Addressing Conscientious Objection of Rural Canadian Nurses and Physicians

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science
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ADDRESSING CONSCIENTIOUS OBJECTION OF RURAL CANADIAN NURSES
AND PHYSICIANS

(Thesis format: Monograph)

by

Natasha Tandy Morton

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment
of the requirements for the degree of
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Abstract

This thesis considers how conscientious objection of a nurse or physician in a rural setting should be addressed when that objection is based on a centrally held value or belief, and considers whether current strategies are morally sufficient. Current literature fails to specifically consider the complexity and challenge facing health care professionals with limited support, time, and resources who encounter conscientious objection in the rural environment. Conscience and conscientious objection are explicitly defined based on a literature survey, and reflective equilibrium is used to assess evidence from law, policy, and published sources. The author concludes that current strategies fail to meet moral obligations to rural nurses and physicians and recommends a strategy of accountability and openness requiring physicians, nurses, and administrators to defend their reasons for conscientious objection and expecting peers and subordinates to respect objections that qualify as conscience based. This strategy provides an "at the bedside" method for ensuring objections are documented, allowing for accountability at all levels of care.

Keywords

Conscientious objection, conscientious refusal, rural health care, conscience, moral distress, reflective equilibrium.
Co-Authorship Statement

Section 2.3 contains portions of the paper Morton, N. T., & Kirkwood, K. W. (2009). Conscience and conscientious objection of health care professionals refocusing the issue. HEC Forum, 21(4), 351-364. The paper is co-authored by Dr. Kenneth Kirkwood. Dr. Kirkwood served as this author's supervisor and provided feedback on the article and advice on publishing; however, this author formulated the concept, researched, wrote, and published the article.
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Chapter 1

1 Introduction

The goal of this thesis is to consider how conscientious objection of a nurse, nurse practitioner, or physician in a rural setting should be addressed, when that objection is based on a centrally held value or belief, and to examine whether current strategies are morally sufficient.

Technological advances have changed the kinds of treatments that nurses and doctors can provide, in situations ranging from family planning (e.g. "Plan B" emergency contraceptives) to artificially prolonging life using ventilators, feeding tubes, etc. (Dickens & Cook, 2000; Fielder, 2005; Garcia, 2007). As a result, recent scholarly attention in bioethics has focused on the role of conscience within medicine (Dimmitt & Artnak, 1994; May, 2001; Strom-Gottfried, 2007). Conscientious objection, the refusal to provide a service or treatment based on a value or conscious belief, was brought to the forefront by global pandemic concerns in 2003 with the emergence of Severe Acute Respiratory Syndrome (SARS). Doctors, nurses, and nurse practitioners needed to choose between reporting to work and treating an illness of unknown virulence and fatality, or refusing to work in order to protect family members (especially young children and the elderly), from potential exposure to the illness (Sokol, 2003). The challenge of resolving conflicts between competing duties to society, patients, employers, and family continues to spur discussion. Curlin, Lawrence, Chin, and Lantos (2007) conducted a study looking at how doctors view and react to value conflicts with treatment options. A portion of doctors in the study indicated that they had failed to inform patients of treatment options in situations of conscientious objection (Curlin et al., 2007). This raises concerns that conscientious objections affect the care that patients receive.

In rural communities, limited numbers of Health Care Professionals (HCPs), increased complexity and severity of emergency cases, and limited resources all increase the challenge of addressing conflicts of conscience (Cook & Hoas, 2008; Mitura & Bollman, 2003; Nagarajan, 2004; Rosenthal, 2006). In this thesis Health Care Professional (HCP)
refers specifically to doctors, nurses and nurse practitioners. Cook and Hoas (2008) and Nelson and Weeks (2006) conducted literature reviews of resources specifically used in, and created for, addressing rural ethical conflicts experienced by HCPs. Of those resources, none addressed conscientious objection in a rural setting.

The current standard for conscientious objection in a life-threatening situation without the ability to transfer care requires nurses and doctors to lay aside personal conflicts and provide care (Canadian Medical Association, 2004; Canadian Nurses Association, 2008a). In such a situation, when patient transfer to another provider or an urban center (in the case of smaller rural communities) is not possible, a conscientious objection carries a sufficiently negative consequence that it is reasonable to assume that some people would conclude objecting is morally reprehensible.

1.1 Purpose

The purpose of this thesis is to consider whether current strategies used to address conscientious objection of HCPs working in rural communities in Canada are morally sufficient. This was undertaken using the method of reflective equilibrium to consider the current practice context of HCPs working in a rural setting, as well as the regulations and policies in place to guide these HCPs.

1.2 Overview of the chapters

This thesis is presented in monograph format. Chapter II contains a review of the pertinent literature including explications of key terminology and scholarly positions in the areas of duty, conscience and conscientious objection, and moral distress. Additionally, the term "rural" is defined as it is used in this thesis, and specific considerations from the preceding three areas are revisited as they relate specifically to the rural context.
Chapter III lays out the rationale for this thesis. The limitations of current research regarding duty, conscience and conscientious objection, and moral distress within the rural context are identified.

Chapter IV outlines the specific application of the method of reflective equilibrium within this thesis and considers critiques of reflective equilibrium as they relate to this application.

Chapter V explicates the criteria used to assess the quality of this thesis.

Chapter VI details the three principles reached through reflective equilibrium and an analysis of the considered moral judgements and competing background theories as they relate to those principles. This chapter also provides a brief recommendation for addressing conscientious objection in the rural context and a discussion of the conclusions, strengths and limitations, and future research suggested by this thesis.

### 1.3 Biases and motivations

My interest in rural health ethics and conscientious objection began during my undergraduate degree in Health Science in which I had the opportunity to meet several rural HCPs and discuss some of the challenges they face in practice settings. I became interested in the challenges faced by doctors in regard to religious belief conflicts in rural health care settings. Post-graduation, this interest was sharpened as I began working with individuals who have various disabilities. I was challenged by the requirement of the position to balance the needs of the individual, the constraints of the funding agencies, and the requirement for measurable results to ensure future funding to meet the needs of the individual. For me this highlighted the challenge faced by an individual who is forced to act against his or her beliefs, or forced to choose between conflicting values of equal weight.

I am not a health care professional, and so I come to this research as a relative outsider within the world of health care. This increases my opportunity to see the issues with a fresh perspective, but also limits my personal understanding of the challenges faced by HCPs in the field.
I approach this research with the assumption that each person brings his or her own values to any given situation, and that those values cannot be simply laid aside or picked up at will. I use value, belief, or conviction to mean a firm position or opinion held to be true by the bearer, which affects his or her actions consistently in similar situations in all areas of his or her life. Although the terms do have distinct meanings, in the literature they tend to be used interchangeably; in order to remain consistent between the various authors, I will continue this practice except when explicitly indicated otherwise. Furthermore, I hold that values can meaningfully improve patient care when they are understood and respected by others, and that there is a knowable good and bad, or better and worse, way to address most situations. However, I acknowledge that a person’s understanding of what is a good or bad approach entails varies with experience and personal history.
Chapter 2

2 Literature Review

To consider the question of how to address conscientious objection of a nurse or physician in a rural setting, when that objection is based on a centrally held value or belief, a survey of the relevant literature was conducted. For the purpose of this thesis, nurse refers both to nurses and nurse practitioners, as nurse practitioners in Canada are registered nurses who have additional training (Health Canada, 2006). Useful article indexes were identified within philosophy, health sciences, social sciences, law, life sciences, physical sciences, medicine and dentistry, and education using The University of Western Ontario’s subject specific resources (2008). The University of Western Ontario and The London Public Library Catalogues were searched, and a query of the following databases was done: Journal Storage (JSTOR), The Religion and Philosophy Collection, PubMed, Project Muse, Allied and Complementary Medicine (AMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL), EMBASE, ProQuest, SocIndex, and SCOPUS. The following search terms, and their various versions, were included in the search: profession, professional, physician, doctor, practitioner, health professional, and nurse; obligation and duty: value, moral, belief, ethics, bioethics, intuition, and conscience; conflict, conscientious objection, challenge, difficulty, motivation, refusal, and conscientious commitment; moral distress, moral residue, and compassion fatigue; attraction, retention, and recruitment; medical ethics, nursing ethics, ethics education, moral education, and ethics curriculum; medicine, health care, rural, remote, and country; and reflective equilibrium and moral epistemology. The results were restricted to those available in full-text, English, and published in 2000 or later, which marked the research body that followed the outbreak of SARS, but also includes some of the discussion immediately preceding that outbreak. Some exceptions were made for earlier works where the paper is considered foundational or where there is minimal available literature. Clinical trials were eliminated by reading through the titles, and all other abstracts were considered for applicability. The remaining applicable papers were accessed and considered in full, and references were examined for other relevant resources. Finally, a specific search of the Canadian Journal of Rural Medicine,
the Rural and Small Town Canada Bulletins, the Canadian Nurses Association, the Canadian Medical Association, and the Rural Health Initiative was sourced to identify other relevant resources. These sources were used to synthesize this work.

While the focus of this thesis remains on Canadian Health Care and Conscientious Objection, the majority of published literature (especially earlier publications) tends to be limited to discussions of the United States of America or North America as a whole. Effort is made to provide a clear understanding of the topic discussed using this available literature. When possible parallels are drawn to show how the discussion may relate to Canada.

This chapter will consider duty as it relates to the HCP and to the patient, conscientious objection in health care, a definition of conscience as it will be used in this thesis, a discussion of moral distress and moral residue and how they relate to conscientious objection. The use of rural in this thesis is defined and a discussion of its implications for the preceding topics follows using a determinants of health approach. The chapter ends with a discussion of the available resources in the rural health care environment.

2.1 Duty

In general, duty is the obligation to do something, or not to do something, for an individual, family, group, population, or community either directly or indirectly. The former is a positive duty, a duty to do something; the latter a negative duty, a duty to abstain from something (Alexander & Moore, 2007). Duties can apply universally, to all people, or specifically, only to specific groups (e.g. professional or religious groups) or individuals. Furthermore, one can separate duty, things one should do or not do, from supererogatory ideals, things that are applaudable but not required by duty or obligation.

2.1.1 Duty in medicine and health care

In medicine and health care the duties or obligations of HCPs are set out explicitly by a profession’s regulating body, which often derives from the body that advocates nationally and provincially for that profession. In addition, duties for a specific profession may derive from a combination of legal precedents, societal expectations, the individual’s
personal beliefs, and contractual agreements—between the profession or professional and his or her employer or clients. For example, a nurse may have a duty to put his or her patients’ interests ahead of his or her own. That duty may arise from the expectations outlined by his or her regulatory body, legal rulings imposing punishment for nurses who fail to care, from the contract with his or her employer, and from the societal expectations that nurses will meet specific professional standards when providing patient care.

2.1.2 Duty in society and the community

All people have duties that derive from their roles as members of a family, a community, and society in general. For professionals, these duties may either compete with or augment the duties imposed by their profession. For example, during the outbreaks of Severe Acute Respiratory Syndrome (SARS) in 2003, many HCPs faced treating an infectious disease of unknown virulence and fatality, and struggled to determine which duty took priority: the duty to protect their family members (especially small children and immune-compromised adults), or the duty to treat their sick patients (Sokol, 2003).

2.1.3 Duty as a health care professional

HCPs have additional, profession-specific, duties that do not apply to most individuals, due to their specialized knowledge and expertise in health and health care provision, their assumption of risk in selecting their profession, and their social contract obligating them to provide care in emergencies when practicing in countries with socialized medicine systems, such as Canada (Ruderman, Tracy, Bensimon, Bernstein et al. 2006). The justification for this reasoning is explored extensively, and the aforementioned reasons (for having additional profession specific duties) accepted, within the literature addressing Duty to Care within infectious disease outbreaks (Thompson, Faith, Gibson, & Upshur, 2006; University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group, 2005). While some scholars offer guidelines or suggestions to health care scholars for beginning the process of developing a list of specific duties for nurses and doctors to adhere to (Godkin & Markwell, 2003; Sokol, 2006), few authors do more than call for an explicit list of these duties, or discussion among HCPs and the public in order to derive a list. Several authors try to define specific values that might guide the
creation of such lists; however, despite discussion of similar ethical issues very little overlap between the values espoused seems to exist. These values include compassion (Canadian Medical Association, 2004), beneficence (Canadian Medical Association, 2004; DeMoulpied, 2001), non-maleficence (Canadian Medical Association, 2004; DeMoulpied, 2001), respect for human worth or dignity (Canadian Medical Association, 2004; Illingworth & Parmet, 2006), trustworthiness (Illingworth & Parmet, 2006), justice (Canadian Medical Association, 2004), accountability (Canadian Medical Association, 2004), moral integrity (Wicclair, 2000), and professionalism (Illingworth & Parmet, 2006). The lack of explicit consideration within these texts is concerning, as “values serve as the criteria for judgment, preference, and choice” in moral dilemmas (Cook & Hoas, 2000 p.335). Without some consensus it is easy to understand the lack of an explicit set of duties that doctors and nurses are expected to use to guide difficult decision making in practice.

Specific duties for HCPs fall into a few main categories: duties to the patient or client, duties to society or the community, and special duties during emergencies and within the role of fiduciaries. The provincial regulatory bodies for nursing and medicine generally adopt the ethical guidelines outlined by the national nursing and medical associations, either explicitly or through minor rewording. For this reason common themes originating in these policies, but mentioned by the regulating bodies, are cited as the national association’s originating document. When items are only adopted by specific bodies this is noted. These guidelines make allowances for nurses and doctors to object to providing care, with the understanding that reasonable alternative care arrangements will be made where possible or when reasonable notice that care will be terminated is given either to the client or the employer (Canadian Medical Association, 2004; Canadian Nurses Association, 2008a). However, most professional associations or regulatory bodies do not explicitly outline what counts as reasonable notice or grounds. One exception is the College of Registered Nurses of British Columbia (2008), which specifies that objections to a client or his or her lifestyle do not qualify as reasonable grounds.
2.1.3.1 Duty to the patient

Both nurses and doctors have specific duties to their patients within their professional roles. Both have allowances to choose who to refuse as a patient (FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, 2006; Illingworth & Parmet, 2006), and both the Canadian Nurses’ Association (CNA) (2008a) and the Canadian Medical Association (CMA) (2004) support this in their policies. However, these allowances are particularly limited for nurses who for example, may refuse to provide care in the case of an abortion when he or she holds prolife views, but may not refuse care in the case of an emergency if no one else can provide care (Canadian Nurses Association, 2008a). Legally doctors do not have this duty. Although specific Canadian precedent is not available, this is supported by American case law that supports a doctor’s legal right to refuse to treat someone in an emergency if a prior patient-doctor relationship does not exist, even though it resulted in death, due to a similar policy held by the American Medical Association (2007). It is noteworthy that this may simply be a legal and not ethical precedent, since the judge called the action morally reprehensible despite the law, and generally it is expected that those with the ability to help in an emergency situation have some duty to do so, if helping will not put them in undue danger (Illingworth & Parmet, 2006).

