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A qualitative study of physicians' conscientious objections to medical aid in dying

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Abstract

Background: Under Quebec's Act respecting end-of-life care, physicians may refuse to provide medical aid in dying because of personal convictions, also called conscientious objections. Before legalisation, the results of our survey showed that the majority of physicians were in favour of medical aid in dying (76%), but one-third (28%) were not prepared to perform it. After 18 months of legalisation, physicians were refusing far more frequently than the pre-Act survey had anticipated.

Aim: To explore the conscientious objections stated by physicians so as to understand why some of them refuse to get involved in their patients' medical aid in dying requests.

Design/participants: An exploratory qualitative study based on semi-structured interviews with 22 physicians who expressed a refusal after they received a request for medical aid in dying. Thematic descriptive analysis was used to analyse physicians' motives for their conscientious objections and the reasons behind it.

Results: The majority of physicians who refused to participate did not oppose medical aid in dying. The reason most often cited is not based on moral and religious grounds. Rather, the emotional burden related to this act and the fear of psychological repercussions were the most expressed motivations for not participating in medical aid in dying.

Conclusion: The originality of this research is based on what the actual perception is of doing medical aid in dying as opposed to merely a conceptual assent. Further explorations are required in order to support policy decisions such as access to better emotional supports for providers and interdisciplinary support.

Keywords

Qualitative research, clinical ethics, medicine, refusal to participate, euthanasia

What is already known about the topic?

- Philosophical analysis and debates about conscientious objection in medicine
- Prevalence of conscientious objection measured by surveys in different controversial clinical practices such as abortion, reproductive issues and euthanasia.
- No qualitative study regarding the motives behind stated conscientious objection of clinicians who received medical aid in dying requests

What this paper adds?

- A majority of physicians receiving a request for medical aid in dying used conscientious objection as a mechanism to opt out of medical aid in dying for a multitude of reasons other than religious or moral objections.
- It was the term used when the refusal to participate stemmed from, among others, unacceptable emotional burden, high administrative workload and perceptions of incompetence.
- A majority of physicians who refused to perform medical aid in dying stated they were in favour of a patients' right to request medical aid in dying in appropriate circumstances.

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Implications for practice, theory or policy

- This study raises the question of whether medical aid in dying guidance is sufficiently specific with respect to what kinds of reason for refusal should be acceptable.
- The data could help initiate an orchestrated and attentive approach to supporting physicians with their expressed concerns in order to prevent delays in access to medical aid in dying for appropriate requesting patients.
- Further research is needed to determine whether participants' views and changing perceptions reflect those of other physicians who are faced with requests for medical aid in dying.

Background

In Canada, in February 2015, the Supreme Court of Canada decriminalised medical assistance in dying.[1] These criminal code exemptions came into effect in July 2016. In Quebec, in December 2015, a provincial health law unrelated to the Supreme Court proceedings came into effect: the *Act respecting end-of-life care*. Although there are similarities between the federal and Quebec laws, they differ on many requirements. Since this study was conducted in Quebec, it had to follow the requirement of the provincial law. The Quebec Act set out an overall, integrated vision of 'end-of-life care' which includes palliative care provided to end-of-life patients as well as euthanasia, referred to in the Act and in this article as 'medical aid in dying'. In Quebec, medical aid in dying consists 'in the administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death'.[2] Unlike the federal law, it excludes the provision of assisted suicide.

Under this law, physicians may refuse to provide medical aid in dying because of personal convictions, but they then need to abide by a specific notification system so that an eligible patient can receive medical aid in dying from another physician.[3] When refusing, a physician must notify and forward the request form to the executive director of the institution (or any other designated person), who must then take the necessary steps to find another physician willing to deal with the request as soon as possible. The term 'conscientious objection' refers to a physician's refusal to proceed with an intervention for reasons of personal conscience.[4] In medicine, conscientious objection has mainly been raised for interventions related to women's reproductive issues, such as emergency contraception and abortion, and end-of-life issues, such as assisted suicide and euthanasia.

