if inclusion criteria is being met. Individual study authors will be contacted if additional information on methodology or results are required to support the determination of inclusion. This will be followed by a second round of reviewing by two reviewers examining the full text article to the article inclusion criteria to determine final inclusion into the scoping review. Should disagreement between study inclusion occur at the full text screening stage, the third reviewer will be asked to review and determine final study inclusion or exclusion.

**Charting the Data**

A data collection tool has been developed *a priori* to extract the study characteristics and findings of the final identified studies (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 Excel™ document 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.[26]

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 (i.e. pregnancy termination, reproductive technology, genetic choices, end of life care practices, organ/tissue donation, biomedical research).

**Collating, Summarizing and Reporting Results**

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 flowchart outlining the review decision processes study identification containing 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. The thematic analysis approach includes text coding, development of descriptive themes and further generation of analytical themes. [26] Descriptive themes typically remain closely aligned to the primary studies, whereas analytical themes will facilitate interpretation of the data to produce explanations and constructs.[26] Depending on the volume of the data generated, computer software facilitated coding (i.e. NVivio™[27]) may be utilized 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 one of the Arksey and O'Malley framework.[18]

## STRENGTHS AND LIMITATIONS

The goal of this scoping project is an enhanced understanding of the factors 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 the 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, synthesis of 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.

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 conscientious objection, 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 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, and an enhanced understanding of non-participation and its multifaceted impacts will be crucial to guide practice and facilitate care that is appropriate for both the care provider and the care recipient.

There may be a number of limitations in the identified project. Motivations for non-participation may differ depending on practice areas and professional groups, within individual cultural contexts and within healthcare practice areas. Utilization of identified databases is to the exclusion of others and searching of these other data bases may result in additional studies for inclusion. Additionally, careful consideration, and the revisiting and adjusting of medical subject headings, key words and synonyms will occur throughout the iterative process of study identification. Inconsistencies and ambiguity in terminology within the academic literature of this field may result in some studies inadvertently being excluded. Questions regarding operationalization 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 the inadvertent exclusion of studies of other health professional groups.

## ETHICS AND DISSEMINATION

Ethical approval and consent to participate is not applicable. The PRISMA-P checklist will be utilized to support transparency of findings 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 occur regarding 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. Scoping project findings will be disseminated in peer reviewed journals and conferences via abstract and presentation.

## DECLARATIONS

Availability of Supporting Data: This is a study protocol. All literature cited in the protocol is available through the University of Saskatchewan and University of Regina libraries system and cited in the reference list.

Ethical approval and consent to participate: Not applicable

Competing Interests: The authors declare that they have no actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

Funding: This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Authors Contributions

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

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## Appendix A

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>Search Strategy

| | |
|---|---|
| 1 | conscientious objection.mp. (370) |
| 2 | Refusal to Treat.mp. or Refusal to Treat/ (2892) |
| 3 | Conscience/ (1379) |
| 4 | Ethical Relativism/ or ethical relativism.mp. (490) |
| 5 | objector.mp. (26) |
| 6 | objection.mp. (1412) |
| 7 | moral obligations.mp. or Moral Obligations/ (6379) |
| 8 | personal autonomy.mp. or Personal Autonomy/ (15789) |
| 9 | PROFESSIONAL AUTONOMY.mp. or Professional Autonomy/ (9519) |

| | |
|---|---|
| 10 | LEGISLATION, MEDICAL/es [Ethics] (66) |
| 11 | Attitude of Health Personnel.mp. or "Attitude of Health Personnel"/ (109553) |
| 12 | exp NURSES/ (81963) |
| 13 | exp PHYSICIANS/ (119185) |
| 14 | exp Health Personnel/ (455515) |
| 15 | 1 or 2 or 3 or 4 or 5 or 6 or 7 (11710) |
| 16 | 11 or 12 or 13 or 14 (513874) |
| 17 | 7 or 8 or 9 or 10 (30148) |
| 18 | 15 and 16 (2797) |
| 19 | 17 and 18 (1567) |
| 20 | limit 19 to (english language and yr="1998 -Current") (717) |

