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Article abstract

In the light of current legislation on Medical Aid in Dying (MAiD; also known as euthanasia and assisted suicide) in different countries worldwide, there have been some arguments devoted to the right to conscientious objection for healthcare professionals in these specific practices. The goals of this scoping review are to provide an overview of the motivations and causes that lie behind conscientious objection identified by previous literature according to professionals' experiences and to verify if these motives match with theoretical debates on conscientious objection. As the results show, there is a dissonance between the motivations included in the traditional and mainstream definition of conscientious objection used in theoretical and speculative frameworks and the actual factors that empirical studies note as reported motivations to object to MAiD. Hence, either we consider new factors to include as causes of "conscience", or we accept that there are motivations that are not actually applicable to conscientious objection and should be addressed by other means. As conscientious objection to MAiD is multifaceted, there can be different kinds of motivations acting at the same time. It is thus pertinent to rebalance theoretical and empirical considerations to fully understand the complexity of the phenomenon and so provide insights on how to best deal with conscientious objection.

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Causes for Conscientious Objection in Medical Aid in Dying: A Scoping Review

Rosana Triviño-Caballero[a], Iris Parra Jounou[b], Isabel Roldán Gómez[c], Teresa López de la Vieja[d]

Résumé
À la lumière de la législation actuelle sur l'aide médicale à mourir (AMM; aussi appelée euthanasie et suicide assisté) dans différents pays du monde, certains arguments ont été consacrés au droit à l'objection de conscience pour les professionnels de la santé dans ces pratiques spécifiques. Les objectifs de cette étude exploratoire sont de fournir une vue d'ensemble des motivations et des causes qui se cachent derrière l'objection de conscience identifiée par la littérature précédente selon les expériences des professionnels et de vérifier si ces motivations correspondent aux débats théoriques sur l'objection de conscience. Comme le montrent les résultats, il existe une dissonance entre les motivations incluses dans la définition traditionnelle et courante de l'objection de conscience utilisée dans les cadre théoriques et spéculatifs et les facteurs réels que les études empiriques relèvent comme motivations déclarées pour s'opposer à l'AMM. Par conséquent, soit nous envisageons de nouveaux facteurs à inclure dans les causes de la "conscience", soit nous acceptons qu'il existe des motivations qui ne sont pas réellement applicables à l'objection de conscience et qui devraient être traitées par d'autres moyens. L'objection de conscience à l'AMM étant multiforme, il peut y avoir différents types de motivations qui agissent en même temps. Il est donc pertinent de rééquilibrer les considérations théoriques et empiriques pour bien comprendre la complexité du phénomène et ainsi donner des pistes sur la meilleure façon de traiter l'objection de conscience.

Mots-clés
objection de conscience, euthanasie, suicide assisté, aide médicale à mourir, causes

Abstract
In the light of current legislation on Medical Aid in Dying (MAiD; also known as euthanasia and assisted suicide) in different countries worldwide, there have been some arguments devoted to the right to conscientious objection for healthcare professionals in these specific practices. The goals of this scoping review are to provide an overview of the motivations and causes that lie behind conscientious objection identified by previous literature according to professionals' experiences and to verify if these motives match with theoretical debates on conscientious objection. As the results show, there is a dissonance between the motivations included in the traditional and mainstream definition of conscientious objection used in theoretical and speculative frameworks and the actual factors that empirical studies note as reported motivations to object to MAiD. Hence, either we consider new factors to include as causes of "conscience", or we accept that there are motivations that are not actually applicable to conscientious objection and should be addressed by other means. As conscientious objection to MAiD is multifaceted, there can be different kinds of motivations acting at the same time. It is thus pertinent to rebalance theoretical and empirical considerations to fully understand the complexity of the phenomenon and so provide insights on how to best deal with conscientious objection.

Keywords
conscientious objection, euthanasia, assisted suicide, medical aid in dying, causes

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INTRODUCTION

Dealing with the end of life is difficult for patients and healthcare professionals alike (1,2). Thus, integrating procedures like Medical Assistance in Dying (MAiD) into usual professional practice is still a theoretical and a practical challenge in many countries, probably because it has been experienced qualitatively differently than clinical procedures (3). In such a scenario, conscientious objection (CO) appears as a mechanism for resolving ethical conflicts and respecting healthcare professionals' moral convictions in liberal democratic societies. Practitioners may find themselves in a dilemma between their own beliefs regarding life and death and the patient's will to end their life by asking for MAiD. Since the 1990s, following legislation of this practice in certain jurisdictions, the provision of assistance in dying has been introduced as a part of the aims of the clinical practice (4-6). However, there is a tradition that persists significantly in healthcare training and practice in which the preservation of life is an absolute value; hence, practices such as euthanasia or assisted suicide are considered outside the scope of professional duties, or even contrary to them (7-9). In addition to this professional *ethos*, professionals may also hold deep personal convictions that make it difficult for them to assist a person to die without feeling that their own moral integrity is damaged and/or that there is some kind of a loss of identity (10-14).

Moral motivations to justify CO have mainly relied on references to this deep-seated sphere of beliefs (10-23). However, along with this type of argument, authors have noted a myriad of other problems linked to practical difficulties or psychological impact,

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that also seem to be at stake and can lead to CO (12-14). For this reason, it is essential to have a broader view on the issue. This article, therefore, aims to summarise and increase our knowledge about the causes that lead healthcare professionals to claim CO when facing MAiD (or euthanasia and assisted suicide). As this is a fairly recent and underdeveloped area of study, the proposed scoping review will provide a synthesis of the available evidence on CO by healthcare professionals to guide both clinical practice and ethical reflection in the context of MAiD, and so contribute to discussions regarding which motivations can be really considered "*of conscience*".