Once a relationship is established, doctors and nurses are obligated to declare, and for nurses to explain, personal value conflicts. As well, both professions have duties to declare conflicts of interest, limit dual relationships, to act in the patient’s best interests ahead of self-interest, and refer or arrange for transfer of care when the HCP is unable to provide a service (Adlersberg, 2007; Canadian Medical Association, 2004; Canadian Nurses Association, 2008a; Capozzi & Rhodes, 2003). Dual relationships in health care practice occur when an HCP knows a patient outside the health care context. For example, a physician or nurse who both treats a patient and receives childcare services for his or her children from that patient engages in a dual relationship. Both nurses and doctors also carry a duty not to abandon patients or clients (Canadian Medical Association, 2004; Canadian Nurses Association, 2008a).
In the case of conscientious objection, some HCPs may explain their objections to the patient, arrange transfer of care, or simply refer the patient to an alternative HCP. Disagreement exists regarding which course of action is most appropriate, with a lack of consensus regarding the degree of explanation required, and whether transferring care is required in non-emergency situations. For example, physicians may object to providing a treatment, but may not provide differing characterizations of treatments to sway a patient's choice (FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, 2006). The predominant view in non-emergency situations recommends referring patients to another practitioner (American Medical Association, 2007; Cantor & Baum, 2004; Charo, 2005; Curlin et al., 2007; FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, 2006); however, Wicclair (2000) argues that despite "opting out" the provider must still assist in the transfer of care, and also recommends a case-by-case evaluation of whether the obligation to transfer care is fair. May (2001) similarly argues for transfer of care (while cautioning that unlimited right to conscientiously refuse in favour of transferring care may lead to discrimination) and argues for an HCP's right not to offer professional services that conflict with the HCP's own beliefs. May (2001) goes on to demonstrate that distinguishing between conscience and needs for tolerance of other's beliefs might resolve many concerns that lead to conscientious refusals and require a transfer of care. May (2001) focuses on the scope of conscience claims and makes a clear distinction between the HCPs conceptualization of his or her professional role and what that role legitimately entails, and the patient's value judgements on quality of life. May provides the following example to clarify this difference,

A Jehovah's Witness is in need of a surgical procedure without which he will die. He is only willing to undergo the procedure, however, if he can be assured that blood products will not be used. In 9 out of 10 cases, the procedure does not require the use of blood products. However, the surgeon involved in the case refuses to perform the procedure unless she has the option of using blood products. The surgeon acknowledges that she could perform the procedure without the use of blood products (as it normally
does not require the use of these), but believes the additional risk imposed by removing the option to use blood products is too great (2001, p. 112).

May (2001) argues that an HCP can object based on type of activity, providing a surgical procedure that will probably lead to a patient's death, but not based on the patient's differing evaluation of the desirability of that activity. In the example, the physician is making a judgement about whether the risks to the patient (death in 1 out of 10 cases should blood products be required) outweigh the benefits (recovery). May (2001) argues that unless the physician always objects to this type of surgery, and does not provide it to any patients, that the surgeon is objecting to the patient's valuation of the activity (surgery without blood products) and unacceptably imposing the physician's value system on that patient. This is not an issue of conscience, but an issue of tolerance of differing beliefs.

These prescriptions, while convincingly argued, fall short of the practice reality. Curlin and colleagues (2007) showed that a large portion of the physicians they sampled would neither transfer care nor explain their objection. This suggests that current prescriptions neither meet the needs of the HCPs who object, by providing an acceptable course of action, nor are those prescriptions being implemented in an effective manner. Thus many patients may not be provided with the information to which they are entitled and consequently are unable to make value judgements concerning their quality of life.

These duties create considerable challenges for HCPs who experience a conflict between duties and personal values or beliefs. Any foreseeable conflict must be declared up front (to the employer or patient depending on the situation), and conflicts that are not in the patient’s ‘best interests’ might serve as sufficiently weighty to overrule the HCPs objection. As will be discussed further in Section 2.5, transferring care and avoiding dual relationships presents a special challenge for rural practitioners in small communities, where there are limited alternative providers and community members often know each other (Rosenthal, 2006; Scharff, 2006).
2.1.3.2 Special Duties within emergencies and as fiduciaries

Certain duties only apply in specific circumstances or to specific individuals. First, in situations of imminent harm, physicians and nurses must set aside any objections, based on values or beliefs, and provide treatment if no other qualified HCP is available (Canadian Medical Association, 2004; Canadian Nurses Association, 2008a). There may be a legal exception to this in cases where no previous patient-doctor relationship exists for doctors noted by Illingworth and Parmet (2006). This is discouraged by public policy, and generally, doctors are considered to have a moral duty to provide reasonable treatment in an emergency, regardless of relationship to the individual requiring care (Capozzi & Rhodes, 2003; Strom-Gottfried, 2007; Wicclair, 2000). Secondly, as fiduciaries, HCPs have the duty not to abandon patients (Canadian Medical Association, 2004; Canadian Nurses Association, 2008a). These specific injunctions to provide care in emergencies, regardless of conscientious position, and not to abandon patients, are particularly salient to the discussion of how the conscientious objection of an HCP in a rural setting should be addressed, when that objection is based on a centrally held value or belief. The first duty eliminates the ability for the HCP to object (as limited alternative providers mean the HCP will have to set aside their values and beliefs more often than urban counterparts in order to provide care), while the second presents challenges for providers who do not have access to alternative HCPs to whom they can transfer their patients.

2.1.3.3 Duty to society

Compared with scholarly discussion on an HCP's duty to patients, there is little consensus among scholars regarding the duties of an HCP to society. Most commonly mentioned duties include protection of the well-being of society, refusal to support practices that violate human rights, devotion to improving health care, and (for nurses) promotion of justice and accountability (Canadian Medical Association, 2004; Canadian Nurses Association, 2008a). Gold (2010) suggests that HCPs also have a duty to stay alive during emergencies (war or pandemic) in order to provide ongoing care after the crisis is averted.
2.1.4 Duty as a patient or member of society

In addition to the duties of HCPs to the patient, several authors also raise the issue of a patient’s duties to his or her HCP (Gold, 2010; Sokol, 2006) or patient’s duty to recognize his or her physicians’ rights and responsibilities that supersede a patient’s right to treatment (Pahlman & Gylling, 2010). Since the informed consent revolution, paternalistic practice has lost favour and medical ethics has tended to view the patient’s choices as good, simply because those choices are made by the patient (Draper & Sorell, 2002; Gold, 2010; Sokol, 2006). However, the issues of limited resources and infectious diseases have recently caused some authors to question the generally held, but unspoken, view that “patients never make, or cannot make, bad decisions” (Draper & Sorell, 2002, p.338). Various authors have questioned this view of patients’ requests as good simply by virtue of them originating from the patient, (Draper & Sorell, 2002; Sokol, 2006) and have begun to suggest the current consumer model of healthcare considerably limits practice of ethical medicine and health care in favour of a legal and technical model (Benner, 1991; Gold, 2010). Specifically, the view of the one-way interaction, in which the patient is passive, and HCPs have all the power, and thus all of the responsibility for health care decisions and delivery, has received considerable criticism as a holdover from the paternalist era (Gold, 2010). Some have even suggested that part of a patient’s duty is “not to require doctors to transcend the bounds of reasonable risk during treatment and to respect and acknowledge their [the doctors’] roles outside the realm of medicine” (Sokol, 2006, p.1239). These authors refer to patients’ need to recognize the competing duties HCPs face: duties to their other patients, their families, their communities, and their physical health imbued by both the HCP's status as human beings, citizens, and individuals with a responsibility to society as a whole (Gold, 2010; Sokol, 2006). It is conceivable that a hitherto unconsidered competing duty is the duty doctors and nurses have to themselves as moral and spiritual individuals in addition to the explicated duties. Especially if causing harm to an HCP's conscience prevents the HCP from providing that necessary level of care to patients after the emergency. Potentially patients also have a duty to recognize and respect those aspects of their HCPs.
2.2 Conscientious objection

Conscientious objection in general refers to a refusal of duty. Initial discussion regarding conscientious objection within ethical literature concerns individuals whose personal beliefs prevent them from participating in war. These Conscientious Objectors refuse conscription, and are exempt from the requirement to serve their country in the armed forces. Some of the reasons given for this allowance included the general laudability of the beliefs (e.g. killing is wrong, therefore I will not kill even in war), the understanding that many would go to prison rather than transgress their beliefs, and often these beliefs do not affect those outside the individual or community (Childress, 1979). These discussions progressed to include medical personal and their role in war; whether or not doctors might be required to further the war efforts through use of their expertise in areas such as chemical warfare and torture, as an example (Rubenstein, 2004).

2.2.1 Conscientious objection in medicine and health care

Over time, the scope of the discussion surrounding conscientious objection expanded outside the scope of war. In 1973 the ruling of Roe vs. Wade (Wicclair, 2000) marked the first statutory recognition of medical conscientious objection in the United States of America. The 'abortion wars' brought conscientious objection to the public's attention, and left 45 states with 'conscience clauses' (Charo, 2005). Years later the increased use of emergency contraceptives brought conscientious objection back into popular discourse as pharmacists refused to dispense medications, in some cases at penalty of their positions (Cantor & Baum, 2004). Recently, technological advances in life prolongation, legalization of physician assisted-suicide in some parts of North America (e.g., Oregon) and ongoing debate regarding the practice in Canada (specifically in British Columbia and Quebec), and embryonic stem cell research worldwide, has renewed interest in conscientious objection within medicine (Dimmitt & Artnak, 1994; May, 2001; Strom-Gottfried, 2007; Wilton, 2013).

Interest in the specific role HCPs may play in dictating health care delivery resurfaced in 2003 and again 2007. First, the outbreak of SARS (especially in Toronto, Ontario) spurred some ethicists to question the limits of HCPs duties to provide care in
emergencies (Sokol, 2006). Subsequently, the release of a study considering how HCPs view and react to situations in which they have a value conflict with generally available treatment options, spurred heated debate (Curlin et al., 2007). Recently, the ongoing threat of a global pandemic flu outbreak has added to the discussion in the literature including research into anticipated HCP responses to these situations (Shabanowitz & Reardon, 2009). Those findings motivated the publication of various articles and books addressing the topic, and interest continued to expand in the literature. While this is a concise overview of the history of conscientious objection, it indicates the ongoing interest in health care related conscientious objection, and its applicability to current discussions on health care delivery.

2.2.1.1 Definition of conscientious objection used

For the purposes of the following discussion, conscientious objection will specifically refer to the refusal to follow a specified course of action requested by a patient or expected by general practice guidelines on the basis of a conflict with personal values, beliefs, or morals. It is worthwhile to note that conscientious objection is recognized within the literature under several synonyms including, conscientious refusal (Wicclair, 2011), and conscientious commitment. Conscientious refusal entails refusing an action for moral reasons (Wicclair, 2011), while conscientious commitment entails insisting on an action for moral reasons (Dickens, 2008); conscientious commitment is strictly not synonymous with conscientious objection, but may be a sub-category of objection. Examples include the insistence on delivering care according to health professional duties to the patient, instead of according to legal policies and guidelines (Dickens, 2008).

2.2.1.2 Conscientious objection of physicians and nurses

In Canada, primary health care is provided directly by general medical practitioners, family physicians, nurses, nurse practitioners, pharmacists, social workers, telephone advice lines, and various allied health professionals (Canadian Institute for Health Information, 2013b; Health Canada, 2012 August). These services include "prevention and treatment of common diseases and injuries, basic emergency services... palliative and end-of-life care... primary maternity care" (Health Canada, 2012 August) and
psychosocial services (Canadian Institute for Health Information, 2013b). Acute inpatient hospital care and emergency hospital care provide treatment for severe illness over short time periods (Canadian Institute for Health Information, 2013a). In rural communities, limited numbers of practitioners mean that acute care in situations of severe illness must be provided by primary health care practitioners, and any speciality practitioners, often associated with the hospitals, who are available (Nagarajan, 2004). Because nurses and physicians, especially in rural areas, provide the majority of emergency care, they are most likely to be placed in situations where conscientious objection may lead to imminent harm or death for the patient. For this reason, the focus in this thesis is specifically on the conscientious objection of physicians and nurses. As previously noted, the current policies in place to assist HCPs who experience conflicts between their profession’s duties and other values or duties, involve the transfer of care or reasonable notice that care will be terminated. These policies do not address the problem of conscientious objection in cases where there is an urgent need for care without the ability to transfer the patient to another provider. The tangential research considering refusing to care during pandemic outbreaks may help inform this discussion as it considers a limited number of HCPs and patients who may be under quarantine (Shabanowitz & Reardon, 2009; Sokol, 2006). The current standard for conscientious objection in a life-threatening situation without the ability to transfer care requires nurses and doctors to lay aside personal conflicts and provide care (Canadian Medical Association, 2004; Canadian Nurses Association, 2008a). In such a situation, when patient transfer to another provider or an urban center (in the case of smaller rural communities) is not possible, a conscientious objection carries a sufficiently negative consequence (death) that it is reasonable to assume that some people would conclude objecting is morally reprehensible.

Although the literature considers ethical conflict for pharmacists, psychologists, and psychiatrists within the rural context (Brownlee, 1996; Cook & Hoas, 2006; Coyle, 1999; Knapp, Gottlieb, Berman, & Handelsman, 2007; Simon & Williams, 1999), these professions are excluded because of the existing discussion and the lack of an emergency or life-threatening aspect to the majority of those issues. Other allied health professionals,
such as Occupational Therapists, and Physical Therapists, are also excluded for the non-life-threatening nature of their typical practice.

2.3 Conscience

The following section will discuss conscience specifically. The research and discussion in this section motivated the publication of the following article: Morton, N. T., & Kirkwood, K. W. (2009). Conscience and conscientious objection of health care professionals refocusing the issue. HEC Forum, 21(4), 351-364. The article is reproduced in part below. The final publication is available at www.springerlink.com.

While conscientious objection is the focus of this project, any discussion on the topic requires a clear understanding of what is meant by the term ‘conscience’. In the past, the topic of conscience has raised considerable disagreement as scholars have debated its existence, function, and purpose. Bernard Wand succinctly conveyed this plurality of conceptions of conscience (1961).

It has been said of conscience that it is fallible (Broad), that it is infallible (Butler); that its ultimate basis is emotional (Mill), that its ultimate source is rational (Rashdall); that it is the voice of God (Hartmann), or the voice of custom (Paulsen); that it is merely advisory (Nowell-Smith), that it is a command internally imposed (Mayo); that it is conscious (Butler), that it is unconscious (Freud); that it is a faculty (Butler), that it is not (any contemporary moral philosopher); that it is the disposition to have certain beliefs, emotions, and conations

1 which, when operative, issue in conscientious actions (Broad), and that it is conscientious action (Ryle). (p. 771).

