

Should Institutional Conscientious Objection to Assisted Dying be Accommodated?

Jeffrey Kirby

Volume 4, numéro 1, 2021

URI : <https://id.erudit.org/iderudit/1077623ar>

DOI : <https://doi.org/10.7202/1077623ar>

[Aller au sommaire du numéro](#)

Éditeur(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (numérique)

[Découvrir la revue](#)

Citer cet article

Kirby, J. (2021). Should Institutional Conscientious Objection to Assisted Dying be Accommodated? *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, 4(1), 15–20. <https://doi.org/10.7202/1077623ar>

Résumé de l'article

Le débat controversé et d'actualité sur la question de savoir si les organisations de soins de santé confessionnelles devraient se voir accorder un accommodement sur la base de l'objection de conscience institutionnelle à l'aide médicale à mourir (AMM) est abordé par le biais d'une analyse comparative des arguments des deux côtés de la question qui fait référence à des considérations pertinentes telles que : la revendication d'une « autorité morale », les revendications concurrentes fondées sur les droits, les obligations découlant des principes du bien-être du patient, la justice formelle, la dissemblance des conséquences, et deux arguments illustratifs tirés de l'analogie. L'analyse conduit à la conclusion que l'accommodement non conditionnel sur la base de l'objection de conscience institutionnelle à l'AMM n'est pas éthiquement acceptable au Canada. Un mécanisme de compromis, consistant en un ensemble de conditions pragmatiques, est proposé pour équilibrer efficacement les responsabilités morales concurrentes qui découlent de cette conclusion et d'une hypothèse centrale de l'article, à savoir que certains établissements de santé confessionnels dominants peuvent légitimement demander et s'attendre à ce que les gouvernements provinciaux/territoriaux leur accordent un certain respect dans leur prise de décision opérationnelle en matière de prestation de soins de santé, en raison de la longue histoire de ces établissements en matière de prestation de soins de santé de haute qualité au Canada. Il est en outre suggéré que les gouvernements provinciaux/territoriaux n'autorisent les grandes organisations de soins de santé financées par l'État et fondées sur la foi à adopter une version conditionnelle de l'accommodement sur la base de l'objection de conscience institutionnelle à l'AMM que dans les cas où l'organisation a conclu un accord officiel avec le ministère de la Santé concerné pour satisfaire aux conditions de compromis proposées (ou à un ensemble de conditions similaires).

© Jeffrey Kirby, 2021



Ce document est protégé par la loi sur le droit d'auteur. L'utilisation des services d'Érudit (y compris la reproduction) est assujettie à sa politique d'utilisation que vous pouvez consulter en ligne.

<https://apropos.erudit.org/fr/usagers/politique-dutilisation/>

érudit

Cet article est diffusé et préservé par Érudit.

Érudit est un consortium interuniversitaire sans but lucratif composé de l'Université de Montréal, l'Université Laval et l'Université du Québec à Montréal. Il a pour mission la promotion et la valorisation de la recherche.

<https://www.erudit.org/fr/>

ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Should Institutional Conscientious Objection to Assisted Dying be Accommodated?