MATERIALS AND METHODS

While there were few reviews on topics related to the motivations for CO in clinical practice areas such as abortion, organ donation or end of life (24-28), or to professionals' perspectives on MAiD (29), we decided to conduct a scoping review that particularly addressed motivations for CO to MAiD both from a theoretical and empirical literature in countries with positive legislation when the data of the articles was collected. This scoping review has followed the recommended five-step framework for scoping reviews (30-33). The research questions were the following:

1. What are the causes for CO identified in the literature on MAiD (euthanasia and assisted suicide), according to professionals' experiences?
2. Do these motives match the theoretical frameworks and arguments regarding CO?
3. Are there factors involved in a decision to object to a MAiD other than motivations of conscience?

Search Strategy and Selection Process

We carried out our search using the PubMed, Scopus, PsycInfo, WOS, Embase, and LILACS databases, until October 24, 2022. The search strategy was initially developed in PubMed and then adapted to the other databases after considering different crossed words and possible synonyms and finding no significant differences (Table 1). Studies fulfilling the criteria shown in Table 2 were eligible. Following the removal of duplicates, four members of the review team, in pairs, screened all studies by title and abstract, and papers were cross-checked by the other pair. Full-text articles were obtained for full review, following the same division in the review team, based on our inclusion and exclusion criteria. In case of disagreement, the final decision was made by two data screeners and a third party.

Table 1. Search Strategy

PubMed	("conscientious refusal to treat"[Text Word] OR "conscientious object*"[Text Word] OR "refusal to participate"[Text Word] OR "refusal to treat"[Text Word] OR "conscientious refusal"[Text Word]) AND ("euthanasia"[Text Word] OR "assisted suicide*"[Text Word] OR "mercy killing*"[Text Word] OR "assisted dying"[Text Word] OR "aid in dying"[Text Word] OR "assisted death"[Text Word] OR "medical assistance in dying"[Text Word] OR "right to die"[Text Word])) AND (humans[Filter])
PsycInfo	noft(euthanasia OR "assisted suicide*" OR "mercy killing*" OR "assisted dying" OR "aid in dying" OR "assisted death" OR "medical assistance in dying" OR MAID OR "right to die") AND noft("conscientious refusal to treat" OR "conscientious object*" OR "refusal to participate" OR "refusal to treat" OR "clause of conscience" OR "conscientious refusal") Limits applied
Scopus	(TITLE-ABS-KEY (euthanasia OR "assisted suicide*" OR "mercy killing*" OR "assisted dying" OR "aid in dying" OR "assisted death" OR "medical assistance in dying" OR maid OR "right to die") AND TITLE-ABS-KEY ("conscientious refusal to treat" OR "conscientious object*" OR "refusal to participate" OR "refusal to treat" OR "clause of conscience" OR "conscientious refusal")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re"))
Embase	('euthanasia'/exp OR euthanasia OR 'assisted suicide*' OR 'mercy killing*' OR 'assisted dying'/exp OR 'assisted dying' OR 'aid in dying' OR 'assisted death' OR 'medical assistance in dying'/exp OR 'medical assistance in dying' OR maid OR 'right to die'/exp OR 'right to die') AND ('conscientious refusal to treat'/exp OR 'conscientious refusal to treat' OR 'conscientious object*' OR 'refusal to participate'/exp OR 'refusal to participate' OR 'refusal to treat'/exp OR 'refusal to treat' OR 'clause of conscience' OR 'conscientious refusal') AND [embase]/lim AND [humans]/lim
WOS	euthanasia OR "assisted suicide*" OR "mercy killing*" OR "assisted dying" OR "aid in dying" OR "assisted death" OR "medical assistance in dying" OR MAID OR "right to die" (Topic) and "conscientious refusal to treat" OR "conscientious object*" OR "refusal to participate" OR "refusal to treat" OR "clause of conscience" OR "conscientious refusal" (Topic) and Article or Anticipated Access or Review Article (Types of Documents)
LILACS	Euthanasia AND Objection

Table 2. Inclusion/Exclusion Criteria

Inclusion criteria	
Types of publication	Studies with quantitative methodology, mixed methodology, qualitative, interventions, narrative reviews, scoping reviews, systematic reviews
Subject or domain being studied	Articles focused on or with mention of CO in euthanasia and assisted suicide
Language	English, Spanish, French, Catalan, Italian
Participant/population	Healthcare professionals: physicians, nurses
Country of study	In empirical articles, works about countries where MAiD is legal
Intervention	Any intervention related to our conditions
Date	In empirical articles, works published and accepted after the approval of MAiD legislation of the country until Oct 24, 2022. Date limitation for articles centred on theoretical aspects of CO, until Oct 24, 2022.
Exclusion criteria	
Type of publication	Editorials and letters to editor, books, and theses, not accepted for publication preprints, conferences, and abstracts
Subject or domain being studied	Articles that do not include or do not mention causes or motives for CO in MAiD. Articles focused only on a theoretical framework that do not include reported or potential causes for CO
Language	Other than English, Spanish, French, Catalan, or Italian
Participants/population	Other healthcare professionals apart from physicians and nurses; and animals
Intervention	No exclusion criteria
Date	Articles prior to the legalisation of MAiD in the relevant country