Wand’s statement clearly shows the extensive and contradicting opinions that exist concerning conscience. Conscience regained the attention of scholars after the publication of a study in the New England Journal of Medicine (NEJM) that surveyed

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1“an inclination (as an instinct, a drive, a wish, or a craving) to act purposefully” (Encyclopedia Britannica, 2008)
American doctors and the role of conscience in medical practice. The results revealed that although 63 percent of physicians claimed that it was appropriate to express and explain moral objections to patients, fourteen percent did not feel obligated to disclose information, and 29 percent did not feel the need to refer patients “for morally contentious medical procedures” (Curlin et al., 2007, p.593). Publication of the study was followed by heated debate about the role of conscience in the practice of medicine, and the status of an HCP's right to refuse to treat based on conscience. This fervour prompted the American Journal of Bioethics (AJOB) to publish an issue focusing on conscience and its application to conscientious objection in December 2007, and that was followed by various other publications both in the form of books and articles that continued to fuel the debate. The issue published by AJOB featured the varied and conflicting positions of many prominent authors on conscience (Adams, 2007; Barfield, 2007; Cook, 2007; Emerson & Daar, 2007; Glenn & Boyce, 2007; Ladd, 2007; LaFollette, 2007; Lawrence & Curlin, 2007; Night, 2007; Orr, 2007; Savulescu, 2007; Wicclair, 2007). Given the vast and disparate literature on conscience, I will confine my consideration to the positions articulated by these key authors and other publications addressing these positions on the topic since that time. These publications are useful as they focus specifically on conscience as it applies to health care and medicine. As well, they provide a range of perspectives including religious and secular views, and various positions on the appropriate status of conscience in health care decisions. The following definition derives from the assertions about conscience that appear in that body of literature.

In this thesis, conscience is the mental process that strives to maintain an individual's authenticity and integrity by alerting the individual to potential violations of his or her values; and acts on those violations by persistent badgering or harassing of the person until the violations (both general and specific) are remedied or the person becomes desensitized to the warnings (Morton & Kirkwood, 2009). ‘Remedies’ encompasses both the option for the conscience to grow through experience or education, changing the value or application of the value that caused the conflict, and the potential to reverse the contravening action or make amends for it (Morton & Kirkwood, 2009).
2.3.1 Conscience in medicine and health care

This discussion focuses specifically on conscience in light of its value in directing ethical decision making within the health care context. I will first address the fallacy that there exists a ‘religious’ conscience, before considering the major challenges to accepting ‘conscience’ as an essential element in ethical health care delivery.

2.3.1.1 The religious vs. secular conscience fallacy

Given the presented definition, it intuitively follows that the conscience functions similarly for every individual. Thus, only the content of the conscience, the moral laws or values of the individual, and how that content is obtained differs from person to person. It also follows that there is no difference in the mechanism of the conscience between individuals, and it is pointless to refer to a 'religious' or 'secular' conscience mechanism as put forward by some authors (Lawrence & Curlin, 2007). Since the conscience is unique only in content and application of that content, not its function or effect on each person, it is the content of the conscience that is religiously or secularly informed. Although this difference seems minor, it is significant, because the effect of a contravention of a centrally held value is expected to affect an individual equally regardless of the source of that value. As such, “it is the place or role of the belief in the life of the individual, not its source or foundation that is decisive” (Wicclair, 2007, p. 31) in determining how the belief should be addressed.

2.3.1.2 Challenges to conscience and conscientious objection

The following discussion considers whether arguments given for ignoring or superseding conscience claims in health care and medicine apply in this context. There are a few major arguments for why objections due to conflicts with conscience among HCPs should not be honoured. The majority of these revolve around patient welfare and the potential for patient harm when HCP’s, especially physicians’, consciences are allowed to take a role in how they deliver medical care. Several authors articulate this to varying degrees (Curlin et al., 2007; May, 1983; Savulescu, 2007). For the authors who highlight this as an issue, the main concerns are the difficulty of separating genuine conscience claims and objections from prejudice and discrimination, delayed access to care, and
inefficiencies introduced by needing to move patients about from provider to provider. A final objection concerns the voluntary acceptance, by the HCP, of the duties of his or her profession, and the professional's ethical obligation to meet requirements that he or she accepted in choosing his or her career.

The first major challenge to respecting conscience involves distinguishing between claims that are truly based on conscientious beliefs and those that are prejudiced or discriminatory. Note that the definition presented states that conscience grows and changes with education and experience. This implies that the individual who refuses to re-evaluate or modify aspects of his or her moral code when presented with evidence that his or her value is based on erroneous information does not act on conscience but instead on something similar to superstition or discrimination. This distinction may be made provided the presented evidence is consistent with the individual's method of reasoning and beliefs. Here, superstition is an irrational belief held in the face of disproving evidence, presented in accordance and consistent with a particular individual's way of acquiring knowledge. In addition, LaFollette and LaFollette (2007) address this issue of distinguishing a legitimate claim to conscience from a fallacious or erroneous one. Key points in their consideration are how central the value is, how plausible the justification is (that the justification does not simply repeat another person's views), and how willing the individual is to respect others' rights to object. They also consider the voluntary choice to join a profession as a reason to consider overriding a claim to conscience in favour of a more significant claim, which will be addressed later. Finally, it is worth noting that the difficulty in differentiating between the three categories, actual appeals to conscience, prejudices, and discriminations, does not relieve us of any ethical responsibilities that a true appeal to conscience may place on us. Although it means application of the ethical action may be difficult, the normative ethical implications do not change. As such, although this objection offers a challenge, it does not waive any responsibility for addressing the implications of conscientious objections.

Similarly to the discrimination challenge, the second and third criticisms of respecting conscientious objection reflect administrative issues, and do not impact the ethical implications created by a true appeal to conscience, except when combined with another
obligation—for example a duty to prevent delays in access to care, or to maximize the efficiency of the health system. As such, the fourth objection presents the most weighty reason that one might override a claim to conscience in support of patient welfare, and may carry sufficient weight when combined with the first three concerns to reconsider them as ethical impediments to honouring the HCP's conscience, despite the benefits of doing so. In this argument, the conscientious objector voluntarily agrees to accept the commitments and duties of his or her profession. Therefore, it is the objector who was ethically obligated to determine if he or she could meet the requirements of the profession before practicing, and should his or her position change, to leave the profession (Savulescu, 2007). However, for this to hold true it must be feasible for an individual to predict potential conflicts and avoid placing him or herself into those situations.

According to this view, a professional entering a field should determine his or her ability to adhere to the field's requirements prior to accepting those obligations; because, the individual voluntarily enters the field and there are specific requirements expected of professionals in this field (LaFollette & LaFollette, 2007). However, this requirement is not necessarily realistic. Since the conscience mechanism grows and changes as it gains experience, a person entering an undergraduate nursing program at seventeen or eighteen years old, or a medical school as early as twenty years old, will not necessarily possess sufficient experience to have a fully developed conscience, nor would he or she necessarily be aware of where conflicts between his or her beliefs may arise with the profession's requirements. One goal of health professional training is to develop the consciences of future HCPs (Cook, 2007; Goldie, 2004; Shelton, 1999). So, at the time of entry into the program, it is not always possible to predict what objections a person might develop or lose over time with experience and education. As such, requiring students to anticipate potential conflicts prior to enrolment is impractical; new objections are likely to be created or old ones eliminated by the education itself.

The next feasible point for this decision might be at certification after the HCP's training. Potentially, individuals could determine their ability to meet the requirements of the profession prior to accreditation. However, while the recent nursing or medical graduate has some clinical experience to refine his or her conscience, I would posit that much
learning and development occurs once an HCP begins working consistently within his or her field. Since the conscience develops through experiences that force resolution of value conflicts, it is reasonable to expect that ideals developed in formal education would be refined in the workplace. Only through the experience of practicing and confronting conflicts can a practitioner discover which personal values conflict with his or her professional duties, and determine whether those conflicts are the result of erroneous beliefs or not. Therefore, as he or she acquires experience, the recent graduate’s beliefs may change drastically through the refining and educating process of experience. For that reason, while a recent graduate may be able to identify some potential conflicts that may arise, it is probable that even those values will be modified and revised as the new graduate gains more experience. Furthermore, large changes have continued to occur in health care practice. New issues are arising surrounding end-of-life care and intensive interventions each year (Dickens & Cook, 2000; Fielder, 2005; Garcia, 2007); each of these challenges could cause even expert HCPs to re-evaluate their conscience as they adapt to changes in the practice environment. As such it may not be possible or reasonable to expect all graduates to determine their ability to practice within the field, based on an understanding of their values and the implications those values hold (Cook, 2007). Instead, we need individuals who have the tools to evaluate and respond ethically to new and difficult ethical dilemmas.

Finally, although some values might be more likely to lead to conflict than others, every person brings his or her own set of moral values to practice. In a multi-cultural and multi-faith society these will eventually conflict with a client or patient, regardless of how reasonable or benign the value (Shelton, 1999). It is more important that we recognize this as a feature of being a conscientious member of society, and facilitate the development of skills for addressing these issues, than that we attempt the impossible feat of screening out every person with an offending view. Such an extreme policy might result in very few, if any, people qualifying for practice, or worse, only allow those individuals without a sensitive conscience to practice (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005).
2.4 Moral distress

As with most research on both conscience and conscientious objection, the majority of literature addressing moral distress, originates from the United States and countries other than Canada. However, recent research conducted by the Joint Centre for Bioethics at the University of Toronto suggests the findings from other countries are transferable to Canada (Bell & Breslin, 2008). Moral distress occurs when an HCP knows what is ethically and morally required, but is unable to act on that knowledge (Corley, 2002), the definition originally related specifically to organizational constraints faced by nurses; however, recent research has removed that stipulation (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). Authors now include “an error of judgment, some personal failing (for example, a weakness or crimp in one’s character such as a pattern of ‘systemic avoidance’), or other circumstances truly beyond one’s control”, as potential constraints (Webster & Baylis, 2000, p.218). It is noteworthy that some authors distinguish between moral distress, recognizing what is ethically required and being unable to act, and a moral dilemma, a situation in which two or more values conflict and recommend opposing actions (Kälvemark et al., 2004). In a moral dilemma there is a feeling of loss regardless of the course of action taken. For this thesis, moral dilemmas are considered within the umbrella of moral distress, because in both situations the result is from the inability to meet the dictates of conscience whether in part or in whole.

Ethical stress or distress is generally considered the outcome of moral distress, although some authors do use the terms interchangeably; it usually refers to the “emotional, physical and psychosocial consequences of moral distress” (Ulrich, O'Donnell, Taylor, Farrar et al., 2007, p.1709). Moral distress can be divided into initial and reactive moral distress. Initial distress includes the feelings of “frustration, anger, and anxiety” when faced with the initial conflict between perceived duty and ability to act (Corley, 2002, p.637). Reactive distress is felt when an individual does not act on his or her initial distress.
2.4.1 Moral distress in health care professionals

The literature on moral distress focuses on nurses and the challenges inherent in fulfilling their commitments while functioning as part of a hierarchical HCP team (Hamric & Blackhall, 2007; Ulrich et al., 2007). However, recent cross-discipline research has confirmed moral distress as an issue experienced by all HCPs (Kälvemark et al., 2004; Oberle & Hughes, 2008).

Evidence suggests nurses experience moral distress more often than doctors (Hamric & Blackhall, 2007), and research suggests factors that increase or ease this burden. Corley (2002) notes the main issues increasing moral distress are

“harm to patients in the form of pain and suffering, the treatment of patients as objects when meeting institutional requirements, health policy constraints, medical prolongation of dying without letting the patient or the family know about choices concerning care, the definition of brain death, inadequate staffing, and the effects of cost containment” (p.639).

Generally environments that fostered discussions about treatment decisions tend to mitigate the impact of moral distress on the HCPs (Hamric & Blackhall, 2007; Ulrich et al., 2007).

2.4.2 Moral residue

The ongoing experience of distress leads to moral residue, “that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised” (Webster & Baylis, 2000, p.218). Moral residue is normally linked with threats to or betrayal of core beliefs or values (MacPhail, 2003). As such, moral residue can be considered an outcome of a failure or inability to conscientiously object in the face of a conflict with a core value or belief.
2.4.2.1 Consequences of moral residue

Unaddressed, whether due to real or perceived failure to act, moral residue can increase financial burden and decrease quality of patient care within health care delivery (Blough, 2006; Mark & Stanton, 2004). Research shows that between 25% and 45% of nurses and 3% of physicians have either considered leaving or have left a position or the profession due to ongoing causes of moral distress and moral residue (Bell & Breslin, 2008; Hamric & Blackhall, 2007; Ulrich et al., 2007). As pointed out by Austin and colleagues (2005) this may be a grievous loss as those most affected by moral distress at the bedside and the most likely to leave, are also those most sensitive to patient issues and make the best patient advocates. Even in situations where HCPs do not leave their employment, moral distress has been significantly correlated to emotional exhaustion (Meltzer & Huckabay, 2004), which supports other findings that moral distress leads to poorer care delivery. Emotional exhaustion is a key component of compassion fatigue (Leon, Altholz, & Dziegielewski, 1999). Compassion fatigue, also known as secondary traumatic stress disorder, affects those emotionally affected by the trauma of another (Leon et al., 1999; Robins, Meltzer, & Zelikovsky, 2009). Compassion fatigue includes "decreased concern for clients," decreased empathy, "physical and emotional exhaustion," increased job dissatisfaction, and hopelessness regarding work which affects other areas of an individual's life (Leon et al., 1999). Compassion fatigue carries many similarities to moral distress. Similarly burn out, which is identified by emotional exhaustion, reduced personal accomplishment and depersonalization, is linked to a stressed conscience (Juthberg, Eriksson, Norberg, & Sundin, 2008). Burn out has further been shown to result in a deadened conscience, which results in decreased commitment and decreased care for patients (Juthberg et al., 2008). Burn out, moral distress, and compassion fatigue show very similar risk factors and outcomes which suggests that they are linked (Juthberg et al., 2008; Leon et al., 1999). Most studies note the challenge of stimulating responses from HCPs who are burned out or emotionally exhausted. Rather than discrediting the findings that link challenges to conscience with moral distress, burn out and compassion fatigue, this limitation suggests that the extent of the problem may be still greater than research has found (Bell & Breslin, 2008). The cost moral residue presents to the health care system appears to be quite high. Bell and Breslin (2008) estimate a cost of $60 000
just to replace and train a new specialty nurse, without including the impact on staff morale and patient care.