**Appendix B**

| Study Information (year, author, country and journal) | Study Design (objectives, methodology, participant profession, and sample size) | Factors precipitating or influencing practitioner's participation in care (list) | List the reasons/factors that are in relation to conscience (list) | List the reasons/factors that are not related to conscience (list) | Healthcare practice area |
|---|---|---|---|---|---|
| | | | | | |

Janine Brown
Faculty of Nursing, University of Regina
111-116 Research Drive
Saskatoon, Saskatchewan S7N 3R3
306-664-7131 | Janine.brown@uregina.ca

April 29, 2018

Dr. Trish Groves
Editor
BMJ Open

Dear Dr. Groves,

Please find attached submission documents for a manuscript, *Factors contributing to practitioner choice when declining involvement in legally available care: A scoping protocol* on behalf of myself and co-authors Donna Goodridge, Lilian Thorpe and Mary Chipanshi. We believe this scoping protocol is an excellent fit with the aims and scope of BMJ Open. We feel it is a valuable contribution to research and will be of significant interest to your readership specifically within the areas of professional choices, health systems and health policies.

There are no submissions or previous reports that would regarded as redundant publication. The authors do not have any issues with regard to the journal's policies. The authors declare that they have no actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

All authors have contributed to the manuscript and have approved the manuscript for submission.

We look forward to correspondence regarding this submission.

Sincerely,

Janine Brown, RN MSN

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# PRISMA-P 2015 Checklist (Used in absence of a specific scoping checklist)

This checklist has been adapted for use with protocol submissions to *Systematic Reviews* from Table 3 in Moher D et al: Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic Reviews* 2015 **4**:1

| Section/topic | # | Checklist item | Information reported | | Line number(s) |
|---|---|---|---|---|---|
| | | | Yes | No | |
| **ADMINISTRATIVE INFORMATION** | | | | | |
| **Title** | | | | | |
| Identification | 1a | Identify the report as a protocol of a systematic review | ☒ | ☐ | 44,66 |
| Update | 1b | If the protocol is for an update of a previous systematic review, identify as such | ☐ | ☒ | N/A |
| **Registration** | 2 | If registered, provide the name of the registry (e.g., PROSPERO) and registration number in the Abstract | ☐ | ☒ | N/A |
| **Authors** | | | | | |
| Contact | 3a | Provide name, institutional affiliation, and e-mail address of all protocol authors; provide physical mailing address of corresponding author | ☒ | ☐ | 4-22 |
| Contributions | 3b | Describe contributions of protocol authors and identify the guarantor of the review | ☒ | ☐ | 300-303 |
| **Amendments** | 4 | If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments | ☐ | ☒ | N/A |
| **Support** | | | | | |
| Sources | 5a | Indicate sources of financial or other support for the review | ☒ | ☐ | 297-298 |
| Sponsor | 5b | Provide name for the review funder and/or sponsor | ☐ | ☒ | N/A |
| Role of sponsor/funder | 5c | Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol | ☐ | ☒ | N/A |
| **INTRODUCTION** | | | | | |
| **Rationale** | 6 | Describe the rationale for the review in the context of what is already known | ☒ | ☐ | 87-147 |
| **Objectives** | 7 | Provide an explicit statement of the question(s) the review will address with reference to | ☒ | ☐ | 148-153 |

| Section/topic | # | Checklist item | Information reported | | Line number(s) |
|---|---|---|---|---|---|
| | | | Yes | No | |
| | | participants, interventions, comparators, and outcomes (PICO) | | | 168-175 |
| **METHODS** | | | | | |
| **Eligibility criteria** | 8 | Specify the study characteristics (e.g., PICO, study design, setting, time frame) and report characteristics (e.g., years considered, language, publication status) to be used as criteria for eligibility for the review | ☒ | ☐ | 177-180<br>184-188 |
| **Information sources** | 9 | Describe all intended information sources (e.g., electronic databases, contact with study authors, trial registers, or other grey literature sources) with planned dates of coverage | ☒ | ☐ | 180-184<br>189-195 |
| **Search strategy** | 10 | Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated | ☒ | ☐ | 372-375 |
| ***STUDY RECORDS*** | | | | | |
| Data management | 11a | Describe the mechanism(s) that will be used to manage records and data throughout the review | ☒ | ☐ | 206<br>224-226 |
| Selection process | 11b | State the process that will be used for selecting studies (e.g., two independent reviewers) through each phase of the review (i.e., screening, eligibility, and inclusion in meta-analysis) | ☒ | ☐ | 206-217 |
| Data collection process | 11c | Describe planned method of extracting data from reports (e.g., piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators | ☒ | ☐ | 219-225 |
| **Data items** | 12 | List and define all variables for which data will be sought (e.g., PICO items, funding sources), any pre-planned data assumptions and simplifications | ☒ | ☐ | 226-230 |
| **Outcomes and prioritization** | 13 | List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale | ☒ | ☐ | 232-238 |
| **Risk of bias in individual studies** | 14 | Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis | ☐ | ☒ | N/A |
| ***DATA*** | | | | | |
| **Synthesis** | 15a | Describe criteria under which study data will be **quantitatively** synthesized | ☐ | ☒ | N/A |
| | 15b | If data are appropriate for quantitative synthesis, describe planned summary measures, methods of | ☐ | ☒ | N/A |