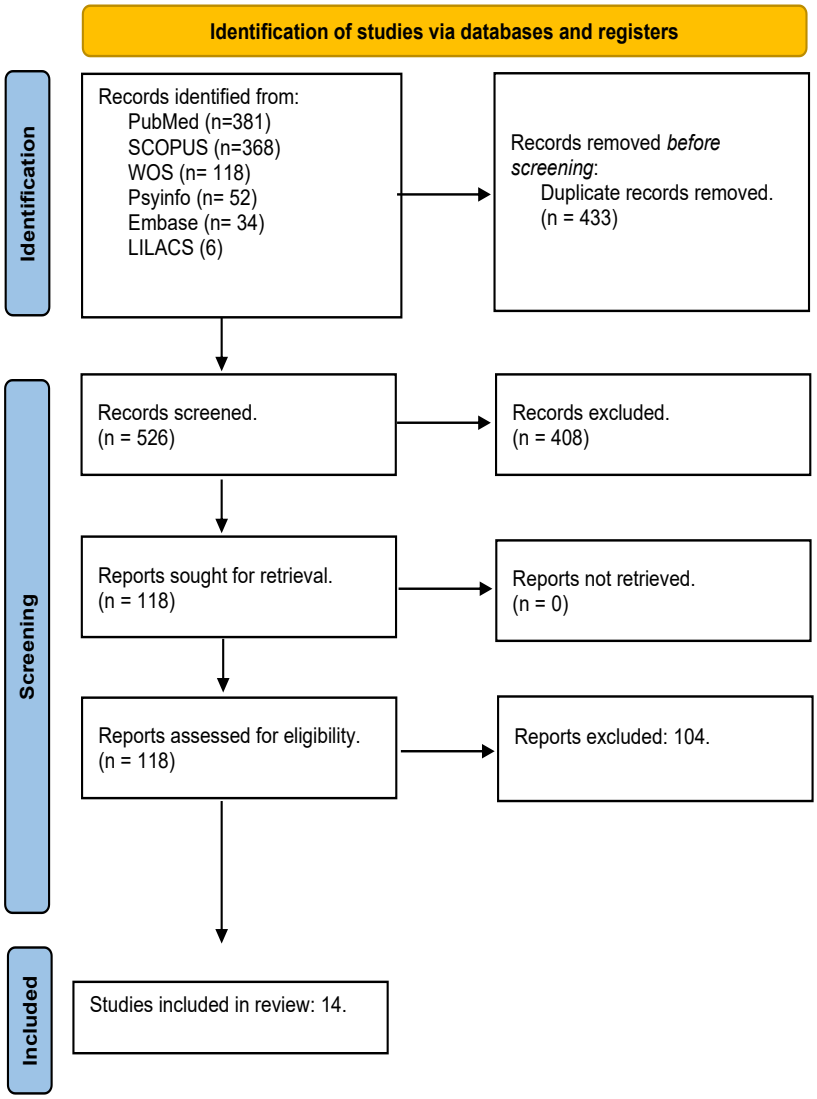
Data Extraction and Data Synthesis

Data extraction was undertaken by the four members of the review team using a template previously designed by consensus. We created a table gathering the main characteristics and results of the studies to collect information from the data extraction. The areas were: “Definition of CO”, “type of professionals”, “motivations for CO”, “CO to which part of the process”, “other causes to reject participation in a MAiD”, “general perception of CO”, “recommendations about how to deal with OC in MAiD”. Finally, we developed a narrative synthesis of the most relevant findings.

RESULTS

After screening by title and abstract, of the 526 articles identified after duplicate removal, 118 were included for full-text review, and fourteen met the criteria for the extraction of relevant information (Figure 1).

Figure 1. Scoping Review Flow Diagram



Following the PRISMA 2020 approach proposed by Page et al. (34)

Of fourteen selected articles published between 1998 and October 24, 2022, eight were qualitative studies (1-3,35-39), four original articles (40-43), there was one quantitative study (44), and one narrative review (45). Organised by country, there were ten articles from Canada; two from the region of Victoria, in Australia; one from the Netherlands; and one from other countries (See Table 3).

Table 3. Selected Articles Published Between 1998 and 2022

Article	Year	Country	Methodology	Key findings
(1)	2018	Canada	Qualitative, phenomenological research. Semi-structured interviews with eight nurses in Ontario.	CO in MAiD is a critical issue for Canadian nurses. Ethics education, awareness, and respect for nurses are needed to support nurses to address their issues of conscience in professional practice.
(2)	2021	Australia	Qualitative research. Semi-structured interviews with 17 health professionals in Victoria with a self-identified CO to voluntary-assisted dying.	The broad protection offered by the 2017 Voluntary Assisted Dying Act encourages a range of behaviours from conscientious objectors, due to the minimal obligations imposed. To assist conscientious objectors, more policy, institutional guidance, and education are needed explicitly addressing how to effectively manage CO. Such guidance is imperative to ensuring that moral integrity is preserved and that they are exercising their CO appropriately.