Some authors argue that some experience of moral residue and moral distress maybe beneficial to HCPs. Experiencing moral residue can clarify core values, competing commitments, and duties that an HCP may have. Similarly to conflicts with conscience which provide an opportunity for individuals to further develop their understanding of their personal values and conscience, these experiences of moral residue may also allow HCPs to determine when conflicts are personal and do not require action, or when they are communal or institutional and require advocacy on the part of the HCP (Webster & Baylis, 2000).

For example, in the recent Golubchuk case in Canada, an elderly man was admitted to hospital with pneumonia, pulmonary hypertension, and a pre-existing brain injury from four years prior. He had poor heart and kidney function and was admitted to the ICU one month later. Physicians recommended Mr. Golubchuk be removed from life support due to minimal brain function and little hope for recovery. Physicians claimed that keeping Mr. Golubchuk on life-support was ‘torture’. The family argued that to hasten his death by taking him off life support was ‘murder’ according to their beliefs as Orthodox Jews. During the legal battle that followed three of Mr. Golubchuk’s doctors resigned due to what might be termed conscientious objection to the patient’s treatment, and Mr. Golubchuck subsequently died before the trial date set to resolve the concerns between family and HCPs (Mundle, Dec 10, 2008). A case such as this one, might allow HCPs to clarify if their objections to continuing life-sustaining treatment in futile cases are based on personal values that might require transferring the case to another provider, but did not require advocacy. Or if their objections are based on broader societal and communal values that required the HCPs to act on behalf of the patient to ensure the ‘right’ course of action is followed.

However, just as moral residue might lead to some benefit it can also cause harm, leading to error. Webster and Baylis (2000) argue that moral residue can lead to “denial of the incoherence between beliefs and actions, trivialization of the incoherence between beliefs
and actions, or unreflective acceptance of the incoherence between beliefs and actions” (p.225). Essentially, as noted by authors addressing issues of conscience, failing to respect or recognize conscientious judgments can decrease future ethical decision making ability.

2.5 Rural context

Each of the topics reviewed so far, duty, conscientious objection, conscience, and moral distress, all have specific implications when viewed from a rural health care context. As such the following section will define and discuss that specific context.

2.5.1 Definition and general concerns

Generally scholars agree that creating a single definition of what it means to be rural is impossible; consequently, authors need to define clearly how they intend to use 'rural' in each context (du Plessis, Beshiri, Bollman, & Clemenson, 2001; Rourke, 1997). Rourke defines rural practice as "practice in nonurban areas, where most medical care is provided by a small number of general practitioners/family doctors with limited or distant access to specialist resources and high technology health care facilities" (1997, p. 113). In this thesis, I define rural as sufficient distance to alternative emergency health care services to make transport unlikely or impossible, as well as a restricted number of HCPs who can provide emergency care, meaning that only one or two are generally available at any given time. I define a sufficient distance to be within one hour of transport (based on transportation available in the considered area). The one-hour timeframe is based on evidence suggesting that 30% of deaths occur within minutes to a few hours of injury or accident. This has given rise to the term "golden hour", because death will occur if emergency treatment is not received in this timeframe (Yawn, Bushy, & Yawn, 1994). In addition, I consider the rural environment to lead to an increased scope of practice for the considered health care professionals, and I recognize that environmental conditions in Canada may place some areas within this definition of rural only for specific periods of the year. For the purpose of this thesis, I consider 'remote' within the category of rural, unless specifically indicated otherwise.
2.5.1.1 Challenges defining rural

Definitions of rural fall into two categories, technical or geographical and social-cultural (Troughton, 1999). *Technical or geographical* definitions rely on land features or population statistics for determining ‘rural’ (Pitblado, 2005), while *socio-cultural* definitions consider “a community of interest, a culture, and way of life” (du Plessis et al., 2001, p.4).

Technical or geographical definitions, categorized as descriptive definitions by Halfacree (1993), rely on population size, density, commuting areas, land features, and land use statistics (du Plessis et al., 2001; Troughton, 1999). Most commonly cited within the literature is the non-metropolitan region, an American system adapted by Philip Ehrensaft and Jennifer Beeman, which focuses on population size and proximity to urban settlements (du Plessis et al., 2001). These descriptive definitions are heavily criticized for their reliance on the definitions of the variables, their historical relativism, and for the lack of qualitative consideration in the data. Ultimately, they are highly specialized and hard to use as a general measure of rural, and they often rely on picking boundaries that have little to do with health care issues (Pitblado, 2005).

In contrast, socio-cultural definitions assume that environment affects behaviour. Nelson and Weeks (2006) imply this when they state that “the rural community is not identified only by its small population density and distance to an urban setting but also by a combination of social, religious, geographical, cultural, economic and health-related factors” (p.411). Other examples include Louis Wirth's *ruralism*, which characterizes rural “by stability, integration and rigid stratification, with individuals coming into contact with the same people in a variety of situations” (Halfacree, 1993, p.25), and the more recent rural-urban continuum. However, these types of definitions are criticized for relying on a fallacious urban-rural dichotomy, and for their idealization of rural as the positive aspects lacking in urban. As a result of the above criticisms some authors hold that no successful social definition of rural exists (Pitblado, 2005).

Given the failure of these two major categories, Halfacree (1993) proposes using a combination of the two. A recognition that “when we consider (rural) space, we must not
only consider the structures producing that space but also the way in which that space is subsequently used to produce other space” (p.27). The presented definition attempts to marry these two categories, utilizing the strengths of each.

2.5.2 Context - a picture of rural life

When considering the health of rural communities and rural individuals compared to their urban counterparts, it becomes clear that rural people already have compromised health (Leipert, 2006). This difference makes it even more important to consider the implications of HCP conscientious objection in the rural environment. Using the determinants of health approach, the following aspects of rural health will be discussed: Income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping strategies, healthy child development, health services, gender and culture (Public Health Agency of Canada, 2003). Biological and genetic endowment is omitted as this thesis assumes no significant difference between urban and rural populations in this determinant.

2.5.2.1 Income and social status

Lower income and social status are consistently linked to poorer health outcomes for Canadians. Specifically, the lack of control over stressful circumstances associated with lower income and social status seems to correspond with fewer choices and fewer coping skills for addressing stressful situations. The resulting stress decreases immune and hormone responses (Public Health Agency of Canada, 2003).

Rural citizens generally have lower income status when compared to urban counterparts (Singh, 2004). It follows that rural individuals can be expected to have poorer health outcomes related to their lower income status (DesMeules, Pong, Lagace, Heng et al., 2006).
2.5.2.2   Social support networks

Good social support from family members and friends appears to act as a buffer to negative health outcomes and seems to mitigate serious health risk factors such as smoking, high blood pressure, and obesity (Public Health Agency of Canada, 2003).

While rural communities are idealized as having stronger relational ties and better support networks, vulnerable members of the community may not experience this support (Leipert & Reutter, 2005). Specifically, for women, who often live in northern and rural communities because of a spouse’s employment, isolation from family members and other social support networks can be the reality (Leipert, 2006). This is especially true if the community member is not accepted by the larger community (Leipert, 2006).

2.5.2.3   Education and literacy

Education helps to equip individuals increasing, their skills and knowledge for problem solving and coping with stressful events. Education also increases opportunities for employment and control over an individual's life circumstances, and as a result is closely tied to socioeconomic status (Public Health Agency of Canada, 2003).

Rural communities typically have lower percentages of individuals with high school completion or post-secondary education when compared with their urban counterparts (DesMeules et al., 2006; Rothwell & Turcotte, 2006).

2.5.2.4   Employment and working conditions

Employment and working conditions includes both paid and unpaid work (for example housework and childcare). Combined these activities affect the mental, physical and social health of individuals. While unsafe workplaces lead to injuries, a good work environment helps provide individuals with purpose, identity, and income, as well as a sense of personal growth and increased social interactions (Public Health Agency of Canada, 2003 Key Determinant 4).

Rural communities have a lower percentage of skilled workers in the workforce and an increased number of unskilled positions compared to urban settings (Alasia &
Magnusson, 2005). In Canada rural communities also have high percentages of unemployed individuals (DesMeules et al., 2006). A notable exception to this is mentioned by Beshiri and Bollman (2001b) who found tourism employment is on par with urban areas. Furthermore, rural occupations tend to be more hazardous as they are often based in the outdoor environment or with wildlife (Leipert, 2006). Farming particularly exposes workers to dangers from farm machinery, agricultural chemicals, long hours, over exertion, environmental issues such as insect, animal and snakebites, and diseases related to animals and dust (Turner & Gutmanis, 2005). When considered in conjunction with the previous determinant, the result is a less educated workforce with greater potential to be injured or killed on the job.

### 2.5.2.5 Social environment

Community institutions and civic involvement reflect the strength of the social networks in a community. A greater sense of community membership and trust is associated with better health outcomes and allows members to share resources (Public Health Agency of Canada, 2003).

As previously mentioned, rural communities are often idealized as having closely connected members (Leipert & Reutter, 2005; Leipert, 2006). However, this can create challenges for individuals trying to flee dangerous situations and seeking assistance for sensitive issues. Leipert (2005) discusses how an individual who parks his or her car at the local women's centre is assumed by community members to be going there for help or counselling. Leipert (2005) also discusses that seeing a counsellor in a small community comes with the understanding that one might see the same counsellor in a social situation. In both cases an individual may feel that confidentiality is at stake and fail to seek assistance (2005).

### 2.5.2.6 Physical environment

Exposure to contaminants from air, water, food and soil affect an individual's health and includes considerations such as housing, air quality, and transportation. Adverse effects can include "cancer, birth defects, respiratory illness and gastrointestinal ailments" (Public Health Agency of Canada, 2003 Key Determinant 6).
The geography surrounding rural communities plays a part in the health of rural populations (Romanow, 2002). Rural and northern communities often face "challenging terrain, long distances" and "lengthy winters with little sunlight", these contribute “to physical and mental health issues” (Leipert, 2006, p. 83) and limits access to social support and health care resources (DesMeules et al., 2006). Furthermore, travel in the winter months can be dangerous, expensive, and time consuming (Leipert, 2006). As previously mentioned, the areas of employment in rural communities are primarily in the agriculture, fishing, forestry, mining, gas and oil sectors, which carry increased health risks for workers (Alasia & Magnusson, 2005).

2.5.2.7 Personal health practices and coping skills

Personal health practices and coping skills allow individuals to take control of their environment, make choices regarding their health and self-care, and help individuals to cope with life challenges and change (Public Health Agency of Canada, 2003).

The physical environment of rural communities makes travel arduous in the winter months (DesMeules et al., 2006; Leipert & Reutter, 2005). In addition, agriculture, fishing, forestry and tourism are typically seasonal occupations (Alasia & Magnusson, 2005; Beshiri & Bollman, 2001b). The combination of difficulty traveling in the winter months and short window of access to seasonal work can lead individuals to postpone seeking care for illness and injury until they are too sick to cope rather than taking time off work to address issues immediately (Leipert & Reutter, 2005; Leipert, 2006). Mitura and Bollman (2003) note that rural populations are significantly less likely to take action on their health than their urban equivalents. In addition, individuals in rural communities have higher percentages of smoking, obesity, arthritis, and depression than urban counterparts (Mitura & Bollman, 2003). This may mean that patients arriving for treatment arrive sicker than urban counterparts and are more likely to experience complications due to poor health practices.

2.5.2.8 Healthy child development

Research suggests that childhood experiences have a profound influence on a person's later health. Specifically, children and infants who experience abuse or are exposed to
tobacco and alcohol in utero are at increased risk for poor birth outcomes, health problems, behavioural issues, and social issues in later life (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). In addition, researchers are becoming more aware of how other determinants such as social environment, physical environment (e.g. housing), family income, and education affect childhood health, which can affect healthy outcomes in later adulthood (Curtis, Dooley, & Phillips, 2004; Public Health Agency of Canada, 2003).

Study findings from Canada and other countries seem to agree that young children, youth, and teenagers experience both positive and negative health effects growing up in rural communities. These outcomes include closer social ties and closer bonds between members, but also challenges in accessing social opportunities (available activities, choices in friendships, and traveling to visit friends), limitations imposed by conservative community values and norms (especially surrounding access to sexual health care and education), and the risk of social exclusion (Eriksson, Asplund, & Sellstrom, 2010; Shoveller, Johnson, Prkachin, & Patrick, 2007).

2.5.2.9 Health services

Population health is affected by the availability of health services including preventative care, health promotion, health maintenance, and services providing treatment of illness and injury (Public Health Agency of Canada, 2003, Key Determinant 10). This includes services not included in universal health care such as eye care, dentistry, counselling, and medications (Public Health Agency of Canada, 2003).

Health care delivery in rural areas is impacted by limited access to HCPs (due to a lack of providers and due to travel distance between providers), increased cost per person of delivering the service, and a lack of specialists forcing HCPs in rural communities to become expert generalists (Rosenthal, 2006; Scharff, 2006). For services not covered by universal health care (such as dental), challenges in access also include a lack of insurance; because, the types of work available in rural areas often do not provide insurance benefits that might cover these services (Lui, Probst, Martin, Wang, & Salinas,
As a result, individuals experience greater barriers to accessing certain health services than urban individuals.

HCPs face further challenges in communities where dual relationships are a necessity and where patients may not agree to transfers to urban centers because of a lack of "trust" that urban HCPs understand or listen to rural patients' concerns, or because it is difficult for family members to travel with the patient (Capozzi & Rhodes, 2003; Cook, Hoas, & Guttmannova, 2000; Cook & Hoas, 2000; May, 2001). This perspective may result from rural health care being seen as more personal and caring, and rural individuals expecting to be treated by someone who knows them (Scharff, 2006).

2.5.2.10 Gender

Gender includes societal norms, social roles and power relationships, values, attitudes, and behaviours that influence community actions and health service priorities and delivery to the different sexes (Public Health Agency of Canada, 2003). It can also affect how individuals access and experience these services.

Rural communities can both empower and make individuals vulnerable. Various reasons may contribute to this dichotomy. For example, Little (2002) suggests gendered roles are perceived by some women as giving them power over their health, their lives, and their community by creating a space of expertise that is off limits to male community members. However, other authors have noted that the close community ties and the traditional roles often expected of women can lead to silence and isolation that prevent women (and men) from escaping abusive situations, and limit the accessible resources available to these individuals (Adelson, 2005; Leipert, 2008). As a result, while gender may lead to more control over health care for some women, many still experience challenges related to access.