| Section/topic | # | Checklist item | Information reported | | Line number(s) |
|---|---|---|---|---|---|
| | | | Yes | No | |
| | | handling data, and methods of combining data from studies, including any planned exploration of consistency (e.g., $I^2$, Kendall's tau) | | | |
| | 15c | Describe any proposed additional analyses (e.g., sensitivity or subgroup analyses, meta-regression) | ☐ | ☒ | N/A |
| | 15d | If quantitative synthesis is not appropriate, describe the type of summary planned | ☒ | ☐ | 239-247 |
| **Meta-bias(es)** | 16 | Specify any planned assessment of meta-bias(es) (e.g., publication bias across studies, selective reporting within studies) | ☐ | ☒ | N/A |
| **Confidence in cumulative evidence** | 17 | Describe how the strength of the body of evidence will be assessed (e.g., GRADE) | ☐ | ☒ | N/A (scoping) |

BMJ Open

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



| | |
|---|---|
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| | |

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

Janine Brown, RN, MSN (Corresponding Author)
Ph.D Student, Health Sciences Graduate Program, College of Medicine, University of Saskatchewan and Faculty of Nursing, University of Regina 306-664-7395
111-116 Research Drive, Saskatoon, Saskatchewan, S7N 3R3
**janine.brown@uregina.ca**

Donna Goodridge, RN, Ph.D.
Professor, College of Medicine, University of Saskatchewan
donna.goodridge@usask.ca

Lilian Thorpe, MD, Ph.D, FRCP
Professor, Departments of Community Health & Epidemiology and Psychiatry, University of Saskatchewan
lilian.thorpe@usask.ca

Mary Chipanshi MLS, AHIP
Nursing Liaison Librarian
University of Regina Library
Mary.chipanshi@uregina.ca

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**ABSTRACT**

**Introduction:** As legislation addressing medical treatments continues to evolve, there are several circumstances (e.g. 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 the 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 January 1, 1998 to current will be sought utilizing MEDLINE, CINAHL, JSTOR, EMBASE, ProQuest Dissertations and Theses Global, PsychINFO and Sociological Abstracts. MeSH headings, key words and synonyms will be adjusted utilizing 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 PRISMA checklist will be utilized 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.

**Keywords: conscientious objection, medical ethics, refusal to treat, abstention, health, non-participation**

**STRENGTHS AND LIMITATIONS:**

- This protocol will be utilized 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 analytic 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, key words and synonyms, as well 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 operationalized 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."[1, p.4] Practitioners may find their understanding and application of ethical principles differs from that of the patient or the healthcare delivery system, or the practitioners' moral and ethical beliefs are in conflict with the care that the care recipients request or are available.[2]

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, judgment 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 legalization of medical assistance in dying has elicited polarizing 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 Conscientious Objection**