Jeffrey Kirby^a

Résumé

Le débat controversé et d'actualité sur la question de savoir si les organisations de soins de santé confessionnelles devraient se voir accorder un accommodement sur la base de l'objection de conscience institutionnelle à l'aide médicale à mourir (AMM) est abordé par le biais d'une analyse comparative des arguments des deux côtés de la question qui fait référence à des considérations pertinentes telles que : la revendication d'une « autorité morale », les revendications concurrentes fondées sur les droits, les obligations découlant des principes du bien-être du patient, la justice formelle, la dissemblance des conséquences, et deux arguments illustratifs tirés de l'analogie. L'analyse conduit à la conclusion que l'accommodement non conditionnel sur la base de l'objection de conscience institutionnelle à l'AMM n'est pas éthiquement acceptable au Canada. Un mécanisme de compromis, consistant en un ensemble de conditions pragmatiques, est proposé pour équilibrer efficacement les responsabilités morales concurrentes qui découlent de cette conclusion et d'une hypothèse centrale de l'article, à savoir que certains établissements de santé confessionnels dominants peuvent légitimement demander et s'attendre à ce que les gouvernements provinciaux/territoriaux leur accordent un certain respect dans leur prise de décision opérationnelle en matière de prestation de soins de santé, en raison de la longue histoire de ces établissements en matière de prestation de soins de santé de haute qualité au Canada. Il est en outre suggéré que les gouvernements provinciaux/territoriaux n'autorisent les grandes organisations de soins de santé financées par l'État et fondées sur la foi à adopter une version conditionnelle de l'accommodement sur la base de l'objection de conscience institutionnelle à l'AMM que dans les cas où l'organisation a conclu un accord officiel avec le ministère de la Santé concerné pour satisfaire aux conditions de compromis proposées (ou à un ensemble de conditions similaires).

Mots-clés

objection de conscience institutionnelle, aide médicale à mourir, établissement de santé confessionnel, accommodement, soins de santé financés par l'État

Abstract

The contentious, topical debate about whether faith-based health care organizations should be granted accommodation on the basis of institutional conscientious objection to medical assistance in dying (MAiD) is addressed through a comparative analysis of arguments on both sides of the issue that references such relevant considerations as: claimed 'moral-authority', competing rights-based claims, obligations arising from patient welfare principles, formal justice, dissimilarity in consequences, and two illustrative arguments from analogy. The analysis leads to the conclusion that nonconditional accommodation on the basis of institutional conscientious objection to MAiD is not ethically acceptable in Canada. A compromise mechanism, consisting of a suggested set of pragmatic conditions, is proposed that could effectively balance the competing moral responsibilities that arise from this conclusion and a core assumption of the paper, i.e., that some dominant faith-based health institutions can legitimately request, and expect, that provincial/territorial governments pay them a measure of respect in their operational, health-care-delivery decision making because of these institutions' long history of providing high quality, health care in Canada. It is further suggested that provincial/territorial governments only allow large, publicly funded, faith-based health care organizations to enact a conditional version of accommodation on the basis of institutional conscientious objection to MAiD in circumstances where the organization has entered into a formal agreement with the relevant health department to meet the proposed, compromise conditions (or a relevantly-similar set of conditions).

Keywords

institutional conscientious objection, medical assistance in dying, faith-based health institution, accommodation, publicly-funded health care

Affiliations

^a Department of Bioethics, Faculty of Medicine, Dalhousie University, Halifax, Canada

Correspondance / Correspondence: Jeffrey Kirby, Jeffrey.Kirby@dal.ca

INTRODUCTION

In the few years since the implementation of legal medical assistance in dying (MAiD) in Canada, there have been fractious, unresolved debates in the media and health care delivery forums about whether claims by faith-based health care organizations for accommodation on the basis of institutional conscientious objection (CO) to the provision of MAiD services should be accepted by the health departments of provincial/territorial (P/T) governments, health care provider communities and the general public (1). Most of these institutional CO accommodation claims have been made by dominant, faith-based health institutions (F-BHIs) that have a long history of significant, constructive engagement in health care delivery in Canada (2).

After making two core assumptions and articulating the paper's scope of consideration, arguments for and against considering accommodation on the basis of institutional CO to MAiD to be ethically acceptable are introduced and compared. The analysis leads to a conclusion that nonconditional, institutional accommodation is not ethically acceptable. A compromise mechanism, consisting of a set of pragmatic conditions, is proposed that could effectively balance the competing moral responsibilities that

arise from this conclusion and the paper's assumption that some dominant F-BHIs can legitimately request, and expect, that P/T governments pay them a measure of respect in their operational decision making because of their long tradition of providing high-quality health care. It is further suggested that Canadian P/T governments only allow large, publicly-funded, faith-based health care organizations to enact a conditional version of accommodation on the basis of institutional CO objection to MAiD in circumstances where the F-BHI has entered into a formal agreement with the relevant P/T health department to meet all of the proposed, compromise conditions (or a relevantly-similar set of conditions).