2.5.2.11 Culture

A community's valuation of language and traditions, stigmatization, and marginalization of specific community members creates and mitigates additional health challenges for community members (Public Health Agency of Canada, 2003).
Factors surrounding gender are exacerbated for aboriginal populations (including First Nations, Inuit, and Métis) whose quality of living and health care access has been compared to third world conditions (Adelson, 2005; DesMeules et al., 2006). As noted by Adelson, this means that it is even more important to respect and be sensitive to the cultural and religious decision making strategies and value systems of these vulnerable individuals. In Canada, the majority of aboriginal communities are located in northern and rural areas (DesMeules et al., 2006). Extensive studies have highlighted the challenges in rural communities of aboriginal individuals who experience poorer health outcomes than non-aboriginal Canadians (Adelson, 2005; DesMeules et al., 2006). These include higher rates of "diabetes, heart disease, hypertension, cancer... arthritis," and smoking; and mortality "due to cancer, motor vehicle accidents, circulatory diseases, diabetes, alcoholism and suicide" (DesMeules et al., 2006, p.36). In addition, immigrants and minority groups can experience these challenges depending on the specific community's approach to those minorities.

As result, it is essential that HCPs in rural areas be both aware of potential biases toward their patients, as well as be held accountable for their interaction with those patients. This insures that individuals who are more vulnerable have an advocate in the community, and that HCPs do not unintentionally allow their biases to perpetuate the conditions that cause the vulnerability of these individuals. While this is true of HCPs anywhere, the lack of alternative HCPs in rural communities makes vigilance even more important for rural HCPs. It is also important that others in the community (not just HCPs) can hold an HCP who does perpetuate these conditions accountable, and help to mitigate the power imbalance experienced by the more vulnerable rural individuals.

2.5.3 Rural health care delivery

Rural health care delivery demands flexibility and a willingness to learn and depend on others. HCPs are required to cross the lines that delineate both their profession and areas of expertise in order to deliver essential care to their patients often expanding what would be considered normal areas of practice (Scharff, 2006).
2.5.3.1 Who is involved?

The delivery of health care services in rural communities depends on each HCP's ability to work both independently and as the core member of a team, which may include registered nurses, nurse practitioners, doctors, and/or a variety of other service providers (Troyer & Lee, 2006).

This thesis focuses on the first three, whose specific roles blur in the rural environment. Jane Scharff (2006) refers to this blurring as intersections. In this thesis that definition is expanded: intersections are points at which HCPs meet and interface with other HCPs, expanding practice into the domains of other professions when needed. Practically, this plays out with nurses providing essential care that extends their scope of practice, and doctors providing care that crosses into the nurse’s area of purview, but also that exceeds his or her training (Rosenthal, 2006; Scharff, 2006).

The scope of practice for rural HCPs generally exceeds that of an urban HCP. While urban HCPs may only work in one or two specialty areas, Scharff (2006) found that a rural HCP needs to move between at least three or four specialty areas during any given shift. He or she must be able to provide surgical support for one patient, treat individuals in the emergency room, deliver infants, provide palliative care, and provide cardiac care. This requires that a much broader range of skills be maintained than might be expected of an urban HCP, often without as much opportunity for the rural HCP to engage in continuing education and practice opportunities. Interestingly, rural physicians are more likely to rely on, read notes, and respond to notes from nurses than urban counterparts (Scharff, 2006); however, this willingness does not eliminate the experience of HCPs lower in the organizational hierarchy of the community from feeling powerless in the same manner experienced by urban HCPs (Austin et al., 2005). As reported by Austin and colleagues (2005) while often discussed as physicians causing nurses to feel powerless, the source of that powerlessness may not be other HPCs, but may be "hospital administration and policies” and even the law (p. 36).

In general rural HCPs need a willingness to learn; a love for being a “jack-of-all-trades;” have knowledge of their limitations; ability to use common sense when determining
which rules to break; and flexibility (Rosenthal, 2006; Scharff, 2006; Troyer & Lee, 2006). Often HCPs within a community will “specialize” in a specific area, but are expected to maintain competence and comfort working in all other areas. For example, Doctor A and Nurse A may have developed specific expertise in cardiac care and obstetrics through additional study and practice, while Doctor B and Nurse B have developed additional expertise in emergency care, and cancer care. All HCPs would still be expected to be capable of providing surgical support and care, and all of the above would be expected to move competently and comfortably between each area often within a single shift, with an understanding that specific individuals are more skilled in particular areas.

2.5.3.2 Challenges

Within rural health care delivery, HCPs and communities face two main challenges: retaining and recruiting HCPs to provide necessary services, and providing or acquiring the necessary resources (medical, technological, educational, and ethical) to provide those services. However, despite these challenges, rural communities carry the potential to be able to respond more quickly to changing professional dynamics that require greater inter-professional communication and co-operation due to their smaller size and increased levels of communication between HCPs compared to urban counterparts (Scharff, 2006).

2.5.3.2.1 Recruitment and retention

Recruitment and retention of HCPs poses a significant challenge to rural centres. Lori Hendrickx (2006) notes that pay differences and barriers to continuing education pose added challenges to recruiting and retaining professionals in rural areas.

In Canada, and specifically in Ontario, several programs have been introduced to address this issue such as providing financial incentives during formal education, during practice, or after practicing for a specified period of time in a rural setting (Ministry of Health and Long-Term Care, 2009a; Ministry of Health and Long-Term Care, 2009b; Ontario Medical Association, 2002). In addition, the Rural and Northern Physician Groups agreement (RNPGA) attempted to address concerns about continuing education, locum
relief, stable remuneration and isolation by providing block funding for groups of physicians (Society for Rural Physicians of Canada, 2008). While each initiative attempted to address the challenges of recruiting and retaining HCPs, they tend to focus on physicians, and have generally attracted those already interested in rural practice, but have not convinced individuals to move from urban to rural. As of 2009, 35 northern Ontario communities and 98 southern Ontario communities still qualified as underserviced despite these programs.

Beyond this, retention continues to be important. As previously discussed, HCPs leave practice for a variety of reasons including ongoing causes of moral distress and moral residue (Hamric & Blackhall, 2007; Juthberg et al., 2008; Ulrich et al., 2007). The isolation of rural communities has the potential to both mitigate and exacerbate these situations.

2.5.3.2.2 Resource provision: medical, technological, educational, ethical

Within the literature review, the budgetary restrictions of rural health care facilities appear repeatedly. These restrictions decrease access to supplies and the ability to provide certain services (such as round-the-clock care). Additionally, funding restrictions mean challenges for providing staff with the most recent instruments and continuing education to maintain and learn new skills (Hendrickx, 2006). Finally, and most pertinent to this discussion, both finite financial and time resources, along with a lack of past academic attention, presents significant challenges for providing useful and current ethical resources, that can be feasibly used within the time frames available to rural HCPs (Cook & Hoas, 2008; Nelson & Weeks, 2006).

Recently, a review of available ethics literature (Nelson & Weeks, 2006), followed by a related call for action on the lack of resources (Nelson, Pomerantz, Howard, & Bushy, 2007) drew attention to the lack of consideration of rural ethical issues. Cook and Hoas (2008) subsequently released findings concerning ethical issues faced by rural HCPs that are often overlooked in traditional ethical analyses. The authors noted the lack of availability of ethical resources, but also the lack of use of those resources when available
by HCPs. Cook and Hoas recommended the following three strategies to address these issues:

1. Expand what counts as an ethical issue, as rural dilemmas often occur within more complex situations with multiple factors that need consideration;

2. Provide integrated resources that account for values and rural context, while assisting HCPs to overcome issues that prevent willingness to act; and,

3. Finally, use system level approaches to bring dialogue to the bedside (2008, p.55-56).

Other key issues identified include the limited time available to use traditional ethical resources, such as ethics committees. Various authors have critiqued and added to this work. Critiques include proposals for more effective use of ethics committees in both rural and urban settings (Pope, 2008) and the Texas A&M Health Science Center Rural Community Health Institute’s virtual peer review and ethics committee as potential solutions (Bolin, Mechler, Holcomb, & Williams, 2008). While laudable for creativity in providing a more independent review and accountability, these recommendations fail to address the time concern expressed by the HCPs in the Cook and Hoas' (2008) findings. A concern identified as a motivating factor in the lack of use these similar existing structures receive.

Crowden (2008) and Aultman (2008) recommend additions to Pope's (2008) and Bolin and colleague's (2008) proposals to accommodate rural values through a virtual ethics approach and discussion forums respectively. These ideas responded to other critiques that there is a failure to account for rural culture (Crowden, 2008). While both Crowden (2008) and Aultman (2008) show how their approaches address this oversight, and move toward addressing the need to integrate rural context and values into the consideration, they fail to consider the lack of rural HCP time and ethical education that presents a barrier to use of these systems.

In contrast, Morley and Beatty (2008) and Vernillo (2008) argue that Cook and Hoas (2008) are correct that a new systems approach is necessary; however, suggest that Cook
and Hoas’ (2008) proposal merely addresses the symptoms of the problem. Vernillo (2008) notes that ethical solutions have two potential approaches to resolution: the pointy (HCP focused) end that Cook and Hoas (2008) address and the blunt (administrative) end that is ignored. Vernillo (2008) recommends a reversal that starts with manager, administrative, and policy changes. While Vernillo (2008) clearly points to the need to change more than the views and knowledge of HCPs, the proposal rings of idealism that appears to forget the complex and messy nature of ethics in rural communities. While useful, Vernillo’s (2008) proposal would do better in conjunction with the already proposed strategies by the other authors.

Ultimately, none of the presented recommendations fully address the call for resources that “integrate value assumptions and contextual realities with strategies that help healthcare providers overcome the barriers that inhibit a willingness to take action” (Cook & Hoas, 2008). If solutions are to meet specifically rural needs, they need to address these recommendations and the HCP identified need for those resources to be “interactive, non-academic, inclusive, timely, practical, and [able to] sustain dialogue about everyday problems within and across professions” (p. 55).

This chapter considered duty as it relates to the HCP and to the patient, conscientious objection in health care, a definition of conscience, as it is used in this thesis, a discussion of moral distress and moral residue and how both relate to conscientious objection. How the term rural is used in this thesis was defined. Finally, a determinants of health approach was used to discuss the implications of the rural context for these areas.
Chapter 3

3 The Gap

The goal of this thesis is to provide a discussion of how conscientious objection by a nurse or physician in a rural setting should be addressed, when that objection is based on a centrally held value or belief, and whether current strategies are morally sufficient. This section will summarize the discussion thus far and explicate the areas needing attention as highlighted by the preceding literature review.

3.1 Duty

HCPs face conflicting duties: duty as individuals and family members to protect and care for their own families, and duty as HCPs to provide care to patients or arrange for alternative care if the HCP is unable to provide the required care (this includes declaring conflicts of interest, limiting dual relationships, and acting in the patient's best interests). In situations of imminent harm, HCPs are expected to set aside concerns for their own well-being (including personal values and beliefs) and provide the necessary care.

These duties create considerable challenges for HCPs who experience a conflict between their duties and personal values or beliefs. Any foreseeable conflict must be declared up front, and conflicts that are not in the patient’s ‘best interests’ might serve as sufficiently weighty to overrule the HCP's objection. Moreover, for rural HCPs, transferring care and avoiding dual relationships presents a special challenge in small communities where there are limited alternative providers and community members often know each other.

In addition, the duty to put patient's needs ahead of their own in situations of imminent danger eliminates the ability for the HCP to object, while the duty to transfer care if prevented by an alternative duty (such as personal belief) from caring for a patient presents challenges for providers who do not have access to alternative HCPs to whom they can transfer their patients. While this standard (Canadian Medical Association, 2004; Canadian Nurses Association, 2008b) assumes these events to be an exceptional situation, it is foreseeable that these situations occur more frequently in rural settings.
given the poorer health status typical of rural populations and lack of alternative HCPs to whom patients can be transferred, which leaves HCPs in a position of needing to set aside values and beliefs in favour of patient needs.

### 3.1.1 Duty of patients

Some discussion of patient’s duties to HCPs is beginning to permeate the literature. Potentially patients have a duty to recognize the conflicting duties of their HCPs and not expect the HCPs to transcend what counts as reasonable risk.

It is conceivable that a hitherto unconsidered competing duty is the duty doctors and nurses have to themselves as moral and spiritual individuals. Potentially, patients have a duty to recognize and respect those aspects of their HCPs as well.

### 3.2 Conscientious objection

The current standard for an HCP who conscientiously objects, but who is unable to transfer the patient in need of urgent care to another provider, requires the HCP to lay aside personal conflicts and provide the required care. In such a situation, when patient transfer to another provider or an urban center is not possible, a conscientious objection carries a significantly bad consequence that it is reasonable to assume that some people would conclude objecting is morally reprehensible.

However, if

(a) conscience is considered to impact an HCP’s ability to make good/ethical choices both present and future, and

(b) conscience development is harmed when one is forced to contravene actions dictated by conscience (leading to ethical distress and moral residue),

then

(c) the preceding duty could mean that HCPs are placed in a position that harms their ability to practice ethically in the future.
Given (a), (b), (c), and 

(d) the poorer health status typical of rural populations, and 

(e) lack of alternative HCPs to whom patients can be transferred,

The conclusion follows that

(f) HCPs are potentially lead to a position of needing to set aside values and beliefs in favour of patient needs more frequently than previously considered and as a result potentially harming their conscientious development.

3.3 Moral distress

Moral distress is experienced by all HCPs, but what situations cause moral distress varies from person to person depending on moral sensitivity (MacPhail, 2003). As shown, moral residue might be considered the outcome of a failure or inability to conscientiously object in the face of a conflict with a core value or belief. The literature clearly indicates that environments that foster discussions about treatment decisions and where HCPs feel able to voice concerns diminish both the resulting moral distress and moral residue. Unaddressed moral residue leads to increased financial burden and decreased quality of care delivery, in addition moral residue appears to increase the rate of HCP attrition. However, moral distress can help an HCP to clarify core values, competing commitments and duties, and help HCPs determine when issues are personal or system based and need advocacy from the HCP to create change. However, failing to address issues of conscience and failing to respect or recognize conscientious judgments can decrease future ability for ethical decision making by leading to denial, trivialization and unreflective acceptance of incoherent beliefs and actions.

3.4 Rural context

Rural HCPs experience an expanded scope of practice, with a decreased number of peers who can provide support, and a decreased ability to transport patients for alternative care. Rural inhabitants are often sicker than urban counterparts and experience factors in almost every determinant of health that increase the risk for poorer health and poorer
health outcomes. As a result rural HCPs can expect to be working with more acutely ill individuals who have waited longer to access health services and will be more likely to be in need of urgent care. Situations that make patients vulnerable, especially issues surrounding dual relationships, gender, and culture mean that HCPs hold even more influence and authority than urban counterparts, with less peer supervision. The potential consequences to misuse of that influence and authority, even accidentally, are greater and therefore requirements for ethical expertise and vigilance from those HCPs are even more important than in urban areas, as discussed in the previous chapter. Ethical expertise refers to the ability to assess and respond to ethically challenging situations in specific area. For example, a doctor may be expected to have medical ethical expertise that allows said doctor to discern the best course of action given two treatment options (a) a more expensive, but more effective therapy or (b) a more economical and reasonably effective therapy given the patient’s presentation.