Conscientious objection, 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, there is general agreement, in the balance of practitioner's' and care recipient's needs that 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 conceptualization 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 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 utilized to summarize 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 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 utilize 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, summarizing and reporting results.[28] Levac, Colquhoun and O'Brien et al.'s enhancements to the original framework[29] and the PRISMA checklist[30] (in absence of a specific scoping checklist) will be utilized 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 be involved in the scoping review itself upon 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 January 1, 1998 to current and this timeline 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; 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, Cumulative Index to Nursing and Allied Health Literature (CINAHL), JSTOR, PsycINFO, ProQuest Dissertations and Theses Global, EMBASE and Sociological Abstracts. The search will be conducted utilizing the Sampson et al. evidence based-practice guideline for the peer review of electronic search strategies.[33] The search strategy will include Medical Subject Headings (MeSH), key words and synonyms as appropriate e.g. Physicians, Nurses, Health Personnel, conscientious objection, conscience, refusal to treat, attitude of health personnel, professional autonomy, and objector (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 (i.e. preprints, preliminary progress and advanced reports, institutional, technical and

statistical reports, market research and commission reports).[34] The final subjected headings, key words 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 utilize the pre-set 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 (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 Excel™ document 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 (i.e. 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 flowchart outlining the review decision processes study identification containing 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 (i.e. NVivio™[38]) may be utilized 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 one 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 the 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. Utilization of identified databases is to the exclusion of others and searching of these other data bases may result in additional studies for inclusion. Additionally, careful consideration, and the revisiting and adjusting of medical subject headings, key words and synonyms will occur throughout the iterative process of study identification. Inconsistencies and ambiguity in terminology within the academic literature of this field may result in some studies inadvertently being excluded. Questions regarding operationalization 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 the inadvertent exclusion of studies of other health professional groups.

**ETHICS AND DISSEMINATION**

Ethical approval and consent to participate is not applicable. The PRISMA checklist will be utilized 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 health care 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 conscientious objection, 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, and 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 both the care provider and the care recipient.

**DECLARATIONS**

Availability of Supporting Data: This is a study protocol. All literature cited in the protocol is available through the University of Saskatchewan and University of Regina libraries system and cited in the reference list.

Ethical approval and consent to participate: Not applicable

Competing Interests: The authors declare that they have no actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

Funding: This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Authors Contributions

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.

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**Appendix A**

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>Search Strategy

| | |
|---|---|
| 1 | conscientious objection.mp. (370) |
| 2 | Refusal to Treat.mp. or Refusal to Treat/ (2892) |
| 3 | Conscience/ (1379) |
| 4 | Ethical Relativism/ or ethical relativism.mp. (490) |
| 5 | objector.mp. (26) |
| 6 | objection.mp. (1412) |
| 7 | moral obligations.mp. or Moral Obligations/ (6379) |
| 8 | personal autonomy.mp. or Personal Autonomy/ (15789) |
| 9 | PROFESSIONAL AUTONOMY.mp. or Professional Autonomy/ (9519) |
| 10 | LEGISLATION, MEDICAL/es [Ethics] (66) |
| 11 | Attitude of Health Personnel.mp. or "Attitude of Health Personnel"/ (109553) |
| 12 | exp NURSES/ (81963) |
| 13 | exp PHYSICIANS/ (119185) |
| 14 | exp Health Personnel/ (455515) |
| 15 | 1 or 2 or 3 or 4 or 5 or 6 or 7 (11710) |
| 16 | 11 or 12 or 13 or 14 (513874) |
| 17 | 7 or 8 or 9 or 10 (30148) |
| 18 | 15 and 16 (2797) |
| 19 | 17 and 18 (1567) |
| 20 | limit 19 to (english language and yr="1998 -Current") (717) |

**Appendix B**

| Study Information (year, author, country and journal) | Study Design (objectives, methodology, participant profession, and sample size) | Factors precipitating or influencing practitioner's participation in care (list) | List the reasons/factors that are in relation to conscience (list) | List the reasons/factors that are not related to conscience (list) | Healthcare practice area |
|---|---|---|---|---|---|
| | | | | | |