ASSUMPTIONS AND SCOPE

For the purposes of the analysis, I make two assumptions which I do not argue for in the paper:

Assumption A: Consistent with a long history of accepted, health care and regulatory practices in many high income countries (HICs) including Canada and, more broadly, in alignment with general societal support in liberal democracies for the freedom of conscience of health care providers (HCPs), it is assumed that conditional, health-regulator-limited accommodation of HCPs on the basis of CO to the provision of legal health services, including MAiD, is ethically acceptable (3,4). This assumption is reinforced in the Canadian legal domain by the fact that the participation of individual HCPs in the provision of MAiD services cannot be compelled given: 1) relevant provisions of the Canadian *Medical Assistance in Dying Act* (Bill C-14), which went into effect in November 2018, and 2) the prior ruling of the Supreme Court of Canada in *Carter v. Canada* (5,6).

Assumption B: The long history of meaningful engagement in health care delivery by some dominant F-BHIs in Canada provides these organizations with a legitimate claim to respectful consideration of their core commitments/positions by the health departments of P/T governments in their operational decision making about health care delivery.

The scope of consideration of institutional CO in this paper is limited to publicly funded, inpatient, health care settings including hospitals, palliative care units within hospitals, and large, long-term or continuing care organizations. The paper does not address institutional CO in the context of private health care delivery, other than to use it as a comparator in an illustrative argument from analogy. Very small, long-term care settings and hospices, where it is possible that all staff and patients share the same faith-based belief system, are also excluded from the paper's scope of consideration (7).

ARGUMENTS IN SUPPORT OF INSTITUTIONAL CO ACCOMMODATION

Most of the arguments offered in support of accommodation on the basis of institutional CO to MAiD fall into two general categories of inductive arguments, i.e., arguments from authority (*argumentum ad verecundiam*) and arguments from analogy. Arguments from authority are grounded in the decisions and/or positions of an authoritative source. They typically take the form of: X says so, X is an authority, therefore it is so. In general, arguments from authority are not considered to be particularly robust in nature because, typically, no direct justification(s) is provided for the authority's position. Arguments from analogy are based on perceived similarities between two things that infer some other similarity that has not been proven. The general formulation of arguments from analogy is described later in this section.

With regard to relevant arguments from authority, proponents of institutional CO accommodation typically cite the moral authority of a dominant, faith-based entity/organization such as the Roman Catholic Church. They assert that established religious institutions operate under a comprehensive set of moral rules, e.g., that it is always harmful and dignity-degrading to terminate life ('sanctity of life' position), that, taken together, constitute the organization's moral conviction and conscience (8). The essential claim is that such religious institutions have distinct moral identities that are expressed in their mission statements, policies and practices (9). In the same vein, Spencer Durland asserts that "a Catholic hospital has, in the *Directives*, a comprehensive set of moral rules it can claim as its conscience" (8, p.1681). Some dominant religious organizations claim that their inherent moral authority allows them to exclude from provision within their F-BHIs certain legal, health care services that they believe are morally objectionable.

A rights-based contention that is often articulated by proponents of institutional CO accommodation is the authority-referenced claim that the right of freedom of conscience and religion, which is protected under section 2(a) of the *Canadian Charter of Rights and Freedoms*, applies to both individual persons and faith-based organizations (10). This and other rights-based claims and arguments are addressed in the next section of the paper.

Supporters of institutional CO accommodation sometimes cite the macro-level authority of government. In Canada, health care delivery is primarily the operational responsibility of the P/T governments. In the province of Ontario, for example, two pieces of legislation have had significant bearing on the matter/issue under consideration. Bill 41, often referred to as the *Patients First Act*, prevents the province's local health authorities and Ontario's Health Minister from issuing an operational or policy directive that "unjustifiably" – as determined under section 1 of the *Charter of Rights and Freedoms* – goes against the religious positions of a provincial health care organization (11). This bill provides legislative support to Ontario's F-BHIs in their claims for accommodation on the basis of institutional CO to MAiD. Bill 84, the *Medical Assistance in Dying Statute Law Amendment Act*, shields Ontario's F-BHIs from mandatory disclosure of how they are handling/managing requests for MAiD within the province (12).