(3)	2020	Canada	Qualitative research. In-depth interviews with 7 Quebec physicians engaged with end-of-life care.	The major themes of MAiD in relation to aggressive treatment, CO and uneven distribution of work emerge. MAiD was experienced and thought of as qualitatively different to other end of life procedures. Findings expose a complexity and contentiousness within the practice, which remains under researched and underreported, indicating avenues for further research.
(35)	1998	Netherlands	Qualitative research. Semi-structured, in-depth interviews with 20 nurses employed in a Dutch hospital.	To make clear the role of nurses in euthanasia, the issue was split into four phases: observation of a request for euthanasia; decision making; carrying out of the request; and after-care. This article is a brief report on the most important results regarding these four phases. Special attention was paid to nurses who have CO.
(36)	2019	Canada	Exploratory qualitative study. Semi-structured interviews with 22 physicians who refuse MAiD.	The reason most often cited for CO is not based on moral or religious grounds, but on motives related to emotional burden and fear of psychological repercussions after participating in MAiD. All participants expressed more than one concern (between 2 and 7).
(37)	2019	Canada	Qualitative research. Semi-structured interviews with 20 Quebec physicians who did not integrate MAiD into their medical practice.	This paper explores the reasons for opposition to or ambivalence towards MAiD. The secular reasons given by participants were grouped into four main categories: 1) the ends of medicine and professional identity, 2) the philosophy of palliative medicine and resource allocation in palliative care, 3) benevolent paternalism, the “good death”, and the interests of future selves, 4) the risk of a slippery slope and the protection of vulnerable people.
(38)	2021	Canada	Exploratory qualitative study. Semi-structured interviews with 5 patients, 11 family members, and 14 healthcare providers.	Patients, families, and healthcare providers highlighted access and delivery concerns regarding program sustainability, care pathway ambiguity, lack of support for care choices, institutional conscientious objection, navigating care in institutions with a CO, and post-death documentation. Healthcare professionals were uncertain about professional roles and responsibilities.
(39)	2021	Australia	Qualitative, phenomenological research. Semi-structured interviews with 17 health professionals in Victoria, in any medical discipline and career stage, who self-identified as having a CO to voluntary-assisted dying.	This paper aims to understand how CO operates in the context of voluntary-assisted dying. Participants identified multiple motivations, which can be broadly categorised as: concerns for oneself; concerns for patients; concerns about the current Victorian legislation; and concerns for the medical profession. Participants’ moral commitments included personal, professional, and political commitments. In some cases, CO was specific to Victoria’s current legislation rather than voluntary-assisted dying more broadly. Findings suggest CO motivations extend beyond those traditionally cited and thus a need to better understand and manage CO in the healthcare context.
(40)	2016	Canada	Theoretical. Expert commentary with a legal approach.	The Supreme Court of Canada unanimously ruled in Carter v. Canada (2015) that the Canadian Charter of Rights and Freedoms protects the right of every competent, consenting adult suffering from a grievous and irremediable medical condition to choose death, assisted by a physician. It is considered that CO is not legally guaranteed for physicians, prioritising patients’ right to MAiD.
(41)	2016	Canada	Theoretical. Philosophical approach (Deontological ethics and the Doctrine of Double Effect).	Under Canadian law, a religious or conscientious objector has conflicting duties, i.e., a duty to respect the “right to life” and a duty to respect the tenets of their religious or conscientious beliefs. Discussion of religious or CO to MAiD have not explicitly considered competing duties of conscientious objectors. They have focused on the existence of CO but ignored the normative question of whether the duty to respect one’s conscience or religion supersedes the duty to respect the patient’s right to life.
(42)	2017	Canada	Theoretical	Canadian policy makers have proposed requiring all physicians to provide an effective referral for MAiD upon the patient’s request. It is argued that forcing physicians to refer their patient to a colleague willing to cause the patient’s death will seriously compromise moral integrity of CO physicians and undermine quality of care.
(43)	2020	Canada	Theoretical	Refusal by practitioners should be tolerated where it could be accommodated in practice groups without burdening willing providers or adversely affecting patient access. Regarding institutions, the cost to vulnerable patients of MAiD being delayed or denied is much greater and the burdens of conscience to institutions. Since it cannot be accommodated without impairing both patient access and well-being, refusal by publicly funded healthcare institutions to offer MAiD must be completely disallowed.

(44)	2020	Canada	Quantitative research. Cross-sectional survey of members of the Canadian Spine Society (CSS).	Most members of the CSS supported both the right of patients to participate in MAiD and the right of physicians to provide this service if they so choose, while still respecting the principle of CO. Yet, only a small minority were willing to be actively involved in MAiD.
(45)	2021	Different countries	Theoretical. Integrative review of 39 articles from different countries, that included a definition of CO and at least one criterion justifying its acceptability, or not, in the Western context of care.	CO and its criteria of acceptability are articulated in relation to four poles. Two of these, care and professional competence, underpin the very definition of CO. The other two poles, collective and individual, convey the values and powers involved in healthcare CO. The interaction between these four poles illustrates the criteria of acceptability or non-acceptability of CO. This model allows a dynamic view of CO and tries to be adaptable to various types and contexts of care, beyond MAiD.

Definitions of Conscientious Objection in Medical Aid in Dying

Conscientious objection was not specifically defined in all the articles analysed. In those in which it appears (1,36,43,44), CO is mostly referred to as: 1) a healthcare professional's right to refuse to participate in procedures considered incompatible with their conscience, values, or beliefs (1,36,43); 2) a care provider's right to non-participation in MAiD as a legal practice (44). The use of 'right' in both kinds of definitions may be regarded either in a binding sense – the right to CO as a prerogative explicitly recognised from a legal point of view – or in a non-binding sense, that is, the moral rather than legal right to CO. In those articles where it is not specifically defined, CO is usually understood as a moral right not to offer MAiD or not to participate in practices perceived as incompatible with core values or as inappropriate, in spite of the fact that these are legally established (35,37,40-42,45). The concepts used in these articles are freedom of conscience, act of conscience, conscience claims, conscience rights, and conscientious and religious objection.

A frequent argument found to justify CO is the commitment to personal convictions, values, and beliefs (36,44). However, the terminology to support the refusal of some healthcare practices is wide-ranging: ethical beliefs, moral integrity, moral norms, moral intuitions, moral reasons, moral grounds, moral right, moral gravitas, moral injury (37,42,44) or moral distress (43). Healthcare professionals could also invoke their commitment to religious beliefs, moral grounds, or religious objections (43). Therefore, reflections about the issue mention both secular and religious convictions (2).

Depending on the country's legal framework (Canada, Australia [Victoria], and the Netherlands), CO has been regulated and implemented in different ways. The papers based on empirical methodology analysed here have registered some divergences between the theoretical definition of CO and its actual application in the MAiD processes (1,3,36,37). For instance, some motivations are different from the idea of protection of moral integrity and beliefs, a relevant aspect of the topic that will be developed in the next section of this paper.