There have been philosophical debates about conscientious objection,[5–7] and surveys have assessed its prevalence among physicians, residents and medical students.[8–11] However, most of these surveys have asked respondents for philosophical opinions without addressing actual practices. Few in-depth studies have explored conscientious objection for abortion.[12,13] To our knowledge, none have suggested a qualitative exploration with physician conscientious objectors facing medical aid in dying requests. This study attempts to fill this gap by answering these primary questions: Why do physicians object? What are the motives behind their refusals?

The first part of this article briefly presents the results of a survey conducted before medical aid in dying was legalised; the second part focuses on the results of a qualitative study conducted 18 months after legalisation.

Pre-legalisation survey

The survey was conducted in Laval, a city in the province of Quebec, Canada, with a population of 435,000 people. As part of the preparation leading up to the legalisation of medical aid in dying, the authors, in charge of the medical aid in dying programme, constructed a 15-question (multiple-choice and open-ended) online survey with the aim of better understanding physicians' viewpoints and the potential challenges.

Methods

In 20 October 2015, an email containing a link to an online questionnaire was sent to all physicians (n = 783) practising in the CISSS de Laval, the regional health care centre that comprises 32 facilities, 621 hospitalisation beds, 751 long-term care beds and 1638 beds in community resources. A reminder was sent on 15 November 2015. The survey could only be taken once per email address. In September 2015, the Scientific and Research Ethics Committee of the Centre intégré de santé et de services sociaux de Laval concluded that the survey did not fall within the scope of research ethics review. However, the authors made sure the physicians were given all the information about the survey (aim, length, voluntary, data protection). Completing the online questionnaire was considered as consent to participate in the study. The data were stored on a computer secured by a password.

Results of pre-legalisation survey

The survey participation rate was 26% (207/783), and 55% of respondents were female. Other socio-demographics are shown in Table 1.

Table 1. Characteristics of participants.

	%	*n*
Age (years old) (*n* = 204)		
<30	6	13
31–40	27	54
41–50	31	63
51–60	22	45
>60	14	29
Type of practice (*n* = 204)		
Family physician	49	101
Medicine and sub-specialties	20	40
Surgery and sub-specialties	7	15
Oncology	2.5	5
Palliative care	2.5	5
Other	19	38
Settings (*n* = 204)		
Hospital	54	109
Family medicine clinics	16	33
Private offices	12	25
Community setting	8	17
Other	10	20
Exposed to end-of-life patients (*n* = 204)		
Yes	60	122
No	40	82

The results of the online survey show that the majority of physicians were in favour of medical aid in dying, but approximately one-third (28%) were not prepared to perform it. Physicians also identified issues that concerned them about being able to provide medical aid in dying in view of the impending legislation and strategies that could support them (see Table 2). Because of the small sample size, we did not perform correlational tests or make comparison of subgroups of respondents. These descriptive statistics provided a portrait of trends in conscientious objection in order to prepare for legalisation.

Since December 2015, the authors have prospectively kept data on every medical aid in dying request received by a physician regardless of the setting (outpatient office, long-term care residence, inpatient or other). After 18 months, it became clear that physicians were refusing far more frequently than the pre-Act survey had anticipated. The rate of refusal was 61% (Table 3). In addition, there were difficulties in finding a willing alternate physician. This resulted in significant burdens on the few physicians who were identified as willing to perform medical aid in dying.

Methods: study 18 months after legalisation

Research question

After observing the significantly high number of refusals to perform medical aid in dying, the authors conducted an exploratory qualitative study to understand what underlies the conscientious objection stated by physicians.

Design

An exploratory qualitative study using semi-structured interviews.

Setting

The research was conducted in the same regional health care centre (CISSS de Laval) and with the same population of physicians as the pre-legalisation survey.

Participants

The authors contacted the 41 physicians who expressed conscientious objection between December 2015 and September 2017, and 22 (53.6%) agreed to participate in an interview.

Data collection

Data were collected between May and November 2017. A semi-structured interview guide containing eight open-ended questions was developed (Table 4). Interviews ranged in length from 15 min to 1 h, with a mean length of 24 min (median length = 21 min). Interviews were conducted by phone or in person, based on distance and physician preference. Interviews were not audio-recorded, but notes were taken at the time of the interview both by the interviewer and by a secretary who provided exact written verbatim of the participants' answers. Participants were asked to think back to their first medical aid in dying request (as some physicians had received more than one request) and describe the reasons which motivated their refusal. Participants were also asked when, in the multi-step medical aid in dying process, it would be legitimate to make a conscientious objection. They were also invited to reflect on what conditions would have helped them in the situation they faced.

Data analysis

The approach to the empirical data was inductive and explorative.[14] The researchers avoided applying a predetermined conceptual framework to the findings so that the physicians' voices could emerge. Following each interview, the interviewer wrote up research notes containing observations, ideas for future interviews and potential themes. The interviewer subsequently merged the secretarial transcripts of the interviews with the interview notes to compile a single unique file for each interview. The researchers read each interview several times and subjected the interviews to a descriptive thematic analysis.[15,16] During the

Table 2. Survey main results.

	%	*n*
Are you in favour of medical aid in dying? (*n* = 204)		
In favour	76	155
Not in favour	18	36
Neutral	6	13
Would you provide medical aid in dying for patients who meet the criteria?[a] (*n* = 204)		
No, I would never do it	28	56
Yes, all patients	22	45
Yes, but only once I have known for a long time	14	29
Yes, but only for certain pathologies	12	24
I refuse to answer	9	18
Yes, even those who do not meet the criteria	1	2
Other (gave qualitative answers)	29	60
In which setting would you be willing to provide medical aid in dying?[a] (*n* = 204)		
Hospital	44	89
In a palliative care unit	27	54
I would never do it	26	53
Wherever, it's the patient's choice	22	44
In a long-term care facility	16	33
At the patient's home	10	21
I refuse to answer	9	18
When a physician refuses to provide medical aid in dying for personal reasons, what should be put in place to help find a willing physician?[a] (*n* = 200)		
A list/bank of willing physicians	69	137
A dedicated team (swat)	64	127
Each department is responsible for finding an alternate	16	32
Whatever the strategy, I would never do it	9	17
I refuse to answer	2	4
Other (gave qualitative answers)	3	6
What are your concerns with medical aid in dying?[a] (*n* = 203)		
High emotional charge of medical aid in dying gesture	56	113
Lack of training	52	105
Lack of support, feeling lonely when providing medical aid in dying	48	97
Burdensome process (lots of paperwork)	40	82
Banalisation of euthanasia	34	69
Managing the frustration of patients when they do not meet the criteria	33	66
Non-respect of criteria	28	57
Fear of prosecution	26	52
Conscientious objections of colleagues	23	46
Criteria are too strict	10	20
I don't have any	8	16
Getting paid for it	6	12
Other	6	12
What should be put in place to help physicians?[a] (*n* = 204)		
Interdisciplinary support group for the whole process	88	176
Administrative support	27	54
Technical support	16	33
Emotional support	10	21
Other	9	18

[a]More than one answer possible.

analytical process, researchers produced a list of codes and frequently returned to consult the transcripts. The researchers discussed and challenged the coding list in an iterative process until consensus was reached. They verified that their findings pertained to and reflected the data set as a whole. The credibility of the themes was further tested via a group discussion with physicians involved in medical aid in dying. The authors also produced a global portrait of the

Table 3. Situation 18 months after legalisation.

Official medical aid in dying requests signed by patients from December 2015 to July 2017	102
Physicians involved	56 received a medical aid in dying request 14 agreed to participate 41 refused to participate 1 missing data
Medical aid in dying requests that required an alternate and willing physician	62 out of 102 = 61%

Table 4. Semi-structured interview questions.

1. In general, are you in favour of medical aid in dying?
2. Thinking about your first medical aid in dying request,
- How did you react?
- Did you agree to your patient's request?
- How long had you known the patient?

3. Can you explain why you refused to provide medical aid in dying (other than not meeting the legal criteria)?
- Was it for moral reasons?
- Religious reasons?
- Other reasons? (lack of time, lack of competence, pay too low, emotional/clinical burden, fear of prosecution, fear of death, clinical fatigue, fear social stigma, etc.)

4. Is it acceptable to consider conscientious objection as reason not to provide medical aid in dying?
5. There are multiple steps in the medical aid in dying process:
- Listening to the medical aid in dying request
- Explaining end-of-life care options (palliative care, palliative sedation, medical aid in dying, etc.)
- If medical aid in dying request, patient must sign written consent form
- First medical aid in dying evaluation by physician
- Second evaluation by independent physician
- Administration of medical aid in dying
- In your opinion, in which step is it acceptable for a physician to make a conscientious objection?

6. Are there other parts of the medical aid in dying process in which a physician could object?
7. In your first medical aid in dying request, what would have helped you?
8. In general, what would help physicians who refuse to participate in medical aid in dying for reasons of conscience?

data in order to give an overall reflection of the answers provided by the participants.[17]

Ethical considerations

The interviewer re-explained the purpose of the study and obtained verbal confirmation of participants' free and informed consent. Participants were assigned a numeric code to maintain confidentiality; these codes are used throughout the article. The data were stored in a computer secured by a password. This study was reviewed by the Scientific and Research Ethics Committee of the Centre intégré de santé et de services sociaux de Laval, March 2017, and reported to be compliant with the local jurisdiction for this type of research.

Results

Participants were aged 26 to 67 years (mean: 45 years), 12 of them were male (54.5%) and they averaged 13 years of experience (1–40 years). More details about their practice and views on religion are shown in Table 5.

Physicians who stated a conscientious objection and chose not to participate in their patients' request for medical aid in dying are in favour of the principle of medical aid in dying (72.7%, 16/22), 13.6% (3/22) were neutral or ambivalent, and only 13.6% (3/22) were against it. Most participants said they were not against medical aid in dying being available to patients, but felt uncomfortable, and unable to administer medical aid in dying themselves for a multitude of reasons that will be further explored in this section (Table 5):

> I am in favour of the principle behind medical aid in dying, but I would be very uncomfortable to do it. (MD10)

Physicians were questioned further to explore the possible reasons behind their refusal, probing specifically for the following reasons: religion, moral, clinical burden, lack of time, money, lack of expertise, legal, fear

Table 5. Characteristics of physicians interviewed.

	n = 22
Age, range (mean), years	26–67 (45)
Experience, range (mean), years	1–40 (13)
Type of practice	
Family medicine	14
Specialties	8
Geriatrics	1
Intensive care	1
Nephrology	1
Neurology	1
Oncology	2
Psychiatry	1
Pneumology	1
Religions	
Catholics	20
Jewish	1
Taoist	1
Attitudes towards religion	
Believe in God	11
Atheist	10
Agnostic	1

of stigmatisation and fear of death. Their answers were classified in two categories:

1. Refusal on moral or religious grounds:
   (a) The 'moral' category includes express statements about medical aid in dying conflicting with personal or professional secular principles, such as protection of life and do no harm. These principles were treated as moral when the physicians did not relate them to a particular religion.
   (b) The 'religious' category refers to the conflict between medical aid in dying and the religious beliefs expressed by physicians, for example, the sanctity of life as described in the Catholic religion and identified as such by the physicians.
2. Refusal for reasons other than conscientious objection, which were then divided into two subcategories: 'emotional reasons' and 'reasons related to capacity and competence'.
   (a) 'Emotional reasons': references to the various emotions and fears described by the physicians such as emotional burden and psychological impacts, fear of stigmatisation, fear of medicolegal repercussions and fear of death;
   (b) 'Reasons related to capacity and competence': refusals motivated by self-assessed inadequate expertise, heavy clinical burden and lack of time.

One of the most surprising findings in our study is the diversity of motives for refusal. The reason most often cited is not, as expected given the definition of conscientious objection, on the basis of moral and religious grounds. Rather, the emotional burden related to this act and the fear of psychological repercussions were the most expressed motivations for not participating in medical aid in dying. All participants gave more than one reason for not having performed medical aid in dying. The interviewer further probed the participants to determine which of the reasons cited was the primary reason for refusal, rather than a contributing secondary reason. As this is an important finding, contradicting what was expected from the formal definition of conscientious objection, a table is provided to expose the relative weight of each emerging theme in terms of frequency and priority (see Table 6).

Although participants named a principal reason for declining to participate in medical aid in dying, all participants expressed more than one concern, ranging from 2 to 7 reasons (mean = 3; median = 3).

Conscientious objection for moral or religious reasons

Among the few physicians who had a 'true' conscientious objection (moral or religious according to the definition), moral grounds were more common than religious grounds. Only 18% (4/22) said they refused for religious reasons, but 27% (6/22) manifested a refusal on moral grounds. Physicians' most frequently stated reasons dealt with their perception of a conflict between performing medical aid in dying and the tenets of medicine and palliative care. Specifically, they said they had been taught to save lives rather than actively help end them. They also expressed, especially those practising palliative care, having a different construct of end-of-life care, with a focus on alleviating suffering with the exclusion of medical aid in dying. They expressed concerns about being given the power to end a life:

> It would be difficult for me to administer medical aid in dying to someone. Who am I to decide to end a life? My wish is to assist them and alleviate suffering at the end of life so they can take advantage of the life that remains. That is why I chose to practice in palliative care. If I perform medical aid in dying, I would be in conflict with my practice. (MD4)

Refusals for emotional reasons

The principal reason for refusal was related to the various emotions elicited in the physician by the act of medical aid in dying; these were categorised as 'emotional reasons'. The majority, 77% (17/22), expressed personal reasons

Table 6. Reasons cited.

Reasons cited	%	*n* = 22	Main reason	Secondary reasons
Refusal for emotional reasons				
Emotions/psychological effects	77	17	7	10
Fear of legal repercussions	32	7	–	7
Fear of social stigma	14	3	–	3
Fear of death	0.05	1	–	1
Refusal related to capacity and competence				
Clinical burden	55	12	2	10
Lack of time	50	11	3	8
Lack of experience/expertise	36	8	2	6
Refusal on moral or religious grounds				
Moral convictions/principles in conflict	27	6	3	3
Against religion	18	4	1	3

such as adding to their clinical fatigue, fear of the highly emotionally charged gesture of medical aid in dying as well as fear of suffering emotional difficulties subsequently:

> My conscientious objection is not a real one, it is more on an emotional level. I can't bear participating in this currently, I can't right now. If a patient I've known for 30 years were to ask me, I would be there for him, I could assist, but it would affect me deeply. (MD9)

Physicians also mentioned medicolegal concerns; 32% (7/22) feared prosecution given their perception of the law's lack of clarity:

> There are still gray zones in the law. It would help if some criteria were better defined. (MD1)

Finally, the other motives claimed by the physicians were fear of stigma from their colleagues (27% or 6/22); one mentioned the fear of death, specifically seeing someone die:

> What people will think about me if I participate in medical aid in dying is a consideration – a small one (10%), but a real one. (MD13)

Refusals related to capacity and competence

Physicians mentioned a lack of time (50% or 11/22) and the clinical burden (55% or 12/22) it represents as important elements; these reasons were categorised as 'reasons related to capacity and competence':

> There is a significant administrative burden that comes with providing medical aid in dying. It is not the main reason for my refusal, but it is definitely a contributing factor. It is already difficult enough for physicians to keep their heads above water, especially the new ones. I don't know how I could make it. (MD1)

More than a third of physicians (36% or 8/22) said they refused due to concerns about their competence, including insufficient clinical experience and being unfamiliar with the pharmaceutical agents used in the protocol:

> 'It takes more than a few PowerPoint slides to make you better at this'. (MD6)

The right to conscientious objection

All physicians strongly defended the right to conscientious objection. All agreed that it is legitimate to respect the decision to not provide medical aid in dying, and that physicians should not be forced. Ahead of this final intervention, however, they considered that invoking conscientious objection was less acceptable. Only 32% (7/22) considered it legitimate to refuse to help their patient sign the written consent for medical aid in dying, and only 18% (4/22) considered it acceptable not to give their patients explanations of the details regarding end-of-life care options. Only one physician considered it acceptable to refuse even to hear a medical aid in dying request.

Strategies to support physicians

Participants who invoked religious or moral objections stated that no intervention would change their convictions. Those who refused for other reasons suggested possible solutions that would decrease their resistance. For example, mentoring by a physician was raised. Others mentioned that, over time, their hesitance would likely decrease as they had time to reflect on the issues surrounding medical aid in dying. Some physicians indicated that they would be more willing to participate in the context of a patient they had followed for a long time. However, one physician felt the contrary:

> I thought it would be easier if the request came from one of my patients. I would be more engaged and concerned. Now I think it would be more difficult. You get burned out with misery, and with compassion, comes fatigue. I cannot add the final act to all of this. (MD15)

Discussion

Main findings

One of this study's significant strengths was to distinguish between the philosophical medical opinion identified in a survey conducted before the law allowing medical aid in dying came into effect and the behaviours (willingness to act) witnessed in the same physician population after medical aid in dying had been in practice for 18 months. Exploring physicians' narratives about why they object and the underlying reasons adds to the growing body of empirical knowledge on conscientious objection.

Implications for practice and policies

Although a single term is used – 'conscientious objection' – there are important differences in what this term means for different physicians. The terms used in the end-of-life legislation and *Code of Ethics* as justification for refusal, 'personal reasons' and 'personal convictions', leave room for interpretation.[18,19] This raises the question of whether medical aid in dying guidance is sufficiently specific about what kind of reasons for refusals should be acceptable. Given that access to medical aid in dying could be limited due to the high rates of physician refusals, like Magelssen,[20] the authors ask under what circumstances should society accept conscientious objection.

Wicclair recommended that institutional policies include four requirements for fair, consistent and transparent management of conscientious objection.[21] However, less than half of physicians (9/22) were 'real' conscientious objectors according to his definition (refusals based on the provider's moral convictions). The majority expressed a diversity of other reasons to decline participating in their patient's request. Physicians seem to be using the term conscientious objection to mask their emotional and professional vulnerabilities. As Van Marwijk et al.[22] also highlighted, many physicians said they did not object on moral grounds, but feared detrimental psychological effects because of the high intensity of the medical aid in dying gesture. It is therefore important to consider conscientious objection from more than one angle, including the act's societal acceptability as well as organisational practices and individual sensitivity. Caring for medical aid in dying providers, as well as for the other physicians and health care professionals involved, should be an essential dimension of a sound, ethical medical aid in dying programme.

Strategies to achieve this goal could be addressed effectively through policy decisions such as access to better emotional supports for medical aid in dying providers, interdisciplinary support, peer sharing, access to better training, mentoring by experienced physicians and medicolegal and administrative support. These data could help initiate an orchestrated and attentive approach to supporting physicians with their expressed concerns in order to prevent delays in access to medical aid in dying for appropriate requesting patients. It could also prevent physicians from suffering moral distress, vicarious trauma and burnout.

Limitations of the study

The limitations of the study are the relatively low response rate to the survey, the small number of physicians who agreed to be interviewed, and whether the physicians who agreed to participate are reflective of all the physicians who refused to participate in medical aid in dying. Informal discussions with Quebec physician groups lead us to believe that our results provide an accurate representation. Quebec is a secular society. Therefore, it is not clear whether our results would be the same in other cultures.

Conclusion

This project sheds some light on (1) what the actual perception is of doing medical aid in dying as opposed to merely a conceptual assent and (2) the motives behind physicians' objections. Using empirical evidence, this study shows that a majority of physicians receiving a request for medical aid in dying used conscientious objection as a mechanism to opt out of medical aid in dying for a multitude of reasons other than religious or moral objections. It was also the term used when the refusal to participate stemmed from, among others, unacceptable emotional burden, high administrative workload and perceptions of incompetence. Furthermore, a majority of physicians who refused to perform medical aid in dying said they were in favour of a patient's right to request medical aid in dying in appropriate circumstances.

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intellectual content. All authors have read and approved the final version to be published and agree to be accountable for this work.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethical approval

This study was examined by the Scientific and Research Ethics Committee of the Centre intégré de santé et de services sociaux de Laval, March 2017. Reported as compliant according to the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TPCS2 2014, a. 2.5) and the *Regulation respecting the distribution of information and the protection of personal information* published by the 'Éditeur officiel du Québec (chapter A-2.1, r. 2).

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