Other arguments in support of institutional CO accommodation attempt to justify an expansion of the usual scope of authority of F-BHIs. Barry Bussey claims that when social conditions fundamentally change, as they did with the implementation of MAiD in Canada, F-BHIs should be allowed to resist or slow down the rate of change in their particular domains of practice or influence (13). Philip and Joshua Shadd claim that F-BHIs can assert “an institutional right of non-participation...because they possess a more general right of self-governance” that can be exercised through the placing of limits on the scope of care offered and provided by the health care organization (14, p.209). According to this conceptualization, the self-governance agency of F-BHIs must be grounded in “legitimate reasons to exercise...discretion” such as “moral principle”, “[lack of relevant] expertise”, “institutional specialization”, “philanthropic funding implications” and “conflation of palliative care and MAiD in [the] public consciousness”. With reference to the first listed reason, i.e., moral principle, Shadd and Shadd comment that “a health centre might find a procedure accepted by the wider medical community nonetheless morally objectionable” (14, p.211-212).

Arguments from analogy base their claims on known similarities between two things that are supposed to infer some further similarity that has not been proven. To say that something is analogous to something else is to say that it is similar to that something else in a respect that is understood to be relevant in the context in which it is claimed (15). Mark Wicclair articulates that claims to similarity “can be advanced on behalf of health care institutions that bear a family resemblance to appeals to conscience by individuals” and, as such, these claims “warrant substantial deference.” According to Wicclair, the distinct identities of F-BHIs, expressed in their mission statements, policies and practices “provide the basis for what might be considered analogues to appeals to conscience (9, p.148-149). Traditionally, arguments from analogy take the following, general, inductive form (15,16):

(Similarity Premise 1) A and B are similar/analogous in a way(s) that is relevant to what is being argued-for in that they both have property F1,...Fn.

(Premise 2) B has the additional property D.

Therefore, A has the property D.

For the purposes of the paper, “A” is a publicly funded F-BHI and “B” is an individual HCP, i.e., a physician or nurse practitioner, who could potentially engage in the direct provision of MAiD services in Canada. Using the general formulation of arguments from analogy, what appears to be claimed by proponents of institutional CO accommodation is as follows: an individual HCP and a F-BHI are similar/analogous in that they both have the properties of: 1) capacity for moral reflection, and 2) engagement in morally relevant agency, including their decision making and actions concerning the delivery of health care to patients (Similarity Premise 1). As per Assumption A of this paper, an individual HCP has the additional property of ethical acceptability of accommodation on the basis of the provider’s CO to the provision of MAiD services (Premise 2). Therefore, the ethical acceptability of accommodation on the basis of CO to the provision of MAiD services is also a property of F-BHIs. This basic argument from analogy could be supplemented in Premise 1 by adding other properties that the arguer claims that an individual HCP and a F-BHI share, e.g., characteristics that are sometimes used as descriptive qualifiers for the granting of accommodation to individuals on the basis of CO, i.e., genuineness and sincerity (17,18). Challenges to this argument from analogy are explored in the next section.

ARGUMENTS AGAINST INSTITUTIONAL CO ACCOMMODATION

There are a variety of ways for opposers of institutional CO accommodation to argue their position. The approaches articulated in this section relate to: 1) rights-based claims/arguments, 2) obligations that arise from patient welfare principles, i.e., nonmaleficence and (beneficent) non-abandonment and continuity-of-care, 3) introduction of an illustrative argument from analogy that highlights the relation/connection of funding to moral agency in the delivery of health care for patients, 4) a relevant, formal justice consideration, and 5) a utilitarian-based challenge to claims to relevant similarities between individual HCPs and F-BHIs made by proponents of institutional CO accommodation.