A benefit of rural practice is that rural HCPs are more likely to listen to and communicate with each other, and as a result may be able to respond more quickly to changing professional dynamics that require greater inter-professional communication and co-operation. This may be due to practice contexts that are smaller in size, as well as increased levels of communication between rural HCPs, as compared to their urban counterparts. However, like their urban counterparts, health care services in rural areas are still provided within the context of an organizational hierarchy, and this can lead to feelings of powerlessness by those lower in the hierarchy whether actual or perceived, for example nurses compared to doctors (Beshiri & Bollman, 2001a).

These issues of isolation, and reduced access to alternative providers, are aggravated by challenges in recruiting sufficient HCPs to rural areas, further decreasing community members' access to health care services. Financial issues mean that rural HCPs also have less access to medical and technological resources that might mitigate some of the ethical challenges these HCPs face. Lack of extra personnel makes rural HCP time valuable and in demand, and decreases the ability of HCPs to attend further education and investigate and debate ethical dilemmas. Finally there are a lack of ethical resources that meet the unique needs of rural HCPs, specifically the need for resources to be “interactive, non-
academic, inclusive, timely, practical, and [able to] sustain dialogue about everyday problems within and across professions” (Cook & Hoas, 2008, p.55).

3.5 Conscience

The definition of conscience explored in this thesis raises some serious questions surrounding the current treatment of HCPs who make a claim based on conscience. Currently HCPs are permitted to make claims to conscience, but whether claims based on "secular" reasoning are treated equally to those made based on "religious" reasoning is unclear, especially in rural situations where alternative HCPs are limited at best. This definition also potentially allows for a greater ease in distinguishing between bias and prejudice, and veritable conscience claims.

Furthermore, this discussion suggests that conscience plays a significant role in the development of moral distress. This suggests that there is a lack of consideration regarding that potential avenue for decreasing distress and improving HCP retention in rural communities where attrition is due to moral distress and HCPs feeling unsupported.

3.6 Need for a better method

Despite fragmented discussion in various subject areas, solutions proposed for addressing issues of conscientious objection, patient vulnerability, ethical conflicts and dilemmas, within a rural setting have consistently failed to meet the needs of HCPs in that setting. The thesis proposes to consider whether current standards for addressing conscientious objection of HCPs in rural health care are sufficient, and will then provide recommendations for moving forward in this complex problem.
Chapter 4

4 Methodology

Wide reflective equilibrium (WRE) was chosen both as a theory and method for this thesis to meet several key criteria: accessibility to a range of audiences, acceptability to individuals of varied backgrounds, beliefs, and perspectives, credibility among experts in moral reasoning, practicality for use in addressing specific moral problems, and flexibility in use (Arras, 2007). WRE provides a method for choosing between competing values and beliefs (Rashid, 2002).

To provide a clear explication of both the theory and application of WRE, review of the literature pertinent to reflective equilibrium relied on two general strategies: review of the initial major explications of reflective equilibrium to form a foundation of understanding; and a literature survey from 1990 to present to assess uses and recent developments in the theory and method. Major contributors to the formulation of WRE that predate 1990 are also cited within this section.

An exhaustive review of WRE exceeds the scope of this thesis; as such, this section will provide a broad understanding of the theory with a focus on its specific application to this project.

4.1 Overview of reflective equilibrium

Rawls (1999) introduced the concept of reflective equilibrium (RE) as a method for providing justification for theories about justice in "A Theory of Justice". This work systematized and set out the method, even though others had discussed similar concepts previously, and served as a major starting point for many subsequent scholars. RE as proposed by Rawls consisted of two elements, considered moral judgements and moral principles, and was explicitly expanded by Norman Daniels to include a third, relevant background theories. The initial explication of RE became recognized by the term Narrow Reflective Equilibrium (NRE), while the broader explication by Daniels incorporating relevant background theories became recognized as WRE.
Considered moral judgments are conclusions or judgments that are reached under conditions likely to avoid errors (Daniels, 1980), by individuals who are reasonable, impartial, intelligent, informed, imaginative, etc. (Arras, 2007). For example, when trying to determine whether to break a promise, Scanlon (1992) considers 'why is it wrong to break a promise?' Initially, a person may take into consideration various 'judgments' that contribute to that individual's reasoning about why or why not it may be wrong to break a promise. Second, the individual would identify those 'judgments' or reasons that were derived in situations where the individual lacked all relevant facts, were unreliable (formed while angry, frightened, or upset), made with hesitation, or that change over time (Scanlon, 2002; Schroeter, 2004) and those judgments are removed from consideration leaving only the "judgments" the individual is most confident with. These are the considered moral judgments.

Moral Principles are developed from these considered moral judgements, in an effort to "match", 'explicate', 'accord with', 'fit', or 'account for', the body of intuitions amassed by the competent moral judges" (Arras, 2007, p.50). The goal of the chosen moral principles is to provide the best possible explanation for the considered judgements, recognizing that a perfect match with all considered judgements is unlikely (Scanlon, 1992).

Practically, moral principles attempt to explain the collection of considered judgements in the most complete or comprehensive way possible for that set of considered judgements, so that an individual following those principles would arrive at the same set of considered judgements (Scanlon, 2002). Given our example, the individual would attempt to find a set of principles that explicate the considered judgements. When principles did not completely explicate the original set of considered judgements, the individual would need to make the most plausible adjustments (Schroeter, 2004) between the two groups. Sometimes the principles may clarify why two considered judgements contradict each other and the individual would eliminate or adjust the one that is least reliable or plausible. This working back and forth continues until the considered judgements coincide with the moral principles (Schroeter, 2004). The result is a set of moral principles that explicate the considered moral judgements in a state of narrow reflective equilibrium (NRE).
Relevant background theories consist of theoretical considerations that are used to challenge the moral principles and considered judgements. Arras (2007) outlines five classifications of theoretical considerations: "(1) alternative 'moral conceptions' (e.g. utilitarianism, perfectionism, Kantian ethics) and their respective philosophical warrants; (2) theories of moral personhood; (3) theories of procedural justice; (4) theories of moral development; and (5) empirical theories bearing on the nature of society and social relations" (Arras, 2007, p.52). The goal of challenging the moral principles and considered judgements with relevant background theories is to introduce alternative sources of information that would elucidate errors and challenge the thinker to move beyond biases and pre-conceptions.

Completing the process of developing moral principles that explicate the considered judgements brings the individual into NRE. NRE has been critiqued for systematizing any existing biases and smoothing inconsistencies in an individual's beliefs, but not leading to new knowledge or helping resolve confusing and complex issues (Schroeter, 2004).

Daniels (1996b) proposed Wide Reflective Equilibrium (WRE) as a solution to this critique. In WRE the individual must go further and seek any relevant background theories and/or conflicting perspectives in order to challenge NRE and expose all assumptions, considered judgements, and moral principles to scrutiny and potential revision. By doing so, the individual hopes to highlight and utilize the strengths of each element, resulting in a more robust product (Tersman, 1993). Essential to the strength of this process is the independence of the relevant background theories from the original considered judgments and moral principles (Daniels, 1996b). The same dynamic process of working between the three components continues, adjusting the least reliable/plausible components as they are elucidated by other components.

The conclusion of this process (a matching set of judgments, principles, and background theories) is achieved when the individual is no longer inclined to change or revise any of
these components because they have the "highest degree of acceptability or credibility" (Daniels, 2003).

4.2 Critiques

4.2.1 WRE is foundational or intuitionist

One major criticism of WRE focuses on the initial considered judgments. Critics argue that the initial considered judgments hold a greater weight than the moral principles or relevant background theories, because these judgments have already been passed through some scrutiny to eliminate any judgments considered unreliable. As a result these judgments are held more firmly and are less likely to be revised than the moral principles or relevant background theories when adjustments are required (Hare, 1973; St. John, 2007). A secondary and related criticism argues that this tendency creates a system that essentially determines its own trueness based on consensus with like-minded individuals (Hare, 1973).

Scholars who ascribe to WRE represent a spectrum from using some foundational\(^2\) and intuitionist\(^3\) claims (McMahan, 2000; Nielson, 1994) to arguing adamantly for the equal reversibility of all components within WRE (Curtis et al., 2004). This thesis adheres to the methodology explicated by the latter and this is the position defended below.

Numerous scholars have elaborated on, and defended, Rawls’ proposal (Daniels, 1980; Rashid, 2002; Tersman, 1993); they argue that while it may appear that considered judgments hold a preferential place, this is erroneous, and each element is independent and equally considered. Daniels (1996a) acknowledges that while considered judgments do initially carry additional weight, the process of first developing moral principles and then seeking contradictory background theories helps to reveal these biases and brings to

\(^2\) Foundationalism holds that some moral facts are self-justifying and do not require the support of other facts to be justified (McMahan, 2000)

\(^3\) Intuitionism holds that we come to know about moral facts through observation, not through their relationship to self-justifying moral facts (McMahan, 2000)
light inconsistencies. As a result initial preference gives way as the process progresses and this testing process can lead to surprising conclusions.

Daniels' independence constraint (1980) answers the charge of a system that establishes its own trueness via consensus. The relevant background theories used to challenge the initial considered judgements and the moral principles must not derive from those same judgements or principles. This independence of elements that provide support for the argument ensures the quality of the argument. Daniels advocated that external and potentially contradictory evidence must be sought to insure that moral judgments that would otherwise go unchallenged are considered for revision. This may include "well justified and widely accepted empirical factual beliefs including beliefs about the functions of morality, the functioning of parts of the social structure (including the economy) relevant to social facts, political realities, and relevant scientific developments." (Nielsen, 2008, pg. 220). This answers criticism that RE allows an individual to substantiate biased judgments with biased principles by introducing new and contradictory sources of evidence to the process.

4.2.2 Initial considered judgements lack credibility

Another major critique centres on the source of the initial considered judgments, as some scholars suggest that these lack credibility. Richard Brandt argues that without initial credibility, there is no reason to conclude that the initial considered judgements lead us toward truth (Brandt, 1979; Brandt, 1990)

Daniel's has addressed this criticism in varying ways. He has argued that the burden of proof for moral "facts" should lie on the theory that emerges from WRE. Daniels suggests that instead of initially offering a credibility argument, once the theory is reached, the theory should indicate which 'facts' support the initial considered judgments (Daniels, 1980). In later work Daniel argues that many moral theories (e.g. Utilitarianism) experience challenges justifying their preliminary moral facts, but the WRE is explicit about sources of bias' and historical accident and works to expose these to criticism and correction instead of resorting to causal stories for justification (Daniels, 2003).
4.2.3 WRE is too comprehensive to be useful

Since its formalization, WRE has gained acceptance and has been heralded as a systematic way to justify moral theories. WRE granted equal priority to all types of evidence, appealing to previously opposed factions in the debate over ethical methods (Arras, 2007). Arras argues that WRE removes from each method "whatever is partial, fragmentary, or one-sided about them, while their remaining valuable features are preserved and elevated within a more comprehensive synthesis" (Arras, 2007, p.54).

However, critics argued that WRE is too comprehensive and provides no way to guide decisions, and does not guarantee a true conclusion even if equilibrium is achieved.

The challenge of WRE lies is the comprehensive nature of the equilibrium called for. Arras (2007) argues since all competing theoretical considerations must be included in order to truly achieve WRE, and as this could easily occupy a professor's life's work, WRE is too comprehensive, and the scope far too wide to make WRE useful. Nielson addresses this arguing for a “wider” but not “wide” reflective equilibrium (1985, pg.139). Other scholars also recognize the unlikelihood of achieving perfect equilibrium and advocate for consideration of the most salient points in the use of relevant background theories instead of attempting to reach complete WRE (Arras, 2007; Scanlon, 2002).

However, Arras’ argues that this restricts WRE to the theoretical ethicist and leaves the practical bioethicist to work within the confines of something that resembles NRE (Arras, 2007). Arras concludes that WRE lacks the ability to guide how an individual should proceed and provides little hope of drawing the widely disparate background theories into a tight enough circle of equilibrium to guide decisions (2007, p57).

Ultimately, these critiques are not damaging to the use of RE or WRE in this thesis. The goal is more aptly viewed as achieving agreement or consensus on the current moral status of the treatment of Health Care professionals in rural settings who conscientiously object, and suggest another direction (or directions) that might be considered, only recommending a better, or potential, direction for action that is coherent with current legal, societal, and moral expectations. This use is supported by Neilson who advocates
recognition of this aspect of RE which allows “a recognizable kind of objectivity by that intersubjective agreement” (1985, pg. 28). Furthermore, this use of RE to assess the current moral status of the treatment of HCPs in rural settings who conscientiously object, can be considered to fit neatly into Neilson’s argument that justice in modern societies requires equal weight to the considerations of all parties’ interests (Nielsen, 1985, p. 58), which is precisely the goal of WRE.

4.2.4 WRE does not guarantee moral truth

A final critique suggests that coherence among the various elements of WRE does not guarantee the conclusion is "moral truth", but merely that the elements do not contradict each other (Arras, 2007; Hare, 1973)

This critique largely focuses on a larger issue within coherence theories, but does not greatly impact this thesis. It is acknowledged that WRE does increase the probabilities of converging on moral truth, by providing a systematic method for considering various sources of evidence (Arras, 2007). WRE is unable to compensate for lack of information or knowledge needed to make a decision, whether that lack is due to negligence on the part of the user or due to a lack of progress in that area of knowledge acquisition by society. This is a weakness of the method; however, lack of perfection does not remove the obligation to do our best with the resources at hand. As such, this critique is a valuable consideration in understanding the conclusions of this thesis; however, the conclusions will provide the best possible answer to the question, given the information currently available.

4.3 Specific application

Within this thesis the goal was to demonstrate whether current strategies for dealing with HCPs who conscientiously object are incongruent and require reworking, given Canadian ideals and standards, based on law, practice, and values. The goal of WRE is not to achieve a perfectly delineated set of principles to explicate all moral questions, but instead to provide sufficient guidance and flexibility to allow beliefs to progress morally (Scanlon, 1992).
It is important to recognize that while full WRE may not be attainable within the limits of this thesis, wider reflective equilibrium is preferable (in this thesis) to NRE. This is because NRE does not provide a means of considering alternative perspectives and systems (Daniels, 2003). Similarly, it will be necessary to clearly indicate the considered moral judgements, moral principles, and background competing theories that are considered, to clearly demonstrate the equal consideration provided to each and avoid the charge of favouring one element over the other. This thesis cannot be compared and assessed based on the typical criteria used to assess thesis work within the natural sciences. However, limiting the scope to discussing the specific treatment of Health Care Professionals in the rural Canadian context, evidence and competing considerations from rural Canadian ideals (as identified in the literature) and standards (based on laws, policies, and reported values), allows for a preliminary assessment of the congruency of current practices and proposal of a more congruent approach.
Chapter 5

5 Quality criteria

The interdisciplinary nature of this thesis produces unique challenges for establishing criteria for assessing the quality of the final thesis. These criteria need to be acceptable to a large audience with diverse views including the traditionally post positivist views of philosophy and the traditionally constructivist views of health science. As such, this thesis attempts to use parallel criteria from quantitative and qualitative research methodologies, which while critiqued in the literature, do allow for disparate audiences to understand and assess materials in a more familiar context (Morrow, 2005).