1

# PRISMA-P 2015 Checklist (Used in absence of a specific scoping checklist)

This checklist has been adapted for use with protocol submissions to *Systematic Reviews* from Table 3 in Moher D et al: Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic Reviews* 2015 **4**:1

| Section/topic | # | Checklist item | Information reported | | Line number(s) |
|---|---|---|---|---|---|
| | | | Yes | No | |
| **ADMINISTRATIVE INFORMATION** | | | | | |
| **Title** | | | | | |
| Identification | 1a | Identify the report as a protocol of a systematic review | ☒ | ☐ | 48,64 |
| Update | 1b | If the protocol is for an update of a previous systematic review, identify as such | ☐ | ☒ | N/A |
| **Registration** | 2 | If registered, provide the name of the registry (e.g., PROSPERO) and registration number in the Abstract | ☐ | ☒ | N/A |
| **Authors** | | | | | |
| Contact | 3a | Provide name, institutional affiliation, and e-mail address of all protocol authors; provide physical mailing address of corresponding author | ☒ | ☐ | 4-22 |
| Contributions | 3b | Describe contributions of protocol authors and identify the guarantor of the review | ☒ | ☐ | 303-306 |
| **Amendments** | 4 | If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments | ☐ | ☒ | N/A |
| **Support** | | | | | |
| Sources | 5a | Indicate sources of financial or other support for the review | ☒ | ☐ | 300-301 |
| Sponsor | 5b | Provide name for the review funder and/or sponsor | ☐ | ☒ | N/A |
| Role of sponsor/funder | 5c | Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol | ☐ | ☒ | N/A |
| **INTRODUCTION** | | | | | |
| **Rationale** | 6 | Describe the rationale for the review in the context of what is already known | ☒ | ☐ | 89-150 |
| **Objectives** | 7 | Provide an explicit statement of the question(s) the review will address with reference to | ☒ | ☐ | 151-155 |

| Section/topic | # | Checklist item | Information reported | | Line number(s) |
|---|---|---|---|---|---|
| | | | Yes | No | |
| | | participants, interventions, comparators, and outcomes (PICO) | | | |
| **METHODS** | | | | | |
| **Eligibility criteria** | 8 | Specify the study characteristics (e.g., PICO, study design, setting, time frame) and report characteristics (e.g., years considered, language, publication status) to be used as criteria for eligibility for the review | ☒ | ☐ | 178-188 |
| **Information sources** | 9 | Describe all intended information sources (e.g., electronic databases, contact with study authors, trial registers, or other grey literature sources) with planned dates of coverage | ☒ | ☐ | 189-203 |
| **Search strategy** | 10 | Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated | ☒ | ☐ | 189-203 |
| ***STUDY RECORDS*** | | | | | |
| Data management | 11a | Describe the mechanism(s) that will be used to manage records and data throughout the review | ☒ | ☐ | 206<br>217-223 |
| Selection process | 11b | State the process that will be used for selecting studies (e.g., two independent reviewers) through each phase of the review (i.e., screening, eligibility, and inclusion in meta-analysis) | ☒ | ☐ | 205-215 |
| Data collection process | 11c | Describe planned method of extracting data from reports (e.g., piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators | ☒ | ☐ | 217-224 |
| **Data items** | 12 | List and define all variables for which data will be sought (e.g., PICO items, funding sources), any pre-planned data assumptions and simplifications | ☒ | ☐ | 224-228 |
| **Outcomes and prioritization** | 13 | List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale | ☒ | ☐ | 232-238 |
| **Risk of bias in individual studies** | 14 | Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis | ☐ | ☒ | N/A |
| ***DATA*** | | | | | |
| **Synthesis** | 15a | Describe criteria under which study data will be **quantitatively** synthesized | ☐ | ☒ | N/A |
| | 15b | If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data, and methods of combining data from studies, including any planned exploration of consistency (e.g., $I^2$, Kendall's tau) | ☐ | ☒ | N/A |

3

| Section/topic | # | Checklist item | Information reported | | Line number(s) |
|---|---|---|---|---|---|
| | | | Yes | No | |
| | 15c | Describe any proposed additional analyses (e.g., sensitivity or subgroup analyses, meta-regression) | ☐ | ☒ | N/A |
| | 15d | If quantitative synthesis is not appropriate, describe the type of summary planned | ☒ | ☐ | 230-244 |
| **Meta-bias(es)** | 16 | Specify any planned assessment of meta-bias(es) (e.g., publication bias across studies, selective reporting within studies) | ☐ | ☒ | N/A |
| **Confidence in cumulative evidence** | 17 | Describe how the strength of the body of evidence will be assessed (e.g., GRADE) | ☐ | ☒ | N/A (scoping) |