To begin with disavowal of a claimed right, proponents of institutional CO accommodation at times claim that the right of freedom of conscience is guaranteed for F-BHIs under the section 2(a) of the *Canadian Charter of Rights and Freedom*. However, the Charter does not address collectives of persons in its endorsement of this right – it only guarantees the right of freedom of conscience and religion of individual persons in Canada (10).

Opposers of institutional CO accommodation can argue that such accommodation interferes with the autonomy of individuals as it pertains to their pursuit of, and access to, health care, i.e., every person has the right, and should have the opportunity, to make meaningful decisions about their health care, including those related to the accessing of legal, health services in the health care organizations in which they are situated as inpatients or residents (8). Considering the particular context of MAiD, individuals have an autonomous right to request assessment for MAiD in the hospital or long-term / continuing care facility in which they are situated, and to have MAiD procedurally implemented in the same setting when relevant criteria are met. Although the positive right of persons to available, publicly funded, health care services is contested, it is widely accepted that individual persons in Canada have a negative right to not be interfered with in their pursuit of available, legal, publicly funded, health services including MAiD and therapeutic abortion (when legislative and regulatory criteria for provision of these services are met).

Another, strong, rights-based argument can be effectively employed by those who oppose institutional CO accommodation. The granting or allowing of such accommodation jeopardizes the Charter's section 2(a) protection of the right of freedom of conscience of individual HCPs working within F-BHIs. In the MAiD context, some Canadian physicians and nurse practitioners have called upon this accommodation, on the basis of conscience and strong moral commitments to providing MAiD services to patients/residents who request them while they are situated within the health care organizations in which they work (19,20). And there may be no alternative, secular, health care organizations located in the regional, geographic areas in which they reside because of socially important factors such as spousal employment and the maintenance of ready access to local, dependent family members. If a F-BHI does not permit attending HCPs to directly provide such legal, health services to inpatients/residents, the conscience-based moral agency of these HCPs is thwarted by their health care organization. As articulated in an online educational article of the Royal College of Physicians and Surgeons of Canada, support for institutional CO accommodation "could undermine the affirmative aspect of individual conscience, such that institutional conscience could require physicians and other employees to act in accordance with the institutional guidelines, [and, as such] physicians would be unable to exercise their own conscience if it disagrees with the institutional practices" (21, p.2).

With regard to the consideration of relevant patient welfare principles, there is a widely accepted ethical, nonmaleficence-related obligation of HCPs and health care organizations to do as little as possible harm to patients who are entrusted to their care. There are documented accounts in the Canadian public domain since the implementation of MAiD in November 2018 that have illustrated how enactment of faith-based, institutional requirements for patients to leave their in-hospital settings to obtain requested MAiD services elsewhere has caused significant physical health harms (e.g., exacerbated pain experience) and/or psychological health burdens (e.g., profound psychological distress) to four patients (and their family members), i.e., H.S. in Comox, I.S. in Vancouver, D.W. in Edmonton, and a unnamed patient at Hotel-Dieu Grace Hospital in Windsor (22). If institutional CO to MAiD were not to be accommodated in Canada, the significant, physical and psychological harms/burdens associated with such patient transfers to access MAiD services would not happen to patients situated in publicly funded hospitals and long-term or continuing care organizations.

On the basis of beneficence and duty-of-care considerations, HCPs and health care organizations have non-abandonment and continuity-of-care obligations to continue to provide patients with the health care services that they had been receiving prior to the making of a MAiD request, until such time as the patient no longer requires such care or the capable patient (or legitimate substitute decision maker) actively refuses this care (23). The requirement for patients to leave their existing hospital or long-term care settings to access MAiD services disrupts these patients' established, beneficent, therapeutic relationships with their attending HCPs, and constitutes a form of patient abandonment, discontinuity-of-care and care infidelity.