To ensure the quality of the research and conclusions of this thesis the following criteria are used as recommended by Caelli, Ray, and Mill (2003):

1. Clear description of theoretical positioning

2. Consistency between methodology and methods used

3. Knowledgeable and theoretically informed approach to rigor

4. Explicit discussion of the researcher's presuppositions as they come to bear on the research.

5.1 Clear description of theoretical positioning

As outlined by various authors (Caelli et al., 2003; Eakin & Mykhalovskiy, 2003; Morrow, 2005) the researcher's theoretical positioning and background as it influences the research should be clearly articulated.

5.2 Consistency between methodology and methods used

The techniques used for gathering and analyzing the research should be consistent with the methodology's underlying assumptions, especially those assumptions surrounding truth and how value is assessed to the various aspects of the research (Caelli et al., 2003; Morrow, 2005). This is especially important in a methodology such as Reflective
Equilibrium, as this requires continual adjustment of the principles, considered moral judgments, and competing theories.

5.3 Knowledgeable and theoretically informed approach to rigor

The research needs to articulate a theoretically informed approach to ensuring rigor (Caelli et al., 2003), which reflects a "philosophically and methodologically congruent" (Caelli et al., 2003, p. 15) approach. This approach needs to allow for dependability (parallel to reliability in quantitative research) in results that come from a clear articulation of the development of the research design and an audit trail that other researchers might follow (Morrow, 2005).

5.4 Explicit discussion of the researcher's presuppositions as they come to bear on the research

Caelli, Ray and Mill (2003) use the term analytic lens to refer to the biases and values researchers bring to their data that ultimately affect how that data is viewed and interpreted. Morrow (2005) and Eakin and Mykhalovskiy (2003) also discuss the importance of explicating these presuppositions so that the audience is clear on how they may have influenced conclusions and how data was gathered.

5.5 Specific application

For this thesis these quality criteria are met by:

1. Clear explication of the author's position and background

2. Using a methodology (WRE) that, while acceptable to both qualitative and quantitative audiences, allows for multiple sources of evidence to be assessed and considered in parallel. This methodology does not ascribe privileged status to any one source of information (considered moral judgements, moral principles, or relevant background theories). This methodology has a clearly delineated method that helps to ensure consistency. In this thesis, that includes establishing a set of considered judgements based on a literature review, developing moral principles that explicate those considered
judgements and seeking additional relevant background theories that challenge both the considered judgements and moral principles through additional literature review and discussion with faculty. At all times during development, each component of the thesis is open to complete revision based on new or challenging sources of evidence.

3. By ensuring adherence to the method of RE, and ensuring a wide source of the evidence (principles, considered judgments, and competing theories) used in reaching conclusions; as well as providing an audit trail of conclusions reached. In addition, a diverse group of scholars have provided criticism of this thesis. This includes Dr. Kenneth Kirkwood, health ethics, who provided direction for the thesis as a whole; Dr. Eliza Hurley, bioethics and philosophy, who provided input on the methodology and method; Dr. Beverly Leipert, nursing and rural health care, who provided input on the literature review and critiques of assumptions regarding rural issues including the inclusion of nurses and nurse practitioners; and Dr. Marilyn Evans, nursing and health ethics, who provided later input and critical consideration of the thesis as a whole suggesting further areas for consideration. Dr. Evans provided considerable critique leading to the incorporation of compassion fatigue, burn out, and challenges related specifically to nursing and elimination of other conclusions from the final thesis. In addition, early in the research process Dr. Sokol (External to The University of Western Ontario) provided email discussion and suggestions regarding avenues for research specifically surrounding conscience and moral distress.

4. By explicating which evidence was given greatest weight and justification for those choices so that the audience may understand why conclusions were reached. This was done throughout the literature review.
Chapter 6

6 Analysis

The preceding chapters outlined the background information and literature related to rural health care delivery and the HCPs involved; described the challenges faced in the rural environment that lead to ethical challenges and conscientious objection; and outlined a methodology for analyzing current practices and suggesting new strategies for addressing these issues. This chapter will synthesize this information, identifying the considered moral judgements that evolve from this information, distilling those judgements to moral principles that match with and explicate this body of information, and consider competing background information in order to provide recommendations in wide reflective equilibrium. For ease of understanding, the information is presented as the moral principle, followed by the considered moral judgements and competing background theories related to those principles.

Upon review of the preceding literature and information, three major principles become evident as explaining and fitting with that body of information:

1. People, who are responsible for making challenging and irreversible ethical decisions, should be provided with the tools (education, resources, etc.), power, and practice (or experience) to make those decisions and develop the “ethical expertise” for doing so competently within that field.

2. If there is a way to prevent or reduce harm (specifically ethical trauma or moral distress) in a specific set of health care professionals, then the people who have authority over those individuals have a responsibility to act on that ability to reduce or prevent that harm, if it is feasible, and practical to do so.

3. Human beings and citizens are social creatures with multiple competing loyalties and duties. Their professional roles cannot be considered in exclusion to these competing interests. This is especially true of rural professionals who play multiple roles within a community.
An explication of the support for each of the preceding principles follows and expanded discussion of the specific principle below. To aid in understanding, the example cited from May (2001) is revisited in each step.

6.1 Principle 1

HCPs in rural communities are placed in positions that require them to make both challenging and often irreversible ethical decisions regarding patient care and treatment. These HCPs need to be provided with the requisite education (including ongoing education) and resources, as well as the authority and experience to make those decisions and to ensure that the best care and most ethical conduct are the outcomes of each situation. This requires opportunities to develop the skills for negotiating ethical dilemmas in health care, and recognizes the increased influence and authority already present that requires greater ethical expertise to negotiate situations that may challenge HCPs trying to negotiate between strong competing values.

6.1.1 Developing ethical decision making skills

As discussed, rural HCPs are more likely to encounter situations where delay in treating a patient could lead to imminent harm and even death. Moreover, because rural HCPs practice in a greater number of areas, and need to maintain expertise in those areas, there is a higher probability that HCPs will be placed into situations in which they do not have recent training or experience to direct their decisions. Additionally, as discussed there is a higher the probability of the rural HCP encountering a greater variety of ethical dilemmas than an HCP in an urban setting might encounter.

In addition, the personal health practices, workplaces, context of rural health care delivery, and longer travel times to health care services often leads to patients arriving for treatment sicker and with more complications, than urban patients. This can be further complicated by a lack of ability to transfer patients for various reasons including weather conditions, availability of alternative providers (or willingness or ability of those providers) to take over difficult cases, and the refusal of rural individuals to be transported away from trusted providers and support networks.
Finally, the proclivity of dual relationships in rural communities, the inability to access continuing medical education regularly, and lack of time to wait for ethics committee decisions, due to increased medical complications upon arrival and demands on HCP time, can further challenge an HCP who attempts to make sound ethical decisions.

As a result, it is important for HCPs to have the opportunity to develop the skills to manage these situations and make the required decisions through continuous practice and opportunities to learn. This requires exposure to more challenging experiences over time, in situations with increasingly severe consequences for making incorrect choices. These experiences should progress with decreasing support and an ongoing opportunity to learn from and correct mistakes throughout the process, so that when faced with challenging novel situations the HCP has a bank of previous experience to draw on when determining how to proceed.

In the presented example, the patient will die without the needed surgery; however, the surgeon is unwilling to provide the surgery unless the patient agrees to accept blood products if needed. If the patient cannot be transported to the nearest alternative hospital that could provide the surgery, and the objecting surgeon is the most capable HCP of performing the surgery in the area, then the dilemma becomes more complex as transferring patient care is no longer an alternative.

If, during training electives, the surgeon had been given specific ethically focused preparation then she would be able to make the distinction between issues of conscience which relate to type of activity as opposed to situations where she is imposing a value judgement. For example objecting to all such surgeries on principle compared with assessing whether a ten percent chance of death without blood product is worth the risk to the patient. Education surrounding ethical decision-making, combined with experience negotiating dilemmas throughout the training process, would allow this surgeon to navigate the presented scenario with greater ethical expertise.
6.1.2 Increased authority and influence requires increased ethical expertise

In addition to facing complex and unique ethical dilemmas, HCPs in rural areas are often in situations of potentially greater power (influence and/or authority) over both patients and depending on the HCP's position in the hierarchy, coworkers (including administrators). In part, this difference is due to the isolation from alternative providers where patients might access the same service, and the potential for decreased health status among rural citizens, which forces them to utilize what health services are available. This increased power requires increased accountability, but also an increased ability to make ethically challenging decisions as the increased power provides opportunities to make, but also to hide, ethically challenging decisions.

First, in rural areas several subsets of the population, especially minorities, are considered vulnerable with less ability to advocate for themselves (Leipert, 2006) making it more important to respect and be sensitive to the cultural and religious decision-making strategies and value systems of these vulnerable individuals. For example, in her research with rural and northern women, Leipert (1999) discusses how physicians may be unaware of abuse suffered by women in their community because the women feel they cannot talk to the doctor that their husband sees. This speaks to the extreme importance of physicians being perceived as not only trustworthy, but holding a high standard of confidentiality. By ensuring that HCPs are aware of potential biases toward their patients, and that HCPs are held accountable for their interactions with those patients in a manner patients can recognize, it is possible to minimize this effect. Patients need to have the confidence that they can speak up to other providers of inappropriate treatment or breaches in confidentiality, which may translate to a willingness to trust HCPs with sensitive information. In addition, if HCPs are already working to minimize situations that may cause difficulty for patients, this will also improve this challenge.

Furthermore, HCPs often encounter situations in which they know a specific course of action is necessary, but are constrained from following that action. In that situations HCPs may bend the rules to ensure that a patient receives care. However, without safe guards in place, one patient may receive additional care while another goes without. Also,
such decisions are not usually documented (Kälvemark et al., 2004), which means policy makers do not have the opportunity to correct systemic issues; because, they are unaware that the issues exist. For example, doctors and nurses in Kälvemark and colleague's (2004) study discuss bending rules to provide patients with medication they could not afford, choosing not to provide a treatment to older patients despite regulations and justifying it officially as too risky in order to preserve resources for other patients and prevent discomfort to the patient, and many other examples. In many of these situations the reasoning is laudable "you do it for the patient," "you do it because it is more ethical in a humanitarian way," (Kälvemark et al., 2004); however, it is doubtful that this rule bending occurs for all patients in the same situation. Would a nurse bend the rules to provide additional medication to the aggressive patient in the same way he or she might for a child of destitute parents? Even if both will go without needed medication? Possibly, possibly not. Ultimately the HCPs are aware they make these decisions to avoid issues of conscientious conflict (Kälvemark et al., 2004). Without oversight and documentation on these situations, there is no way to ensure that these episodes of rule bending are evenly distributed and no long-term method in place for addressing the issue.

Furthermore, individuals in rural communities need to trust their HCPs, or they are less likely to seek treatment. Unlike urban communities, rural individuals have less opportunity to select an alternative HCP in situations of impaired trust. This trust and isolation, further decreases the opportunities a patient has to control his or her interactions with the HCP. This is further decreased by the lack of education, which is common, among community members other than the HCPs and other professionals. In a situation with limited alternative providers, with limited knowledge of his or her right to request transfers of care and alternative types of care, a individual may feel trapped under the care of a physician he or she does not trust. If this individual is in dire need of treatment that only a physician can provide, he or she may be hesitant to voice his or her concerns for fear of angering the physician on whom he or she is reliant for good care.

It is important for HCPs to be more vigilant and have good ethical expertise to navigate the potentially challenging situations that may arise day to day, even seemingly minor ones such as the examples of rule bending, which still have ethical implications. In
addition, the HCPs need to have some form of accountability in place to facilitate both refining of those abilities and prevent missteps from going unnoticed, even better would be the opportunity to document exceptions to allow for future changes to the policies that cause conscience conflicts that result in these choices.

6.2 Principle 2

Generally, it is accepted that individuals in authority have a duty to provide for the needs of those they are in authority over. Fire chiefs must ensure that fire fighters have the appropriate equipment to fight fires without undue risk, doctors and nurses must address the needs of patients, and administrators, policy makers and managers must provide for the wellbeing of their employees as it relates to the workplace environment. This value in Canadian society has recently been confirmed by the passage of Bill 168 holding employers ethically and legally responsible for not taking action when an employee is in danger, or if an employee is suffering emotional harm (in the form of harassment or bullying at work) (Government of Ontario, 2009). It follows that if there is a way to prevent or reduce harm (specifically ethical trauma or moral distress) in a specific set of health care professionals, then the people who have authority over those individuals have a responsibility to act on that ability to reduce or prevent that harm, if doing so does not cause undue hardship to that employer (it must be feasible and possible).

6.2.1 Methods exist to decrease moral distress in HCPs

A key element imposing responsibility for action on those in authority over HCP's who may conscientiously object and experience moral distress, is the requirement that a resolution be both feasible and possible. Several researchers have determined that there are ways to decrease moral distress for HCPs, and since moral distress, as discussed previously, is an outcome of a conscientious objection that is not respected (whether by the individual or the institution) it follows that administrators should work to decrease both if these recommendations are attainable given the limitations placed on administrators.

While some moral distress can be positive, forcing the individual to clarify values and commitments; overwhelmingly, the research indicates that most moral distress is
detrimental both to the individual and to the employer. As Webster and Baylis (2000) argue, moral distress leads to moral residue, and this can lead to “denial of the incoherence between beliefs and actions, trivialization of the incoherence between beliefs and actions, or unreflective acceptance of the incoherence between beliefs and actions” (p.225). Essentially, the individual’s ability to act as a moral agent, someone who makes and acts on ethical decisions, has been harmed.

Furthermore, it is reasonable to expect that moderate inconvenience to these individuals in authority would be tolerable, given the financial implications and detriment to patient outcomes as 25-45% of nurses and 3% of doctors leave their positions, or are considering leaving due to these issues, and the quality of care received by patients has been shown to decrease when providers have moral residue (Bell & Breslin, 2008; Hamric & Blackhall, 2007; Ulrich et al., 2007). This represents a significant financial cost, both in recruitment and training efforts to replace these HCPs, and in the lack of productivity leading up to the HCP's decision to leave. It also represents a cost to the quality of care received by patients.