Arguments for Conscientious Objection to Medical Aid in Dying

The studies analysed show that arguments for CO cannot be generally classified according to one single category (36,39), but rather to several that may interact with each other. For the sake of clarity, we have organised these into four categories: 1) CO grounded on religious/secular variables; 2) CO specifically related to the goals of medicine and the expected conduct of healthcare professionals; 3) CO linked to the possible moral distress of physicians and nurses who are asked to provide euthanasia or assisted suicide; 4) CO linked to contextual factors, where reasons such as disinformation or bureaucratic obstacles might be crucial.

First, according to the religious/secular distinction, three articles in our study use it as a category to classify motivations (36,37,39); two articles use it to refer to religious institutions appealing to CO (39,43); and one article mentions the relation between CO and a Christian philosophy of life (35). Moreover, in most of the theoretical articles, when CO is analysed from a normative perspective, 'religious' is used as tantamount to 'conscience' – i.e., 'freedom of conscience and religion' (40,41,43). Nevertheless, all things considered, most of the reasons for CO adduced in the empirical literature fall into the category of 'secular', understood as not tied to an explicit religious motivation; in other words, religious reasons are seldom cited for CO (39). Sumner, for example, states that the distinction between religious and secular should not be considered as relevant for CO: "The fact that moral convictions are religiously based does not make them deeper or more central to a person's self-identity than convictions held without benefit of the divine, nor does it make them more costly to abandon or betray." (43, p.10) Therefore, the following motivations presented in this scoping review will be considered as secular.

Second, regarding the ideas related to the goals of medicine, several articles mention some motivations for CO based on what the ethical core of the medical profession should be. According to the authors of these articles, MAiD is incompatible with medicine's intrinsic core values (i.e., non-maleficence, protecting life, health promotion, etc.) and this is one of the main reasons reported for CO (35-39,42). In this regard, the literature defends the existence of some alternative practices to MAiD – e.g., palliative care – that are more suitable for the goals of healthcare professions (1,2,35-39,43).

Third, there is a concern for the moral distress or emotional burden that performing euthanasia might cause for healthcare practitioners (1,3,35,39,43). Several causes can be attributed to this moral distress. For instance, if we understand that the connection to moral integrity is a key factor in moral distress (46), the fear of a supposed slippery slope (i.e., the lowering of

ethical standards over time) is one of the main reported concerns that leads to ambivalence about or rejection of MAiD among professionals (3,37,39). Other concerns like the fear of legal repercussions (36) or the emotional consequences of performing euthanasia (3) have also been mentioned as triggers of moral distress.

Fourth, some reasons mentioned as motivations for CO are actually more related to the procedure and context than to the moral or ideological core of euthanasia and assisted suicide. For instance, according to the literature, some of the reasons that may determine attitudes towards MAiD are the lack of time to properly consider a patient's request (2), legal insecurity, fear of social stigma, high administrative workload (36), and lack of competence (38). The institutional context can also exert a decisive influence on health professionals, even if they would personally not feel uncomfortable with the performance of MAiD. This is the case of so-called 'institutional objection', which is mentioned in several articles (2,36,38,41).

Practices related to Medical Aid in Dying that are targets of Conscientious Objection

Discussions about the kind of practices that one may object to vary among the articles. There seems to be a different approach to the topic depending on if the CO refers to the whole practice (a *categorical* CO) or if it only concerns a concrete stage of the process (conversation about euthanasia as an option, patient transference, prescription, or administration), in which case it can be considered as a *partial* CO.

Among categorical conscientious objectors, some refuse even the option to give information about MAiD to their patients (35). They feel that, by providing a referral, they would be complicit in the patients' death, and this would compromise their moral integrity (1,2,40,42,44). In extreme cases, professionals not only object to providing MAiD but also actively persuade their patients to withdraw their request. These professionals are categorised as dissuasive non-referrers (2).

Apart from categorical conscientious objectors, we also find reference to professionals who refuse to participate in MAiD but are willing to discuss the procedure with a colleague or to refer their patient to an alternative provider for MAiD (38). In doing that, they feel that their moral objection against participating in a practice of which they disapprove is compatible with the patient's right to request euthanasia or physician-assisted suicide (2). There is still another position that relies on casuistry: those conscientious objectors who would perform a MAiD under strict conditions, in exceptional situations based on a decision case-by-case, and after a deep reflection (2).

What about nurses who object? Empirical studies show that they defend their right to CO as healthcare professionals. Nevertheless, they also experience a kind of contradiction when they object insofar as they believe that CO is contrary to the nursing duty to participate in patients' caring tasks (35). To add another layer of complexity to the situation, they admit that it would be hard to take care of the patient the day before euthanasia administration because they could not support the patient's decision or could not share their point of view freely (35). In this sense, nurses find it difficult to inform their patients about their moral standpoint, fearing that patients may not understand their reasons to object.

In general terms, the literature has noted the difficulty of proving the sincerity of the refusal to get involved in dying requests (36,45,39). As a widespread rule, it has been established that care providers could object to a practice, but not to the request of a specific patient (40). They must maintain professional standards (1) and make sure patients can access healthcare services no matter the circumstances (42).

Degrees of Conscientious Objection recognition

Mostly, the sources analysed consider that CO is acceptable and worth protecting so that professionals are not sanctioned for their refusal to participate in the procedure. However, at the same time, it is suggested that this right should have some limits and conditions. This is specifically true from a 'patients-centred' perspective and the guarantees of access by public healthcare systems. Therefore, we find different degrees of recognition regarding CO in the MAiD context.

On the one hand, CO is considered deeply legitimate in healthcare practice because authors perceive that MAiD falls out of the scope of standard medical competencies and can thus be seen as a special duty (35,45). Furthermore, some professionals have significant concerns about the compatibility of MAiD with good medical and nursing care (35,42). The background idea of this position is that MAiD causes harm (40) and, for that reason, medical ethics may be at issue during the whole process (42). Hence, CO is considered a mechanism to preserve healthcare professionals' moral integrity and avoid moral damage (2,36). These two dimensions – moral integrity and moral damage – are sometimes linked to professionals' religious reasons and their view of euthanasia as a morally wrong practice (37).

On the other hand, some of the articles argue for a balance between CO and patients' autonomy and their right to access specific services (2,41), including MAiD (43). For instance, according to Canadian legislation protecting equitable access to care, patients should not be discriminated against and, consequently, healthcare professionals have a duty towards those patients that require medical services (40,45). In this sense, Brown et al. (38) note that CO recognition may imply a break of the social contract between healthcare professionals and patients as the right of healthcare providers to object may collide with the patients' right to access MAiD. As a solution, some articles defend the view that healthcare professionals should be prepared to perform the MAiD practice in case it is requested (35,45), regardless of their CO. Attaran (40) appeals to the obligation to follow the law, that is, to provide MAiD. He argues that physicians should adapt themselves to social demands, especially in publicly funded healthcare systems.

From a legal point of view, countries where MAiD is a legal practice have either recognised the possibility for healthcare professionals to not participate in the process (43), as is the case in the Netherlands, or regulated CO as an individual right that should be respected, as is the case in Spain. However, some articles seem to find the right to CO at risk when confronted with the right to MAiD. According to this perspective, there are not enough safeguards for professionals who stand for CO (38,43) nor enough legislative provisions for a robust respect of CO (39,41,42). Additionally, it is worth highlighting that there are healthcare professionals, both for and against performing MAID, who feel that they are under pressure or stigmatised by their peers, clinical leaders, institutions, and society when seen as acting contrary to mainstream views about euthanasia and assisted suicide (1,39,45).

Proposals to improve Conscientious Objection Practice in Medical Aid in Dying

A number of the articles analysed the offer of different proposals to improve the situation related to CO in the institutional, professional, and personal realms. Measures presented were in three main areas: 1) definitions of CO and the division of tasks by professions, 2) concrete processes to object, and 3) repercussions for conscientious objectors.

First, on the institutional/legal level, there is a need to improve the framework for CO in MAiD. That includes, firstly, the need to define or clarify the current definitions that inform the role of the different professions involved in MAiD, and secondly, the need to underpin the non-religious reasons or reasons not directly related to conscience behind CO. As a pragmatic measure, Caux et al. (45) propose the creation of a model list of CO acceptability, as well as some sort of adaptive CO depending on the geographical area (rural/urban) and its possible impact on professionals' lives and collective values. On the personal/professional levels, promoting self-reflection and education in moral competencies would be important to identify possible frictions and ethical tensions among professionals as well as to better manage ethical dilemmas (45). Professionals need to have enough time to think about MAiD so they can decide whether to participate (36). Even more importantly, institutions should give better emotional support to professionals (36) and be attentive to their needs as these could be a source of emotional distress (38). As there might be stressors that guide the professionals' decision not to participate in a MAiD, Brown et al. (38) suggest reconciliation as a process that harmonises endogenous factors (previous experiences, comfort with death, conceptualization of duty, end-of-life care approaches, spiritual beliefs, and self-accountability) with current practices.

Second, it is urgent to clarify and evaluate the processes by which a CO may be declared (1). If professionals decide to object after reflecting on their practices and beliefs, there are some points to consider. Institutions should "identify how the facility and staffing logistics are managed concerning MAID, and how, when, and to whom objection will be communicated to ensure the continuation of safe care" (38, p.1796). Some authors agree on the importance of communication of a CO to the rest of the team and their patients. This has two aims. On the one hand, having frank and open conversations with patients could allow for more space to appreciate patients' motivations for requests (1) and open the discourse (38). On the other hand, it is required to assure collectively that MAID is available to any patient who asks for and qualifies for this service (45). There is consensus in the literature that referral pathways should be implemented (38,41). Every time that a professional declares a CO, there should be an easy transfer to another colleague to facilitate MAiD access without neglecting professionals' moral integrity. One way to solve this issue is to accept multiple MAiD access pathways, including physician- and patient-initiated referrals (38). Nevertheless, this measure would not work if there were not enough professionals who agreed to perform MAiD (41). Moreover, as a public medical service guaranteed by law, public awareness of CO should be a priority. That includes informing the population about the possibility of CO in their medical centres (45). Christie et al. (41) go further and suggest requiring a justification of the CO motives, even though there is a freedom to object.

Third, some authors who take a pro-CO position are concerned with the impact on professionals who object and recommend an improvement of institutional support to professionals who declare a CO as well as their destigmatisation (1,38). These measures could help conscientious objectors to voice their positions and feel more respected.

DISCUSSION

After presenting all the findings of the current scoping review and confronting these with similar recently published studies (47), we confirmed that there are still very few articles exploring in-depth the possible causes for CO to MAiD, or the theoretical assumptions and empirical factors that are involved or contribute to their understanding. Thus, there is a clear need for further research on the topic.

If we consider for a moment the theoretical approaches to the topic made by some of the authors, it seems that motivations for CO to MAiD are usually taken for granted, leading them to the synonymous use of language such as "freedom of conscience (and religion)", "protection of moral integrity", or "protection from moral distress" as grounds to claim CO (cf. 1,38,39,43). In a similar vein, most of the articles analysed defend the right to CO as if it was crystal clear that, in cases of a rights confrontation, the right to CO would be at risk and the right of patients to receive MAiD would prevail. This was a surprising finding, since CO has frequently been protected and guaranteed over and above the social rights of citizens to benefit from a service, as has been widely reported in the case of abortion (48). Our findings show that there still exists an important gap between the theoretical and the empirical literature about CO to MAiD. Theoretical discourses keep using the common and traditional definition and motives for CO (that is, protection of freedom of conscience and moral integrity) as the main reason for healthcare

professionals, but without questioning whether these match with the findings of empirical studies. At the same time, the assumed claim that CO is at risk when confronted with the right to MAiD is not backed up by robust empirical data.

Results reveal that CO to MAiD is a multidimensional phenomenon, but this is not included in the theoretical discussion. Although the literature analysed explores one or another dimension of CO to MAiD, there are no comprehensive reviews of the intersection between these different motivations. To make this clear, consider the following example. Some have considered CO as a legal mechanism to guarantee the exceptionality of not obeying the law – the right to MAiD – due to conscience conflicts (39,43). Others have understood this as an ethical and deontological resource when values and beliefs collide with the morally controversial practice (35,42). These values and beliefs can come from a personal source, not necessarily religious, and they can also be part of a core professional *ethos* (36,37,39). There are others who consider contextual factors as the key to CO. These factors include group pressure, institutional mandates, bureaucratic load, ignorance, fear, and stigma (2,36,38), as well as the circumstances (i.e., in the case where the patient is unknown to the healthcare professional or vice versa) and the timing of the MAiD process (i.e., administration, information, or patient's referral).

Regarding institutional CO, it is relevant to consider potential pressures exerted on healthcare professionals when facing euthanasia in institutions where there is a specific mission and values. Insofar as some of these institutions are religiously affiliated (42), religion may play not only an individual role – as mentioned above – but also a collective one. It can be a political catalyst for institutional objection to euthanasia and, thus, affect the controversies on CO.

Among the articles reviewed, there was no proposal to establish a systematic categorisation of the motivations behind CO to MAiD based on their different nature. More recent articles have, however, made attempts in this direction (47). It is not possible to fully comprehend CO to MAiD if the legal, ethical and deontological, psychological, religious, and contextual factors are not all considered together as elements that can both individually and combined trigger a CO. Furthermore, the political and social dimensions should be considered and made crucial considerations in future research. As a public health policy and law, MAiD is under the influence of political parties and citizens' opinions and can be ideologically instrumentalised in the political arena. That, too, has an impact on public, professional, and personal support for or refusal of MAiD, and can easily polarise the decision whether to object. Although it is true that not all the dimensions have to appear at the same time in any given healthcare professional, all should be considered at some point when analysing and theorising about CO. Given this complexity, there is a need for a mixed methodological approach that combines theoretical and empirical research to better understand the nature and interaction of all the factors at play.

As reported above, theoretical approaches to CO focus much more on the religious motivations than empirical work would seem to justify. The latter includes a larger list of secular motives, with religious reasons being one of the many possible causes for CO. The difference between religious and secular causes for CO to MAiD (36,37,39) reveal the moral weight given to each of these motives in the discussion, which, in turn, may have an important impact on their ethical and legal recognition, and on the standpoint for the philosophical debate.

Traditionally, conscience and religion have been understood as interwoven entities since 'conscience' constitutes the core of the individual, at least in the Western-Christian tradition (48). Further, religions have historically articulated issues about the nature and meaning of life, so their influence on public conceptions and individual consciousness have been well studied, especially regarding life and death issues (cf. 50-52). The consideration of religious beliefs and commitments of faith as inalienable has qualified them for special protection that have not always been granted to secular moral sources (53). However, regarding CO to MAiD, secular moral sources should be considered equally to religious sources, since their non-religious justification does not necessarily make them easier to abandon or betray. In fact, the empirical studies examined show that this difference of moral weight has to be reviewed; and the repercussions of this argument include the possible need to reformulate the very same notion of CO.

One of the main problems neglected in the articles under review is the difficulty of establishing which values and beliefs should be considered *of conscience*, and, therefore, worthy of special protection (e.g., becoming an exception on the enforcement of the MAiD law). It was noted above that deeply held moral convictions, with a high individual significance, have been considered as deserving protection under CO. However, are professional values also part of care providers' conscience? Should they be? Some authors in the general bioethics literature, outside the scope of the articles reviewed, propose different answers to these questions. On the one hand, Savulescu and Schuklenk (22), for example, argue that healthcare professionals – specifically, physicians – must be willing to provide all those procedures that are legal, beneficial, required by patients, and that are part of a fair healthcare system. Thus, the values of conscience of healthcare professionals should be put aside to avoid unjustified moral impositions on patients. On the other hand, more traditional bioethics scholars, such as Pellegrino (11), defend the view that personal and professional values are intertwined; healthcare providers cannot renounce their personal beliefs without eroding their moral integrity and losing their identity, so they should not be required to do so.

There are other motives that deserve special attention. Can moral distress and psychological impact be reasons to appeal to CO? What about contextual factors such as the workload associated both with bureaucracy and providing the actual professional intervention? It might seem that they fall outside the standard definition of CO – i.e., understood as a 'conflict with one's core values or beliefs' – and they are also outside what can be considered the professional's *ethos*. However, they are actually some of the reported causes for healthcare professionals to claim CO, according to the empirical articles in our scoping review. If we consider that these motivations exceed the definition of conscience and, thus, cannot be used as a right to CO,

then we have to face another question: What status and name should we give to this kind of refusal from healthcare professionals to provide MAiD? If they are no longer protected by the right to CO, should they have the right to refuse? It is not implausible to assume that some healthcare professionals who are not actually against MAiD may use CO to avoid dealing with other problems with which they might be confronted. For example, when 1) there is no institutional support for healthcare professionals to perform MAiD and also accomplish their other daily tasks, especially in systems that are already overloaded, or 2) when performing MAiD can lead to being judged or stigmatised (particularly in small communities), or can even put a professional's job at risk (if none of the others team members want MAiD to be performed in the unit), is there a right to refuse to take part in a medical practice that it is not based on conscience?

In the case of such a non-conscience-based refusal, we would question the fundamentals of the assumptions that sustain the current right to CO to contribute to reconciling theory and praxis in MAiD. It is unknown if professionals are understanding conscience in the traditional way, but there seems to be a dissonance between words and acts. Definitions remain abstract and lacking interpretation, nor have there been no explicit efforts to identify which cases could be part of conscience motivations and which could not. But it is also clear that determining the sincerity of this immeasurable *content of conscience* – which is frequently considered an essential part of individuals' privacy, intimacy, and identity – will be extremely difficult.

Among the papers analysed, there are vanishingly few authors who dare to propose the need for conscientious objectors to make some kind of public justification of their personal reasons for CO to MAiD (cf. 14,23). These authors usually base their arguments on the need to reconcile the protection of conscience with patients' autonomy and rights. While there is a large and established literature in philosophy on CO and religious exemptions (54,55) to reconcile the two rights, there is need for a deep philosophical investigation to fully understand the different options to include/exclude the secular dimensions of and the multifactorial, hybrid motives for the notion of conscience and, thus, CO. One of the possible options is to rethink the moral debate not in terms of competing rights (healthcare professionals' rights to CO versus patients' right to MAiD) of rational, independent beings, but in terms of relations and responsibilities to others. This approach would include the social, cultural, and political influence on moral decisions.

Instead of using a theoretical-juridical model of morality – i.e., a compact, propositionally codifiable, impersonally fixed action guiding code within an agent or a compact set of universal law-like propositions (56) – we could use an expressive-collaborative model of morality. This model is context-dependent, relational, and analyses actual practices of responsibility through empirical research. It also critically reflects on whether there is any need to modify the previous moral assumptions because they can change over time. In this theoretical framework, we could consider a relational concept of conscience, rather than the standard liberal one. In that sense, conscience should be understood non-dogmatically, but as something that is sensitive to connections between personal and professional moral dimensions, and open to critical (self-)reflection (14,57). A relational perspective might be useful to avoid thinking about conscience in a categorical, fixed, individualistic way (like much of the theoretical literature reviewed, which follows the theoretical-juridical model). In the same vein, a relational approach could contribute to carefully analysis of deeply held beliefs related to notions of life and death, considering not only one's own values, but also responsibilities towards others. Lastly, such a relational framework could be helpful in distinguishing those motivations related to problems that are susceptible to mitigation through different measures, such as emotional support, institutional strategies, and education (i.e., fears of the emotional impact of practising MAiD, lack of legal and clinical knowledge, group pressure, workload, etc.) that act as determinants to current CO but might be addressed by other means. In so doing, it would be possible to give an adequate answer to why there is a gap between theoretical and empirical literature, and to reframe the controversial problems that countries with current MAiD legislation are facing, as well as the derived issues that CO could imply for both healthcare professionals and patients.

LIMITATIONS

The results and discussion contained in the present scoping review are promising and ambitious. Nevertheless, some limitations must be considered. Most of the articles analysed were based on a qualitative methodology (1-3,35-39). Qualitative research is, in the context of CO for MAiD, very useful for capturing the richness of healthcare professionals' discourses, but it has a geographical (articles are mostly from Canada) and sample limitation (small number of participants in each research). Therefore, it would be useful to widen the spectrum of qualitative studies to other countries where MAiD is legal, as well as encouraging more regional and international/comparative quantitative research on health professional CO for MAiD.

CONCLUSION

Conscientious objection is traditionally defined as a healthcare professional's prerogative to safeguard their conscience when they feel it is threatened by the requirement of performing a legal practice, as is the case with euthanasia and assisted suicide (or abortion). But in such situations, the patient's rights might be constrained or even outweighed, since the professional's moral integrity could be at stake. In the light of current legislation on MAiD (euthanasia and assisted suicide) in different countries, there have been some arguments devoted to the right to CO for healthcare professionals in these specific practices. As the results of our systematic review show, there is a dissonance between the traditional definition of CO that is used in theoretical and speculative discussions and the factors reported in empirical studies as motivations to object to MAiD. CO to MAiD arises from a variety of different motivations, in a spectrum that includes personal and moral beliefs (whether secular or religious), conceptions of the goals of the profession (not harming, protecting life, etc.), as well as other practical reasons such as lack of training, social pressures, legal insecurity or workload. Some of these causes seem not to belong to the concept of

'conscience'. However, from the perspective of the theoretical articles, the concept of 'conscience' is sometimes used as a monolithic idea that cannot be questioned and can turn into a hodgepodge that mixes values and beliefs with other causes that eventually might undermine the original meaning and purpose of CO. Hence, we should either consider new causes among the general concept of 'conscience' or accept that there are motivations to use CO that are not actually applicable to CO and that should be addressed by other means. Our review of the literature showed that CO in MAiD is multifaceted, and there can be different kinds of motivations acting at the same time. There is thus a need to rebalance theory and practice to fully understand the complexity of the phenomenon and offer better insights on how to deal with CO. This mixed approach, we argue, is compatible with a relational framework that enables a better reflection about one's own conscience and the impact that CO to MAiD may have on professionals' and patients' end-of-life rights and decisions.

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