Those who oppose accommodation on the basis of institutional CO to MAiD could propose, and then invalidate, an illustrative argument from analogy to further their position. In this argument from analogy, "B" is a private F-BHI that uses only the private insurance benefits of its patients and the charitable donations to its foundation to deliver health care services to patients. (For the purposes of this hypothetical argument, a full scope of health services, including MAiD, is provided by other health organizations within the same regional health jurisdiction.) "A" is a publicly funded F-BHI. The similarity condition (Premise 1) essentially mirrors that of the first premise employed in the previously described argument from analogy: the two health organizations are similar/analogous in that they both have the property of engagement in morally relevant agency including their operational decision making and actions concerning the delivery of health care to patients. Premise 2 is that "B", a private F-BHI, has the property of independent moral agency as it pertains to its decision making about the delivery of health care services to patients. From these two true premises, the argument from analogy concludes that a publicly funded F-BHI has the same property of independent moral agency. However, the drawing of such a false conclusion demonstrates the argument's deductive invalidity as a publicly funded F-BHI is dependent on public funding for its primary moral agency, i.e., its delivery of health care services to patients. Such funding is provided on a mandatory basis by public taxpayers who inevitably, as members of a diverse, pluralist Canadian society, have "conflicting conceptions of what is considered [to be] morally right" (24, p.43). The invalidity of this illustrative argument from analogy lends support to one of the main claims made by opposers of institutional CO accommodation, i.e., that hospitals in Canada should be obliged to provide all publicly funded, non-tertiary/quaternary health services, including MAiD and therapeutic abortion, to their inpatients. This claim can be reframed in ethical terms through appeal to a widely accepted, formal justice notion or conception. Private F-BHIs and publicly funded F-BHIs within the same P/T health jurisdiction can be treated dissimilarly by P/T health departments, in terms of the government's allowance of enactment of institutional CO accommodation, if it can be demonstrated that there is a *relevant* difference between these two types of health care organizations. Many Canadians would consider the distinction between private and public funding of the delivery of health care services to constitute such a *relevant* difference.

In response to arguments from analogy based on claims to relevant similarities between an individual HCP and a F-BHI made by proponents of institutional CO accommodation, opposers of such accommodation can challenge these claims by pointing to fundamental dissimilarities between the outcomes and consequences of enactments of CO in these two circumstances. As per Assumption A and existing health-regulatory norms in Canada, an attending physician or nurse practitioner may choose to not directly engage in the provision of legal, health care services such as MAiD. The way this conditional, limited right of CO for an individual HCP typically works in health care organizations is that an operational arrangement is made for another, qualified HCP within the institution to step-in to provide the health service to the requesting inpatient. However, it does not work this way for a F-BHI that enacts institutional accommodation on the basis of CO. In this circumstance, the health care organization, and the attending HCPs working within it, do not provide the legal, health care service that is requested by the inpatient. This significant dissimilarity in the consequences of enacted accommodation between individual HCPs and F-BHIs sets-up the significant, physical, psychological, and patient abandonment and discontinuity-of-care burdens that accrue to the

inpatients/residents of F-BHIs who are required to leave their health care organization to access legal, health care services. In utilitarian terms, the negative outcomes and consequences of enactments of accommodation are much greater in circumstances of institutional accommodation than they are in circumstances of individual HCP accommodation.

As demonstrated in the last two sections, the inductive arguments from authority and analogy advanced by proponents of institutional CO accommodation either contain no direct justificatory bases for their argumentation or they can be effectively challenged. In addition, considerations of rights, patient welfare principles, formal justice, and relevant dissimilarities in consequences can be used to support and advance the contention that nonconditional, institutional CO accommodation is ethically unacceptable in Canada.

BALANCING OBLIGATIONS THROUGH A PROPOSED COMPROMISE MECHANISM

This paper's argumentation supports a conclusion that nonconditional accommodation on the basis of institutional CO to MAiD is ethically unacceptable in Canadian health care jurisdictions. However, as per Assumption B, F-BHIs have a legitimate claim to respectful consideration of their core commitments or positions by the operational decision makers of the health departments of P/T governments. This assumption is grounded in the long history of constructive engagement in delivery of health care by some dominant, faith-based organizations in Canada. With this in mind, the following practical, compromise conditions are proposed. Taken together, these conditions constitute a pragmatic, achievable way to balance the competing moral responsibilities that arise from the paper's conclusion and the referenced core assumption:

- Publicly funded F-BHIs are required to respond in a timely manner to patient inquiries regarding information pertaining to MAiD, and requests for MAiD assessment made by persons who are situated as inpatients or residents within these health care organizations.
- Direct assessments for MAiD purposes, and procedural implementations of MAiD for those patients who meet the required criteria and choose to proceed, occur in an appropriate health care delivery setting which is an attached component or part of the F-BHI that is not covered under the F-BHI's mission assurance statement or directive. The nature of the physical connection is such that patients can move easily from their inpatient clinical unit or residential room to and from this setting through their own ambulation or the use of a wheelchair or stretcher with no exposure to the external environment or the need to use transport vehicles such as ambulances. If a new-build construction of a small, attached, clinic-like setting is required to achieve this, the cost is covered by the F-BHI through charitable donations to its foundation or through a negotiated, cost-sharing arrangement between the F-BHI and the health department of the relevant P/T government in those circumstances where the new setting is to be used for implementation of other needed, publicly funded health services such as expanded diabetes or heart-function education.
- HCPs who are employed by the F-BHI have the (supported) freedom to participate in the provision of MAiD assessment and procedural implementation services to inpatients/residents who they have been caring for in the health care organization. In this way, continuity-of-care and non-abandonment obligations are respected in circumstances where this is possible because of the presence of appropriately trained physicians and/or nurse practitioners who have conscience-based commitments that support their direct engagement in MAiD. These self-identified HCPs are also allowed and enabled to participate in the provision of MAiD services to other inpatients or residents who they have not been directly caring for in the F-BHI.
- If the F-BHI does not employ HCPs who are willing, and appropriately trained, to provide MAiD services, willing and so-qualified, community-based HCPs or a publicly funded mobile MAiD team are brought into the F-BHI to perform these services in a timely manner.

It is further suggested that Canadian P/T governments only allow publicly funded, faith-based health care organizations to enact a conditional version of accommodation on the basis of institutional conscientious objection to MAiD in circumstances where the F-BHI has entered into a formal agreement with the health department of the relevant P/T government to meet all of the proposed, compromise conditions (or a relevantly similar set of conditions) on a mandatory, audited-for-adherence basis. An operationalized example of this type of conditional accommodation arrangement already exists in the province of Nova Scotia. As the result of a recent, formal agreement (which does not incorporate all of the proposed conditions) between the Nova Scotia Health Authority and St. Martha's Regional Hospital (a Roman Catholic F-BHI that is the only hospital of its kind in a large, geographic area of the province), MAiD assessment and procedural implementation services are provided in the Antigonish Health and Wellness Centre, which is a physically-attached part of the F-BHI that is not covered under the organization's Roman Catholic Mission Assurance Directive.

CONCLUSIONS

Arguments for and against the granting of accommodation to publicly funded, faith-based health care organizations on the basis of institutional CO to MAiD were introduced and compared in the paper. The analysis supported a conclusion that nonconditional, institutional CO accommodation is not ethically acceptable in Canada. A pragmatic, compromise mechanism was proposed that could effectively balance the moral responsibilities that arise from this conclusion and a core assumption of the paper. It is further suggested that Canadian P/T governments only allow publicly funded, faith-based health care organizations to enact a conditional version of accommodation on the basis of institutional CO to MAiD in circumstances where the F-BHI enters into a formal agreement with the health department of the relevant P/T government to meet all of the proposed, compromise conditions (or a relevantly-similar set of conditions).

Reçu/Received: 09/07/2020**Conflits d'intérêts**

Aucun à déclarer

Publié/Published: 01/06/2021**Conflicts of Interest**

None to declare

Édition/Editors: Loubna Affdal & Aliya Affdal

Les éditeurs suivent les recommandations et les procédures décrites dans le [Code of Conduct and Best Practice Guidelines for Journal Editors](#) de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE [Code of Conduct and Best Practice Guidelines for Journal Editors](#). Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

Évaluation/Peer-Review: Ellen Wiebe & Anonymous

Les recommandations des évaluateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme évaluateurs n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de la [Revue canadienne de bioéthique](#) assument la responsabilité entière de l'acceptation finale et de la publication d'un article.

Reviewer evaluations are given serious consideration by the editors and authors in the preparation of manuscripts for publication. Nonetheless, being named as a reviewer does not necessarily denote approval of a manuscript; the editors of [Revue Canadian Journal of Bioethics](#) take full responsibility for final acceptance and publication of an article.

REFERENCES

- Schuklenk U, Smalling R. [Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies](#). *Journal of Medical Ethics*. 2017;43(4):234-240.
- Sumner LW. [Institutional refusal to offer assisted dying: A response to Shadd and Shadd](#). *Bioethics*. 2019;33(8):970-972.
- Blackshaw BP. [No Conscientious objection without normative justification: A reply](#). *Bioethics*. 2019;33(4):522-523.
- Huxtable R, Mullock A. [Voices of discontent? Conscience, compromise and assisted dying](#). *Medical Law Review*. 2015;23(2):242-262.
- [Medical Assistance in Dying Act](#) (Bill C-14). 17 Jun 2016; Implemented 1 Nov 2018.
- [Carter v. Canada \(Attorney General\)](#). Supreme Court of Canada 5, [2015] 1 S.C.R. R 331.
- Sepper E. [Taking conscience seriously](#). *Virginia Law Review*. 2012;98(7):1501-1575.
- Durland SL. [The Case against institutional conscience](#). *Notre Dame Law Review*. 2011;86(4):1655-1685.
- Wicclair MR. *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge: Cambridge University Press; 2012.
- [Canadian Charter of Rights and Freedoms](#). 1982.
- [An Act to amend various Acts in the interests of patient-centred care \("Patients First Act"\)](#). Supreme Court of Ontario, 2016, c. 30 – Bill 41; Assented to 8 Dec 2016.
- [Medical Assistance in Dying Statute Law Amendment Act](#). Supreme Court of Ontario. 2017, c.7 – Bill 84; Assented to 10 May 2017.
- Bussey BW. [The right of religious hospitals to refuse physician-assisted suicide](#). *Supreme Court Law Review*. 2018;85:189-223.
- Shadd P, Shadd J. [Institutional non-participation in assisted dying: Changing the conversation](#). *Bioethics*. 2019;33(1):207-214.
- Meinertsen BR. [A method for evaluation of arguments from analogy](#). *Cogency*. 2015;7(2):109-123.
- Walton D. [Story similarity in arguments from analogy](#). *Informal Logic*. 2012;32(2):190-221.
- McConnell D, Card RF. [Public reason in justifications of conscientious objection in health care](#). *Bioethics*. 2019;33(5):625-632.
- Kantymir L, McLeod, C. [Justification of conscience exemptions in health care](#). *Bioethics*. 2014;28(1):16-23.
- Christie T, Sloan J, Dahlgren D, Koning F. [Medical assistance in dying in Canada: An ethical analysis of conscience and religious objections](#). *BioéthiqueOnline*. 2016;5:14.
- Harman SM, Magnus D. [Early experience with the California End of Life Option Act: Balancing institutional participation with physician conscientious objection](#). *JAMA Internal Medicine*. 2017;177(7):907-908.
- Petropanagos A. [5.3.1 Conscientious objection to medical assistance in dying \(MAiD\)](#). *Royal College of Physicians and Surgeons of Canada*; n.d.
- Magelssen M, Le NQ, Supphellan M. [Secularity, abortion, assisted dying and the future of conscientious objection: Modelling the relationship between attitudes](#). *BioMed Central Medical Ethics*. 2019;20:65.
- Kirby J. [Balancing competing interests and obligations in mental health care practice and policy](#). *Bioethics*. 2018;33(6):699-707.
- Capps C. [Authoritative regulation and the stem cell debate](#). *Bioethics* 2008;22(1):43-55.