In the scenario involving the surgeon who refuses to conduct the surgery without the option to use blood products, simply over-ruling the objection might result in moral distress and ultimately moral residue, especially if the patient were to die. This distress could eventually cause the surgeon to leave practice in rural areas to avoid being forced into a similar future situation. Administrators would then be forced to recruit a new surgeon and incur the costs of both recruitment and the workplace training.

Evidently, recognizing and decreasing moral distress makes sense financially, for patient care, and for preventing harm in HCPs. Moreover, research such as that conducted by Laschinger, Almost, and Tuer-Hodes (2003) shows that increasing autonomy and control improves retention and even attracts HCPs to hospital environments. In addition, the strategies discussed, such as fostering discussions about treatment decisions, do not suggest a large financial or educational investment is needed (Hamric & Blackhall, 2007; Ulrich et al., 2007). As such, strategies exist for decreasing moral distress that are feasible and possible to implement.
For the objecting surgeon, fostering a discussion with the attending nurse regarding the reasons for the objection, might elucidate the faulty reasoning. By allowing the surgeon to recognize that she would provide this surgery in other situations, and is simply making a judgement about the choice the patient makes, not the morality of conducting the indicated surgery, such a discussion might resolve the perceived conflict. But, for such a dialogue to occur administrators would need to foster an environment that both encourages dialogue about conscience issues, and protects subordinate staff from reprisal for voicing concerns. The result of such dialogue would be the prevention of distress in the surgeon, and ultimately the costly requirement to fill her vacancy.

6.2.2 Impact of a value, not the value’s source, should determine the credibility of the value

As previously discussed, whether a value is informed by religious or secular (non-religious) sources does not change the consequences contravention of that centrally held value has on an individual. As such, even values others deem “ridiculous” and “absurd” cannot be lightly dismissed, even when the majority of people concur that the value is “ridiculous” or “absurd”. The only factor that should be used to determine the reaction to a claim to conscience is the impact of that value on the individual, if the value meets the requirements for a claim to conscience. Consider the following examples:

Example 1: Dr. Smith refuses to provide a recommendation for elderly Mr. Jones to receive a heart transplant, because Dr. Smith believes the risk to Mr. Jones is greater than the potential benefit and Dr. Smith believes that the resources must go to a patient in need of treatment who has a better chance to benefit.

Example 2: Dr. Smith refuses to prescribe oral contraceptives to Ms. Jones because Dr. Smith believes that the treatment denies the sacredness of life, which Dr. Smith believes includes interfering with God's plan by preventing pregnancy.

Both scenarios presented involve a judgement where the doctor refuses to provide an accepted treatment option. However, the first example uses an argument on non-religious grounds, while the second uses religious grounds. Based on the definition of conscience, both situations should be treated and evaluated equally if the patient or another HCP
raises concern with this refusal. One refusal should not be considered less credible for being based on religious grounds.

6.2.3 Current provisions do not meet this responsibility in a rural setting

Current strategies in place to mitigate impact on HCPs include allowing HCPs to refuse to provide care and to transfer care if the HCP is unable to provide care or a conscientious objection occurs. However, in practice HCPs are expected to provide care in emergencies or if transfer is not possible. While this practice may allow urban HCPs to avoid situations of conflict, as discussed this is not typically a feasible possibility for rural HCPs due to weather, lack of support, and other restrictions. Although the current standards of practice make allowances for conscientious objection, these allowances are difficult, if not impossible, to apply in the rural practice context. As a result rural HCPs are placed in a position of undue risk to their consciences, because the current standards of practice do not take the rural context into account, and fail to provide the supports and protections they purport to provide.

In the example, current strategies would require the surgeon to provide the treatment she objects to, because no option for transfer is available. As a result the surgeon may leave her position in the community, or to cope with the stress caused by this conflict become less sensitive to challenging future ethical situations.

6.2.4 Presented solutions are feasible and possible

Various potential methods for addressing conscientious objection and decreasing or preventing moral distress have been discussed. These include encouraging inter-professional dialogue, providing improved ethical training to HCPs, and instituting a system of expectations and protections surrounding claims to conscience.

First, several authors discuss the evidence that increased dialogue between professionals decreases moral distress. Some authors suggest that this method is particularly effective in preventing moral distress that occurs when one party (often nurses) feels that the other party (often doctors) has not taken into account essential considerations in making a
decision. For example, Varcoe, Doane, Pauly, Rodney, and colleagues (2004) discuss their findings that junior nurses (in the presence of more senior staff) and nurses in general (with regard to physicians) find it very challenging ethically when those higher in the hierarchy dismiss potentially lifesaving observations. Varcoe and colleagues give the specific example of a nurse whose concerns were dismissed “when she attempted to report that a computer failure was responsible for abnormal cardiac readings for a particular patient” (2004, p. 322). Other authors have noted that rural health care centres already have an increased level of trust and dialogue between HCPs when compared to urban centres and attribute this to the reduced number of professionals involved in providing care, and the need for HCPs to rely on each other with reduced resources (Scharff, 2006; Troyer & Lee, 2006). As such, published recommendations that have shown success at mitigating moral distress, such as increased inter-professional dialogue, are both feasible and reasonable modifications that rural centres are ideally situated to encourage and formalize among HCPs.

Second, various authors have repeatedly identified the need for further ethical resources and training for rural HCPs (Cook & Hoas, 2008; Nelson et al., 2006); however, the challenge in meeting this need often revolves around time available to HCPs and the difficulty traveling to and having time for continuing medical education (CME) (Hendrickx, 2006). Other authors have called for a Rural Health Specialty and several medical and nursing schools have now implemented rural health electives for students (The University of Western Ontario, 2011; The University of Western Ontario, 2013). It would be possible for medical and nursing schools to include more ethical education within the rural electives, and the new virtual ethics committees might also assist in directing HCPs in less time constrained cases. Also, deliberately structuring rural medical rotations to include a progressive exposure to making ethically challenging decisions, first with support and progressing toward independence, would provide rural HCPs the opportunity to develop the ethical expertise needed along with the 'gut instinct' to make the rapid decisions needed as they progress in their medical career. The deliberate inclusion of an ethics component in rural medical education, in addition to the other changes, would require some modification to current methods of training, but do not
require large financial or time investments and as such should be feasible even for small communities.

To address ongoing concerns Morton and Kirkwood’s (2009) recommendation for increased accountability and protection regarding claims to conscience should be implemented. This includes expecting HCPs to defend claims to conscience to other HCPs and administrators, and places responsibility on other HCPs and administrators to provide counter evidence if they believe the objecting HCP is in error. While, HCPs are expected to question actions they consider not in their patient's best interest, this does not always occur. This method would create an expectation of such questioning, ensure that HCPs have the freedom to openly discuss objections, decrease the perceived need for 'justified rule bending' and increase the opportunity for clear documentation of where objections arise so potential systemic issues that need to be addressed can be identified.

Finally, Morton and Kirkwood's (2009) recommendations allow other individuals to mitigate the power imbalance that can occur in rural communities. These recommendations empower patients, administrators, and HCPs who may feel lower on the HCP hierarchy to take action, as questioning and expecting a defence from an objecting HCP becomes expected, and no longer simply an option that someone might choose. In addition, HCPs who choose to object would receive greater protection, because if the HCP defends his or her claims, the claims would need to be respected regardless of whether those claims were based on religious or secular grounds. While this final aspect would require more changes than the preceding two, this option both utilizes the current recommendations from research and acknowledges the potential for rural communities to take a lead in this area due to the already established lines for communication. This recommendation addresses concerns regarding time limits, as the process can be as brief as “doctor, I disagree because you have not considered that patient’s expressed wish to exhaust all non-surgical options” to more in depth discussions. It allows HCPs to continue honing ethical decision making skills and correct

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4 When an HCP feels that they need to bend or break rules to protect duties to themselves or others.
erroneous/superstitious beliefs that would normally go unrecognized or unchallenged. Additionally, this system both protects the objector and also empowers those who may previously have had little power or recourse in the situation (patients). By providing for an environment where questioning and defence of conscientious objection is expected, but also respected, the recommendation that policy makers and administrators take a more active role is incorporated into the process of change.

When considering the example of the surgeon, these recommendations may allow for a drastically different outcome. Instead of the surgeon's conscientious claim being overruled, she might engage in dialogue with the patient's nurse which may elucidate an erroneous sequence of reasoning and allow her to view the dilemma in light of the acceptability of the surgery as opposed to making a judgements of the patient's valuation of that surgery. Secondly, previous education and experience targeting ethical issues may completely prevent the need for such dialogue by preparing the surgeon for a situation where transfer of care is not the solution. Finally, be expecting an explanation for the objection and expecting other staff to raise concerns and challenges a further opportunity to correct erroneous assumptions occurs. Ultimately, the result is a low cost, time effective solution that resolves an otherwise intractable ethical issue.

6.3 Principle 3

Human beings are social creatures with multiple competing loyalties and duties. HCPs professional roles cannot be considered in exclusion to these competing interests, especially in the rural setting where HCPs are (and need to be) integrated into the community in multiple roles.

6.3.1 Health care providers face multiple competing duties

While major authorities in the conscientious objection discussion tend to discuss HCPs’ roles as if this was the HCP’s only responsibility, some authors (Sokol, 2006) have begun to argue that this is a fallacious approach. Even when discussing the professional duties of HCPs, competing obligations can muddy the decision-making process. HCPs are obligated to their patients, their employer, and society simply within their professional roles. Stepping outside of the professional obligations, most HCPs are also obligated to
their communities (whether social, spiritual, etc.), families, and to their own belief system or integrity. This is without considering research interests and other contending factors that may be viewed negatively by some audiences. It is clear, the potential factors that might play into any ethical decision are vast, and simply attempting to resolve an ethically challenging situation in light of an HCP’s duties to a patient would not ultimately consider the other important factors in creating a good ethical choice.

6.3.2 Patients have duties to their HCPs

Finally, patients, as members of their health care team and both their own and the HCP’s community, province, country, have obligations to their HCPs. As discussed by Sokol patients have a duty “not to require doctors to transcend the bounds of reasonable risk during treatment and to respect and acknowledge their roles outside the realm of medicine” (2006, p.1239), this also extends to other HCPs involved in patient care and treatment. For example in extreme situations, such as Ebola and Marburg outbreaks, where treating patients will result in negative HCP outcomes, expectations of HCPs change (Sokol, 2006). This pattern of changing responsibilities based on the circumstances is evident in other professions with similar life or death outcomes for clients. Firefighters are not expected to enter a burning building, even if multiple people might be saved, if the building is considered unsafe or at risk for collapsing or if the firefighter does not have the necessary equipment. This is true even if the individuals die and it is later determined that the building was safe. Firefighters are government employees, paid for with social resources (as are many HCPs in Canada) with a commitment to risk their lives for individuals in danger. However, that requirement is mitigated by considerations outside of the immediate welfare of the individuals in a particular fire situation. Similarly, a systematic method for determining similar extenuating circumstances for HCPs is required, especially for HCPs in rural communities who are more likely to encounter challenging situations.

6.4 Assessment

Together these principles suggest that current policies and procedures fail to meet the moral requirements for protection of HCPs who express or experience conscientious
objection in a rural setting when that objection is based on a centrally held value or belief.

The recommended strategies for moving forward incorporate current research and discussion on addressing the moral distress that can result from failure to respect these conscientious objections. Furthermore, the recommendations in this thesis have been shown to be both feasible and possible, and to consider the financial and time constraint critiques raised against previous recommendations.

As such it is reasonable to conclude that failure to provide these or similar supports to HCPs in rural settings, shows a failure to meet the obligations we as a society have to our HCPs.

6.5 Conclusions and future possibilities for research

As discussed previously, current strategies for addressing the conscientious objection of a nurse or physician in a rural community fall short of their intended purpose and new strategies are needed that empower HCPs, patients, and administrators to hold each party accountable for their actions. Current strategies are based on an urban model, which neither accommodates the complexity of issues addressed in a rural setting, nor the time limitations and power imbalances endemic to health care provision in the rural environment. This thesis recommends respecting an HCP's right to conscientiously object, when that objection is based on a core value or belief (as previously defined) and puts the onus on that HCP to explain his or her reason for objecting. In addition, other HCPs, administrators, and even patients are expected to provide their reasons for disagreement to that HCP, creating a dialogue that will increase the ethical expertise of each party and make areas of objection clear so that policy makers can adjust and amend policies that routinely cause issue. This recommendation fits with the observed interdependence of HCPs in a rural setting, while increasing the power of subordinates and requiring a dialogue when an objection is raised, but also requiring the defended conscientious objection be respected.
The scope of this thesis did not allow for field research to test the recommendations, and this limitation leaves the door open for future research to determine directly from rural HCPs reasons for conscientious objection and the effectiveness of these recommendations compared with current strategies. Further research into how rule bending and failure to present controversial options to patients affects outcomes and care for rural individuals, in contrast to current studies on urban populations, may also further elucidate the need for this issue to be addressed. Research on HCP attrition from rural to urban settings (as opposed to simply retiring from the field altogether), could also assist retention efforts in rural and remote communities that are considered underserved. This type of research should specifically consider the impact of issues of conscience and moral distress.

The theoretical nature of this thesis, and the lack of previous field research on conscientious objection in rural health care settings limit the conclusions that may be drawn. In addition, the author is not an HCP, and therefore conclusions are drawn as an outsider, dependent on published research, without direct insight into how HCPs think and reason. However, this thesis calls to light a need for further research, and demonstrates the error in creating policies and standards for rural health care practice without inclusion of the rural setting in the development of those policies. Finally, WRE can only provide an assessment of whether current strategies are ethical based on the information currently available. WRE cannot overcome limitations inherent to a subject where little direct research has previously been conducted.
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Appendices

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From: Ken Kirkwood
Date: Sun, Mar 10, 2013 at 11:39 AM
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To: Tandy Morton

Dear Tandy,

Absolutely you may do everything with article that you mentioned in the email.

Sincerely,

Dr. K.W. Kirkwood

On 2013-03-09, at 9:39 AM, Tandy Morton wrote:

Dear Dr. Kirkwood,

I would like to formally request permission to include adaptations and significant quotations of the article Morton, N. T., & Kirkwood, K. W. (2009). Conscience and conscientious objection of health care professionals refocusing the issue. HEC Forum, 21(4), 351-364, in my Masters thesis titled "Addressing conscientious objection of rural Canadian nurses and physicians".

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Thank you,
Natasha T. Morton

M.Sc. Candidate
Health Professional Education, HRS
The University of Western Ontario
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Curriculum Vitae

Name: Natasha Morton

Post-secondary Education and Degrees:
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Honours and Awards:
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2003-2004

Canadian Millennium Scholarship Foundation Provincial Award
2003-2007

Related Work Experience
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Chippewa of the Thames Health Centre
2006

Teaching Assistant
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Publications: