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## Exploring the Lived Experience of Conscientious Objection for Registered Nurses in Ontario.

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Nursing

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## ABSTRACT AND KEYWORDS

Nursing is an ethical profession in which nurses are called to act ethically, be moral agents and function with moral integrity. Contemporary nursing practice is morally pluralistic and at times, nurses may be faced with a conflict of conscience that motivates them to voice their ethical concerns about patient care provision that they perceive to be unethical. This concern can result in the format of a conscientious objection.

Conscientious objection involves an individual objecting to doing something they deem unethical and to refrain from participating in that unethical action.

The aim of the question guiding this research study was to gain an in-depth understanding of what it means to be a nurse voicing a conscientious objection in workplace settings. An interpretive phenomenological approach was used to gain a deeper awareness of nurses' ethical experiences through one-on-one, semi-structured interviews with registered nurses practicing across health care settings in Ontario. Data analysis was conducted consistent with thematic analysis of the participant's narratives. Themes that arose around nurses' meaningful experiences with voicing a conscientious objection include: encountering the problem, knowing oneself, taking a stand, alone and uncertain, caring for others and perceptions of support.

The findings inform health professionals of the intricacies of making a conscientious objection for nurses. It is anticipated that such insight will generate further support for nurses addressing ethical dilemmas in professional practice. Implications and recommendations for nursing practice, policy, nursing education and further research are discussed.

Keywords: Conscientious objection, conscience, nursing, nursing practice, education.

## CO-AUTHORSHIP

Christina Lamb conducted this work under the supervision of Dr(s). Marilyn Evans and Yolanda Babenko-Mould and with her doctoral committee members, Dr(s). Carol Wong and Ken Kirkwood. Dr(s). Evans, Babenko-Mould, Wong and Kirkwood are co-authors with Christina Lamb in publications arising from chapters two and three as well as for future publications on the study.

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## CHAPTER ONE

### To Live with Making a Conscientious Objection

*“The genuine kind of being of Dasein corresponding to its utmost and ownmost possibility is what we have characterized as the forerunning of willing to have conscience”.*

*~Martin Heidegger*

Nursing is a profession predicated on doing that which is right, or ethical in practice. Essentially, what nursing is and what nurses do, is directed towards right action. This action is intrinsically concerned with caring for others, in such a way that nurses are perceived to be moral agents (Canadian Nurses Association [CNA], Code of Ethics, 2008). As moral agents, nurses carry a responsibility towards themselves and others that consists of doing what is right by their patients, one another and is an integral part of building up moral communities focused on human health and well-being (CNA, 2008; McCurry, Hunter Revell & Roy, 2009). Yet, doing what is right needs to emerge from a sense of self knowledge, an understanding of what it means to be, from a fundamental ontological stance, a nurse morally and ethically, to provide ethical nursing care. Meaning, as Van Manen (1990), expounds, can be captured in the realities humans encounter within their life worlds, known as lived experiences.

As such, where ethical meaning emerges for nurses and becomes known or understood can be unveiled in the lived experiences of nurses in practice. A question recently overarching the nursing profession at large is whether there is moral unity in nursing (Newham, 2012). This query poses what does it mean to be a moral or ethical nurse? Although frequently used interchangeably with ethics, morality is, instead, a precursor to ethics and can be further delineated as that which is good (moral) being extended into right action (ethical) (Minnesota Nurses Association, 2004). Classified as moral agents (CNA, 2008) nurses' perceptions of what it is to be ethical, as nurses, can

vary owing to multifaceted perceptions of what is good to do in clinical practice, and how to convey that understanding through action calls for nurses to have the ability to make ethical decisions in practice.

The formative source informing nursing practice is education which the founder of modern nursing, Florence Nightingale, asserts is of a moral nature (in Berghs, Diercks de Casterle & Gastman, 2006), disclosing that ethical awareness can be epistemologically conveyed for nurses. Relevantly, ethics education has become a standard of practice in formative nursing programs for some time (Gastmans, 2013). Rooted in such an ethos, nurses are called to act ethically and provide ethical care for patients in a way that is beneficial to them (Austin, Lemermeyer, Goldberg, Bergum & Johnson, 2005; CNA 2008; Corley, 2002). Yet, contemporary nursing can be complex and ethically challenging (Corley, Elswick, Gorman & Clor, 2000; Pauly, Varcoe, Storch & Newton, 2009; Woods, Rodgers, Towers & La Grow, 2015). For example, nurses are consistently encountering ethical issues related to: restrictions in providing quality patient care, or in providing care they do not perceive to be beneficial or ethical to carry out for their patients, and/or encountering care practices they are ethically at odds with, which creates ethical dilemmas and can result in issues of conscience for nurses (Dahlqvist et al., 2007; Davis, Schrader & Belcheir, 2012; Hamric, Borchers & Epstein, 2012; Jensen & Liddell, 2009; Wicclair, 2011).

Some of these issues of conscience pertain to broader, organizational concerns consisting of workload demands and time constraints that can restrict nurses' quality and ethical care provision. Other issues may involve more personal situations for nurses providing care they perceive as unwarranted (such as continuing active treatment in neonates at the end of life as opposed to transitioning to comfort care). Further issues of

conscience can revolve around nurses' participation in abortion, contraception and euthanasia, as well as handling certain reproductive technologies such as in vitro fertilization, that may be at odds with nurses' personal, ethical beliefs (Catlin et al., 2008; Davis et al., 2012; Eriscon-Lidman, Norberg, Persson & Strandberg, 2012; Ford, Fraser & Marck, 2010; Harries, Cooper, Strelbel & Colvin, 2014; Jensen & Liddell, 2009). At times, nurses may encounter an issue in practice that so strongly conflicts with their personal, ethical beliefs that they may declare a conscientious objection (CO) to refrain from participating in or carrying out an aspect of clinical practice.

Typically, CO consists of making an objection to something that one is personally, ethically opposed to doing to stay consistent with one's conscience (Oxford English Dictionary [OED], 2016). Conscience is a phenomenon that has been defined in a variety of ways, predominantly in philosophical, theological, and health care literature (Birchley, 2012; Ford, 2012; Morton & Kirkwood, 2009; Sulmasy, 2008; Waller-Wise, 2005). Morton and Kirkwood's (2009) definition, however, offers a salience of moral decision-making for health care professionals. Their definition accepts that while conscience is not entirely free from error, it is a process that holds someone accountable to his/her sense of self, consequently authenticating the judgments one makes in line with his/her values (Morton & Kirkwood, 2009). However, this definition fails to address the essential notion that since conscience is not infallible, one is therefore responsible for forming and deliberately attending to the development of one's conscience. Conscience is that which makes human existence, more fully human, and can be encountered in one's every day, lived experiences (Heidegger, 2010). Conscience in this research study was defined as: an internal moral decision making process that holds someone accountable to their moral judgment and for their actions.

Emerging research currently reveals that nurses may make COs that range from direct refusals on the nurses' part to performing certain aspects of care, to less direct approaches, such as conversations with leadership in efforts to resolve the ethical dilemma at hand (Catlin et al., 2008). Making a CO can be an intrinsically intimate experience made by professionals who espouse holistically humanitarian values and beliefs, as indicated in nursing codes of ethics in Canada and around the world (CNA, 2008; International Council of Nurses, 2012). However, in some instances nurses do not voice a CO due to fear of being stigmatized, or apprehending that they do not have the right to do something contrary to a patient's wishes (Ford, 2012) or to a physician's orders. Moreover, nurses who make a CO have also been labeled as "troublemaker(s)" (Baker, 1996, p.32EE). Currently, voicing a CO is predominantly discussed in the literature based on theoretical perspectives over what validates nurses' use of CO, versus how nurses themselves make meaning of this phenomenon. Given the lack of knowledge regarding CO as it has been taken up in nursing practice as opposed to theorizing how it could be used, the experience of making a CO needs to be brought to light through the perspectives of nurses who have made a CO themselves.

### **Background and Significance**

Traditionally used in a military context, CO has historically been used by pacifists to opt out of combat based on grounds of conscience (Sciarrino & Deutsch, 2003). In the Canadian nursing context, nurses receive ethical guidance for their practice through the Canadian Nurses Association's Code of Ethics (2008). Conscientious objection was added to the CNA's Code of Ethics after the Canadian experience of Severe Acute Respiratory Syndrome (SARS) in 2003 (Ford, 2012). The addition of a CO clause to the CNA Code of Ethics was due to the potential for nurses to choose to refrain from



providing care that could endanger their lives, such as the SARS pandemic. However, the language supporting CO in the Code of Ethics (CNA, 2008) does not limit nurses to objecting only in the case of pandemics and the code states that nurses may ask permission to be relieved of an assignment if care for a patient should prove to be ethically compromising to their “moral or religious beliefs” (CNA, 2008, p. 23).

Provisions for CO are also protected throughout international, regulating nursing bodies and clauses for its protection populate most of westernized nursing disciplines, revealing that it is a concept widely recognized across the profession (American Nurses Association [ANA], 2015; Australian Nursing and Midwifery Federation, 2015; United Kingdom’s Nursing and Midwifery Council (NMC), 2015). Moreover, for Canadian nurses, the right to freedom of conscience is also protected under the Canadian Charter of Rights and Freedoms (1982).

Despite being a recent term in the CNA’s Code of Ethics, CO can also be conceptually understood in Canadian nursing when it comes to duty to care (College of Nurses of Ontario, [CNO], 2009; College of Registered Nurses of British Columbia, [CRNBC], 2015). While not all Canadian nurses may be familiar with the formal term of CO, they may already understand objecting to aspects of patient care on personal, ethical grounds under the caveat that they have a duty to provide quality care to their patients (Ford, 2012). In Canada, nurses can challenge what is considered the quality of patient care either when they perceive the care to be harmful to their patients or when the care is unethical for them to carry out, personally (CNA, 2008; CNO, 2009; CRNBC, 2015). Answering the call of conscience, by way of using CO, does not mean that nurses abandon patient care or assignments given to them, but it does signal that nurses can preserve their personal right to question care provision if it infringes upon their

conscience and it is reasonable that an objection is warrantable (CNA, 2008; Jensen & Lidell, 2009; Lachman, 2014; Waller-Wise, 2005). As Lachman (2014), points out, when faced with a question of conscience, the answer lies in doing what one “ought to do” (p. 196) to ensure both the moral wellbeing of the patients that a nurse cares for, and the moral integrity of the nurse.

Currently, the prevalence of ethically challenging practice settings is increasing. While conscience plays a significant role in CO in the context of nursing practice, there has been minimal research conducted on what it is like for nurses to experience CO in the first place. As such, there is a gap in the literature related to how nurses confront their issues of conscience and ethical dilemmas in practice, and what meaning those experiences hold for them. Given the lack of research on this topic, this study will address the gap in the literature on nurses’ use of CO by exploring how nurses have lived with their experiences of voicing a CO in professional practice settings and what meaning those experiences held for them.

### **Purpose of the Study**

The purpose of this Heideggerian phenomenological study was to uncover nurses lived experiences of making a CO in professional settings, and what meaning this experience held for them in the context of their nursing lifeworld.

### **Research Question**

The phenomenological research question guiding this study was:

What is the lived experience of making a CO for registered nurses practicing in Ontario?

Sub questions of the study included:

- 1) What does conscience mean for nurses?

2) What meaning do these nurses make of the ethical encounters that prompt their conscientious objections?

3) How do these situations come to be and how do nurses respond to them?

### **Significance of the Study to Nursing**

Nurses play a crucial role in health care and in the lives of patients. Ethical decision making is a critical part of nursing education and practice. How nurses encounter ethically complex situations and respond to ethical dilemmas is relevant knowledge for the profession to advance safe, quality patient care and support ethical nursing practice. Recognizing that nurses practice as ethical professionals in keeping with being moral agents, nurses need to be able to work without compromising their moral integrity and stay true to the right course of action in ethical dilemmas (CNA, 2008; Davis et al., 2012; Hardingham, 2004). However, a challenging aspect of contemporary practice for nurses today is making sense of what is the right thing to do while considering patient rights and professional demands. Nurse professionals today practice in settings that converge in morally pluralistic contexts and the struggle to express one's ethical beliefs needs a strong platform for tolerance from others, paralleled with professional support in which nurses and health care professionals (HCPs) at large are encouraged to understand as well as defend their beliefs, particularly with respect to their demands of conscience (Morton & Kirkwood, 2009; Sulmasy, 2008).

Gaining an in-depth understanding about the experiences of nurses when making COs can increase professional knowledge about ethical nursing practice and what it is like to be, identify and address ethical issues as a practicing nurse to advance nursing science from ontological, epistemological and ethical approaches to knowledge.

Understanding how nurses make sense of ethical issues in practice can support evidence-

informed education, since the meaning of nurses lived experiences can provide knowledge to enhance nurses' conceptual understanding of conscientious objection. Conceptual understanding can enhance formal nursing education through: 1) the application of study findings into classroom settings, 2) offering opportunities for ongoing and formal modes of learning through ethical case study examples and 3) reinforcing nursing codes of ethics that address CO by explicating the processes that practicing nurses have found helpful or restrictive when making a conscientious objection.

Incorporating an appreciation of CO into formal and ongoing nursing education programs could further increase practicing nurses and nurse educators' knowledge on how to be aware of, as well as theoretically facilitate, nurses' conscience responses into practice to foster morally sensitive workplace environments (Ford et al., 2010). Gaining an in-depth understanding about nurses' meaningful experiences of making a CO can also inform institutional, health care policies on conscience and conscientious objection. For example, findings can explicate what nurses considered supportive, or what is needed to feel supported when they voice a conscientious objection.

Understanding nurses' experiences of CO can also lead to creating and implementing institutional processes for quality improvement and best practice initiatives that enhance quality patient care outcomes. Such initiatives could fortify nurses who address situations of ethical conflict, since lack of knowledge around the meaning that such conflict can hold for nurses when addressing their conscience issues can leave them unsupported at the forefront of an ethical dilemma (Ford et al., 2010; Stammers, 2015; Wicclair, 2011). Nurse managers and administrators may further benefit from understanding these experiences of nurses since they also might face conscience issues

given that they could be the ones having to make ethical decisions when objecting nurses turn to them for support. Further knowledge on nurses' experiences with CO could advance the understanding of nurse managers and administrators in this area and subsequently support front line nursing staff and nursing leaders alike.

Finally, the care one has for themselves and for others is what makes one human and marks the difference in living a meaningful life, or not (Heidegger, 2010). To live through such experiences reveals what it means to exist in today's world as nurses who make COs in practice settings. This meaning could shed light on how to weave through the contentious fabric of what it means to be an ethical nurse in contemporary practice.

### **Declaration of Self**

While the need exists for more knowledge surrounding nurses' encounters with making a CO, my own experience of making a CO also prompted this research. The position of the researcher is significant in the process of conducting qualitative research and interpretive phenomenological inquiry (Malterud, 2001; Parsons, 2010). Researchers bring their own experiences and assumptions to the lived experiences under study, which reflect their ontological and epistemological stance to the inquiry as a mode of connecting the knowledge of the researcher to the phenomena being explored, since understanding cannot be removed from pre-conceptual awareness and beliefs (Malterud, 2001; Rew, Bechtel & Sapp, 1993). As Heidegger (2010) notes, one cannot bracket out what they already know about a phenomenon to discover more about it. As the primary tool for collecting data and writing up the research, the researcher needs to openly state their preconceived understanding and experiences to stay true to the participant's narratives and to not impose their own experiences or interpretations on what the participants are telling them (Appleton, 1995; Rew, Bechtel & Sapp, 1993). Subjective

inquiries can produce bias when the effect of the researcher is not addressed (Malterud, 2001). As the researcher, to ensure that I maintained a neutral stance in conducting this research I acknowledged my own lived experience as well as the expertise, preconceived ideas, beliefs and assumptions that I brought to this research.

When engaging in interpretive phenomenological research, one should ask themselves why they are exploring the phenomena in question, because each investigator will bring a unique background and set of experiences that “affect” (Malterud, 2001, p. 483) the subjective orientation of this type of inquiry. Furthermore, to enter the hermeneutic circle of analysis necessary for Heideggerian phenomenological research, the researcher must note their fore structure or prior context for understanding, which arose from my own experiences (Parsons, 2010). As such, it was further necessary for me to reflect on my own experiences that lead to this research and disclose my preconceptions prior to conducting it.

I am a doctoral candidate focusing in an educational stream with research interests in ethics, education, pediatrics, global health and conscience-driven care which serves as the nexus point for all my interests. I have over a decade of experience in nursing practice, both as a front-line nurse and a nursing practice leader. Moreover, I have academic and clinical bioethics expertise, as my masters was in bioethics and I worked as a clinical ethics fellow and have sat on a research ethics board as well as ethics committees at two different hospitals. The first ethics committee I was a member of was in a large, tertiary-care, teaching hospital where I was a staff nurse. More recently, I currently sit as a community member on a palliative care hospital ethics committee and my involvement on a research ethics board was part of my corporate responsibilities as a nursing practice leader in a palliative care, research-based institution.

My research experience has been cultivated in the Health Sciences through this doctoral research and working as a Graduate Research Assistant as well as a Research Associate in a school of Nursing Science. I have theoretical and normative research experience from writing a philosophically based master's thesis for my graduate degree in bioethics. Although none of my past research activities addressed CO, in my work as a pediatric oncology acute care nurse I made COs in my clinical practice that were supported by my formal education in philosophy and bioethics. The knowledge that I incorporated about conscience and CO into my practice did not arise from my formal nursing education.

As a novice health scientist and as a human being, I believe that what we know can be both objectively and subjectively oriented. I accept the tenets of both moral philosophy and phenomenology to appreciate how to understand and encounter truth in one's existence. While I view human experience as an important way of knowing and embrace interpretive phenomenology as a lens that explicates how humans can subjectively interpret what is meaningful to them, my beliefs about truth are not limited to inter-subjectivism since I believe that truth exists objectively, and we can subjectively come to understand it. For example, I believe that good and evil objectively exist and that humans can use their reason to determine what is the right, or ethical thing to do, and this is not limited to a subjective perspective of morality, but rather, that one can also subjectively understand what is the objective, or right thing to do. In keeping with my appreciation for this subjective route of discovery, I elected to use interpretive phenomenology as it was the most appropriate mode of inquiry to ascertain how individual nurses made meaning of their experiences of voicing a CO in clinical practice. While I do not personally, fully accept the philosophical premises of phenomenology,

throughout this research process I stayed true to the tenets of interpretive phenomenology by being aware of my reservations while simultaneously following the methods involved with this mode of research inquiry. Further, I think that all human beings have a conscience and that it is directed towards shaping not only one's moral self, but as a mode of understanding others as part of the human experience.

As a registered nurse, I have personally encountered ethical dilemmas in my own practice experience and made my COs to participating in care and following care orders that I perceived to be unethical. These personal experiences as well as my academic interest in ethics and conscience prompted me to consider what other nurses would do in a similar situation and sparked my curiosity about the experience of nurses' making a conscientious objection. For me, at the time of making my COs, they seemed to be the only option available to express my reservations and not abandon my patients, which was due in part to the lack of authority I held in my nursing position. As a nurse, I could not refuse to carry out an aspect of care on my own; I was inextricably bound up in my responsibilities towards the 'others' in my professional capacity. The 'others' are considered as patient, nursing leaders, physicians who wrote the orders I ethically disagreed with and my regulating college that I was licensed under.

I can remember the mental turmoil of my internally competing interests as in the moment I asked myself: Do I tell the physician? Do I just tell my manager? I can recall questioning, are there other nurses like me? What was it like for them to address an ethical conflict? Was I alone in thinking this way? Were there supports in place for other nurses who might have held similar beliefs that I did? Was there something I could have done differently? All these questions instilled in me a desire to uncover more about nurses' experiences in addressing ethical dilemmas that evoked their conscience and



motivated their desire to address their ethical concerns in practice. These past experiences were ones that troubled my conscience. Yet, once I acted in accordance with what I perceived to be the ethical course of action by deliberating and approaching my charge nurse about the issue to which I objected, I felt greatly relieved. Moreover, I maintained integrity between my own ethical values and professional obligations because I voiced my ethical concern about care assigned to me in practice, and by making a CO I did not have to go against my conscience nor did it result in a negative outcome for the patient.

However, at the time of my experiences, I understood conscience and knew what CO was, which gave me the courage to voice my concerns. Because of these experiences, I am interested in enhancing understanding of what it is like for other nurses who experience similar situations in their own practice, to discover what supports they had in similar situations and what supports they might need. Additionally, my exploration of CO as experienced by other nurses emerged from a sense of compassion for their ethical and moral well-being and for them to be able to provide quality nursing care without compromising their moral integrity. As I can personally attest to, this is very challenging to do if one is stressed over an ethical issue encountered in a practice setting.

My beliefs going into this study can be summarized as:

- 1) I believe that everyone has a conscience.
- 2) Every human being should be able to maintain a sense of an integrated self.
- 3) Religious beliefs are important to forming one's conscience.
- 4) Conscientious objection is a valid way to express one's ethical concerns in a situation of conflict.
- 5) Not everyone in healthcare agrees that conscience and CO are valid options for nurses to guide their ethical practice and voice their personal concerns.

Moreover, it has been my experience from discussion with nursing colleagues in clinical practice that many nurses do not know what CO formally means, although they can identify with a troubled conscience and not agreeing to aspects of care that they are sometimes asked to provide. At times, some of these nurses would voice their objection, but did not necessarily identify it as conscientious objection. My own technical knowledge of CO may have helped me address my ethical issue in practice as opposed to my profession, colleagues or the organization I worked for. However, had I not known what CO was, I still would have encountered stressful, ethical situations in practice and had to decide about how to respond to them.

My assumptions about nursing and the phenomena under investigation prior to conducting this research were:

- 1) Nursing is an ethical profession.
- 2) All nurses need to attend to their moral self.
- 3) A nurse's moral self is as important as any other aspect of their practice.
- 4) Nurses may not formally know what CO is, but will have experienced it in some capacity.

### **Organization of the Dissertation**

This dissertation has been composed in monograph style and consists of seven chapters. The first chapter is an introduction to present the specific aims, research question and significance of the study. Chapter two provides background, philosophical information on the phenomena being explored since both conscience and CO are typically situated within moral and ethical, philosophical discourse. Thus, chapter two was written to provide a deeper understanding about the philosophical perspectives in which the phenomena under study are typically associated and historically rooted.

Chapter three contains a review of the empirical literature on conscience, CO and nursing practice. In chapter four I describe the interpretive methodology and the research methods I used to guide this study and contains a discussion of the sample characteristics, recruitment strategies, semi-structured, in-depth interviews, process of analysis and ethical considerations. In chapter five I share the in-depth narratives of the nurse participants as they relayed their lived experiences to me. Chapter six explicates in detail the themes that emerged from their narratives. The final chapter, seven, contains a discussion of what can be learned from these nurses' encounters with CO, implications and recommendations for nursing practice, education and policy, as well as recommendations for future research and the conclusion.

## CHAPTER TWO

### **The Phenomena: Framing the Experience**

Conscience and conscientious objection are widely discussed concepts in ethics and health care practice. Arising from ethical discourse rooted in varying philosophies and perspectives, the phenomena of conscience and CO vary extensively in how they are taken up in contemporary ethics discourse at large. In the last decade, writing has surfaced on conscience aligned with a fervent debate for and against claims of conscience and CO for health care professionals (Lawrence & Curlin, 2007; Schucklenk & Smalling, 2016; Shaw & Downie, 2014; Trigg, 2015). As ethical concepts, the current contexts of the phenomena can be contentious owing to the pluralist landscape of ethical and moral views that undergird them. For example, within contemporary discourse some view CO as an ethical option for HCPs to voice in professional practice while others state that HCPs have no personal right to object to professional norms of practice, regardless of reason or the dictates of their conscience (Cowley, 2015; Schucklenk & Smalling, 2016; Trigg, 2015; Wicclair, 2011). Despite this disparity however, conscience and CO remain highly relevant concepts in ethical nursing practice. Framing nurses' lived experiences in this study, it is important to understand how conscience and CO are contextualized in the broader, philosophical discourse. This chapter will focus on explicating the philosophical background and some of the ethical arguments on conscience and CO relevant to health care and nursing to form a basis of prior understanding for the phenomena that were explored in the study.

### **Defining Conscience**

Definitions of conscience have ancient origins and have been used in various schools of thought throughout history. Contemporary approaches and use of the concept

vary and considering that the scholarship on conscience is vast, only major approaches to conscience will be discussed in the following sections. Some of the significant disparities amongst these approaches will also be put forward to generate an essential understanding of the current, conscience discourse.

**Ancient origins.** The word conscience arises from Latin, *conscientia*, and French, *conscience* (Oxford English Dictionary Online, [OED], 2016). Translated from their original languages, conscience can be defined as the internal sense of what is right or wrong, as well as one's ability to choose between and act upon what one perceives to be the right thing to do (OED, 2016). Historically, conscience is a philosophically rooted concept with theological and ethical orientations. As far back as Aristotle (McKeon, 1941), conscience was loosely perceived as a means to attaining happiness based on a desire for the good and, as such, one could order their lives to a good *telos*, or end. Centuries later, medieval philosopher and theologian Thomas Aquinas is credited with some of the most extensive work on conscience. Aquinas described conscience as the application of reason to circumstances of the practical knowledge of what is good, or right, and what is evil, or wrong; this knowledge arises from natural law, or the law pertaining to the practical reason of human beings, and the understanding that flows from this knowledge leads one to make a moral decision (Aquinas, 1998; Rhonheimer, 2011). Aquinas (1998) further delineated that since conscience is fallible, acts of conscience vary based on the state of one's conscience and subsequently there are types of conscience with a central locus that all require a moral decision making process.

The distinctions that Aquinas made regarding conscience reveal, as per Rhonheimer (2011), that a person makes a moral decision through the application of "moral knowledge to concrete judgments of action or to actions already accomplished"

(p.312). The importance of ascertaining the aspects of conscience laid out by Aquinas is to understand that any decision made about conscience arises from a distinct type of decision-making process (Lamb, 2016). For example, to resort to CO requires that someone understands a moral decision making process, becomes aware of a situation in which their participation would be wrong, and resolves that the only course of moral action available is to object and refrain from doing it (Lamb, 2016). Specifically, then, with respect to CO, when one makes a judgment after deliberating and reflection upon past and future acts that to perform a specific act would not be in keeping with a commitment to morality, that person may choose to voice an objection to that action on the grounds of their conscience (Lamb, 2016; Sulmasy, 2008). This is one way to show that making a CO is rooted in a decision discerned by way of one's conscience. Although Aquinas' approach is older, his seminal work is still used in current ethical scholarship and offers a robust starting point for understanding conscience.

**Historical definitions.** Stemming from medievalist times, throughout subsequent history conscience was perceived in varying ways by major philosophers. Kant referred to conscience as the voice ascribed to moral law and which each person has the moral duty to follow, rising out of reason as opposed to emotion or mere intuition (Adorno, 2001). Utilitarian, John Stuart Mill, regarded conscience as an internal connection to duty motivated by feelings (Mill, 1987). This approach suggests that humans can use their desires to unite over a common goal or end to which their life is directed. However, utilitarianism largely neglects the individual response to which is good and not wholly made up of feeling, or desires, but rather ones' reason. In contrast to the subjectivism of utilitarianism, Newman (2012) outlined that conscience is a fundamental, metaphysical orientation of humans to what is objectively good. Humans can thus use their reason to

attend to what is objectively right using reason and an understanding of the relationship one has in connection to their metaphysical orientation and which can be lived out in each person's existence (Newman, 2012). Similarly, contemporaries Rhonheimer (2011) and Ratzinger (2007) follow in the historical vein of Aquinas. Rhonheimer (2011) describes conscience as following the mind of God, intimately connecting each person with an external objectivity, authenticating that each person's response to what is good can be validated outside of oneself. Ratzinger (2007) posits that conscience is twofold. It can alert one to the origins of mankind as rooted in God through an intuiting, as well as a more developed knowing of what is right, which occurs in following natural law and revelation by deliberately judging one's moral actions.

**Modern approaches.** Modern perceptions of conscience are considerably varied, conflicting and depart from an objective conceptualization of a moral reasoning process. Instead, conscience is largely aligned with individual versus professional approaches, or as a relational and social construct. Approaches to conscience that retain a personal emphasis have been espoused by scholars such as Childress, Blustein and Wicclair. Childress (1979) asserts that conscience is a function of being conscious, providing a person with the ability to deliberate and act (often based on knowledge from past experiences), on how to choose right action in the moment or future. In this sense, conscience is personally situated, in that each person can formulate how to act given their ability to consciously decide to do so which stipulates that a person cannot be required to conform to acts outside of their conscience constraints. One is often motivated by a sense of guilt, which can be a useful emotion since it attunes one to the status of their moral position and offers a forward thrust to one's ethical actions; for example, guilt can be a motivator to refrain from future, unethical actions (Childress, 1979). Wicclair posits a

values-based approach to personal conscience in which one makes ethical choices to align their beliefs and values in salience with a sense of moral integrity (2008; 2000). Moral integrity refers to the personal and professional consistency that strikes a sense of moral balance within a person.

Blustein (1993) advances Wicclair's view as well, but stipulates that in some circumstances HCPs will need to compromise their conscience stance for the sake of accommodating professional or patient values differing from their own. Yet, as Laabs (2011) points out, when HCPs such as nurses are confronted with professional situations that conflict with their conscience, this can compromise their moral integrity, which is one's congruence between his/her personal and professional, moral sense of self. Such compromise creates a rift in a nurse's ethical life owing to the dichotomous stance that as a rule nurses should follow their conscience in their professional practice, but then could be asked to compromise it in some scenarios. For instance, nurses who conscientiously disagree with providing care that they perceive as futile, but due to competing professional opinions and their lack of authority to make treatment decisions, are not exempt from providing such care, and may feel they are compromising their sense of morality in doing so.

A competing argument has been put forward that HCPs who conscientiously disagree with a professional aspect of care should leave the profession (Schuklenk & Smalling, 2016). Yet, one's moral beliefs, which can be moderated by their conscience, are aligned to their value frameworks, which are part of the fundamental fabric of what it means to be a human and to freely express that is part of their inherent, human right to do so (Kantymir & McLeod, 2014). As such, individual claims of conscience need to be considered since conscience is not merely a private function, but something that



humanity can commonly relate to. Rather, the tension that can arise with conscience claims stems from what people view to be moral in the first place. Thus, those espousing opposing moral views need to discern what their conscience morally binds them to. Yet, because conscience can err due to its subjective manifestation, one person's individual conscience cannot be necessarily held commensurate with another's, revealing that some objective standard of morality needs to be upheld to moderate between personal claims of conscience.

### **Natural Law Approach**

One way to appreciate an objective standard of morality is by way of natural law. Natural law is the application of reason to one's circumstances to ascertain what the right or good (moral) thing would be to do (Rhonheimer, 2011). Essentially, this natural, or practical (reason arises naturally or is found to be naturally occurring in a person) way of processing or thinking through what is right necessitates a consideration of what the right originates from and is ordered towards. Not to be confused with discourse ethics which seeks to apply an answer to a given situation, natural law already offers this consideration, which is eclipsed in a discourse orientation to ethics. The reason for this is that to attempt to apply an answer to an ethical question or discussion, discourse ethics already assumes that there is some way for humans to arrive at an answer. Yet, to arrive at such an answer is the function of practical reason. While discourse ethics is predominantly inter-subjectively oriented, natural law is too, in the sense that through natural law, each and every human, individually, and in relation to each other, can derive an answer to what is the right thing to do and therefore is always striving to be objectively oriented in the first place (Rhonheimer, 2011). The difference between natural law and discourse ethics is that this objective orientation is overtly acknowledged

in the former but not in the latter. Thus, an orientation to the good is first necessary to concretely address questions of morality, in inter-subjective discussion or otherwise.

In the case of conscience, it can be further added that while each person's conscience can form judgments unique and individually binding, this is not necessarily disparate from the good that can be held in common amongst people. Rather, conscience can measure the good in a society at large, given that a good society overall is constitutive of its individual members who respond to what is good or moral in the first place, by way of their conscience (Lamb, 2016; Maritain, 2011). Likewise, a majority does not necessitate conscience consensus, unless that majority is also ordered towards the good at large to be found amongst the individuals making up a society (Lamb, 2016; Maritain, 2011).

What is often at stake in individual claims to conscience is whether the individual's conscience claim is ethically legitimate, (i.e. free from discrimination) and that it is formed. For example, even though the majority may dissent with an individual's conscience claim, the relevant factor is that morality is achieved through a commitment to do that which is right, which may or may not be aligned with the majority consensus (Stein, 2006). Formation of one's conscience necessitates an orientation to what is good, and then to act upon it, which arises from both a disposition of one's will and the "rectitude of one's actions" (Rhonheimer, 2011, p. 379). In short, one needs to intend to do what is right or good, as determined through practical reason and mediated through one's conscience.

Conscience, being the innate presence in each person to make moral decisions, will vary depending on how one forms or develops it. Methods of formation could be through formal education or other ethical influencers such as codes of ethics, societal

norms and religion to determine how to order ones' right or ethical actions (Davis et al., 2012). Subsequent to the methods used, one's conscience formation may therefore differ in terms of the depth and breadth of formation. For example, one who has formal education in conscience and philosophy may have a deeper understanding of how to develop and attend to one's conscience than someone who has had no such formal education. This example, while not exhaustive, shows how one's ability to determine how they individually respond through their conscience to order their right actions, or ethics, can directly result from the extent to which they have formed that conscience in the first place.

Notably, the necessary function of ethics is not merely how to determine a right action, but that a right action is determined by an ordering of one's will towards the object or intention towards which one acts (Rhonheimer, 2011). This ordering is more essential than the circumstances that surround the actions and occurs in relation to those proximate to the action that is willed. For example, in health care practice, to do what is right (ethics) is predicated on one's intention and for the good of the society comprised of the people that the action affects. In healthcare, those affected would be patients as well as health care professionals. As such, it would be a matter of justice to ensure that each person act in accordance with the intention to do what is right for every person involved, since no human action occurs in isolation within a society (Rhonheimer, 2011). In this way, conscience, as a way for people to express their orientation to morality, is something that is shared and the moral decisions one makes in alignment to their conscience is part of a broader, inter-subjective, human experience. Thus, it is necessary to ensure that each person can express their conscience concerns since to do otherwise would indicate that someone is not part of the human experience, given that conscience is

not merely an individual phenomenon. Further, that an individual's conscience claim be respected is necessary to a democratic and just society, in which everyone has the right to express their personal beliefs as commensurate with the freedom of expression (Charter, 1982; Maritain, 2011).

### **Conscientious Acts**

Further departure from contemporary efforts to conclusively define conscience lie in the perspective that conscientious acts should be promoted instead, as a solution to the controversy generated by differing viewpoints on conscience (Emerson & Daar, 2007). Yet, perspectives vary on this point as well, where advocates for conscience support that maintaining a focus on conscience is empowering from an individualistic perspective and should not be distanced from acts of conscience (Sulmasy, 2008; Wicclair, 2011). Others assert that political and public authority trump personal or private, autonomy, which is often espoused as the ruling ethical principle when it comes to deliberating between who's conscience has the right to be expressed (Birchley, 2012; LaFollette & LaFollette, 2007; Schuklenk & Smalling, 2016). However, asserting the presence of a public versus private conscience does not necessarily resolve how individuals are to follow their conscience in some cases and not in others. This problem also raises the question by what moral authority is each person to make moral, autonomous decisions, since health care professions are built upon professionals' ability to self-determine and be altruistic in discerning ethical situations, which necessitate individual, ethical decision making abilities.

A duty to care, which is a principle espoused by health care professions (CNA, 2008) could counteract individual claims to conscience, since it ascribes the moral authority that regulates ethical unity within the health care professions. Yet, at times, the

regulatory aspect of a duty is outweighed by the moral aspect. For example, if a HCP believes that what their profession is asking of them is morally constraining to their fundamental beliefs of what is good and right to do, they may object to what is being asked of them (Stein, 2006). An example could be if there is a law condoning prenatal sex selection and if that practice is upheld by regulated health care professions, there may be doctors and nurses who refuse to participate in sex selective abortions. Health care professionals might refuse on the moral premise that choosing to have an abortion by privileging one sex over another does not align with their personal, moral belief that all sexes are equal. In which case an objection based on their conscience that such an action would be wrong infers that this would not only be personally wrong for them to do, but also places them in a position of voicing an objection on behalf of another. In this case the other is the unborn baby to be aborted based on discrimination of their sex.

Thus, making a conscience based decision is not necessarily isolated to an individual, but signals that there can be a moral responsibility that precedes a duty to care based on a sense of fundamental morality and a duty towards others, such as the unborn babies HCPs may refuse to abort. In this way, one's will to act is rectified with the intention of their actions, even though there may be opposing norms of practice that conflict with one's moral orientation influencing those actions. Also, this example supports that acts of conscience cannot be distanced from one's conscience itself, which is aimed at satisfying the intention of one's moral actions, which is directed towards someone or something outside an individual as well.

Clearly, views on conscience are mixed and conflicts of conscience and conscience issues persist, particularly in the context of health care professions and nursing practice. Yet, despite the disparity over the concept, conscience is a fundamental

part of the human experience and a beneficial concept that serves to support HCP's moral decision making (Sulmasy, 2008). Moreover, conscience is a fundamental right for humans and the right to express it entails thoughtful, tolerant and respectful discourse to appreciate the ways in which one endeavors to live a moral life, through their actions (Charter, 1982).

Closely oriented to the need for a tolerant and respectful outlook on conscience are the health care professions, specifically, nursing, in which issues of conscience are often hidden in nurses' everyday practice encounters and need to be brought to light. As Sulmasy (2008) points out, much of the contention around conscience surfaces from neglecting the meaning of conscience itself, and modern discourse on conscience in health care is often brought up only in conjunction with issues extending from conscience. As a result, the contemporary meaning of conscience is in need of further understanding in light of fundamental, as well as more specific, HCP conscience concerns.

### **Conscience and Nursing**

Conscience for nurses has not been as conceptually discussed or developed as it has for other disciplines such as medicine, although considerably more writing on the topic has emerged in the last decade with respect to nurses. However, conscience in nursing is largely taken up as a cornerstone for ethics and considered relevant to ethical nursing care (Dahlqvist et al., 2007). Within the context of nursing, conscience is broadly perceived as an authority, a warning signal, demanding sensitivity, an asset, a burden and culturally dependent (Dahlqvist et al., 2007). However, conscience for nurses is predominantly addressed in the literature in the broader context of health care discourse.

## **How Conscience Relates to Conscientious Objection**

Although current definitions and perceptions of conscience are widely variant, they are consistently brought up in conjunction with CO and conscience related issues in health care practice. Moreover, conscience is a long-standing phenomenon that can be appreciated as that which grounds human existence and authenticates one's actions in keeping with their moral decision making process (Heidegger, 2010; Morton & Kirkwood, 2009). As such, while disagreement on definition in the literature is dominant, conscience in connection to CO in this research was taken to mean that which motivates and grounds a human, individual's conscience to object to providing or participating in health practice that an HCP finds immoral or unethical to do.

## **Conscientious Objection**

For the last half century, CO has been used by HCPs to make objections over patient care provision and professional norms of practice they deem unethical. In healthcare, CO has been identified as a mechanism where one can be transparent in their moral behavior. Physicians and nurses have been known to object to performing or referring for abortions, contraception and euthanasia (Baker, 1996; Beal & Cappiello, 2008; Kane, 2009; Waller-Wise, 2005; Wicclair, 2011). Pharmacists, in more recent years, have been exercising their right to conscience in making a CO over dispensing contraception and the morning after pill (Wicclair, 2011). Due to the underlying moral views over issues that often surround the incidences over which CO is utilized, the use of CO in clinical practice is a controversial subject. Current philosophical, ethical health care discourse on CO involve tensions regarding competing patient and provider rights and privileges, as well as differing opinions of what CO is and how, as well if, and when, it should be enacted in practice.

**Controversy over conscientious objection.** The legitimacy of CO has been criticized in the theoretical literature. For example, the justification of CO has been questioned by some authors who perceive that CO leave patients vulnerable to lack of service provision to care that objectors refrain from providing (Schucklenk & Smalling, 2016). Lawrence and Curlin (2007) as well as Shaw and Downie (2014) question whether HCPs, or physicians, specifically, can or should object to providing services their professions espouse. Conscientious objection is also contested by those who stipulate that HCPs have no moral claim to trump set, professional norms of practice or patient rights in accessing services that are legally available to them and therefore HCPs should not be allowed to be part of a profession in which they will make a CO in (Savalescu, 2007; Schucklenk & Smalling, 2016).

Tempering these viewpoints, supportive views for CO argue that HCPs making COs have been consistently called upon to openly declare their objections and follow their regulatory bodies and code of ethics in doing so, and, as such, decrease the incidence of objections being substantiated on primitive motivations, such as discrimination or racism (CNA, 2008; Trigg, 2015). Rejecting conscience and COs for HCPs is also put forward in the literature as a secular discomfort with accepting that legitimate conscience claims can from HCPs that are grounded in religious perspectives (Schucklenk & Smalling, 2016). Yet, as the findings of Davis, Schrader and Belcheir's (2012) study examining the influencers of nurses' ethical beliefs show, nurses who have reported making COs indicate that this is due to a range of belief systems, including non-religious views.

Further perspectives supportive of CO respond to disagreement noting that judgments of conscience are integral to quality health care and that rights to CO are, in



fact, already quite limited (Birchley, 2012). Health care professionals faced with making a CO have the burden of proof placed upon them and are expected to articulate to what they are objecting to, why and how they will address it. Moreover, just societies typically set very high standards for tolerance of transparency and HCPs would suffer serious professional and legal consequences for COs made that would compromise patient rights and privileges (Trigg, 2015).

Health care professionals to date have complied to being transparent in several instances, either individually and as already regulated by their colleges. For example, physicians in a situation of objection might make it publicly known for incoming patients that they will or will not provide certain services they are ethically opposed to, such as abortion (Shaw & Downie, 2014). Nurses are supposed to tell their managers when they encounter an aspect of care they wish to object to in response to their conscience (CNA, 2008). Some codes of ethics restrict when, where and how nurses can object to the extent that in some scenarios, such as emergency care in the United Kingdom, nurses are explicitly forbidden to make a conscientious objection (CNA, 2008; NMC, 2015). Often, COs are made on issues that carry serious, moral weight such as perceptions of when life begins and what constitutes appropriate care at the end of life and in view of what is best for the patient and, as such, should be approached with the gravity such fundamental discussion deserve (Trigg, 2015).

The central disagreement over what constitutes legitimate COs in health care practice largely pivots on controversy over personal, moral claims with COs, but COs can be a healthy option in health care practice, helping to keep conscience discussions and moral decision making robust and multifaceted. While moral disagreements can arise on conscience related issues owing to a lack of consensus on what legitimizes conscience

and how it is formed and used in care settings, a sense of conscience can be positive, since conscience is central to one's morality and grounds moral decision making in the first place. Moral decision making is a process that holds considerable weight in health care as well as just, political societies in which health care communities can be contextualized (Sulmasy, 2008).

**Mediating approach.** Amidst the controversy surrounding HCP's use of CO, some authors have attempted to strike a balance to maintain that HCPs have the right to declare and find support for their issues of conscience in professional practice. One such example is found in Wicclair's (2011) work in support of CO outside of what he refers to as absolutist and incompatibility approaches. Wicclair states the right to make a CO does not stem from an "absolutist approach" (2011, p.44), in which an HCP can refuse any and/or all care provision and participation on the grounds of conscience, nor does it rise from an "incompatibility approach" (Wicclair, 2011, p.44) where declaration of CO is considered incompatible with professional practice because primacy is given to the professional, ethical aspect of an HCP over the personal, ethical aspects of an health care professional (Lamb, 2016; Wicclair, 2011). Instead, Wicclair (2011) presents a mediating approach to HCPs use of CO that centers on moral integrity. As Wicclair (2011) relates, the right to use CO in health care practice arises from every person's autonomous freedom to cultivate and act with moral agency to maintain a reasonable congruence between one's personal and professional self.

Moral integrity, in Wicclair's view, hinges on each person's ability to reason for oneself what is the right thing to do and to make a CO if needed to maintain one's moral integrity, when external, or professional demands, gravely compete with one's personal beliefs (CNA, 2008; Lamb, 2016; Wicclair, 2011). While Wicclair (2011) asserts that

COs should not unduly burden a patient, COs can be ethically warranted because the essential position one takes when making a CO is to act in accordance with his/her belief to do what is right. To suppress this right can unjustly restrict the freedom to be human, a necessary component for making ethical decisions in the first place (Lamb, 2016; Rhonheimer, 2011).

### **Effective Referral**

Another issue arising in the philosophical and bioethics discourse is whether HCPs who make a CO to providing or participating in an aspect of care are duty bound to ensure another HCP provides the contentious care they object to (Kantymir & McLeod, 2014). For nurses, such a proviso can fall under ensuring they are not abandoning their patient; for physicians, this could entail referring to another physician who would carry out the care, such as ensuring that contraception or an abortion would be offered and performed by another physician if the objecting physician did not ethically believe in prescribing contraception or facilitating an abortion (Kantymir & McLeod, 2014; Wicclair, 2011). Yet, HCPs might find themselves objecting to a referral as well, should that contribute to their complicity in the action.

Complicity refers to a proximity to an act that deems participation inclusive of moral blame; in the case of an HCP objecting to referring a patient for an abortion, for example, they would do so because while they may not perform the act themselves, they would be ensuring that such an act would occur. As a resolution to the concern over referral, HCPs can offer a reasonable rationale as to what would constitute their complicity and much of the referral concern could be mitigated by HCPs openly declaring their stance and their moral limitations to the action involved. However, this indicates that COs and issues of referral be made known ahead of time, and does not fully

address scenarios in which a CO might be made in the moment (e.g., whistleblowing, patient safety issues). It does indicate, however, that a significant degree of moral awareness and decision making ability is requisite of a conscientiously objecting HCP, substantiating that HCPs need to be able to defend their moral position. Although, to counteract potential discrimination for HCPs that make a CO free from effective referral, a strong culture of moral sensitivity also needs to be upheld in care settings, which a common understanding of the nature of conscience and decisions evolving out of one's conscience could serve to offset. Essentially, all HCPs should have a working understanding of what CO is and how to address it in care settings so as to not unduly impose effective referral on HCPs who need to articulate a CO inclusive of freedom from effective referral.

Evidently, there is no simple solution to resolving opposing views on conscience and conscientious objection. What is paramount, however, is that support for CO is necessary to maintain an appreciation for HCP's perceptions of conscience and conscience motivating objections since this is the respect due to every person in a just, tolerant society at large and the health care community, in particular (Sulmasy, 2008; Trigg, 2015). Room for dialogue and multidimensional approaches to resolving conscience issues and COs should continue to be an ethical position underlying current dialogue on the concepts commensurate with a respect for fundamental values such as freedom of expression, belief and conscience, since they are essential to augmenting all individuals' issues of conscience and, when necessary, their conscientious objections (Cowley, 2015; Lawrence & Curlin, 2007).

### **Conscientious Objection and Nursing**

Nurses have a particular role to fulfill in respect to their professional obligations.

Since the primary focus of nursing is to provide care for patients, nurses are uniquely positioned to carry out a plan that involves an extensive amount of accountability: to their patients, their colleagues, the organization they work for, their profession and their regulating college (Baker, 1996; CNA, 2008). Moreover, nurses need to possess a professional, moral agency with an ensuing responsibility to uphold the integrity of their profession by making judgments about the ethical situations they routinely encounter (CNA, 2008; Jensen & Liddell, 2009). However, ethical challenges that arise for nurses and lead to CO can, at times, evolve directly out of their professional roles.

If nurses encounter an aspect of care they are expected to provide but personally, ethically disagree with, the situation can be particularly compounded by nurses' lack of prescriptive authority to make care decisions. In which case, nurses who object to an aspect of prescribed care based on a matter of patient safety or deeply held personal convictions may find themselves in situations where they are "responsible for implementing important decisions that affect people's lives-and powerless over the decision-making involved" (Baker, 1996, p.32). For example, continuing to provide acute interventions for patients at the end of life because they are not in the position of authority to make the decision to switch to comfort care (Catlin et al., 2008).

When nurses find themselves in such disagreement over care decisions, they may have a conflict of conscience over what constitutes ethical care given their lack of professional authority to change or not follow physician's orders for care that they disagree with (Catlin et al., 2008). However, while professional differences of opinion do not always constitute grounds for CO, they can shape the context in which nurses may have a conflict of conscience, signaling the need to explore nurses' conscience issues with inter-professional dialogue to support a resolution. While nurses may use CO in

response to ethical dilemmas and conflict of conscience that arise in professional settings, previous research indicates that nurses might find it further challenging to declare a CO in their workplace due to the lack of knowledge nursing leaders, such as educators, managers and administrators have regarding CO, and who could support nurse's COs in practice settings (Baker 1996; Ford et al., 2010).

**Moral distress and conscientious objection.** When nurses encounter ethical dilemmas, they do not always respond with conscientious objection. Some nurses react to ethically distressing situations with silence, or become silenced by others; resulting in their moral agency being challenged and their voice muted due to constraints that either result from themselves, the environments they work in or the people they work with (Ford et al., 2010; Newton, Storch, Makaroff & Pauly, 2012). This silencing can lead to moral distress (MD) (Newton et al., 2012).

Moral distress, for nurses, occurs when a nurse knows the right thing to do, but due to restricting circumstances is not able to follow through on it (CNA, 2008; Jameton, 1984). Unresolved MD can also result in moral residue. Moral residue can occur when concrete episodes of MD are not addressed and can stay with a nurse for an extended period (Webster & Baylis, 2000). Effects of moral residue include prolonged, personal suffering with feelings of guilt and remorse and can fragment one's values, resulting in the changing of one's beliefs depending on the situation (Webster & Baylis, 2000).

Patient care can also become compromised; when nurses are silent or silenced and unable to resolve their MD they may discontinue voicing their ethical concerns over patient care altogether as a result of not being heard (Newton et al., 2012). Specifically, nurses may refrain from becoming involved in ethical aspects of practice or connecting to clinical situations that require their moral concern (Epstein & Delgado, 2010). Disconnecting

from ethical care can stifle the fundamental ontology of the nursing profession which pivots on moral agency, or nurses' commitment to be ethical (do what is right) in care provision and cause nurses to disengage from the moral dimensions of their patient care needs (CNA, 2008; Hamric, 2012).

Moral distress has also been shown to arise from staffing shortages and influence mid-career changes where nurses leave the profession at a midway point in their career due to their experience of moral distress (CNA, 2003). Research further shows MD may influence a nurse's decision to make a CO to address it, and nurses who are not able to resolve their MD are at risk for leaving the profession altogether (Catlin et al., 2008; Hamric, 2012; Newton et al., 2012). While some evidence suggests that there are nurses who find MD a positive learning experience, or one that drives them to confront the conflict that arises in their workplace, the highly subjective nature of MD remains a concern for nurses at large since not being able to address one's MD in practice can fracture a nurse's moral agency, owing to the nature of 'voice' being an essential aspect to confronting an ethical issue (Carnevale, 2013; McCarthy & Deady, 2008; Musto, Rodney & Vanderheide, 2014). Nurses who experience MD but cannot resolve it or are silenced in attempting to do so, may signal that there is a need for nurses' moral concerns to be better heard and making a CO is one way in which nurses could do so (Carnevale, 2013).

**Conscientious objection and professional protection.** Conscientious objection is taken up in nursing codes of ethics and governments across western countries. The language around nurses' ability to object differs in each code, although each aligns nurses' use of CO with voicing their objections to someone in authority. For Canadian nurses, CO is briefly defined, and the language in the code outlines that nurses need to

discuss their requests with their management (CNA, 2008) to make their objections. The American Nurses Association Code of Ethics (2015) stipulates that nurses can voice personal objections, make COs known in morally limiting situations and when nursing practice is at risk, acknowledge that CO's may stem from moral courage and that nurses should make their reservations known as soon as possible to leadership. In even more depth, the Australian Nursing and Midwifery Foundation (2015) outlines at length the expectations and process for nurses to make conscientious objections. Conversely, Britain's Nursing and Midwifery Council (NMC), (2015) stipulates that there are only two scenarios in which nurses can lawfully declare an objection with respect to abortion provision and embryonic research.

One concern arising from the disparity in the language found in these codes is that nurses could receive varying professional support in certain countries over others. At the same time, the lack of prescription in some of the codes, for example, in the Canadian Nurses Code of Ethics (2008), could be positive given that ethical parameters need to be wide to allow for the range of objections that could ensue in nursing practice. Given that the issues nurses conscientiously object to cannot be predicted, it could be beneficial to have a code that broadly outlines how nurses address their COs in practice, rather than limiting their COs to specific ethical issues in practice, as is found in Britain's Nursing and Midwifery Council Code of Ethics (2015).

In Britain's code of ethics, nurses can only make COs over abortion and embryonic research issues. These specific stipulations could be seen as restrictive and nurses could struggle to make their ethical views known over concerns outside of reproductive dilemmas. Such stipulations also suggest that COs can be foreseen or only allowed as prescribed within a code of ethics. Yet, on the other hand, the NMC's code of



ethics' grounding in legal statutes reflects a proximate relationship between ethics and law. This could be beneficial, given that nurses' COs would be legally as well as professionally protected, consistently upholding fundamental freedoms to conscience and creating precedent for maintaining conscience rights (Lamb et al., 2017). However, research available indicates that front line nurses do not always understand what CO is, exposing a gap between CO guidelines and how they are taken up by practicing nurses (Catlin et al., 2008; Ford et al., 2010; Ford, 2012).

**Theoretical findings.** The philosophical, ethical and theoretical healthcare literature on CO lays out some of the criticisms for CO and nursing. Tensions in this literature largely pivot on patient versus provider rights where some question the legitimacy of nurses objecting to care provision, stating it could lead to patient abandonment and neglect of care services (Cannold, 1994; Kane, 2009; McHale, 2009; Shaw & Downie, 2014; Waller-Wise, 2005). Conversely, codes of ethics, such as the Canadian Nurses Association Code of Ethics, which offers a clear definition of CO could support mitigating between conflicting concepts such as patient abandonment and what legitimately constitutes a conscientious objection (CNA, 2008). However, such confusion may also indicate that CO is not sufficiently delineated from patient abandonment in Nursing Codes of Ethics as well as nursing ethics education (CNA, 2008). Conscientious objection within the theoretical scholarship is also perceived as a right within the scope of nursing practice and parameters have been set out to ground nurses' objections based on the premise that maintaining moral integrity is necessary to ethical practice, nurse well-being and quality, patient care provision (Baker, 1996; CNA, 2008; Ford, 2012; Lachman, 2014; Waller-Wise, 2005). Ultimately, to move theoretical discussion and action oriented initiatives around CO forward, further dialogue could be enhanced with

additional empirical evidence over nurses' use of CO in clinical settings and the meaning that making a CO held for them.

### **Summary**

Major philosophical perspectives on conscience and CO were presented in this chapter. Conscience is an ancient concept with a longstanding history in philosophical and ethical contexts. Current appreciations of conscience vary greatly, but it is considered pivotal to the nursing profession as a benchmark for individual moral decision making and is frequently associated with conscience related issues, such as conscientious objection. Conscientious objection is a contentious topic in health care, has a comparatively more recent presence in health care literature and remains largely underreported in the context of nurses. Across countries, nursing codes of ethics and provisional guidelines are currently available to outline how nurses can make COs in professional practice although how nurses understand and use these guidelines as well as CO in practice remain unclear. While this chapter addressed the philosophical context of conscience and CO, the following chapter will be a review of the literature on what is known about conscience, conscientious objection and nursing.

## **CHAPTER THREE**

### **Review of the Literature**

This chapter is a review of the literature on conscience, CO and nursing. While CO is an under-researched concept in nursing and health care practice, the literature on conscience is more evolved. The literature on conscience is relevant to review to get a sense of what CO is, since one first must grasp what kind of objection one is making when using CO, which is an objection based on one's conscience. However, in the empirical nursing literature, conscience arises as an ambiguous term with a concerted amount of conceptual overlap amongst conscience related terms such as troubled conscience, stress of conscience and conflict of conscience. Notably, sparse attention has been paid to the meaning of conscience itself and little connection was made in the literature on conscience and conscientious objection.

#### **Search Strategy**

A review of the literature was conducted using online search engines including: CINAHL, ProQuest Nursing and Allied Health Source, Dissertations and Theses, and PubMed. For the purpose of this literature review, I selected studies that directly investigated conscience and/or conscience specific issues related to nursing practice. I then explored the empirical literature on CO related to nursing practice to appreciate what is currently known about nurses' use of this option in professional settings. Inclusion criteria for the review consisted of full text, English, academic, peer-reviewed, empirical articles including qualitative and quantitative studies as well as one, directly relevant thesis, that addressed conscience or CO for nursing practice. Key words and phrases used in the search were: conscience, conscience and nursing, conscience and nursing practice, perception of conscience, issues of conscience, stress of conscience, conscientious

objection, conscientious objection and nursing as well as conscientious objection and nursing practice. The search was not time limited to ensure a comprehensive understanding of conscience and CO, since both phenomena were identified in health care and nursing decades ago although all the data retrieved from the literature available on the concepts dates from the late twentieth century into the present-day twenty-first century.

While a plethora of theoretical scholarship exists on conscience and conscience-related issues in health care, little theoretical or empirical research exists to date on CO related to nursing although studies on conscience are more available in the nursing context. Initial searches on conscience and nursing yielded a high volume of 318 articles. When re-searched with the term nursing practice, the number was reduced to 76 and eventually only 14 were included. Articles were reviewed in full only if they met the inclusion criteria. Articles that did not were excluded. Searches for CO and nursing as well as nursing practice generated significantly lower results. In PubMed, for example, the initial results were 37 and 12, respectively. Again, given the inclusion criteria and article overlap between databases, only three were retained for analyses. In total, 17 articles comprised of empirical literature on conscience and CO directly related to nursing practice were included for review.

Categories used to describe the literature that was reviewed consisting of qualitative and quantitative studies addressing the concept of conscience in nursing in this chapter are: 1) influence of conscience, 2) perceptions of conscience, 3) a troubled conscience, 4) stress of conscience, and 5) conflict of conscience. Similarly, categories capturing the empirical research comprised of quantitative and qualitative studies on CO and nursing are: 1) nursing awareness of CO and 2) factors that influence nurses' use of

conscientious objection. Methodological insights from the empirical research on conscience and CO are also addressed.

### **Influence of Conscience**

Conscience is outlined in the nursing literature as an essential concept to the profession, but little to no work has been done to understand what conscience means conceptually to nurses themselves. A rationale put forward by some researchers is that conscience is socially constructed and as such, it is not possible to isolate one definition (Dahlqvist et al., 2007). Instead, the research that has been conducted has been composed of investigations that look at conscience more broadly, addressing wider aspects pertaining to conscience as opposed to conscience itself. These aspects are: influence of conscience, perception of conscience, a troubled conscience, stress of conscience and conflict of conscience.

Jensen and Lidell (2009) conducted a phenomenographic study to explore how conscience can influence nurses as understood through their practice experiences. Interviews were conducted by the researchers with 15 nurses working on inpatient units across three different hospitals in Sweden. Semi-structured interview questionnaires were used with categorical analysis resulting in three descriptive categories consisting of conscience as a driving force, restricting factor and a source of sensitivity (Jensen & Lidell, 2009). Elements of rigor or trustworthiness, were not reported in this study. The categories that emerged revealed that nurses described conscience as key in their response to personal values in professional settings. In this study nurses described that their sense of conscience drove them to provide good care, which at times required courage and self-sacrifice (Jensen & Lidell, 2009).

Contrarily, nurses also perceived conscience as restrictive (Jensen & Lidell, 2009). When nurses did not address conflicting issues, such as working under time constraints or physician's orders that they were unsure of, nurses were not able to provide care at the level their conscience desired. Nurses also reported a desire to be relieved from the moral obligations when situations arose with patients that they found to be challenging; nurses conveyed that they wanted to hand over their ethical responsibilities to someone else and sought support in troubling scenarios through discussion with co-workers (Jensen & Lidell, 2009). However, an appreciation of conscience also allowed nurses to be more sensitive, stay true to their values, be aware of the vulnerability of their patients and of themselves, and prompted nurses when they needed direction to support their quality care provision (Jensen & Lidell, 2009).

Results of Jensen and Lidell's (2009) study showed that conscience can affect nursing actions, whereby the influence of nurses' conscience can play both supportive and restrictive roles in their patient care provision. While the findings did not methodologically denote the essence, or meaning of what conscience is for nurses, conscience was presented as something that mediates what is right or wrong for a nurse to do. Influence of conscience for nurses was broadly expressed as a sense of moral wrongdoing that included feelings of inadequacy when they thought they were restricted in providing quality care to their patients. Yet, outside of providing an appreciation of conscience as an asset in providing quality nursing care, it was not clear in this study how conscience itself was taken up by nurses to make a personal, conscientious decision contrary to norms of professional practice or how they would address a specific, ethical issue that raised concern for their individual conscience. To understand more about the conscientious decisions of nurses, it is important to appreciate how nurses make meaning

of conscience in the first place. As such, further knowledge is needed to appreciate how nurses make meaning of conscience in their conscience based decisions over the ethical issues that arise in their practice.

### **Perception of Conscience**

Perceptions, or the different ways in which something can be appreciated or understood, offer an emerging understanding of a concept. While not as helpful in defining a concept as a way to explore or empirically measure it, looking at how nurses perceive conscience fosters an initial awareness over the relevance that conscience has for nursing practice. Nurses' perceptions of conscience have been initially explored in conjunction with other, HCP's perceptions of conscience as validated by a Perception of Conscience Questionnaire (PCQ) developed by Dahlqvist et al. (2007). Dahlqvist et al. (2007) developed the PCQ to create and validate a tool that would examine the various ways in which HCPs relate to their conscience when making ethical decisions. Conscience in their study was taken to be something that could inform one on how to conduct them self from a moral perspective, since in order for a HCP to be a morally integrated professional, he/she needs to balance the demands of his/her professional obligations with his/her personal values (Dahlqvist et al., 2007).

The PCQ was generated after ten interviews with various HCPs and laypeople, male and female, of varying ages (18-59 years) to see how people in Westernized society viewed conscience (Dahlqvist et al., 2007). Literature reviews were also conducted and interviews with 60 health care experts were analyzed through content analysis to generate items for the questionnaire (Dahlqvist et al., 2007). A 15-item questionnaire was developed consisting of items identifying aspects of conscience that respondents could agree with using a six point Likert scale, rating items from one through six for

respondents to completely disagree to completely agree on each item (Dahlqvist et al., 2007) with additional space allotted for individual, written responses. The tool was then validated from a sample of 444 health care providers consisting of nurse and physician respondents with an unknown response rate recruited by mail from hospitals and in person at a health care conference. Validation was ascertained by looking at the communicative effectiveness and practicality of the questionnaire instead of a test-retest owing to the reflective nature of the questions (Dahlqvist et al., 2007).

Results from the principal component analysis (PCA) showed six factors of conscience: “authority, warning signal, demanding sensitivity, asset, burden, depending on culture” (Dahlqvist et al., 2007, p. 187). Inter-relationships between the factors and their loading items varied, although they can be generally described as conscience being a driving force that guides how one behaves towards self and others, involving a process of deliberation in which one needs to take time to think and deliberate about the right course of action. Conscience was perceived as being too strict at times, driving one to stifle it as the only way to get away from it (Dahlqvist et al., 2007). Additionally, conscience can be conflicting when weighing the context of social situations with an HCP’s personal views in discerning moral courses of action that could influence their professional practice (Dahlqvist et al., 2007). Ultimately the PCQ questionnaire offers a starting point to identify how HCPs view their conscience as something that can be an asset or burden in their care practice. Subsequently, further research can be conducted to establish ways in which such burdens could be mitigated to alleviate the stress that can arise from perceptions of a burdened conscience.



## **Troubled Conscience**

When conscience is negatively perceived as a burden by a person, this can lead to what is described as a troubled conscience, or when a person starts to be concerned about not having done what they perceive to be right, or doing what they perceive to be wrong, made known to them through their conscience. A descriptive, qualitative study using semi-structured interviews with 20 nurses and nursing assistants working in an elderly care home was conducted by Ericson-Lidman and Strandberg (2013) to explore how care providers described their experiences of a troubled conscience. Thematic content analysis revealed four themes: 1) dialoguing with oneself, 2) dialoguing with others, 3) taking measures in perceived right direction and 4) distancing and energizing. Fourteen sub-themes also emerged and overall the themes revealed that nurses dealing with a troubled conscience used dialogue with themselves and others to manage it, took measures to act on what they perceived to be right and involved a process of distancing from their issues to consider and re-energize over the issues contributing to their troubled conscience. Trustworthiness in this study was established through open and critical dialogue between all the researchers throughout each step of the research process, consensus was obtained for textual interpretations and quotes from the participants were used to present the results (Ericson-Lidman & Strandberg, 2013).

Findings show that nurses appreciated confirmation of what they thought was right for themselves and others as a positive means to deal with a troubled conscience (Ericson-Lidman & Strandberg, 2013). Open communication with one's colleagues was perceived to be a positive way to deal with challenging situations in practice. Findings from this study show that nurses report wanting to discuss their conscience based issues in professional practice. Understanding more about how nurses communicate by way of

making a CO to address their ethical issues in workplace settings could further nursing professional awareness on how nurses act on what they perceive to be right, offering a deeper appreciation of the ethical concerns that nurses face in the context of their care practice and strategies they utilize to resolve them.

In another qualitative study conducted by these same researchers (Ericson-Lidman & Strandberg, 2015), the researchers came to findings similar to their 2013 study. Using a Participatory Action Research approach, Ericson-Lidman and Strandberg (2015) explored how care providers dealt with a troubled conscience in relation to their perceived lack of sufficient activity provision for elderly clients in their care. The 13 participants consisted of nurses, nurse assistants and one nurse manager working in a residential care home in Sweden. Participants took part in 12 intervention or group discussion sessions to discuss the issues that the participants described as leading to their troubled conscience and how they could collectively address those issues. Data from the sessions were analyzed through content analysis and yielded four domains of intervention that would address their troubled conscience by providing a process to address their perceptions of shortcoming in caring for their clientele. The domains consisted of: 1) brainstorming and the care providers' descriptions of the problem, 2) actions taken to gain increased understanding about meaningful activities, 3) activity actions taken and activity actions planned, and 4) evaluation of the intervention actions. Elements of trustworthiness were not reported.

Findings of the study indicate that care providers have a need to share knowledge to ease their troubled conscience and that open communication amongst team members as well as person-centered patient care can facilitate dealing with a troubled conscience. A manager was included amongst the participants in this study which could be an asset in

dealing with conscience related issues in clinical practice, since most of the research on conscience indicates the need for dialogue with co-workers but when it comes to addressing conscience issues for nurses, nursing management is also needed to support front line nurses (Ford et al., 2010).

Ericson-Lindman, Norberg, Perrson and Strandberg (2012) found in the analysis of their qualitative, descriptive study interviewing 20 nurses caring for the elderly in care homes that a troubled conscience was described by the nurse informants as having restricting qualities, thematically expressed in their study as: 1) feeling caught between patient, colleague and personal demands at work and home, 2) not having time to provide all the care patients need, 3) feelings of inability to alleviate resident's suffering and 4) feelings of having to provide poor quality care against one's will (Ericson-Lindman et al., 2012). Trustworthiness was established in this study by the researcher's attendance to credibility, dependability, transferability and confirmability. Attending to these elements entailed attentively delineating the process of analysis using quotes from the participants, routinely discussing findings amongst the researchers, writing rich, descriptions of the participant's stories and consistently reading through the text as a whole to maintain integrity throughout the process of analysis (Ericson-Lindman et al., 2012).

Findings showed that openly communicating as a care team could create an opportunity for transparency amongst health care workers to address some of these themes that express issues leading a troubled conscience. The ways in which nurses communicate their ethical concerns, however, is notably absent in the research to date. This gap exposes the need for research specifically aimed at asking nurses to share how they addressed ethical issues in practice, such as by way of making a CO, to understand

more about the dynamics of personal and inter-professional communication over conscience issues that nurses experience, as communicated by nurses themselves.

A hermeneutic, phenomenological study conducted by Fischer-Gronlund and colleagues (2014) was undertaken by interviewing 10 registered nurses working on a dialysis unit to explore how these nurses experienced ethically challenging situations that gave rise to their troubled conscience. Thematic analysis revealed one theme of calling for a deliberative dialogue and six sub-themes consisting of: 1) dealing with patient's ambiguity, 2) responding to patient's reluctance, 3) acting against patients' will, 4) acting against one's moral convictions, 5) lacking involvement with patients and relatives and 6) being trapped in feelings of guilt (Fischer-Gronlund et al., 2014).

Nurses reported that their troubled conscience could develop in situations where they: 1) felt inadequate at times to handle conversations with patients who were ambivalent about withdrawal of care decisions, 2) struggled to want to care for patients who were aggressive or ungrateful towards them, 3) provided care that went against patient wishes, 4) were unable to follow their own moral convictions for care provision if physicians did not support them, 5) were unable to have end of life discussion with patients and their families about patient care directions, and 6) had feelings of guilt related to failed attempts to resolve their ethical concerns with physicians who disregarded their concerns, as well as faced negative behavior from colleagues who gossiped about the nurses with whom they clashed over ethical issues in patient care (Fischer-Gronlund et al., 2014). How trustworthiness was established in this research study was not reported.

Findings from this study show that when confronted with ethical dilemmas, nurses can struggle with personal and professional integrity, which can lead to a troubled

conscience and feelings of being disempowered, vulnerable and uncertain, particularly when silenced by others or outcast for holding a different ethical perspective than those around them (Fischer-Gronlund et al., 2014). These feelings can lead to compromising one's moral integrity to the extent that a nurse might act against his/her conscience and have a negative desire to victimize someone else to shed feelings of isolation from coworkers (Fischer-Gronlund et al., 2014). Synthesizing these findings suggest HCPs need to work to build positive, transparent relationships to retain moral integrity as well as to establish trust amongst other HCPs such as physicians and the patients they care for (Fischer-Gronlund et al., 2014).

Understanding more about how nurses address their issues of conscience and ethical concerns in practice is necessary to respond to the gap that exists between nurses identifying issues in practice that negatively affect their conscience and then how, as well as what it is like, for them to respond to it. When nurses' conscience concerns go unheeded, this can compromise a nurse's sense of moral integrity and lead to creating feelings of mistrust, disempowerment and a lack of moral action. Instead, more knowledge is needed regarding how nurses experience and communicate their conscience concerns to create awareness over ways to support such nurses, mitigate their feelings of mistrust and disempowerment and find ways to help them counter a sense of fractured, moral integrity when their conscience becomes negatively affected by the ethical situations they find themselves in.

High levels of conscience, or the extent to which nurses identified following their conscience in practice, were reported in a descriptive-correlational study conducted by Gorbazadeh et al. (2015) with 68 oncology nurses across three hospitals in Iran, investigating how nurses make ethical decisions in practice in correspondence to their

conscience. The Perceptions of Conscience Questionnaire (Dahlqvist et al. 2007) was used to measure nurses' perceptions of conscience. Face and content validity were determined through expert opinion with 15 faculty members in the Medical Sciences division at the University of Tabriz in Iran and tested with a pilot study of 20 nurses to test for reliability resulting in a Cronbach alpha of 0.79 (Gorbanzadeh et al., 2015). A demographic questionnaire was also generated by the researchers to look at characteristics of the participant's work and social demographics.

Findings showed that nurses in this study had high levels of conscience and conscience-based caring. Implications of this research support that a strong conscience can be considered an asset in quality nursing care given that lower ratings of conscience for nurses in other studies have contributed to their stress of conscience, although they were conducted in another cultural context. As such, research that furthers an appreciation of how nurses in western culture make meaning of conscience and conscience based options such as CO could provide further insight for the nursing profession over how these phenomena are experienced by nurses in professional settings, and what meaning they hold for nurses' ethical care practice.

### **Stress of Conscience**

Stress of conscience relates to the amount of times one is stressed and the extent to which one finds their conscience to be consequently troubled, as self-rated by health care professionals (Glasberg et al., 2006). To measure nurses' response to issues that trouble their conscience, the Stress of Conscience Questionnaire (SCQ) was created by Glasberg et al. (2006). The SCQ contains nine, two-part questions: the first part queries how often a stressful situation occurs, followed by a second question that asks to what extent one's conscience was troubled by that situation. Part one of each question is

comprised of a six point Likert scale (zero to five with zero counting as one), and the second part uses a visual analog scale, also made up of six points, along which participants could rate their degree of a troubled conscience from a range of not troubled to very troubled (Glasberg et al., 2006). Content validation for the tool was established through expert opinion and face validity involved consensus as to the transparency and relevance of the questionnaire content to varying groups of health care professionals (Glasberg et al., 2006).

Glasberg et al. (2006) tested their questionnaire on a sample of 444 health care professionals working in Sweden. The sample was comprised of 111 nurse aides, 293 registered nurses, 27 physicians and 13 respondents who reported 'other' professions or did not list their profession. Respondents were recruited through a health conference, or through mail to their homes or workplace. Situations indicative of the most stress in testing the SCQ were associated with HCP's lack of time to give adequate patient care, effects of work influencing one's personal life, competing workplace demands, high workloads and role conflict (Glasberg et al., 2006). Factors identified by respondents that contributed to stress of conscience largely came from external, ethical, workplace demands competing with their own, internal, ethical values, striking a discord between professional and personal expectations and convictions (Glasberg et al., 2006). Results of the initial validation for the SCQ showed that conscience is a complex phenomenon that can positively direct a HCP to provide good care, yet could also generate stress from conflict arising out of competing factors motivating one to provide such care. Stressful influences can be either moral, such as someone trying to measure up to what a good person should be, or practical, related to one trying to cope with time and workload demands to provide ethical care.

To further examine nurses' perceptions of conscience related to stress of conscience, Juthberg, Eriksson, Norberg and Sundin (2007) conducted several studies looking at the relationship between perceptions and stress of conscience, burnout and occupational belonging. The initial, correlational study within their larger research initiative to examine all four concepts started by only examining perceptions and stress of conscience amongst 146 nurses in elderly care homes and used the PCQ (Dahlqvist et al., 2007) and SCQ (Glasberg et al., 2006) questionnaires for measurement. With a response rate of 87%, multivariate canonical correlation analysis was conducted and results indicated that nurses perceived conscience as strict, a warning signal to prevent one from acting against others, and that one's conscience had to be deadened to maintain one's job positively related to stress of conscience. Conversely, nurses who thought that their conscience should be followed regardless of others perceptions did not relate to having a stressed conscience.

Another implication from this research indicated that collaboration was key to address stress of conscience because some nurses considered collaboration more important than following through on their conscience. This indicates that collaboration at any cost could subsequently deaden one's conscience. Doing what one ought to from a normative perspective was sacrificed at times by nurses more concerned with being perceived as a 'good' HCP by others as opposed to being a 'good' HCP who did what they thought was right in practice settings (Juthberg et al., 2007). This finding significantly supports that following one's conscience in practice could be more of an individual response and exploring how nurses voice their subjective, ethical perspectives by way of making a CO could explicate this. This study also indicates that further understanding about supportive workplace environments is needed where nurses can



voice their conscience issues and what their perceptions of support were that enabled them to do so.

As part of their larger study on stress of conscience, Juthberg et al. (2007) also looked at stress of conscience and perceptions of conscience in relation to burnout amongst the same participants as the previous study. The Stress of Conscience (Glasberg et al., 2006) and Perceptions of Conscience Questionnaires (Dahlqvist et al., 2007) were used again with a Swedish version of the Maslach Burnout Inventory (MBI) to measure burnout, a 22-item survey with three subscales (Hallsten as cited in Juthberg et al., 2007; Juthberg et al., 2007; Maslach, Jackson, & Leiter, as cited in Juthberg et al., 2007; Maslach & Jackson, 1981). Subscales for the MBI include emotional exhaustion to measure feelings of being emotionally taxed and drained; de-personalization to assess a numbing withdrawal from care provision and personal accomplishment, which looks at how one feels about being successful in the workplace. Surveys were distributed to the same 146 nurse participants and multivariate canonical correlation analysis was again utilized to look for relationships between the variables (Juthberg et al., 2007).

Resulting relationships were revealed between stress of conscience and burnout and perceptions of conscience and burnout, respectively associated with emotional exhaustion, de-personalization and a “deadened conscience” (Juthberg et al., 2007, p. 1905). A conscience can become deadened when a nurse silences his/her conscience, which can occur for a nurse when he/she does not, or thinks that he/she cannot, express his/her conscience at work because others disagree with his/her conscientious perspectives. Findings from the study indicated that stress of conscience is strongly related to burnout, and not being able to express one’s conscience can lead to compromising one’s integrity. This compromise signals the need for nurses to be able to

voice their issues of conscience to keep their sense of self intact and to be able to engage in their work. Findings from this study elicit a need to support nurses to express their conscience issues and a relevant way forward is to understand more from nurses who have done so.

Juthberg et al. (2010) conducted a secondary analysis of data from their previous study using partial least square regression to examine whether there were predicative patterns for nurses' perceptions of conscience and stress of conscience related to burnout and occupational belonging. Results showed that perceptions of conscience and stress of conscience explained 42% of the variance in occupational belonging while burnout did not contribute to the explained variance. In addition, nurses' stress of conscience in relation to not meeting their own expectations of others and work demands were the most significant predictors of occupational belonging (Juthberg et al., 2010). These findings suggest that conscience can be a positive signal, increasing nurses' awareness of how they perceive themselves in their workplace, and if they are living up to their conscience-driven self-expectations (Juthberg et al., 2010). Voicing one's conscience concerns was also viewed as a positive factor by nurses experiencing stress of conscience over time.

A comparison study was conducted by Gustafsson and colleagues (2010) to examine whether perception and stress of conscience, social support and resilience contributed to burnout across two groups of health care workers. One group consisted of 20 care providers on medical sick leave for burnout and the second group was made up of 20 working care providers who were not burned out. Participants were predominantly comprised of nurses and the instruments used were the PCQ (Dahlqvist et al., 2007), to measure common perceptions of conscience, the SCQ (Glasberg et al., 2006), that assessed stress related to a troubled conscience, the Moral Sensitivity Questionnaire

Revised (Lutzen, Dahlqvist, Eriksson & Norberg, 2006), to measure moral sensitivity among health care providers (Gustafsson, Eriksson, Strandberg & Norberg, 2010); the Social Interactions Scale (Lindstrom et al., 2000 as cited in Gustafsson et al., 2010) from the General Nordic Questionnaire to assess social support from respondent's superiors, colleagues, family and friends (Gustafsson et al., 2010), and the Resilience Scale (Skovolt, 2001), a questionnaire that measures degrees of resilience from respondents (Gustafsson, et al., 2010).

Results from the surveys across both groups indicated that expressing what one's conscience mandated in the workplace characterized the non-burnout group over the burnout group. Participants with burnout scored higher on survey items that indicated that one's conscience can fade over time if ignored, one had to deaden their conscience to practice in health care, conscience is strict and one can have a troubled conscience if he/she does not live up to his/her conscience (Gustafsson et al., 2010). Stress of conscience was more present in the burnout group and lower levels of stress of conscience was found in the non-burnout group. Those who did not have burnout were also characterized as viewing life with forbearance, considered conscience an asset and thought they had support from their colleagues and professional organizations for their conscience concerns. Findings from this study indicate that responding to one's conscience in their work environment can decrease the incidence of a troubled and stressed conscience as well as burnout in health care providers, supporting the need to further explore how nurses act on their conscience issues in workplace settings.

Ahlin, Ericson-Lidman, Eriksson, Norberg and Strandberg (2013) conducted a longitudinal study to describe if relationships varied over time between stress and perception of conscience, burnout scores, and person-centered climate and social support

among registered nurses and nurse assistants who worked in municipal care of the elderly. Surveys were distributed initially to 983 nurses with a 50% response rate (n=488) and then sent out again one year later. The second surveys were distributed to 458 nurses from which 277 questionnaires were returned for a response rate of 60%. Instruments used included the SCQ (Glasberg et al., 2006), the PCQ (Dahlqvist et al., 2007), the MBI (as cited in Ahlin et al., 2013), the Person-Centered Climate Questionnaire (PCCQ) (as cited in Ahlin et al., 2013; Edvardsson, Sandman & Rasmussen, 2009) to measure the degree that an HCP assesses the caring atmosphere as client-centered and the Social Support (SocIS) questionnaire that measures working environment for respondents to score their manager's support (as cited in Ahlin et al., 2013) .

Nurse respondents reported a marginal increase in “deadening their conscience” (Ahlin et al., 2013, p. 932) during the twelve-month period to continue working in their profession. A further rise was noted in how nurses saw their own conscience as strict, and some developed a troubled conscience when they could not maintain their personal work standards (Ahlin et al., 2013). Influencing factors were related to changes in increased patient acuity, lower staffing levels, shift schedules (days and shiftwork), and proximity of participant to bedside care versus staff in more supervisory roles from one year to the next (Ahlin et al., 2013).

Positive factors related to decreasing staff's stress of conscience consisted of support from managers as well as adhering to and voicing one's conscience in the workplace (Ahlin et al., 2013). Such findings are significant since they support that voicing one's ethical concerns could be a positive experience for nurses with a stressed conscience. Supportive management has also been described by Ford et al. (2010) as a needed measure for nurses to voice a CO in practice settings, indicating that front line

nurses could benefit from supportive leadership with respect to issues related to conscience.

More research has been conducted to further evaluate if stress of conscience is related to environmental or individual factors (Tuveesson, Eklund & Wann-Hansson, 2012). Recently, psychiatric services in Sweden underwent extensive overhaul, generating cutbacks and care revision, creating stress for nurse's work environments due to lack of resources and potentiating nurse's stress and troubled consciences over high care demands (Tuveesson et al., 2012). Tuveesson et al. (2012) used six surveys to conduct a cross-sectional study with 93 registered nurses and nurse assistants in 12 in-patient psychiatric units in Sweden. Surveys used were the SCQ (Glasberg et al., 2006), the revised Ward Atmosphere Scale (Tuveesson, Wann-Hansson & Eklund, 2010), to measure psychosocial ward atmosphere; the shortened version of the General Nordic Questionnaire for Psychological and Social Factors at Work, the QPSNordic 34+ (Lindstrom et al., 2000 as cited in Tuveesson et al., 2012), to measure psychosocial work environmental factors; the Perceived Stress Scale (Eskin & Parr, 1996 as cited in Tuveesson et al., 2012), to measure general and global stress and the revised Moral Sensitivity Scale (Lutzen et al., 2006) a questionnaire with three subscales consisting of a sense of moral burden, moral strength and moral sensitivity to assess moral sensitivity and the Mastery scale (Eklund, Erlandsson & Hagell, 2012), to measure the control one feels they have over their lives.

The findings indicated that stress of conscience for nurses was better understood by appreciating internal and external factors that affect nurses' responses to ethical demands in practice settings. Internal demands were linked to angry and aggressive behavior, one's sense of moral burden and perceived control at work (Tuveesson et al.,

2012). External demands were related to nurses' sense of moral burden and control at work (Tuveesson et al., 2012). Findings suggest that if nurses are having stress of conscience related to factors such as moral burden, mastery and control, nursing leadership could take this into account and find ways to create supportive workplace environments, thereby potentially alleviating nurses' stress of conscience (Tuveesson et al., 2012).

This study supports an appreciation of how a nurse's conscience could be influenced by either broader, organizational factors or internal pressures generated from personal, ethical expectations. Understanding more about the moral sensitivity and psycho-social responses of nurses could promote awareness over the internal struggles of nurses with a stressed conscience, which further supports the need to look at the experience of nurses who voice a CO by exploring the personal meaning that underscored their decision to do so.

External factors contributing to nurse's stress of conscience were also reported in a descriptive study by Saarnio, Sarvimaki, Laukkala and Isola (2012) who measured stress of conscience with Finnish nurses using the Stress of Conscience Questionnaire (Glasberg et al., 2006). The sample for the study consisted of 350 nurses with a response rate of 80.3% from the original 436 nurses who received a survey. Results showed that the most pertinent factors were related to time constraints in delivering quality patient care and high work demands that interfered with how nurses functioned at home, thus contributing to a troubled conscience in nurses' professional as well as personal lives, indicating that struggling with a troubled conscience at work can also affect one's personal well-being (Saarnio et al., 2012). Nurses who worked full time and had more work experience also reported higher levels of stress of conscience (Saarnio et al., 2012).

To assist nurses experiencing a troubled and stressed conscience, efforts could be drawn from staffing, leadership and organization initiatives aimed at providing a supportive workplace environment for concerns related to conscience (Saarnio et al., 2012).

### **Conflict of Conscience**

Silencing is a theme that coincides with disempowerment, which can result from nurses' conflict over issues of conscience (Ford, 2012). In Ford's (2012) interpretive descriptive study with neonatal intensive care nurses, conflict of conscience was taken to be a comprehensive term defining the situations in which nurses may find themselves disagreeing with professional care and/or obligations that went against their conscience. Research findings supported the negative aspects that issues of conscience held for nurses, highlighted by themes of: 1) unforgettable conflict and pain, 2) finding the nurse's voice, and 3) the unique proximity of nurses to their conflict situations (Ford, 2012). Some of the care that nurses experienced conflict over was mismanaged pain control and end of life suffering with infants (Ford, 2012). Considering this conflict, nurses in Ford's (2012) study reported feelings of not being able to speak up and voice their dissent about their conflict of conscience, either through personal hesitancy or a sense that their professional role superseded their personal opinions, since the care of their patients had to come first (Ford, 2012). The proximity of the participants to their patients also contributed to their conflict experience, since it increased the nurse's sensitivity to issues with patient care that troubled their conscience (Ford, 2012). Significantly, nurses in this study revealed that responses to their conflict of conscience could be refusal of care, request for reassignment, adopting to the situation and compromising personal beliefs to not formally object to the care assigned (Ford, 2012). Elements of rigor were not addressed in this study.

As a response to a conflict of conscience, CO has been somewhat negatively perceived by nurses. At times CO is considered an unfavorable option largely related to the stigma associated with choosing to object (Ford, 2012). Additionally, justifying CO as a response can be a struggle for nurses conscientiously trying to resolve an ethical dilemma, yet who are apprehensive of the outcome related to perceiving CO as abandoning patient care in doing so (Ford, 2012). While objecting to care that a nurse personally disagrees with is not an unfamiliar concept to practicing nurses, choosing to invoke a CO can be viewed as patient abandonment. Yet, on the other hand, not making a formal CO may lead to compromising personal beliefs in lieu of balancing personal, patient and professional obligations (Ford, 2012). Understanding more about how nurses make a CO in clinical practice is warranted to offer a different way of looking at CO perceived by nurses who use CO as an established, ethical option to voice their objections to what they perceive to be unethical in their workplace settings.

### **Methodological Insights**

Studies on conscience and nursing reveal that conscience is not well defined in the empirical literature. Instead, focus has been paid to the different ways in which nurses perceive conscience; accordingly, a range of perspectives exist on conscience for nurses who view it as something that can enhance or restrict their practice depending on whether they view conscience as positive or not, and whether they were able or unable to provide the care they thought or struggled to think was ethically appropriate for their patients. When a nurse perceives their conscience as a negative, restricting factor or had their conscience bothered in practice, a troubled conscience can ensue and lead to stress of conscience. Nurses who work with stress of conscience can, over time, end up silencing



their conscience or experience burnout related to not being able to follow their conscience in clinical settings.

Conflicts of conscience can also arise for nurses over ethical dilemmas, in which a course of action may be warranted in the form of conscientious objection. However, owing to perceived stigma over objecting or confusing CO with patient abandonment can hinder nurses in voicing an objection to address their conflict of conscience in care practice. What is notably absent in the empirical literature on conscience for nurses is a sense of how concepts such as stress of conscience differ from other, related phenomena, such as moral distress. Moreover, some researchers have made mention that the work on moral distress has also not looked at how nurses attribute their constrained moral actions to their conscience, which is a significant factor in moral decision making (Dahlqvist et al., 2007).

The qualitative studies on conscience and nursing were helpful in laying out how nurses perceive conscience as well as identifying situations that could bring about nurses' troubled conscience, stress of conscience or conflict of conscience. These studies were limited in terms of what they explored given that the researchers did not ask nurses the meaning of conscience related to CO or otherwise, as voiced by the nurses themselves. Additionally, the studies did not directly explore how nurses formally addressed their stressed, troubled or conflict of conscience in practice. While Ford's (2012) work did specifically ask nurses about their experience with CO, the overall aim of that research was to explore nurse's responses to conflict of conscience, and did not capture all participant's individual experiences with making a conscientious objection. Even though this research to date supports an initial understanding of how conflict of conscience can arise and how conscience is integral to a nurse's personal and professional integrity as

well as their patient care, it does not glean how nurses act on their issues of conscience in clinical settings through a formal objection.

Quantitative studies on conscience in nursing relay there are factors that influence nurse's perceptions and stress of conscience, affecting their practice. These factors can be practical and external, such as time and workload constraints and competing workplace demands. Other influences can be personal and internal, rising out of conflict with what one believes in relation to professional demands. A stressed or troubled conscience can extend into a nurse's private life, creating potential for compromising one's integrated self and can also lead to burnout.

The quantitative research studies on nurses and conscience consisted of surveys, questionnaires and some interviews to validate measurement tools. Strengths of this research include identifying how nurses perceived conscience and scenarios in which their conscience became troubled or had stress of conscience. Identifying scenarios can lead to finding ways in which to decrease or mitigate stress of conscience. Yet, the quantitative studies also did not capture an understanding of the meaning conscience holds as relayed by nurses themselves. Because eliciting such meaning is not the aim of quantitative research, using quantitative methods perpetuates the gap in knowledge on conscience and CO for nurses. Moreover, most of the studies that used survey measures recruited various HCPs and did not always examine nursing-specific nuances of conscience. Ultimately, further use of qualitative methodologies with interview methods that engage in in-depth, personal discussion with nurses who have experienced a formal response to issues of conscience is needed to penetrate the ethical complexity that conscience issues can hold for practicing nurses and the patients they care for.

## **Conscientious Objection**

The empirical studies available on CO and nurses consisted of one qualitative and two quantitative studies. Categories to describe the research consist of nurses' awareness of CO and factors that influence nurses' use of conscientious objection.

### **Nursing Awareness of Conscientious Objection**

Harries, Cooper, Strebel and Colvin (2014) used a qualitative approach to explore the state of CO in the context of abortion provision amongst HCPs in Africa. While this study did not specifically focus on the experience of nurses, results showed that the different groups of HCPs including nurses who participated understood and used CO in varying, conflicting ways. Emergent themes indicated that HCPs generally misunderstood the grounds for making a CO related to confusion over: 1) when to object to abortion provision through direct or peripheral involvement and 2) the lack of a cohesive process to guide their objection (Harries et al., 2014). Findings suggest that use of CO needs to be clarified and clearly explicated so that those who need to use it do so appropriately across professional health care practice (Harries et al., 2014). How the researchers attended to trustworthiness was not reported in this study.

Further research on CO directly focusing on nurses was conducted in a pilot study by Catlin et al. (2008), who surveyed 66 neonatal and pediatric intensive care unit nurses to examine how these nurses viewed CO in relation to their clinical practice. The survey was created by the researchers and consisted of providing a definition of CO, four demographic questions and eleven multiple choice and open ended questions asking nurses to describe their knowledge, use and barriers for using CO in practice. Factors contributing to nurses' use or desire to use CO as described in their survey responses consisted of aggressive treatments that made no difference to treatment outcomes,

inappropriate interventions on premature babies with palliative diagnoses and pressure from family members who did not want palliative care for their infants.

Results of this study indicated that approximately half of the participants had voiced an informal act of CO, while the remainder never had (Catlin et al., 2008). Informal acts of CO consisted of nurses voicing their concerns to physicians or approaching physicians who were more likely to listen to them; talking to ethics committee members, asking nursing colleagues to switch assignments with them, noting their disagreements in writing in patient charts and at times refusing to follow care orders explicitly or without saying anything (Catlin et al., 2008). The nurses in this study relayed multiple barriers to their objecting on issues of care they found futile for their patients at the end of life, such as physician's directives, institutional policy, and the threat of lawsuits/legal action which could take away nurses' livelihood (Catlin et al., 2008). Catlin et al. (2008) recommended that regulating nursing bodies mobilize endeavors that would specifically assist nurses to create "conscientious objection protocols" (p. 106) that transparently support awareness of nurse's personal, moral perspectives in practice.

### **Factors that Influence Nurses' use of Conscientious Objection**

Davis et al. (2012) conducted an exploratory study to describe the influencers of nurses' ethical beliefs and if these beliefs predict nurses' MD resulting in their conscientious objections. The researchers used an online survey they had created to ask nurses specific question related to the focus of the study. The survey was composed of nine items asking questions on what influenced nurses' ethical beliefs about moral distress (MD) and conscientious objection. Definitions for MD and CO were given based on the literature and the survey was content validated with four health care professionals.

Beta testing was conducted with nurses before the survey was released online to participants. While the overall response rate of 10% was low, the total number of participants was 1141 nurses from an initial sample size of 11,410 consisting of nurses working in the state of Idaho, in the United States of America, recruited through their state board of nursing website. Analysis was conducted with logical content analysis, SPSS and a one-way analysis of variance.

With respect to CO, nurse respondents thought that patient's rights trumped nurses in most cases, and although most of the participants relayed that nurses who worked alone in practice settings should be able to voice an objection in non-life threatening situations, 5.7% (n=62) of those surveyed reported leaving their jobs due to CO, but the rationale was not described (Davis et al., 2012). Influencers of nurses' ethical beliefs as reported by participants were predominantly comprised of work and life experience (34%), religious beliefs (29%), family values (24%), the Nursing Code of Ethics (9%) and legal or political views (3.5%). While influencers of nurses' ethical beliefs were varied, findings supported that ethics education was important for supporting nurses' ethical awareness. The need for professional and educational organizations was identified to create climates for nurses to openly share their personal, ethical beliefs to feel comfortable practicing in accordance with their personal belief systems, identify MD, and freely discuss issues of CO to decrease nurses' negative experiences in practice as well as to ensure patient safety (Davis et al., 2012).

### **Methodological Insights**

The methodologies utilized in the quantitative studies on CO support an initial investigation of how CO is understood by nurses and to identify major categories that influence their ethical beliefs to predict when a nurse might utilize a CO in professional

practice. Strengths of the studies include generating knowledge that could start to identify CO for nurses and support professional dialogue on how nurses can inclusively identify their beliefs to navigate ethical issues that conflicted with their personal or professional, ethical beliefs. The qualitative study on CO for nurses offered participants, including nurses, the opportunity to share the broader contexts that contributed to their lack of understanding of CO, which may not be as comprehensively captured on a structured questionnaire. However, further research is needed to create specific means of supporting nurses in practice by addressing the care issues that give rise to situations in which nurses might find themselves needing to conscientiously object. A limitation that exists in the research to date on CO is the lack of structured, survey methods used to collect data.

While results from the studies conducted on CO indicate that some nurses agreed with CO in certain situations, the studies available do not fully comprehend the breadth of what these ethical situations are like for nurses. For example, the survey from Davis and colleagues' (2012) study did not capture the experiences of nurses who made a CO themselves from actual experiences, but rather only if they agreed with making a CO in scenarios presented to them. Thus, nurses lived experiences with CO were not fully addressed, or the complexities and nuances that can arise in nurses' responses to situations that give rise to their making a CO in the first place.

Limits to current findings on CO include a gap in understanding what CO means to nurses, and in fact, reveal that some nurses aren't clear about when to use CO, may not be supported in using CO, and do not clearly lay out how nurses navigate their ethical concerns with a CO in practice settings. The measures for assessment used in these studies on CO related to nursing practice were semi-structured interviews and surveys. These studies were compromised however by either use of non-validated surveys, lack of

controlled designs and a qualitative approach that focused only on capturing nurse's experience with CO related specifically to abortion provision. To date, empirical research is limited in capturing the meaning to be uncovered related to the intricacies involved in the use of CO by nurses.

### **Summary**

The review of the literature presented in this chapter revealed that conscience and CO are phenomena complicated by varying perceptions, influencing factors and have yet to be fully explored and understood in relation to nurses and nursing practice. The lack of qualitative groundwork on these concepts reveals an imbalance in the research to date which moves from a brief exploration of nurses' perceptions of conscience and CO to a broader focus on technical, measurement scales and nursing responses to conscience. This imbalance offers a lack of salience since it does not take into consideration the meaning that nursing practice experience offers to the profession of nursing by exposing a deficit related to building a holistic understanding of what the use of CO is like for nurses. The findings of this study will support the significance CO holds for nurses and how it informs the practice, as well as patient care provision, for nurses who choose to use it and live with that experience in professional settings. This research will also advance the field of nursing ethics and broaden professional understanding of what it is like to be an ethical nurse, as expressed by nurses themselves, by way of making a CO, as guided by the interpretive phenomenological methodology and methods of Martin Heidegger.

## CHAPTER FOUR

### Methodology and Methods

To address nurses' moral choices and encounters with ethical issues resulting in their COs, I needed a methodology that could shed light on the nurses' experience of voicing a conscientious objection. Since the focus of this study was subjective in nature emphasis was placed on choosing a methodology that would elucidate the individual experiences being explored and called for a research design that was not strictly, objectively oriented (Denzin & Lincoln, 2011). Qualitative research inquiry was therefore considered appropriate to address my research purpose since it allows a researcher to appreciate human experiences as a source of insight (Denzin & Lincoln, 2011; Polit & Beck, 2012). A qualitative approach also afforded me the opportunity to utilize open-ended methods of data collection such as in-depth interviews, to yield results layered with personal meaning, which supported gaining a deeper sense of individual experiences in subjective inquiries and to understand how those experiences can generate a fuller appreciation of the lives of nurses and nursing practice (Denzin & Lincoln, 2011; Mackey, 2004; Polit & Beck, 2012).

#### Interpretive Inquiry

From amongst the established frameworks of qualitative inquiry, phenomenology is a methodology that lends itself well to a purpose of gaining an in-depth understanding of lived experience (Lopez & Willis, 2004). Such a purpose seeks to understand versus explain questions to allow the researcher to become more aware of what it means to be human as grasped through human-being experiences, acquired through interpretation of encountered phenomena in one's everyday existence (Crist & Tanner, 2003; Mackey, 2004). Considering the most appropriate approach within naturalistic inquiry to



appreciate the existential reality of the human person, I elected to use interpretive phenomenology, specifically, to guide how I would gather and attend to the data and myself as the researcher to understand participant's self-interpretations of their lived experiences.

### **Phenomenology**

Both a philosophy and research methodology, traditional phenomenology is often delineated into two main branches of inquiry: 1) descriptive, or transcendental and 2) interpretive, or hermeneutical. The aim of phenomenological research is to explore the meaning of human existence as it is lived in the context of one's everyday life (Van Manen, 1990). Often described as a movement as opposed to a fixed philosophy owing to the diverse methodologies that have emerged within it throughout the twentieth and into the twenty-first centuries, traditional phenomenology is rooted in the renderings of German philosophers Edmund Husserl and Martin Heidegger.

Phenomenology initially gained distinct recognition as both a philosophy and a methodology under the work of Edmund Husserl (1859-1938), a philosopher as well as a mathematician. Husserl's approach to phenomenology consisted of a subjective focus for deriving universal truths about phenomena as they present themselves to one's consciousness. Ideas consistent in Husserl's phenomenology were: 1) intentionality, 2) searching for essences and 3) the phenomenological reduction (Husserl, 2002; Koch, 1999).

According to Husserl, truth existed as captured in the meaning derived from first person encounters with phenomena which are grasped by one's mind, or consciousness and marked a break with positivism that sought to obtain knowledge from examining the world (Lavery, 2003). Instead, Husserl appreciated that it was the human encountering

the world that could offer the most appropriate evidence of the world experienced by the person living in it (Lavery, 2003). For Husserl, consciousness is perceived to be the central source of knowledge where one can come to understand what an object is, described as its essence. Intentionality refers to deliberately attending to objects that present themselves to one's consciousness through lived experiences. In this way one can attempt to uncover the truth of reality obtained through epistemology, or the way one knows that they know what something is (Koch, 1999). To arrive at such a conclusion occurs with Husserl's methods of the epoche and reduction. The epoche consists of bracketing where one suspends all prior knowledge of a phenomenon to transcend the object. Reduction is the meaning of an object, achieved by imaginatively grasping the essence of it and then describing the phenomenon as purely as possible to attain the reality of the person consciously experiencing it (Giorgi, 2007; Husserl, 1958; McWilliam, 2011; Van Manen, 2014).

Husserl's perception that reality is embedded in conscious description gave rise to the term descriptive or transcendental phenomenology, since descriptive phenomenologists attempt to acquire knowledge by transcending the known to grasp what is unknown, thereby returning to the true nature of what that something, or object, is. To use such a method, researchers would ask, what is the nature of a phenomenon? And the answer would be found in the purely subjective description of the object in question, leaving out all pre-reflective understanding or knowledge that one has acquired prior to trying to describe it. However, achieving such pure description is arguably impossible since it disregards any other explanation for human existence; accepting that the essence of being contributes solely to one's understanding of what an object is, as distinct from the person as subject, achieved through conscious awareness. This view

perpetuates the Cartesian duality of the mind as a disembodied locus of understanding that emphasizes individual descriptions of knowledge and does not consider that meaning can also emerge ontologically or across accounts of human experiences. Moreover, as contemporary phenomenological researcher, Max van Manen (2014) asserts, no description can go un-interpreted, since every person's description is at once an interpretation of their own descriptions. Given that the purpose of my research was motivated by my own lived experience with CO and driven by ontologically derived beliefs of reality encountered in inter-subjective relationships, I abandoned descriptive phenomenology for interpretive.

### **Interpretive Phenomenology**

Interpretive, or hermeneutic phenomenology, is based on the philosophical approach of Martin Heidegger (1889-1976), another German phenomenologist, mentored by Husserl. Departing radically from Husserl's approach, Heidegger is credited with diversifying phenomenology to accept that tenants of reality entail a necessary acknowledgement of human existence (ontology) as a way of understanding. Comprehension in this view occurs through interpretations of lived experiences.

In Heidegger's approach, human beings take for granted that they exist, and being-in-the-world was Heidegger's ontological expression of that reality. Heidegger did not view the subject as separate from an object to be encountered solely in the mind. Rather, he postulated that each person is inextricably bound up inter-subjectively with the objective aspects of their existence which are space and time. This corporal spatiality is in the world, and humans exist in the world in time, or temporality, as that mode in which human existence is constantly dynamic. Being in time were, for Heidegger, the lenses through which someone views their experiences and shapes the meaning that can be

drawn from them (Lavery, 2003). This ontological orientation comes from an historical appreciation of one's situatedness in the world, where one's background is culturally embedded and serves as the vantage point that constitutes their reality (Lavery, 2003). In this way, humans are always intertwined with who they are based on a pre-understanding of their cultural identity that forms part of one's background of historicity rooted in the influences within the culture in which one is located (Lavery, 2003). Separating oneself from a pre-understanding of belief that constitutes one's identity is not possible to achieve further understanding of one's experiential existence.

Heidegger's term for the mode of human existence is *dasein* (Heidegger, 2010; Mackey, 2004). As *dasein*, humans recognize that while they are inextricably bound up in the world they are also distinct from it, allowing them to reflect on their existence as such, through their subjective encounters with the objective dimensions of the world in which they exist, known as an inter-subjectivity. This inter-subjective orientation is further approximated through one's encounters with their everyday existence, made known to them through their life worlds, or the context of their day-to-day encounters, described as lived experiences. Van Manen (1990; 2014) describes several, fundamental and existential aspects of human life worlds: spatiality, corporeality, temporality, relationality and materiality. In these different modes of being-in-the-world, one can grasp their experiences as being in a certain space, in time, as beings that relate inter-subjectively to one another and in the material things that one encounters in the world. A life world is the way in which a day-to-day experience presents itself to *dasein*, such as the daily moments of being a nurse. On a given day, if a nurse makes a CO, the meaning that can be derived from that lived experience is what an interpretive phenomenological researcher would aim to capture, to understand the meaning embedded in that experience

(Mackey, 2004). For example, being (existing) in the now (time), as a nurse (life world) shape how an experience (making a CO) with a phenomenon (CO) can be understood through relating to patients or colleagues (inter-relationality) and through the things (material objects, i.e. codes of ethics), that tell nurses something about who they are (Van Manen, 2014).

As a researcher, I wanted to uncover the meaning of nurses lived experiences with making a CO since attending to the motivations for appreciating and seeking to understand something about ourselves, is necessary to a meaningful existence (Heidegger, 2010). How nurses make meaning of the moral dimensions of their professional lives is often unclear and nurses lived experiences with CO need to be uncovered to more fully understand the ethical dimensions of nursing practice. Heidegger (2010) explicates that existence is meaningful when one cares about it; care is the rationale for humans to analyze their existence. Not foreign to the nurse experience, care is also that underlying premise that can motivate the moral actions of a nurse and is what Wojtyła (1979) puts forward as the phenomenological basis for every human inter-subjective interaction. Namely, that such interactions comprise the acts of one's existence, which can be understood through self-interpretation as perceiving the objects (phenomena) that one subjectively encounters. For nurses, in this study, this meant the actions they took to address moral concerns by using conscientious objection.

Heidegger's conceptualization of interpretation is not indicative of the Cartesian dualism maintained in Husserl's transcendent phenomenology and which dominated philosophy since Descartes. Instead, Heidegger sought to diminish the mind-body rift of this dualism aimed at establishing that what is objective is separate and distinct from what is subjective (Koch, 1999). Rather, what Heidegger verged towards was an

orientation to the world that appreciated the unique meaning that each person can make of their inter-subjective encounters (Heidegger, 2010; Koch, 1999).

Heidegger's approach to phenomenology as the pursuit of understanding rested upon his assertion that meaning did not correspond directly to truth as an objective fact, but that truth was something that could be continuously revealed or disclosed to obtain an appreciation for phenomena contextualized through the experiences of human existence (Van Manen, 2014). Propelled by a sense of care (*Sorge*) to characterize human existence, exploring the meaning of lived experiences was also motivated by Heidegger's acceptance of conscience, which corresponded with recognizing that one's existence as spatially oriented in time was also marked by one's finitude (Koch, 1999).

Acknowledging such a temporality gave rise to Heidegger's assertion that one has a conscience to meaningfully navigate one's life (Heidegger, 1992).

Conscience, for Heidegger, was not so much a statement of being ordered to right action as it was another dimension of comprehending existence by being confronted with guilt resulting from the error of not being true to oneself (Heidegger, 1992). For Heidegger, "willing to have conscience" (1992, p. 319) involved being mindful that one's actions would involve a disposal to accept that one could be wrong, or in-authentic, as a way of being by not living a meaningful life. In this negative ontological assertion, conscience is perceived as the antecedent to a certain kind of *dasein* (human existence) and committing, or being true to it. To be true, for Heidegger, consists of an adherence to the acceptance of being as *dasein* and staying consistent in that ontology, as rendered through a sense of intentionality, or the desire to live meaningfully by attending to one's lived experiences (Heidegger, 2016). Asking what it is like to be a nurse making a CO

meaningfully attends to who nurses are, as they live through that experience structured by a desire to care and conscientiously attend to what they authenticate or find to be true.

Truth in interpretive phenomenology is conceptually described with the Greek word *alethia*, meaning disclosure or unveiling, and defines what interpretation aims to grasp: that what can be understood from a meaningful experience becomes disclosed when the insights lying within interpretations of that experience are brought to light (Van Manen, 2014). Truth in this methodology is then taken to be the reality of one's lived experience (Koch, 1999). Conscience can be a way of being if accepted as such by *dasein* that calls *dasein* to be authentic to a meaningful life. As I became immersed in the research I utilized the participant's narratives as the primary source of information but also engaged in more depth with Heidegger's primary works. Recognizing that conscience was a way of being for Heidegger added layers of new meaning to how I engaged with the text and offered another point of departure for appreciating how nurses made meaning of their conscience in their lived experiences of conscientious objection.

My choice to use Heidegger's philosophy of phenomenology was also due to my own stance as a researcher; my beliefs about reality accept that who we are in the world tell us something about ourselves and the truth of our existence. To comprehend what it means to be human is to attend to the ways in which we express ourselves which can arise in a moment or through a process of deliberation, and takes into consideration that humans live in the socio-cultural contexts where our beliefs, prejudices and biases influence interpretations of our lived experiences (Lavery, 2003). Separating the reality of our existence from how we derive meaning from being-in-the-world is not possible. Given that Heidegger asserts that we are entrenched in our human experiences, I accepted that the lived experiences of the participants were true accounts of what was real for them

(Koch, 1999). One way that I attended to this veracity was through the process of co-construction, where together with the participants, I co-created a textual consensus of their lived experiences through textual interpretations, narrative summaries and in the abstraction of themes arising from the participant's narratives (Koch, 1999).

Although I appreciated the tenants of interpretive phenomenology orienting to it in the research process was initially challenging for me. As a philosophy phenomenology was far more open-ended than approaches that I had consistently valued to as modes of meaning prior to this research. Moving into such an open method of inquiry made me feel lost and uncomfortable in the initial stages of the inquiry-I had to remind myself over and over to ask: what is this person telling me? What is their story? Not knowing what stories would emerge from the research question was also unsettling for me at first. The overt inter-subjectivity in Heidegger's philosophy was a departure from my more metaphysical leanings, yet, at the same time, interpretive phenomenology enabled me to recognize the relevance of subjective experiences. I was also afforded an awareness of how nurses' individual lived experiences open multiple windows of insight about the phenomena in question that would be otherwise difficult to appreciate, since interpretive phenomenology accepts what is revealed and does not operate on a positivist approach of deduction to reach conclusions. Instead, I learned to maintain an open stance in the inquiry, accepting that meaning would emerge as opposed to being sought out.

Meaning within a lived experience becomes clear through the unveilings presented through textual illustrations of the interpretations; but they are never revealed directly. Partial glimpses can unfold, but the essence of what is to be seen respond to distinctions made through the probing of phenomenological research constituted through text and is gained through an iterative movement of parts to whole, where disclosure



occurs from attending to the different aspects of an experience as they emerge. To make such distinctions in Heideggerian philosophy is to see the world as a priori, from which all experiences are not disparate but are to be viewed in light of inter-subjective horizons that dialectically converge to reveal, through interpretation, an understanding of a lived experience (Mackey, 2004). Horizons are the ways in which someone views the world and the different meanings between participant's lived experiences are made clear in interpretive phenomenological research when, as the researcher, I engaged in inter-subjective dialogue with the participant's stories.

In interpretive phenomenology, intersubjective dialogue occurs between the researcher and the text of the participant's stories, where I moved back and forth from the nurse informant's individual narratives to participant's collective stories, aiming to capture how each part of their separate accounts threaded across other participants' accounts of their lived experience of making a conscientious objection. By moving from the parts of the text to the whole text I arrived at a co-constructed agreement with the participants of what their lived experiences meant. Readers of this co-constructed consensus can then be offered a new way to understand what it is like to be a nurse living with an experience of making a conscientious objection (Koch, 1999). As such, electing to use interpretive phenomenology provided a way to gain insight into what the phenomena of CO means, as encountered through lived experiences, which are both the starting and end points for interpretive phenomenological inquiry (Koch, 1999; Hassan, 2015). When an experience is understood, meaning is achieved by which the "phenomenon is revealed" (Mackey, 2004, p. 182). For phenomenological research the disclosure of such experiences occurs as *alethia*, or the revealing of the truth of the lived experiences, and appears through the writing of participant's narratives.

### **The Hermeneutic Circle**

To understand something in a new or different light occurs through Heidegger's (2010) iterative method of interpreting lived experiences, known as the hermeneutic circle (Koch, 1996). The circle is metaphor for a process of deriving meaning that allows one to encounter an experience one has had (in time), reflect upon it (in temporality), take it back to the experience, and reflect upon it again, repeating the process in a circular fashion, until an understanding emerges of what that experience might hold for that person (Heidegger, 2010; Moran, 2000). This hermeneutic method is not static; moving through the circle is not meant to be repetitive either. Rather, it is an iterative vehicle of pre-reflection. To pre-reflect on an experience is to consider something that is before the present and necessitates going back to an historical experience to think about it in the now and repeat that process to retrieve new layers of meaning each time. These additions lead to further interpretations by moving again, from the part to the whole and towards further understanding of a thing itself; a process that holds endless potential for deeper meaning (Koch, 1999). Entering the hermeneutic circle as a researcher occurred prior to conducting the study when I acknowledged my pre-reflective stance or fore-structures in the research process. To engage in pre-reflectivity, I located myself within my preconceived understanding, assumptions and biases of my own lived experience of making a CO to hold them distinct from the participant's self-interpretations, while engaging in an inter-subjective dialogue with the text to derive iterative meaning from within it (Mackey, 2004).

Disclosing the meaning embedded in lived experiences occurs through text, where language is the hermeneutic that provides meaning between inter-subjective accounts of lived experiences. Derived from Greek mythology in which the god Hermes was credited

for transmitting messages between the other gods, a hermeneutic is a way to make something known conveyed through language and text as the common mode of understanding between humans (Evans, 2003; Lopez & Willis, 2004). Unearthing the meaning within texts is a long-standing, multi-disciplinary, academic approach to ascertaining what is not explicitly conveyed in the words of a narrative (Lopez & Willis, 2004). Within phenomenology, textural interpretations of lived experiences become a way to bring to light the meaning of everyday encounters that move beyond mere descriptions of lived experiences and aim for a deeper realization of the meaning those experiences convey; often unknown to the person experiencing them until revealed through the narrative itself (Lopez & Willis, 2004). Textually capturing the words of someone's lived experiences offered a mode for interpreting them and gave rise to the term hermeneutic phenomenology, where understanding is mediated through text and iterative interpretation.

### **Writing the Phenomenological Narrative**

Contemporary phenomenological scholar, Max Van Manen, embraces the narrative essence of interpretive (hermeneutic) phenomenological writing and posits that "creating a phenomenological text is the object of the research process" (1990, p. 11) conveyed in the writing of the lived experiences. While Van Manen expounds on traditionalist phenomenology, he leans towards Heidegger and the illumination that interpretative methodology affords. In addition to using Heidegger's approach for this research, I also used Van Manen's method of phenomenological writing as he more clearly explicates how to attend to phenomenological writing than Heidegger. Textual renderings of participant's stories evoke life in participant's narratives. It is in the writing that meaning unfolds-much like language, the words fill a void of blank space and

generate something new to be questioned by the inquirer. What does this text mean? What is being said here? What emotion layers the lines of this narrative? What is it like to be this person? I asked these questions again and again to delve more deeply into the text of other's experiences and support the iterative process of interpretive phenomenology as a way for the researcher and the reader to maintain a dialogue with the participant's lived experiences. Interpretive phenomenology does not draw a close, but, instead, provides a way to continuously seek to disclose and re-discover what it is to be human, and this is made clear through vocative texts that bring life to the stories being told by the participants (Van Manen, 2014).

## **Methods**

**Study sample.** Phenomenological studies call for small sample sizes, owing to the richness of the data that can be obtained using their methods (Morse, 2000). The sampling strategy for this study was purposive and allowed me to purposefully select nurse participants who had made a CO to gain an in-depth understanding of this experience (Morse, 2000). Eight nurses who had made a CO in professional practice made up the study sample. Eligibility criteria for participation, in this study, included ability to speak English, employment as a registered nurse in a health care setting within Ontario and having personally lived through an experience of CO in clinical practice. All care settings were included in this study since the aim was to explore the lived experiences of nurses at large with the phenomenon of CO, not nurses specific to an area of clinical care. Nurses who did not live in Ontario and who had not personally lived through an experience of making a CO were excluded.

## **Recruitment Strategies**

For recruitment, I used traditional methods such as flyers that contained

information describing the study, what it would involve as a participant and how to contact me (Appendix A). Given the wide range of practice areas to draw from without a pre-understanding of where COs could arise, I dispersed these flyers throughout cities across the province and in a variety of community settings to reach a versatile nursing population. To do this, I first called and/or emailed site overseers at community sites across the province consisting of doctor's offices, churches, community centers, ethics centers, various hospitals and all the schools of nursing in Ontario. Once I had obtained approval from site overseers, such as clinic managers, church pastors, directors at ethics centers and schools of nursing, I either went in person to deliver the flyers to be posted to the site overseers or emailed them to site overseers to post them for me, when they were too far away for me to do so in person. For example, if I had to drive more than an hour to a community site to post a flyer I would ask site overseers to do so for me. Since most of the hospitals I contacted required me to go through their Ethics boards for site approval, I elected not to post flyers in hospitals due to the extensive time constraints and in some cases, cost to do so, with the exception of the General Hospital in Guelph. To obtain approval from the Ethics Board at this hospital, I sent them a copy of the ethics application and the Health Research Ethics Review Board approval (Appendix B) that I already obtained from Western University to conduct this research. These documents were reviewed by the ethics committee at Guelph General Hospital and the committee approved the posting of my flyers in their hospital, which one of their nursing directors did for me given my geographical distance from their facility.

To additionally offset the geographical expanse that I was recruiting from, I also used a social media strategy consisting of a recruitment website (Appendix C).

Containing a personal information video clip of myself, the website also consisted of

written information and a confidential emailing system that facilitated potential participants' private correspondence with me to my school email address. Subsequently, a link to this website was circulated to other website domain users for organizations and groups to post on their websites, that would have nurses perusing them. The organizations and groups that I contacted through email or phone to post a link to my website on their respective websites were: all the nursing interest groups in the Registered Nurses Association of Ontario; College of Nurses of Ontario; Nurse Practitioner Association of Ontario; Nurses for Conscience and Nurses for Life since they all had nurses perusing them and some of them specifically had nurse members who were interested in ethical issues related to conscience and pro-life issues, which have been listed in the literature as reasons for nurses to make a CO in professional practice (Harries et al., 2014).

Once the domain overseers of these organizations and groups agreed to do so, they placed a link to my website on their websites and/or Facebook pages. Using a social media strategy enabled: 1) rapid dissemination of information through a highly trafficked social media forum to advertise and recruit participants, 2) anonymity to participants who can access this information from personal as well as public media devices, 3) access to nurses across a wide, geographical area, 4) quickly reach nurses from a variety of clinical areas and across a distance and 5) low, financial cost to myself as the researcher (Child, Mentis, Pavlish & Phillips, 2014). A YouTube video mechanism was embedded within the website to play a short video message in which I briefly described myself, the study and how nurses could become involved in the research. This video was created to generate a familiarity with potential participants who may be hard to reach, owing to the sensitive nature of their experiences and I used it to facilitate an immediate, transparent

connection with viewers (Hammond & Cooper, 2011 as cited in Child et al., 2014; Sadler, Lee, Lim, & Fullerton, 2010).

Recruitment was challenging and often slow paced and there were lengthy periods of time where I did not hear from respondents. To address this, I would, on a daily to weekly basis, either email or telephone these community sites to inquire about posting flyers at their facilities or a link to my website on their online domains. At times, I would go in person to these sites as well and cities or towns that I visited in person were Ottawa, Toronto, London, West Lorne and Barry's Bay.

### **Data Collection**

There were eight nurse participants in this study. Out of the eight, there were seven female nurses, one male and their years of practice experience ranged from less than five to over 45 years (Table 1). Areas of clinical expertise varied and were comprised of nurses working in acute, palliative, mental health and community care settings. Participants consisted of front line staff, leaders, academics and all but one had some level of ethics education that was acquired through either: 1) nursing programs or 2) alternate courses that were not acquired through formative nursing programs. None of the participants had received formative nursing education on the concepts of conscience or conscientious objection. The following table illustrates data outlining the participant's work experiences, ethics education and areas of clinical practice.

The main data collection strategy was semi-structured interviews which were conducted in a conversational style in keeping with a phenomenological approach to obtain rich, in-depth information from the informants. Two interviews were held with each participant and informed consent was obtained prior to conducting the first

Table 1

*Participant Demographics*

| <b>Name of Participant</b> | <b>Level of Nursing Education</b> | <b>Ethics Education in Nursing Yes/No (separate course or integrated with other courses)</b> | <b>Alternate Ethics Education Yes/No</b>               | <b>Area of Nursing Practice</b>        | <b>Years of Nursing Experience</b> |
|----------------------------|-----------------------------------|--|--|--|------------------------------------|
| <b>Annie</b>               | BScN                              | Yes  | No   | Critical Care                          | 5-10                               |
| <b>Tracey</b>              | Masters                           | No   | Yes  | Mental Health                          | >40                                |
| <b>Beth</b>                | Diploma                           | No   | No   | Homecare Manager                       | 20-30                              |
| <b>Robert</b>              | PhD                               | Yes (all three degrees)  | No   | Palliative Care/CNS/<br>Nurse Educator | 30-40                              |
| <b>Kate</b>                | BScN                              | Yes  | Yes: Ethics/<br>Philosophy<br>Elective in<br>undergrad | Oncology                               | <5                                 |
| <b>Nancy</b>               | Diploma                           | Yes  | Yes: one day<br>ethics<br>conference                   | Palliative Care                        | 30-40                              |
| <b>Amy</b>                 | Masters/<br>NP                    | Yes  | No   | Palliative/<br>Community Care          | 10-20                              |
| <b>Ruth</b>                | Diploma                           | Yes<br>(integrated<br>with other<br>courses)   | No   | Acute medicine                         | 30-40                              |

interview. Almost all the interviews were held over the telephone. I read the letter of information and consent as well as the demographic questionnaire aloud over the telephone to nurse informants participating at a distance and obtained their verbal consent (Appendices D & E). For nurses that I met face to face, I provided them with a copy of the consent which they signed themselves; all nurses were given a copy of the letter of information and consent form at their request. All interviews were audio recorded with



the participants' permission and initial interviews lasted approximately an hour to an hour and a half in length to accommodate easing into in-depth conversation (Van Manen, 2014). To facilitate open dialogue, I began the first interview by asking a neutral question: what made you want to go into your area of clinical practice? I also used a semi-structured interview guide to stay focused on the experience in question (Appendix F). New lines of inquiry developed out of the initial interviews and were utilized to further inform the research as I moved from conducting interviews to data analysis (Converse, 2012; Van Manen, 2014). Second interviews were used to member-check participant's interpretations by sharing summaries and emerging themes with participants to ensure that the interpretations held true for them (Koch & Harrington, 1998). The second interviews lasted from fifteen to forty-five minutes in length.

Throughout data collection I used a reflective journal to situate myself in the research process and to maintain my pre-reflective stance in the research (Koch & Harrington, 1998). In the reflective journal, I wrote out my thoughts and beliefs as I listened to the participants' stories since my own beliefs and values could influence my interpretations. This strategy helped me to not influence the participants' stories with my own assumptions but instead, to be aware of them throughout the research process to stay true to the participants' experiences.

I also used field notes to make notes during and immediately following interviews with participants. Notes were written to "illustrate the whole picture" (Mulhall, 2003, p. 307) since what is not verbally expressed in the participant's narrative was significant as well, and I captured these non-verbal expressions through my observations (Mulhall, 2003). The field notes were used to record these observations. Observations were made of participant's facial expressions, body language, silence, emotions conveyed through

tone, voice, eyes and body movement that all bring supportive depth to the narrative for analyses. Between these two methods I was able to maintain an awareness of my own biases since I could not bracket them out, while simultaneously ensuring that I was staying true to what the participants were telling me (Koch, 1999).

At each first interview, I shared with the participants that I had counselling information for them if they felt they needed to talk to somebody about their experiences or if they felt emotionally upset. Free counselling was available for each participant through a provincial service called Mental Health Hotline that provided free counselling across Ontario. At both first and second interviews, I asked the participants how they were feeling and whether they wanted this information. All the participants shared they felt fine, emotionally, and declined the counselling service.

Interpretive phenomenology calls for data analysis as soon as data collection starts. As such, after each interview, I listened to the audio recordings and then transcribed them verbatim. I also reviewed entries from my reflective journal used throughout the research process so that I could distinguish what aspects of the interpretations were mine, the participant's and what might lie in between (Koch, 1996; Laverly, 2003). The process of data collection continued until saturation was reached, where further discussion with participants did not elicit a clearer understanding of the lived experience, no new information was forthcoming and I judged the information was sufficient in depth to answer the research question (Laverly, 2003; Sadler et al., 2010).

### **Data Analysis**

Data analysis was conducted for this study with Crist and Tanner's (2003) process for iterative analysis. I chose Crist and Tanner's method of analysis since it clearly lays out Heidegger's Hermeneutic Circle of iterative analysis. I also complemented Crist and

Tanner's analysis with Van Manen's interpretive phenomenological approach given that his technique supports phenomenological writing in more detail than Crist and Tanner's approach and he draws on the combined actions of reading, interpreting and writing of phenomenological texts to make clear the meaning of the lived experiences embedded within them (Heidegger, 2010; Lopez & Willis, 2004; Van Manen, 1990; Van Manen, 2014). For Heidegger, hermeneutics is interpretation and Van Manen reinforces that understanding is taken up in the renderings of textual illustrations and subsequently his scholarship illuminated my phenomenological writing (Heidegger, 2010; Van Manen, 2014).

**Process of analysis.** Crist and Tanner's iterative method of analysis has five phases that one moves through to attend to the circular process of hermeneutic interpretation, where each phase flows from one to the other, continuously building on interpretations that came before. This method of analysis does not end, but instead rests with the readers of the interpretations since interpretive phenomenology is used to inform and not to explain, offering to generate understanding as opposed to a conclusive resolution (Crist & Tanner, 2003). Prior to the first phase of iterative analysis, I read through all the transcripts once while I listened to the audio recordings to ensure completeness and accuracy.

**Phase one.** Interpretive analysis for this phase consisted of reading each interview transcript as a whole to obtain a sense of the overall focus contained within each participant's narrative (Crist & Tanner, 2003). I made initial interpretations by asking myself: what is this person telling me? These initial interpretations of the participant's narrative accounts made in phase one comprised the iterative process of moving from the interview to transcription, then transcription to initial interpretation.

At this time, I also analyzed my interview techniques. For example, I read through the transcripts to see if my questions were leading or if I had missed prompting participants to elicit a more in-depth response from them about their experiences. If I identified areas where I needed to adapt or change how I asked questions or my use of prompts to further explore participants' responses, I wrote notes on the transcript as well as in my field notes to flag these gaps to change my interview techniques or explore participant's responses further in subsequent interviews (Crist & Tanner, 2003).

*Phase two.* This phase moved from my reading the transcripts in their entirety to using selective and detailed reading approaches which involved reading the transcripts line by line, highlighting words and sentence phrases so that I could begin to label these sections (Crist & Tanner, 2003; Van Manen, 2014). I made notes in the text to denote specific words or lines that further uncovered the experiences and phenomena that this analysis explored by asking myself: what meaning do these words, phrases and sentences have related to the phenomena and lived experience in question (Van Manen, 2014)? I wrote summaries of these interpretations to capture the meaning of emerging central concerns and themes and shared them with my doctoral committee for discussion on the interpretations and elicited their feedback for moving forward. Interpreted after first interviews, summaries of emerging themes were also taken to participants at second interviews, to see if they held true to participant's experiences. Iterative analysis unfolded in this phase from the initial interpretations made in phase one, back to the transcript for a closer read of the data, which generated still further interpretations, committee discussion and participant verification on the layers of meaning that surfaced in central concerns and themes.

*Phase three.* In phase three further interpretations connected the meaning shared across participants' narratives of their lived experiences. To facilitate this process, I went back to written summaries to uncover the central concerns that had been interpreted to this point, within and across participants' narratives. I then explored the central concerns emerging in the summaries amongst the participant's narratives and made in-text notations here as well to denote the connections that emerged. My interpretive writing for summaries in phase three reflected the connections between the central concerns that were being uncovered in the data, supported by use of examples in direct quotes from the participants to illustrate and resonate with the exploration of the phenomena and lived experiences in question. Re-written summaries were again brought forward to my committee members to discuss the interpretations that were unfolding to date. Iterative analysis continued from interpretations made in phase two by identifying common threads across the storied experiences.

*Phase four.* Phase four of analysis brought together the interpretive summaries from phase three, and I reviewed them with interpretive summaries taken from the second interviews given that some interviews finished before others (Crist & Tanner, 2003). I brought all the summarized data together at that time for a culminating analysis of final interview summaries for further interpretation, allowing for continued, iterative analysis of the data to uncover any additional meanings that emerged across and throughout the participant's succeeding narratives of their lived experiences. My research committee was again consulted to dialogue on the development of the final interpretations emerging from this phase.

*Phase five.* The final phase of analysis entailed preparing the findings for dissemination via publication to offer further analysis to a readership audience. The

rationale for this is that interpretation (being iterative) does not end, but is ongoing, and therefore those that take up the research findings are the last to interpret it (Crist & Tanner, 2003).

### **Attending to Rigor**

In order for research to be vigorous, authentic and scientific, it needs to be rigorous. To attend to the notion of rigor, I used Koch's guidelines which arise from Lincoln and Guba's (1986) foundational criteria for rigor in qualitative research, which Koch then applies specifically to the context of phenomenological, nursing research encompassed in the term trustworthiness. While Koch uses some of the same criteria as Lincoln and Guba, I elected to use Koch's (2006) criteria specifically because of the hermeneutic focus that Koch uses to attend to phenomenological research. Koch adheres to Lincoln and Guba's (1986) guidelines for trustworthiness through attending to credibility, transferability and dependability but does not use all the elements Lincoln and Guba encompassed within each term, given the subjective variability in phenomenological inquiry. Koch also includes reflexivity in her criteria for trustworthiness (Koch & Harrington, 1998).

Koch's point of departure from Guba and Lincoln is based on the subjective nature of hermeneutic phenomenology, in which Koch (1996) asserts that researchers using hermeneutic phenomenological approaches need to set their respective criteria for trustworthiness with each study due to the subjective nature of such studies and since the methodologies within phenomenology vary greatly as well. This is due to the fact that in hermeneutic phenomenological inquiry, the dialogue that occurs between researcher and text arising from the participant's self-interpretations will never be the same from one researcher's perspectives to the next, nor from one reader's interpretations of the research

text to another (Koch, 2006). As such, there is no possibility of complete agreement and exact replicability of the research process given the unique perspectives of each researcher involved in hermeneutic phenomenological inquiries; instead, the researcher aims to give an account for how they arrived at their interpretations, in such a way that a reader can make sense of it (Koch, 2006).

Koch's guidelines for rigor, or trustworthiness, consist of: credibility, dependability, transferability and reflexivity. Credibility serves to enhance rigor by sharing the process of the research as described and conducted by the researcher (Koch, 2006). Being aware of myself, as researcher, is essential to being credible. To do this, I kept a reflective journal in which I wrote about the research process: my thoughts, feelings, struggles, wonderings, and discoveries from proposal writing to recruitment, interviewing, and analysis. This reflection kept track of my openness to the meanings that I uncovered in the research and additionally allowed me to be transparent about the process, where I could go back to my journal and appraise where I was located by looking at where I started. I also made note of whether I was maintaining an integration of methodology, method and participants (myself as researcher and nurse informants) throughout the study by reflecting on how my former understanding impacted the research process and dialectic interpretations (de Witt & Ploeg, 2006; Koch & Harrington, 1998). I also attended to being credible by using member checking.

To member check I took summaries of the emerging themes from phase two of interpretive analysis to participants invited to second interviews to ask them if my interpretations were holding true for them (Koch & Harrington, 1998). I also shared summaries of narratives and themes to my doctoral committee to see whether, as readers of the analysis, they intuitively grasped the meaning of an experience that they may not

have had, but resonated with them through connecting to the text of another's lived experience (Lincoln & Guba, 1986). The use of member checking has been debated in the literature, with some scholars positing that there are ethical as well feasibility issues with it, noting that attending to subjective interpretations as they organically arise is more essential than trying to establish an objectively true narrative and that at times, it is simply not possible to follow up with participants whose narrative may change owing to the time lapse between collecting the data and verifying it with them (Koch, & Harrington, 1998; Sandelowski, 1993). However, in an effort to stay true to what the participants shared as their lived experiences, I valued their continued interpretations of their stories and opted to use member-checking as a method of rigor in this research.

Prolonged engagement is another criterion for establishing credibility and involves taking the time necessary to sufficiently attend to becoming aware of distortions of self or informants through extensive contact with the participants and participation in the research process (Lincoln & Guba, 1986). To do this I used in-depth, semi-structured interview techniques to engage in deep conversations with participants about their lived experiences and to establish rapport and trust between myself and the participants. Extensive time was given to immerse myself in the data with detailed attention paid to transcribing and analyzing the transcripts and summaries and to layering the research process in depth with supplementary data from field notes.

I established dependability through an audit or decision trail. To facilitate a decision trail, I clearly outlined the purpose of the research, choice of philosophical methodology and methods for the research study and clearly denoting every step of the research process before, during and after conducting it as outlined in the detailed writing up of the study (Koch, 1996). Studies are found to be dependable when a reader or



another researcher could clearly understand the decision-making process in my research by ‘auditing’ or looking at how I conducted it and either understand or replicating my research process themselves, coming to similar, but not the same or contradictory conclusions, if they followed my process of decision making outlined in the writing up of my research process (Koch, 2006). My decisions throughout the research process were documented in a journal and I referred to the notes in the journal to adhere to this criterion for rigor as I went through the research process and writing up the study.

Transferability speaks to a study being read and appreciated by readers who may or may not have lived a similar experience, but are nevertheless able to resonate with the interpretations that are made. Essentially, this criterion for rigor consists of a study fitting with other’s understanding of it (Koch, 2006). I attended to transferability by ensuring that the research findings were written in such a way that readers could recognize that the experiences have an everyday contextualization in the lives of those who are experiencing them. Specifically, I wrote out thick or rich descriptions of nurses’ storied experiences that included relevant quotes so that readers could recognize or resonate with them, even if they had never encountered the phenomenon of CO themselves (Koch & Harrington, 1998; Lincoln & Guba, 1986).

Reflexivity refers to a researcher making clear what their stance and role was within the research process, so as not to overshadow or misinterpret the participant’s interpretations (Koch, 1996). Essentially, the researcher has to stay true to what the participant’s interpretation of their lived experiences are, without making assumptions that would attempt to define it in an objective way. However, the researcher is also part of the research process, and attending to reflexivity allowed me to maintain my own pre-understandings of the phenomena and interpretations, since neither I or the participants

can bracket out our pre-conceptions when co-constructing the data together. Rather, I maintained a reflexive stance by staying true to the participant's interpretations without interjecting my own, but realizing that as a researcher, I was still making interpretations of other's interpretations. I attended to this criterion for rigor by using my reflexive journal to document my thoughts, impressions, feelings and ideas that emerged throughout data collection and analysis to continuously assess whether I was maintaining a balance between the participant's voices and my own in the research process (Koch, 1996).

Trustworthiness, according to Koch, is an encompassing criterion for rigor in a study that enables the reader to audit trail the events of the research, guided by "theoretical, philosophical and methodological" (1996, p. 178) underpinnings that can support and explicate the rationale, analysis and findings of the research process as I have outlined in all the steps of this research study from defining my research question, choosing an appropriate research methodology, attending to its corresponding methods, and staying true to ethics for research on human subjects. By attending to Koch's criteria for trustworthiness consisting of credibility, dependability, transferability and reflexivity I aimed to comprehensively fulfill Koch's guidelines for rigor in the study.

### **Ethical Considerations**

Ethics approval was obtained through the Health Research Ethics Review at Western University. Letters of information were given to every participant and informed consent obtained prior to conducting interviews. Each participant was made aware of any potential risks to participating in the study. The risk declared with this study was that participants may become emotional or upset when relaying experiences related to conscientious objection. To address this risk, I asked participants how they were feeling

after the interviews, and advised them to have a friend or loved one available that they could talk to should the need arise. Additionally, each participant was informed of free counselling resources knowledgeable about the stressful experiences of HCPs to assist them, if they desired. I also told participants that I was conducting this study with the intent of sharing the findings through publication and doctoral defense and was clear that this research did not provide an answer to their current experiences, but, rather, was being conducted to understand their lived experience.

Participants were informed that they could withdraw at any time without consequences; however, I shared with them that while any information they gave me before data analysis could be withdrawn, any information after data analysis could no longer be removed, as it would be part of pooled data. I also informed them that the data would be used for my doctoral dissertation and potential publications although their information and all the collected data would be kept confidential and destroyed in keeping with ethics regulations as outlined below. Participants did not have to answer any questions that they did not want to. All participants were informed that every effort would be made to ensure that their confidentiality and privacy would be maintained throughout the course of the research process. I respected participant's privacy and confidentiality by using pseudonyms for the participants in the findings.

All the collected data was stored in a safe, locked location: a safe at home in which I kept the audio-recorder, letters of consent, reflective journal, field notes and demographic questionnaires. I was only person to have access to this lockbox. Transcript summaries were shared with my doctoral supervisors and committee members online prior to our meetings for the purpose of analysis and in keeping with the guidelines for rigor for this study. Emails including the transcripts were encrypted and passwords to

access the files were sent to my supervisors and committee members in keeping with standards for privacy and security as laid out by Western University. I analyzed the data on a password secure computer, and will destroy all the data five years after the study is concluded in keeping with Ethics Standards on the storage and destruction of research data.

### **Summary**

Phenomenology is an open-ended lens through which to explore, appreciate and illustrate the experiences nurses may have in voicing a conscientious objection. Offering a pathway through questioning, iteratively analysing and writing the textual components of the research process as composed by Heidegger and supported through Crist and Tanner as well as Van Manen, my choice to use interpretive phenomenology supported my research question. This question marked the pursuit of an in-depth understanding about the meaning nurses make of their lived experiences with conscientious objection. Alethia, or unveiling the truth of these lived experiences and appreciating that conscience is a particularly human intentionality in this world are presented in Heideggerian phenomenology, and framed the phenomena that I explored within this research study. Such an unveiling can awaken the reader through what Van Manen (2014) describes as vocative text which bring to life the meanings derived from the narratives as contained within and obtained from, the collected data. Meaning emerges through one's lived experiences as relayed in the next chapter which will explicate the participants' stories of their lived experiences with making a conscientious objection.

## CHAPTER FIVE

### Nurses Lived Experiences of Conscientious Objection

*“We shall not cease from exploration  
And the end of all our exploring  
Will be to arrive where we started  
And know the place for the first time”*

*T.S. Eliot, Four Quartets*

Lived experiences inform one about the meaning of their life, relayed through the telling of the stories that describe how they lived. To explore one’s life is to continuously engage in a search for meaning, and speaks to a constant re-discovery of what that something is, or a return to the “thing itself”, (Koch, 1999, p.30), by seeing a phenomenon fresh with new insights each time. In understanding one’s lived experiences, nothing is taken for granted or categorized, but is instead discovered in the meaning one finds in such experiences (Van Manen, 1990).

In this chapter the narratives of the nurse participants’ lived experiences of making a CO are presented. This chapter also highlights the main aspects that these nurse participants found meaningful in their lived experience of voicing a conscientious objection. As I listened to the nurse participants it became clear that they shared a desire in common: to engage in a discussion and an opportunity to express situations that they felt compelled to share. For some, talking about their stories was painful as they brought up difficult and emotionally charged scenarios; others had deliberately taken some time between seeing my recruitment information before initially contacting me, owing to a sense of hesitation about experiences that they felt vulnerable about sharing with me. Some participants revealed experiences that they had kept hidden from others for decades. Others relayed situations that had happened more recently. Memories of these situations were emotional for some of the nurses; for others, they were more matter of

fact accounts of how they addressed ethical issues in their nursing practice. For all, the lived experience of CO was contextualized in a concern for their patients, a deep regard for being morally integrated as people and professionals and a commitment to being ethical. Regardless of time or context, I endeavored to attend to all participants with respect as I listened to their personal experiences.

### **Participant's Stories**

In this section I am providing an overview of each participants' storied experience of making a CO in professional practice. For every participant, I created a pseudonym and chose a quote from their narrative that I found meaningful, to capture their individual experience as part of the collective narrative of what it is like to be a nurse voicing a conscientious objection. In the next chapter I will share in more detail how the emerging themes represent the meaning of their lived experiences across their storied accounts.

### **Ruth**

*"It goes on deaf ears. That's your problem, basically".*

### **On your own**

Working a night shift Ruth recalled being confronted with a situation involving the attempted hurried death of a patient. As a staff nurse with over three decades of professional experience, Ruth related the evening had started out well; just another shift on an acute care medicine ward that was also home to palliative care off-service patients. Before long however, a junior nurse came over to Ruth, voicing concern over requests being made by an adult child of one of her dying patient's and the medication orders that were prescribed for that patient for nursing staff to follow. Immediately, Ruth recalled sensing that something was wrong. The medication dosages and frequency that were ordered by the physician, as well as the verbal requests from the family, seemed

aggressive and out of place for a patient who was already comfortable, albeit at the end of life. Ruth remembers the young nurse saying to her, “*the patient is so comfortable and his respirations are nine per minute, so if I give anything now, I’m going to kill him*”.

Reflecting on that moment, Ruth remembered sensing the situation was out of place, that it “*seem[ed] like a hurried death...regime that they’re producing, we both kind of thought that right away*”, meaning that the dose and frequency of the ordered medication and as requested by the family, would certainly have killed the patient. As Ruth described, the term ‘hurried death’ was something that struck her in the moment as words to describe how she was perceiving the orders, and not something that was a common term or colloquialism used on the floor amongst herself and her colleagues.

In discussion, the two nurses resolved that administering the medication as prescribed and requested would not be ethical or clinically appropriate; broaching the rationale with the patient’s family since the patient was unconscious, Ruth’s impression of the situation was that it seemed to have been resolved: the family agreed to longer intervals between doses, eliminating the risk of death as a direct result and realigning the pharmaceutical regime with comfort care measures. This meant that pain medication was still being administered by the nursing staff, but at clinically appropriate intervals. However, when covering for her colleague on break, Ruth was approached by the family to administer the medication in the same aggressive manner as before. At that point, “*shocked*” at what the family was asking her, Ruth questioned the nature of their request, “*are you trying to hurry things along here?!*” Subsequently, Ruth was reported by angry family members to her nursing manager for not complying with their requests. Ruth recalled that while she wishes she had not used that choice of words, she was “*alarmed*” at the request because it seemed to be a form of euthanasia which went against her

conscience. For Ruth, conscience was meaningful as something that is naturally occurring, for everyone, and tells each person what is right or wrong. Conscientious objection to Ruth was objecting to something that goes against one's conscience and for Ruth, helping to kill someone meant going against her conscience.

Ruth's encounter with a hurried death scenario substantiated an ethical problem, prompting her to approach her nursing manager to discuss the issue and voice her CO to being involved in a hurried death, which had ethical and potential legal ramifications for her nursing practice. Ruth related to her manager that she would not participate in a hurried death, much as she had voiced to the same manager a month prior that she would not, for conscientious reasons, participate in euthanasia, which had recently been legalized in Canada under the Medical Assistance in Dying (MAID) legislation.

On both occasions where Ruth made her objections known to her manager, her manager reassured Ruth that she did not have to be involved in euthanasia or a hurried death, but she questioned Ruth's assessment of the hurried death situation, brushing it off at first, saying "*oh no, it wasn't*". However, when the manager explored the issue further by looking up the order history and medication records, she said of the physician's orders, "*well, that's what they kind of almost use for euthanasia*". Assuring Ruth that she had done the right thing to not comply with the orders as it could have constituted a criminal act, the manager's attempts at supporting Ruth continued with her discussing the hurried death situation with a staff physician. When the manager asked the doctor what Ruth could do in the future should the same incident occur, the physician merely said to call the physician on call if Ruth was not comfortable with the medication orders. Ruth responded:



I said I cannot participate in hurried death. Um, but the problem is, if I don't know the plan and I'm on night shift and the family want it, what am I supposed to do? And she [the manager] said, 'well you're supposed to call the doctor on call', but if I call the doctor on call says I have to do it anyway, I'm on night shift I have nothing to go by, I have no support!

Subsequently, Ruth remained anxious and her experience with making a CO is one of uncertainty and futility given that no concrete plan of action to support Ruth, other nurses potentially facing the same scenario, or to report the hurried death attempt by the physicians resulted from this situation. Considering how this type of scenario could reoccur, Ruth suggested to her manager that the manager, *"should get something together to protect freedom of conscience with, especially young nurses who get intimidated easily. I'm a lot older so I can at least address it, but a young nurse is intimidated and they may not"*.

Ruth shared that her manager absently responded to her, agreeing with her back turned to Ruth and walking away from her. No actions have been taken since to further support Ruth regarding her CO to euthanasia or a hurried death scenario. Ruth related that she is conflicted at being left without more support despite voicing her conscientious concerns on two, separate occasions to her nursing manager. Ruth's empathy towards her dying patients creates further tension for her; anticipating being faced with a similar hurried death scenario, she shared that she finds it hard to face families, who, while aggressive, are also upset about their loved one's suffering, which is her role as a nurse to help alleviate:

I guess we would just have to be, to deal with the wrath of the family I guess...and of course...that's another thing, you feel guilty at the same time

because their [loved one] is dying! So... you're caught in the middle because... they're upset because [they're] dying, but then they want something from me that I can't give.

Ruth's limits over being involved in euthanasia arise from her personal, moral perspective that life is sacred from beginning to end and her involvement in intentionally bringing about the death of someone would violate her moral convictions. She is cognizant of the struggle that poses for her as a nurse where assisting someone to die is now legal in her country. This tension is meaningful to Ruth who feels her moral limitations tested by a request for an intervention that she cannot in her conscience comply with. Yet, she is comforted by a sense of knowing that she is right in abiding by her moral beliefs. Ruth shared that for the most part she is confident about making her COs known and standing up for herself. Yet, as time goes by, outside of her nursing shifts, Ruth expressed that she will become anxious when she's been off the floor for a few days, wondering if she will go back to another potential hurried death scenario that she would have to again face on her own. Ruth is even reconciled to being fired if necessary to resolve her potential ethical conflict, as she relates that she has fears of this situation recurring, owing to her lack of support in her workplace:

If I run into this kind of situation again. A hurried death, with no clear plan...then, um, I'm kind of like being thrown into the lion's den. It's kind of like that deer in the headlights situation again and I don't know.

Hopefully not, hopefully when they assign [me] patients they kind of take into consideration. They know my view on it, maybe they'll be fine about it, maybe they will try not to assign me. Although, I didn't get that person in

the first place, but then the problem is, is when the nurse goes for break, then I'm there. That's the only thing.

Ruth's experience of making a CO has been isolating, uncertain and reveals a sense of futility. Subsequently, she is not sure what the future holds for her as a nurse, even though she concretely made her COs known to euthanasia and a hurried death. Yet, her requests for support for herself and for other nurses who might find themselves in a similar scenario, have gone unheard. Since her attempts to seek support have remained unsuccessful, Ruth lives day-to-day as a nurse reconciled to being fired or anticipating having to fight for herself and for her patients in not complying with unethical and illegal, hurried death situations.

### **Amy**

*"It was a huge moment....really watershed, where I went, wow"!*

### **A revelation**

Amy spoke about conscience and identifying as a conscientious objector as "*big moments*" in her nursing life. As a nurse practitioner, Amy was first drawn to her area of practice in community and palliative care through her lived experiences of personal loss, where she encountered home nurses visiting her dying family members and was inspired by the quality care they provided to her family. Entering nursing in her midlife, Amy shared her reason for choosing her clinical area of practice arose from her personal connection to seeing first-hand how nurses in the community worked, "*It was because I saw good home care nursing. And as the idea to become a nurse developed, I thought that that was the best place for me to practice*".

Once practicing, ethical dimensions of care became a relevant part of Amy's practice. Yet, despite Amy's conscientious efforts to attend to her patient needs, there

were limits to how Amy perceived she could professionally contribute to aspects of care that she was in personal, ethical tension with. Specifically, she noted that there were some things that she cannot do professionally because of personal convictions. This difference between personal conviction and professional capacity became clearer to Amy through a moment of epiphany over Medical Assistance in Dying. Following the pre-legislated and final documents outlining the procedure for HCPs, Amy was surprised to find that Nurse Practitioners were drafted into the final legislation for MAID to provide the assisted death to patients. This made her uneasy:

When the final draft came out, the wording actually said physicians and nurse practitioners...it was just when I saw that, identifying as a nurse practitioner and that um, legislation, it was a huge moment. It was just like really watershed, where I went, wow!

This moment for Amy was surreal. In contrast to how she would normally positively perceive an opportunity for Nurse Practitioners to advance their scope of practice, staring at the words of the legislative documentation shook her:

When I was reading that, and it occurred to me, I was- it was a weird moment! Honestly, 'cause, I actually thought to myself, geez, it was a huge eye opener that I had to account for my actions...You know? Not that I don't, in nursing, but it was almost like, well...on the conscientious objector level, I thought... I might have to stand in front of St. Peter and say, and account for this! And that's when I went, wow! I can't actually kill someone!

Reading the documentation on MAID crystalized for Amy that assisting a patient to die would be crossing a moral line for her and she could not in conscience cross it,

*“there’s my line, I can’t, I don’t think I can actually do that”*. For Amy, there is an afterlife that includes a final judgement and she realized that she would have to account assisting someone to die to a higher authority. This clarity lead her to respond to MAID as a conscientious objector.

The experience of identifying as a conscientious objector was a revelation to Amy that she was accountable for her actions as a nurse to someone outside of herself. That there were moral implications for her actions as a nurse. This epiphany prompted discussions with a colleague and further, personal dialogue over how she would address this issue in more minute detail:

Well, then you have to look at the other things involved... well, obviously, we don’t have the prescribing parameters yet, so I can’t prescribe and I think, ok, well I’m not... I haven’t been offered to be in that situation but I’ve decided in advance that I would decline to be the person giving the lethal doses of anything. Or, do I decide, am I comfortable, you know, giving people information about it?

While her decision to be a conscientious objector to MAID came as a momentous realization for Amy, she expressed that for a while her conscience had been *“bubbling up”* over the concept of MAID and for her, this constituted *“the feeling that I couldn’t actively help someone kill themselves”* because *“of my own conscience”*. For a while, Amy had stayed on the periphery of the issue of Medical Assistance in Dying. She had witnessed a close friend follow through with assisted suicide a year ago in another country and had spoken to patients about it as the legislation was emerging. Additionally, Amy found support in her own workplace through the transparency of her management team who had reassured staff that take a conscientious objector stance to MAID for their

client population would be upheld. Yet, it wasn't until Amy came face to face about the implications this action would have for her, as a person, and she spent time deliberating to what extent she felt she could be ethically involved in providing MAID to her patients.

Of her experience to decide to be a conscientious objector Amy noted that *“it affected me positively because it certainly makes me analyze my practice and my thoughts and feelings and beliefs, so it hasn't necessarily been a bad thing, to encourage more reflection”*. Amy's confidence is also attributed to the perceived support she can expect from her managers, noting that her decisive experience with CO *“hasn't bothered me emotionally because I know that I would be supported if it [objecting to MAID], came up”*.

Amy considers conscience meaningfully as something that can be, but is not necessarily, influenced by religion and followed beyond professional obligations. This belief prompted her decision to be a conscientious objector, since conscience, for her, *“is the way you practice your life...not just your nursing practice, but practicing your life and more specifically your nursing practice....the inner feelings that guide your proper actions”* and *“conscientious objection is refusing to participate in an activity that is against your own conscience”* since for her, she has realized that *“I'm legally allowed to do this but I don't feel personally that I'm morally allowed to do this”*.

For Amy, the experience of being a conscientious objector is one of personal conviction and being supported, but it is also one of uncertainty. She has yet to face making her objection to MAID arising from a patient request known to her management, but Amy's revelation has convinced her that being a conscientious objector is now part of who she is. Following through on making a conscientious objection to MAID will now be how she indefinitely lives out that experience in her nursing practice since voicing a CO

will not be a single option in time for her to utilize, but rather, an ongoing aspect of her life as a nurse practitioner.

### **Nancy**

*“You have to be comfortable with the outcome”.*

### **Personal conviction**

Caring for palliative patients is a professional practice area that Nancy is passionate about and finds fulfillment in. Having worked as a registered nurse for over half her life, Nancy shares that her experience of voicing a CO is one of conviction that arose over time and deliberation, *“I spent a lot of time thinking about it and sort of saying, well, if I have to do it, can I? What can I accept, what can I live with”?* When it comes to her decision to voice a CO to her nursing leadership in her clinical practice, Nancy shared that making that kind of objection meant she has weighed out both sides of the issue concerned and has arrived at a place of comfort with her decision and then following through on it as well:

I’ve thought about it, I’ve weighed all sides and I have to go with how I feel about it and what my beliefs are, you know, right or wrong...and after deciding that I’m consciously objecting to something I’m not just saying, oh, no, I don’t feel like doing that, no, consciously I’ve thought about it and it’s something I have to be comfortable with. And, be comfortable, you know, objecting to, if that’s the way it goes.

Nancy’s decision to make a CO also occurred after the legalization of Medical Assistance in Dying. For her, the now legal process of assisting a patient to die was an ethical dilemma. Supporting palliative patients with pain control and clinical interventions to facilitate a peaceful but natural death experience was how Nancy

perceived her role as a nurse with patients requiring palliative interventions. Being directly involved in bringing about a patient's death was not an ethical option for Nancy:

I understand why people would want it [MAID], people that are suffering, I really understand why they would want to do that, but, I just don't think it's right [since] the doctor who performs it [MAID] is murdering them...and people often say, well, isn't that what you guys do in hospice?

Nancy struggled with the disparity between how palliative and hospice care is perceived in contradiction to how it is provided, because the purpose of palliative care is to ensure patient's do not suffer. Yet, the contradiction she finds surfacing with euthanasia, or MAID, is that it's taken for granted that palliative care is aimed at intentionally killing patients already. When, in fact, the goal is to support patient's and alleviate their suffering over time and up to a natural death. Ending someone's life is drastically different to Nancy than caring for patients requiring palliation at the end of life, *"this is suicide, this is murder, how can you do this? That's against what my role is"*.

Her experience of coming to the decision of making a CO was something that Nancy found hard, *"I really, really struggle[d] with that, it was very, very difficult"*. Exacerbating her personal struggle was the dichotomy of reconciling her personal beliefs and professional obligations. As a nurse, Nancy found it important to support her patient's care decisions and to advocate for her patient's needs; with the onset of MAID, however, Nancy's mode of nursing care became a source of inner conflict for her. Speaking to this tension, Nancy related:

I really, really struggled with it because I thought I wasn't being honest, because I could not let [a patient] know my feelings and my beliefs.



Because as a nurse in a professional role, that's not my role; I'm there to support and I found it very difficult.

Complicating her professional struggle further, Nancy shared that she perceived a gap between filling patient's physical and emotional needs and the limitations in medicine wherein providers cannot address every aspect of human suffering:

We're missing, as a medical team, we're missing something...if someone's got physical pain, we can deal with that, give them medication, if they've got nausea, you know, delirium, we've got medication to give, but, how do you deal with something like this when it's emotional? When they don't see the value of the palliative care, when they just mentally, they're so frustrated, they just want to end it and we don't have a medication to deal with that?

Coming to the decision to object was also a spiritual experience for Nancy. Identifying as a Catholic, she was distressed over patient's afterlife if they chose suicide, wondering if they would get to heaven? What was her moral responsibility in being involved with MAID with her patients? She asked herself these questions and turned to her conscience to support her answers, *"everyone's got a conscience...you have to live with your decisions...whether to participate in procedures that maybe you don't agree with"*. Realizing that she could not be conscientiously involved with MAID, Nancy's experience with encountering MAID was an ethical dilemma, one she felt was being put on her, limiting how far she could go as a nurse based on her personal, ethical beliefs:

I think, you know what, there's so many ways to know how to kill yourself, so you know, and maybe its cruel for me to feel this way, but I think it's sorta, you know, putting the responsibility on someone else.

While supported by her nursing management in her decision to object to providing or assisting in any of the patient care for MAID, Nancy relayed that her experience of making a CO was also one of uncertainty. Going forward, she remained unsure how MAID would unfold in her workplace, what support would be provided by her regulating nursing college or how her leadership would maintain their supportive stance, *“my boss was very good, she said, you know, we can’t force you”* but *“I don’t know what the end result will be, I don’t know whether the government will enforce something”* and she hoped that nurses *“would get the support from the college of nurses as well to say, no, this is something that we have to support the nurses as well and...they should have a choice, in some things you should have a choice”*.

Nancy acknowledged that she felt positive about voicing her CO but the ongoing uncertainty as to how long she will be supported in her personal view was unsettling for her professional future. Nancy realized her personal limits to her professional practice regarding Medical Assistance in Dying. Yet, she hoped that it would not result in her having to quit her job or being forced to comply with care that goes beyond the boundaries of her moral convictions.

### **Kate**

*“It’s like a shadow over the work day”*.

### **Conviction and uncertainty**

Kate was practicing as a newly graduate nurse in an acute care oncology setting when MAID become legalized in Canada. Passionate about caring for her patients and addressing ethical issues up front and as soon as they arise, Kate shared that the provision of MAID was not what she signed up for as a registered nurse. While attending corporate orientation for her new staff nursing position, Kate recalled sitting in on an education

session where educators from the palliative care team were relaying how MAID was going to be implemented in their work facility. Hearing this triggered an instant realization for Kate that she needed to address her conscientious decision against assisting patients to die as part of her nursing role:

I will very often say things right away. Instead of hiding what I feel I'm kind of grateful that my natural reaction has always been, oh let's go and clarify the heck out of this! It was the same with this MAID thing. I just kind of went up immediately after their presentation...I was like first in line! I was like, look, it's not that I would ever, ever, ever treat a patient differently, I would never do that, I would never let my personal feelings interfere with the kind of, the caliber of care that I would give somebody. But, I would never be involved in it.

Convinced that assisting someone to die would be an unethical practice to be involved in, Kate reflected on how she came to make that conscious decision, which, for her, was about knowing the difference between what is right and what is wrong, something that her conscience, as an "*inner voice*" told her to do:

When it comes to making certain decisions, is this ok? Is this not ok? Just having kind of a template to go back to...to a certain extent I think all of us have a gut feeling about right or wrong...sometimes I think people rely on their emotions to dictate their conscience as opposed to their reason...to an extent I think emotions can be right...we have a natural attraction to the good and a repulsion from the bad, but there's a point where the lines get blurred and you need to turn to some form of knowledge and reason to determine whether or not that little voice is correct or not.

When Kate shared her CO to the conference leaders outlining the hospital guidelines on MAID, they responded that she needed to further voice her objections to her immediate nursing managers and that it was her “*obligation*” (Kate), as a nurse to ensure that she passed on her patient’s request for MAID to the team, should she disagree with the act. Finding the feedback somewhat frustrating, Kate noted how in that moment there was no clear line of action for her to pursue making her CO known to her manager, since she answered to most of the managers in the facility, given the nature of her float position. Moreover, the manager that Kate could be directly answerable to, was intimidating.

However, despite the onus of responsibility being shifted back onto her, Kate realized that she would not personally be able to assist someone to die through a referral process. She had thought about this ahead of time, having reflected that this form of participation would be even more unacceptable to her than if the direct act of MAID was prescribed for one of her patients. Kate explained that she thought that she might not actually be providing the act of euthanasia, as that would be the physician’s role. However, getting the ball rolling on a patient’s request for MAID meant she would be directly contributing to the act occurring, an action that Kate stated she could not do, offering that it would “*maybe not [be] the same degree of participation but that is participation*”, which, for Kate, was about “*distinguishing those fine lines, of ah, not allowing those fine lines to get blurred*” over what she thought she could morally take part in or would have to object to.

Kate’s nursing practice was motivated by a strong sense of compassion and the desire to help her patient’s “*achieve best level of health they can, both physically, mentally and emotionally and if I’m doing that, that is me doing my job the right way*”.

Offering assistance to her patients to commit suicide was not an option for Kate and if she had a patient request MAID, she noted that:

I wouldn't be like, ok, well, let's set that up for you! I would be like, ok, why are you feeling this way? My first course of action would not be to refer them to the MAID team, my first course of action would be to sit with them and see how can I restore this person's belief in their own dignity? How can I let them unload whatever they need to unload?

Nursing was also about being present with a patient and unravelling the layers of someone's request to die, Kate relayed. She shared that in her care experiences, she was almost always run off her feet due to workload and time constraints, but she noticed what her patients needed on emotional and spiritual levels moved beyond their physical needs. Struck by the loneliness and depression of a patient she had encountered who had requested MAID, Kate was frustrated by the lack of perceived support the medical team offered this patient. Over the course of time that Kate cared for this patient it resonated with Kate just how much pain might have prompted this person to make such a request, which was a "*hopeless*" feeling for Kate:

She was my patient after she went through with the request too, and it was a pretty helpless feeling I gotta say...I've never felt so, yeah, like kind of hopeless! Yeah, like, loving this person and I'm taking care of this person...and in a weird way it kind of made me love her even more because she was so endearing. But I was just like, does she know, does she have any hope? Does she have anything to cling to?

Kate's sadness over her patient's assisted suicide brought her own convictions to the surface. For Kate, her Catholic faith and her belief in God gave her life and her

nursing practice a sense of meaning that went beyond the workload and the suffering she encountered in her clinical setting, *“I do know that when I feel sick of being patient, when I feel absolutely fed up with that call bell....I’m definitely able to use my faith”*. For Kate, her faith allowed her to *“draw those extra drops of compassion and tolerance and patience for whoever I’m with”* because she viewed the *“nurse client relationship is all one way. You’re not getting anything from them, they’re getting everything from you. And if you have nobody to get anything from you’re going to burn out”*.

While her faith is part of what informed her conscience, Kate knew in the moment of encountering her ethical dilemma about MAID, at work, that she had to stand up to what she believed right away. Past experiences as a nursing student had convinced Kate that addressing ethical issues head on was the best way to facilitate awareness and understanding for her beliefs that are not the status quo in nursing. She remembered a nursing teacher calling her out in class for her Catholic beliefs; on seeing Kate’s prolife sticker on her laptop the teacher said to her, *“well it’s not you the Roman Catholic taking care of the patient, it is you the nurse taking care of the patient so you just have to put aside your biases!”* This perceived dichotomy between her personal and professional beliefs prompted Kate to find her teacher after class and convey to her the basis for her position against abortion and her moral limitations, which had nothing to do with disrespecting patients or their choices, *“I need you to understand me”*, Kate had responded to her teacher and feels the same about her stance on MAID; however, after she made her CO known to the educators, Kate sensed that she had *“had hit a roadblock”*.

Although Kate had been told that she had to support herself to make her CO further known, she felt good about the extent to which she had made it known already,

since she felt she had shown due diligence at reconciling her personal beliefs with her professional obligations. Kate's experience of making a CO had been one of conviction, but also as something that hung over her, since she had not been able to find a concrete plan of action over what to do should a patient bring up a request for MAID in her day-to-day nursing practice, *"it's a bit of a shadow on the work day because you never know when something is going to come up"*. This sense of uncertainty for Kate was *"a fear of the unknown...but, there's a bit of peace in it because it's not a stress over, oh, I don't know what to do. Because I know what I'm doing... I've made up my mind"*. Kate's impression of MAID as a conscience issue for herself and for others was that it was an overwhelming one, since the rapid onset of MAID had not been fully settled for nurses and for nurses who object to it. The importance of her patient care amidst this ethical challenge have brought Kate's ethical convictions to the forefront of her early, professional career, but left her uncertain about how to professionally address those convictions in the everyday setting of her nursing practice.

## **Robert**

*"It's like a little alarm ringing"*.

### **Doing the Right Thing**

For Robert, nursing means putting his clients first and ensuring that they are offered the best care, which involved *"doing the right thing"* for his client population. Robert's perception of doing what was right included advocating and offering quality care based on clinical skill and expertise which entailed being comfortable with addressing ethical situations in practice openly, and with frank discussion. Being comfortable with this ability takes time, and experience, as Robert explained, *"over the years, you know, as you gain experience you get a bit more assertive in standing your*

*ground, but it's not easy*". At times, standing up for what is right can take courage that involves addressing issues of ethical concern, and making COs have been a way for Robert to be transparent about what he thinks is right in nursing practice.

Working in front line settings as well as educational and leadership roles, Robert's first experience of making a CO occurred over a conflict with a physician. As Robert explained, he was caring for a client who was critically ill and the client, upon being informed about his prognosis, decided to stop treatment for his condition. The physician attending to this client was adamant that the client continue treatment, to the extent that the physician became threatening towards the client. Perceiving this interaction to be unethical and concerned for his client's well-being and that his wishes be respected, Robert objected to the physician's treatment of his client. Robert's actions involved standing up to the physician to reinforce the client's decision and supporting the client in the presence of the physician, affirming the client's decision and to put a stop to the doctor's threatening behavior:

Finally, I got involved and said to the client, 'tell him [the physician] that you know what you want' ... and I had to challenge the physician because he was still objecting...he was threatening the client, so, that is when I put my foot on the ground ...I gave no choice to the physician but to go into symptom control...this [experience] is the one that challenged me the most, and I was able to stand my ground and from that situation I learned to stand my ground with other issues that come up now.

Recalling that initial experience of making a CO was meaningful to Robert as taking a stand for his client. While the experience had been challenging for him,



personally, he shared that having support at the time from colleagues was reassuring professionally, as it also indicated that he was supported in his clinical setting:

It was quite stressful, because the physicians have ways to intimidate us also, at times, and one thing I kept in mind when I was doing it, I said no, I am a specialist now, I should not put up with this, this is unacceptable; I should stand my ground, this is not right. I was fortunate to have some colleagues working with me that were agreeing with me, so, it gave me a kind of permission to go ahead.

Addressing ethical dilemmas as they occurred made sense to Robert, who did not shy away from confrontation, particularly since he had an extensive background in ethics education, which provided him with the language needed to talk about ethical issues in clinical practice, *“after encountering situations in workplace environments because in theory courses we don’t have much experience, it’s hard to figure out. But by discussing it and using proper facts, proper theory, proper argumentations, you become better at it”*. In addition to ethics education, Robert noted that to be an ethically responsible health care professional it is essential to have the clients on board to ensure the best care is provided to the clients, *“when you have made a decision that is well grounded and the arguments are sound, the client or the resident are agreeing with it one hundred percent, then, we know where we’re going”*.

Adamant that his clients receive the best care, Robert recently made COs again over the legalization of euthanasia through the MAID legislation, because he viewed this option as something that is not in the client’s best interest:

You know, when you’re not giving pain control for persons who have pain, they will suffer. Basic. And that’s why I object to euthanasia right now

because that's the problem. I'm objecting to euthanasia and assisted suicide because of the clinical experience I have...with people who are terminally ill...what about considering pain control, symptom control, doing it right?

To make his COs known to MAID, Robert engaged in widespread inter-disciplinary dialogue through academic conferences where he spoke on the issue to HCPs, the public, and to colleagues when MAID arose in practice. Robert also shared that he viewed his participation in this study as another way to make his CO known. Being in a leadership role, Robert is the authority he registered his objections to. However, discussing his perspective on euthanasia has not always been easy. He related that people "*fall off their chairs*" in conferences when he expressed an alternative view to euthanasia, grounded in clinical expertise. Often Robert is greeted by anti-religious comments, where others try to dismiss his perspective as religious or specifically, Catholic:

I think it's a danger word right now to be associating it [CO] with religion. Because when they neutralize us with the label of 'religion' they say you should not work there, go elsewhere. But the problem is the same, quality care, when it's not up to standard, we have objection[s]. Because when they provide, as an example, when we propose euthanasia, instead of proposing good pain and symptom control, I have an objection for that. Because we are proposing euthanasia instead of proper care! I mean, in my opinion, I object because I'm a professional and we can do something here.

Robert voiced that his COs to euthanasia arose from his clinical knowledge and expertise grounded in the fact that palliative care with appropriate pain control and symptom management was the ethical option in palliative care at the end of life. He

emphasized that he found that due to the lack of federal, financial resources and the extensive lack of knowledge and training that health care professionals have around palliative care, patients at the end of life are not receiving adequate end of life care. Moreover, he noted that euthanasia permitted professionals to psychologically abandon clients who should not have to suffer physically and psychologically due to lack of clinical skill and health resources, *“and we’re not doing it. And we’re not doing it right, that’s the other part too...there’s a lot that can be done about support for pain and symptom control and you’re not abandoning them [patients] psychologically”*. Robert’s experience of making a CO has been one of transparency, motivated by a sense of ethical certainty and a desire to do what is right. While he does have a faith background, conscience is meaningful for him as knowledge and experience that allow one to judge what is right or wrong to do.

As Robert shared, his conscience was influenced by his clinical knowledge and experience, which supported his conscientious objection. Conscientious objection for Robert means to *“stand my ground”*, consisting of making an objection based on professional assessment as to whether good, quality care is being provided or not. Robert insisted that supporting others, particularly novice nurses and nursing students was imperative for ensuring quality care gets provided to clients and being aware of what client’s perceptions of what they do or do not understand about their own care options, *“helping them to understand these things... to be conscious about it. You will know something is wrong and you need to assess if you’re not sure...you know, you’re objecting to something that you perceive as wrong”*.

For Robert, making a CO is an ongoing part of his professional life. Going forward, Robert will not hesitate to continue objecting because he believed it to be in the

best interest of his clients and he has a strong sense of self in which he is not afraid to address what he thinks is right in nursing for his clients as well as himself. Robert was not concerned about standing up professionally for what he perceived to be right; he did not perceive a gap between his professional and personal sense of self in making a CO since it emerged from what he perceived to be professionally ethical to do in the first place.

### **Beth**

*“Being a lone soldier”.*

### **Isolating**

Beth was a nurse manager with almost three decades of nursing practice experience. She primarily oversaw and arranged home care for clients for the end of life/palliative care. In her professional experience, she worked in a variety of practice settings, including a medical surgical unit where palliative care patients would be admitted for intermittent therapy such as acute episodic pain control. In addition, she worked as a home care nurse for over ten years. Beth’s first CO arose in an acute care setting, shortly after her graduation when she was a newly-practicing nurse. Her initial experience of making a CO was over a patient conflict, in which a physician ordered a terminal pain control option that was not appropriate for the patient’s condition and this was largely motivated by family wishes because the patient was unable to speak for them self. Recalling the event, Beth shared that she had been in one of her patient’s rooms one morning, working a day shift, when all of a sudden a physician burst into the room:

In walked this doctor that I had never seen before and scurried around and came over to the bed and I was in the room at the same time and he looks at

me and says, ‘we have things to do here, we have to put this person into a medically induced coma, immediately, end their life!’

Reflecting on how she felt in that moment Beth shared, *“I was shocked. And, ah, I got quite nervous and almost like, it could just be happening before my eyes moment and almost that fight or flight kind of response”!* Commenting that she thought the doctor was a *“strange”* intrusion on that day, Beth’s reaction to that moment was an encounter with a problem that she first addressed with her colleagues, asking them who that physician was, what was the whole story for this patient, why was this request being demanded? Mentally reeling, Beth tried to regain her composure at the bedside, her mind grappling with questions, *“do I do anything? Do I just wait and see? What’s going on”?* As Beth related, this was not a procedure that would have been legally requested at the time or in relation to the patient’s clinical prognosis, which did not warrant such a drastic measure. Yet, Beth was torn because as a nurse, she did not make treatment decisions, but felt combatted by a desire to address the doctor’s verbal orders, given that she felt protective of the patient who could not speak for them self. Beth knew this was not something she could ethically go along with, from a professional perspective:

I’ve always been kind of for the underdog in that way, and so it’s kind of part of that for me, you know, it’s like, you [doctor] will not do this!

Because I have this person under my charge, they’re vulnerable, you know?

They can’t speak for themselves...it’s on me. And so, you’re not getting past me!

Resolution to Beth’s feelings of fear and frustration came through a conversation with her nursing manager, where Beth flatly refused to be part of the placing a patient in a situation that she perceived was not warranted. Reassured immediately by her manager,

ethics had also become involved as the request by the physician had also been perceived inappropriate by leadership at the institution. Relieved, Beth's experience with her initial CO was one of support and resolution, which stood in contrast to her recent objections with respect to the MAID legislation.

Regarding MAID, Beth relayed that she knew she had to stand up to it as the current ethical problem she was facing. Initially, her stance against MAID came about in a surprising way for her. Unsure at first about how to voice to her nursing manager what she was thinking and feeling in terms of expressing a CO to MAID, Beth decided to take a day off work and travel to Ottawa to make a demonstration on Parliament Hill, showing her public opposition to the legislation on Medical Assistance in Dying. Reflecting on this time she shared that this experience was one where she moved through a sense of fear and anxiety, to loneliness, hopelessness and then a little flame of awakening hope, *"I was really worked up even asking for the day off making my plans. So, then ah, the day before I decided that I would make a sign or something that I would wear"*. As an outward symbol of her inner convictions against MAID, Beth decided to wear an emblem that she had designed to share her pride in being a palliative care nurse with pro-life convictions, *"I made this cardboard thing and I pinned on my nursing pin, my hospice palliative care certification pin and I put a rose, and then I just put in RN for Life."*

Upon arrival on Parliament Hill, Beth shared that there were few protesters in solidarity of her cause which she felt was initially a stark contrast to the hundreds of athletic people gathered on the hill at the same time for a yoga class. *"Just seeing such a small group, and, it was actually kind of sad. And there were all those yoga participating people...I just, you know, was let down because I actually thought they were part of the protest at first"* (Beth). Despite this initial letdown, Beth rallied emotionally and ended

up feeling a sense of calm and peace, since she felt she was on a mission to make her convictions known through her physical presence at the protest. *“Then the speakers, when they started talking, you know they really, lifted our spirits and rallied us”*. *“I was quite happy. I was building my confidence too. To tell my manager”* (Beth) that she conscientiously objected to Medical Assistance in Dying. As Beth relayed, her decision to act on her convictions through participating in the protest gave her a sense of solidarity with others that shared her perspectives on MAID, and that being driven by her convictions allowed her to meet others who thought and felt the same way she did, *“I was able to get up off that lawn with some confidence and feeling I had been true to something...with other people that believed as I did...I felt that I did have a role to play”*.

Once living through that public demonstration experience, Beth knew that she could address her manager to share her CO to participating in MAID in a professional capacity because she had reached a point in which she realized she was being true to herself, and her conscience. For Beth, conscience was meaningful as an *“inner self”*, or the *“compass”* each person had to guide one’s decisions about how to live their life, and Beth believed CO meant staying true to that moral compass, or conscience. Beth also believed that making a CO was based on religion since one’s compass is religious and God’s law. Anything that goes against God’s law is a CO, and ending the life of another human being, in any direct or participatory form, through MAID, would be a violation of God’s law as well as her conscience. To stay true to her personal convictions meant facing her ethical problem in practice, knowing that as a professional she ultimately needed to be congruent with what she personally perceived to be right.

Expressing a CO to her manager came about very quickly after the demonstration, *“it was funny timing because the very next day my manager showed up I saw it as kind of*

*that moment that I was being given, there was no one else in the office”* (Beth). Beth voiced her CO to her nursing manager in that moment, believing that God had allowed that moment to happen while she still had some confidence from being present at the protest the day prior:

So, you know, so, I stepped forward because I could see how God set things up for me sometimes to make it easier. And so, I stepped forward and knees shaking of course I sit down and I just kind of tell her, you know, ‘I just want to let you know um, you know I have to tell you something about myself and what I’ve been doing’ and then you know I just kind of made it as simple as possible, you know I’m just going to let you know that in euthanasia and medical assistance in dying I am a conscientious objector.

Beth found her experience of voicing a CO to be a positive one in that moment since her manager supported her in making a CO and shared with Beth that her convictions could be accommodated within her professional role. Once she expressed her CO aloud, Beth felt relieved that she had been true to what she thought was right, and that transparency offered an opportunity to keep working with her objection out in the open. However, since Beth’s experience of making a CO, progressive developments arose to facilitate MAID in areas of nursing practice that Beth never anticipated. Beth was unsure how far things would go and could not predict if her CO would be upheld or if she would have to make further objections in the future. Moving forward, Beth remained unsure of how her nursing career would continue and to what extent her ongoing, ethical problem with MAID would affect her care practice, even though she had addressed it with her conscientious objection.



## **Tracey**

*“Conscientious objection really integrates the person you are with the professional life”.*

### **Integrated Sense of Self**

Tracey was an Advanced Practice Nurse (APN) working in mental health care. With over four decades of nursing experience, Tracey had several experiences of making a CO in her professional practice. The first time that Tracey voiced a CO was in relation to reproductive health aspects of nursing practice that were usually resolved in the moment (such as going to leadership to convey her stance against providing contraceptives to her patients). At the time, her objections were resolved with nursing leadership taking over and allocating someone else to that client’s care (medication provision).

Tracey shared that one of the most pivotal moments in her early nursing career was realizing that a patient she was therapeutically terminating a professional relationship with felt *“abandoned”* by her and as *“though walking in a forest, now alone.”* For Tracey, this patient experience was a significant one and she was adamantly concerned that patients do not feel this same sense of abandonment through the legalization Medical Assistance in Dying. Tracey noted that this is an issue over which she was *“very concerned that nurses will participate in...without really knowing that it’s wrong and that they shouldn’t be doing it”*, because, for her, MAID is not in the best interest of patients and as an APN, Tracey based her *“opinions on the best available evidence and there is published evidence about what happens once assisted suicide and euthanasia become legal”*. In her professional practice, Tracey was concerned about the implementation of MAID because *“people are just stunned, they just don’t know what to*

*think about this issue. They haven't read about it, they don't understand the implications...euthanasia is the ultimate abandonment of the patient".*

Tracey challenged the issue of assisted suicide and euthanasia in her professional life owing to her perception that, particularly for patients with a mental illness, instead of offering the support these patients need, MAID offered them a terminal way out from their illness, which was not consistent with ethical health care provision. She shared this was a serious concern for her as she works with a mental health population and there are considerations that need to be made for patients who may be abandoned in their illness if they are euthanized upon their request versus therapeutically supported throughout their illness experience, *"it's not all about the nurses' ethics or the nurses' conscience, it's because somebody else is going to be killed...as a result of an ethical position"*, and for her, acting on her conscience is so *"that patients don't die, but number two, so that nurses and others don't get coerced to participate in something"* and *"that is unethical because they need a job"*. Tracey was also concerned that some nurses might comply with MAID so that they did not risk losing their jobs, even though they may not ethically agree with it.

To make her CO known over MAID, Tracey largely elected to pursue political action, generate dialogue and share her opinion through writing to nursing regulatory bodies and political groups within the province and the country. In her efforts to make her objection known, Tracey found the experience to be *"exhausting"*, *"draining"*, and one that seemed to *"fall on deaf ears"*, as she encountered colleagues, professional nursing bodies and the socio-political contexts of her cultural existence to be one that is in favour of euthanasia to the extent there is no room to challenge those supporting it, *"I guess the next step for me is to alert other nurses, that this moves too fast, that well, you know,*

*once the legislation is almost in place, the freedom of speech shuts down very fast”.*

Rising out of her appreciation for moral integrity, Tracey shared that her decision to voice a CO to euthanasia evolved from a sense of integrated self, “*conscientious objection really integrates the person you are with the professional life. So, you want to be consistent. Like, you know, that’s a big thing for me. Is to have that kind of integrity”.*

Tracey’s perception of conscience also prompted her to conscientiously object. Understanding conscience to mean that everyone has it and that it is about what is good to do and what is good to avoid, Tracey also saw conscience as something that is fundamentally religious, but that it exists for everyone regardless of such a formative influence, and that it must be informed as well as acted upon. She relayed that conscience, for her, was something that she developed through ethics education and reproductive health care training. As an educator, academic and leader, Tracey could not sit by her conscience while assisted suicide legislation was underway without expressing her ethical concerns about it, “*the fact is people are dying and that kind of compels me to keep doing something”.*

Tracey saw the ethical dimension of her nursing practice as something that kept her alert, and exercised her autonomy in making ethical decisions:

You don’t just have to follow direction all the time, you really need to be thinking, is this right or wrong? Should I be doing this or not? And the bottom line is, it’s going to harm or kill a patient if you decide the wrong thing.

Referring to her experience of making a CO as “*another, full time job”*, Tracey maintained her conscientious stance and her efforts because “*you have to sustain your hope somehow...because patients will still be at risk”*, and she was “*apprehensive”* about

*“young nurses...how it’s going to be for them. Right now, the opinion is that you can object, but how long will that last”?* While her current CO remains an ongoing one, Tracey saw her persistent objection as ethically warranted and will continue to address her ethical concern over it indefinitely, indicating that her CO has not actually resolved her ethical concern over MAID in nursing practice, but that it is necessary for her to continue to voice it as the right course of action, for herself, her patients and potentially any other nurses who might object to it as well.

### **Annie**

*“I just felt really powerless”.*

### **Futility**

As a newly practicing nurse, Annie thoughtfully recollected a recent experience of making a CO that stood out in her mind as something disturbing, stressful and shook her, from a personal and professional context, *“it just frustrates me to feel so angry and helpless, especially witnessing something like that...seeing something so horrific and being unable to alter...even advocating and trying to make a difference and that didn’t do anything. I felt really powerless”.*

Annie’s revelations about her experience of voicing a CO involved a situation that took place in a critical care environment. It was later in the day, close to the end of her shift. A patient had come in coding; alternating between regaining a cardiac rhythm through Cardio-Pulmonary Resuscitation (CPR) with asystole, or no heartbeat, again and again. Distressed over what seemed to be ceaseless efforts to bring this elderly patient back to life, the futility of the situation hit Annie in the midst of what seemed to her to be clinical chaos, *“we had this lady come in who was, I think she was 88....so she came in having a heart attack, she came in coding, I think on the stretcher to our unit”.* At the

time the patient had no vital signs, and the health care team started CPR “*and defibrillating and all that, so, and this went on for like an hour, so usually after ten minutes, you know, we call it but, she would go to eight minutes and then have a pulse again*” (Annie). As Annie relayed, the team kept going, even though the patient would lose her pulse again within minutes, with the team re-initiating CPR over and over. Frustrated and alarmed that the doctors would not call the code and kept on going with aggressive resuscitation, Annie recalled “*our physician wouldn't call it either, and would say 'let's keep going', so, this poor lady, she was probably fifty kilos, tiny thing... it was the biggest guys doing CPR on her, and you heard ribs cracking...it was brutal.*”

Distressed and upset that the doctor would not cease CPR, Annie asked the physician:

Can we just ask the family of this is what they want? She came from a nursing home as well and a lot of the time they have a DNR order, and he was like ‘no’. Meanwhile, they're [the family] just outside, can't we just ask them?!

Wanting the family to be involved in the decision making over the patient's end of life wishes, Annie felt she was not being heard. Seeing her nursing managers present at the aggressive code, Annie turned again to the physician leading the CPR and said, “*it's been an hour, please let's just find out if this is for sure what they [the family] want, maybe if they could see what's happening in here they could make an informed decision.*” However, the physician dismissed her again, responding to Annie with the words “*she hasn't been dead for an hour just because it has taken an hour doesn't mean our efforts have been useless.*” Annie expressed that at that point she had become angry and did not think what they were doing as a team was right, “*I was just so mad and I didn't want to participate in that situation anymore because it went so against what I thought was*

*right*". Frustrated that the team "didn't want to take a second to find out what her wishes were with the family or what the family's decisions were and we were just doing all these things without asking them" Annie felt that she had not been heard repeatedly, even though she had voiced her objections to the doctor with her nursing managers present. At that time Annie made the decision to walk away, "I just couldn't do that, I couldn't participate in that anymore. So, I just left the room and they continued on for another half an hour...I just wanted to be as far from that situation".

Annie shared that her decision to object was triggered by her realization that her participation in this patient's care went against her conscience. For Anne, conscience was one's personal beliefs of right and wrong; an inner voice of morality that is influenced by morals and personal beliefs which can be formed by one's culture, religion and upbringing. She referred to conscience metaphorically as the cricket from Pinocchio, like a little voice in the back of one's mind, reminding one of how to read an ethical situation. For Annie, CO was making an objection over something one considered to be wrong, stemming from an informed decision based on one's morals, conscience and beliefs. When one conscientiously objects, they state that what they are objecting to is wrong and that they do not want to be part of it. Yet, even after having done that, Annie was discouraged over the lack of response that emerged from her leadership, the physician she went up against and even her nursing colleagues:

I don't know if it helped, my response in leaving, because the situation is still carrying on, it's just that someone took my place, right? So, I don't think it made me feel any different. At least, well, I wasn't here, but I was still outside, you could still hear everything they were saying, and yelling out and you could hear them shocking her. So, I don't think it was the most

effective thing, but for me, I just couldn't. I don't know how else to respond to that-you do what you try, and voice your concerns and try to change it, and if you can't, then, you just leave and deal with it.

While this experience of CO for Annie was a big moment, and one in which the experience was largely of futility and uncertainty, Annie also found herself questioning ethical issues that occurred on a much smaller scale in her day-to-day practice as a nurse. At times, she shared she would question why she was doing something that would be appropriate in the sense that it would be following orders, but not necessarily what a patient wanted, or the emotional wear and tear of taking patient and family verbal abuse, to the point where she questioned her practice and whether nursing was the best fit for her. Annie asked herself *“is nursing for me? Is this the right profession for me?”* Bringing her distress home with her, she shared that her husband listened to her while she contemplated her career, telling him at times *“I’m done, I am getting out, I don’t want to do this anymore...why be in this practice where you know, there’s joyous moments, but there’s so many times...you think you’re doing something that’s wrong.”* Anne expressed a desire to leave her practice area as well, saying *“I gotta find something else to do”*.

Annie noted that being able to reflect on her experience of CO by participating in my study had been helpful and she wished that there were more supports in place from her nursing management to address ethical dilemmas as they arose in her practice, such as by way of open conversation and de-briefing sessions. However, Annie’s experience of CO was also one of thinking that she didn’t make a difference, even after standing up to an ethical dilemma and attempting to address. This has resulted in her feeling a sense of futility in her nursing practice and since our first interview Annie shared that she has changed her clinical practice area due to this sense of futility.

**Summary**

The stories captured in this chapter are representative of nurses' individual lived experiences with making a conscientious objection. Some similar characteristics are present across these participant's stories, but they were each analyzed to gain an in-depth understanding of conscientious objection. In the next chapter themes abstracted from these nurses' narratives are discussed to depict shared meanings of those lived experiences, revealing the meaning CO held for these nurses in their everyday lives.



## CHAPTER SIX

### Revealing Nurses' Experiences of Conscientious Objection

Being confronted with an ethical dilemma that prompted the nurses in my study to make a CO was a challenging experience for most of them, but issued from a place of personal conviction and they held no regrets over making COs in their professional practice. Often, the nurses felt compelled by a sense of care for their patients, their profession, and a moral obligation to follow through on what they perceived to be the right course of action in the midst of their day-to-day lives as nurses. For the participants, being a nurse who makes a CO is time sensitive; they encountered an ethical dilemma in time and responded to it in time as well. A common desire emerged to be transparent about their perspectives to others, namely, their nursing managers and colleagues.

The nurses' conscience was a compelling phenomenon that informed how and why they decided to act on their personal convictions. While an ambiguous concept in the nursing literature, conscience for these nurses was expressed as a meaningful basis from which to make their moral decisions, prompting them to address not being able to perform an aspect of their care practice that they considered to be wrong. While each of the nurse participant's experiences were unique, across their collective stories themes with sub-themes that were uncovered from their lived experiences with conscientious objection were: 1) encountering the problem; 2) knowing oneself with subthemes of a) personal and professional, b) influencers of moral beliefs and b) connecting conscience to conscientious objection; 3) taking a stand with the subtheme of a) transparency; 4) alone and uncertain with the subtheme of a) futility, 5) caring for others and 6) perceptions of support with subthemes of a) lack of support, b) presence of support and c) meaningful support (Table 2). In this chapter, I will share these themes in more detail to offer insights

into these nurses' experiences as well as discuss, in more depth, the meaning that conscience and their lived experiences of making a CO held for them.

Table 2

*Themes and Subthemes*

| <b>Themes and Subthemes</b> | <b>1) Encountering the Problem</b>  |
|-----------------------------|---|
|                             | <b>2) Knowing Oneself</b><br>a) Personal and professional<br>b) Influencers of moral beliefs<br>c) Connecting conscience to conscientious objection |
|                             | <b>3) Taking a stand</b><br>a) Transparency   |
|                             | <b>4) Alone and Uncertain</b><br>a) Futility  |
|                             | <b>5) Caring for Others</b>   |
|                             | <b>6) Perceptions of Support</b><br>a) Lack of support<br>b) Presence of support<br>c) Meaningful support   |

Throughout the nurses' narratives, it is important to note that most participants used the terms 'MAID' synonymously with euthanasia. Euthanasia etymologically means a comfortable death, or a death without pain which can indicate a natural death or a dying process supported, but not advanced, with the use of pain control and comfort measures (Sgreccia, 2011). However, common nomenclature defines euthanasia to mean a death that is purposely brought about to deliberately end life using what is known as mercy killing, or through the actions of medical personnel to end a patient's life due to suffering. While the term MAID is not necessarily meant to indicate euthanasia proper,

since there are several forms of euthanasia which vary in mode, it does not, however, vary in intent. For example, in various countries around the world today, euthanasia is sometimes performed passively, actively, directly or indirectly or by way of a lethal overdose, injection, with and without a patient's request (Sgreccia, 2011). However, I will maintain the synonymous use of MAID with euthanasia, because it was expressly asked of me by some participants to do so, given that they are aware of these differences, but saw no distinction within the MAID protocol to note otherwise.

### **Encountering the Problem**

Prior to making their COs, the nurse informants shared that they each encountered an ethical problem in their professional practice. For seven of the participants, this problem surfaced in the form of the newly legislated MAID protocol in Canada, which most of the participants individually and collectively expressed as an unethical practice in their Canadian nursing context. As Kate revealed, when she attended an organizational orientation to her new workplace on the practice of MAID and understanding this to be something that she could potentially be involved in as a nurse, Kate received this news as problematic, and not just from participating in the actual act of bringing about a patient's death, but from the moment in which MAID could be requested of her through a patient, *"what happens if I'm the one the patient brings it up to the first time, because I am certainly not saying, hey, look they want you know, they want to die, let's make this happen!"*

For Kate, participating in the practice of MAID was not *"the reason I became a nurse"* because being a nurse for her, *"is to help people"* which she sees as incongruent with the ethical problem of assisting someone to die. The tension of sharing a patient's request for MAID with the medical team weighed negatively on Kate, *"for me...the*

*scarier thing is when they [patients] first bring it up and nobody addresses that. It's like everybody assumes that you would be ok with the referral"* rather, as Kate shared further *"everyone assumes that the problem people have is with the actual action and the actual procedure and being there"*. Kate's delineation of the parts of the whole process of supporting patients through MAID was an ethical problem for her that she could foresee being initiated at the time of a patient's request for it, indicating a sense of complicity that would certainly drive forward her participatory action in Medical Assistance in Dying. For Kate, referring a patient's request for MAID on to the medical team was no different than participating in the actual procedure; in fact, for her, it was even more complicit than being present for the actual procedure. This complicity arose from her impression that due to the way the protocol for MAID was laid out, she would not have to play an active nursing role at the time of death since she would not be giving the lethal dose. However, she would have a direct role in initiating the eventual death occurring, should she voice or pass on her patient's request to pass away in that manner directly to a doctor or the MAID team who would facilitate the death process.

Nancy shared a similar concern regarding moral complicity in voicing her CO over her own ethical problem with MAID while she was caring for a resident a month in advance of their termination date by Medical Assistance in Dying. For Nancy, her proximity in encountering the problem of MAID was a regular occurrence in her day to day life as she cared for this patient:

The funny thing is our care coordinator said... you don't have to participate and you don't have to be involved [in MAID]...after this experience, I said you know what, that's so not true. Because I said, I was involved, I said I

had to talk to her about it, I had to listen to her... the resident's concerns, I wasn't involved in the actual procedure, but I was involved.

Connecting with MAID as an ethical problem for Nancy was a stressful period for her, "*I would go home and cry...the day it [former patient died] happened was horrible...I really found it hard because I was quite close to this resident...so it was very stressful and emotional*". Nancy recalled this encounter as a time of deep, personal struggle because she did not ethically agree with assisting patients to die, and seeing this person on a day-to-day basis as a nurse brought her close to an issue in her nursing experience that she did not agree with. While this encounter with a problem was prolonged, it gave Nancy the opportunity to dwell and deliberate on what she considered would be the right course of action for herself to take as she weighed her conflicting personal beliefs and patient/professional obligations:

I really struggled with it because I thought...I wasn't being honest because I could not let her [the resident] know my thoughts and feeling and my beliefs. Because as a nurse in a professional role, that's not my role. I'm there to support her and I found it very difficult because part of me just wanted to say what are you doing?! But I had to hide all of that in front of her and I couldn't tell her how I felt.

In contrast to a more concentrated span of time in which Nancy encountered her ethical problem in practice, Annie faced her ethical problem in the moment. Working as a critical care unit nurse she recounted how a patient was brought in coding and while efforts were made by the medical and nursing team to resuscitate the patient for an hour, it was to no avail. Annie shared that the audible breaking of ribs and the blood flying from the patient's central line insertions punctuated by chest compressions made this

situation ethically impossible for her to witness and be a part of. It was in the moments of this situation occurring that Annie became aware that this scenario was a problem for her, personally, and for Annie, *encountering the problem* arose in the moments of living it and lead to her decision to make a CO over it.

Conscientious objections from Robert's narrative revealed that they can either occur in the moment or manifest as an ongoing objection, depending on the issue at hand. For Robert, CO is about doing the right thing in the face of challenge-for himself as well as his patients. In the moment, he related, you can know that something is not right and reason it out tangibly, or tune into it as a gut instinct, which could emerge intuitively, "*I make my objections known because I don't feel good about this, I say if I don't feel good it's because there is something wrong here! Then, let's talk about this*".

There was an inner, personal response to encountering the problem that occurred for each of the nurses. Such a response consisted of moments between encountering and standing up to something unethical in practice, situating the encounter as always fixed in time. Time revealed the encounter to these nurses and temporalized their decision over when and what to do about it. Robert's current COs regarding euthanasia emerged from years of expertise in palliative care, clinical practice, ethics courses and years of open, ethical discussion with colleagues. The time between his initial and present, professional encounters with ethical problems gave him the ability to recognize what he thought about euthanasia so that when he encountered euthanasia as an ethical problem in his practice, he could stand up to what he thought was not right about it, and to maintain that conviction over time, "*over the years as you gain experience you get a bit more assertive in standing your ground, but it's not easy...but you know that when it's wrong, let's speak up*"(Robert).

For Amy, encountering the ethical problem that brought about her decision to become a conscientious objector arose in a moment of epiphany. Noting that her conscience had been pricked for some time about MAID in relation to her nursing practice, Amy's experience of encountering an ethical problem occurred when she confronted the concept of MAID in a gestalt awakening as something that she might have to carry out as a nurse practitioner:

Well, there was surprise initially because of all the discussion, you know, before the legislation [on MAID] went out, was that it was going to be physicians [performing it]. So, at first it was surprise that it was going to be nurse practitioners as well. Well, I think, just reading [the legislation], you go, ok, wow, nurse practitioner, ok that means me, so that was professional association. And that wow, that really expanded the boundaries of the scope of practice...but then, at the same time, it was ah, that means me! And that was really the moment where the tensions really came in and I thought, no, I can't do this, this is personal.

Struck with the meaningful certitude that MAID would involve her in killing someone, Amy shares this violated the moral tenant she lived by, as one of the Ten Commandments: *thou shalt not kill*. Amy's experience of revelation brought to light her decision to be a conscientious objector to MAID in a moment of time in where she made sense of what the legislation would fully mean for her, as a person and not just as a nurse practitioner.

Beth's experience with encountering a problem in professional practice nagged her for a long time; although she knew for months before MAID became legal that her personal, ethical position would limit her from participating in it professionally, she did

not share this with anyone: *“I pretty much kept it quiet because I didn’t know how I was going to live it”*. However, when supportive friends asked her what she would do about it when it came it became a legalized option for patients to request, Beth asked herself *“are you ready to walk? Are you ready to do it [object] if you have to? So, make a stand! So, I decided I had to, whatever it would be, you know, I would take part in it [stand against euthanasia].”*

While Beth’s *encounter with a problem* manifested itself over time and her personal conviction against euthanasia solidified through personal reflection over it and through conversations with her friends and mentors, for yet another nurse, Ruth, *encountering the problem* was something she faced alone. *Encountering the problem* for Ruth was also in the context of MAID which she came face to face with in advance of its legalization, knowing that it was going to happen in advance of it becoming common practice on her nursing unit. However, while MAID was cause for Ruth to make a CO, she encountered another problem in the form of what she described as a hurried death in her nursing practice, prompting her to make a second CO to her nursing manager. For Ruth, a hurried death meant altering routine practices unethically to circumvent a palliative approach to dying and end of life care. Concerned that a hurried death was a way to circumvent standards of practice, Ruth knew, in the moment that she encountered an ethical problem that something had to be done to prevent it, *“it was intended to be a hurried death. Which I don’t, which of course, I will not participate in.”*

As for Tracey, her encounter with an ethical problem had occurred several times over the course of her career as a nurse, persuading her to make COs in the past, but the recent implementation of MAID was another ethical problem for her in her nursing practice. For Tracey, as well as the rest of the nurses who encountered a problem in the



context of MAID, this will be an ongoing problem to face in their practice settings, “*because patients will still be at risk*” for receiving MAID indefinitely into the future. For these nurses, their encounters with an ethical problem was not merely about their personal convictions, but how they perceived their encounters with ethical problems as problematic for their patients as well, which motivated them all to *taking a stand* over their *encounter with the problem* by making COs to them. Their responses however, first arose from *knowing themselves* to act with certainty to address their ethical problems. *Encountering the problem* for these nurses was at the level of a problem versus a dilemma, since a problem can be resolved, which for these nurses, seemed initially to be their belief in using CO to address the ethical issues that they encountered. However, as explicated below, the effects of making a CO on these nurses’ professional lives could result in a personal, ethical dilemma. Dilemmas are heightened problems, because they can indicate a lack of resolution to an ethical issue (Webster & Baylis, 2000).

### **Knowing Oneself**

The theme of *knowing oneself* was abstracted through a sense of personal conviction that each nurse participant had regarding their sense of morality, or what it meant for them to be a moral person in their professional lives. Subthemes that emerged in this theme are a *personal and professional* sense of self and *influencers of moral beliefs*. Encountering an ethical problem brought a sense of personal conviction to the forefront of ethical issues in their everyday lifeworld of being a nurse (Evans, 2003; Van Manen, 2014). As Annie related, everyone has “*an inner voice of what’s right and what’s wrong*”. This inner voice denoted Annie’s perception of conscience which she perceived as the basis for making a CO:

Objecting to what you think is wrong, you make an informed decision based on your own morals and conscience and your beliefs and you just object, you say this is wrong and you don't want to be a part of it.

The delineation between perceiving something as personally wrong to do from what may be otherwise permitted on a professional scale was echoed in Kate's perspective on conscience related to making a moral decision:

To a certain extent I think all of us have this gut feeling about right and wrong, but when it gets into the more nitty gritty, and our feelings of, oh it feels right or it feels wrong, sometimes are not right or wrong and I think particularly when it comes to sympathizing with somebody who is going through something and you understand how they are feeling or making the choices that they're making, you still know it's wrong.

Kate's notion of making a moral decision emerged as something that is not based solely on emotion, gut instinct or professional intuition, which Robert also supported since he derived moral meaning of ethical nursing practice from having a sense of professional intuition which can flag a nurse to apprehend on an irrational level that something is wrong. However, the nurses' stories converged on what Robert also asserted as a consistent registering with asking what is the right thing to do, at all times, as a nurse, which is not relative to being a nurse as a person or to being a nurse as a professional, but rather, to being a nurse as a whole or integrated self.

***Personal and professional.*** An awareness of one's personal, moral sense of them self in keeping with their professional sense of self was a subtheme abstracted from the arching theme of *knowing oneself*. Being an integrated person emerged for these nurses as

something that ethically superseded a sense of personal, ethical conviction over one's professional obligations, as Tracey explained:

It's really high stakes to act on your conscience, well, inform your conscience to know what's right to do and what's wrong to do and then, to have the courage to go ahead and act in that way, because acting, like, doing the good, is more important than whether you're going to keep your job.

Tracey's perception of integrity is informed by her perspective on conscience, which meant being informed by a sense of morality (what is right or wrong) and then acting on it (ethics, or moral action) and transcended these nurses lived experiences, with respect to having an overarching sense of morality that drove their moral decision making into ethical action in nursing practice. *Knowing oneself* through a *personal and professional* sense of self was meaningful for these nurses as being contrary to the status quo. Tracey related:

Articulating a decision in a culture, where, you know, it's not normal to object to an abortion referral, or to administer a medication that might act as a contraceptive...you know, people think you're really extreme to make this decision.

Speaking of her experience of making a CO in her professional role, Beth noted, "*It's painful to rub against all of that business with people...because you're going against the current, you're ugghh, every step of the way... you're walking that tight rope*". While perceptions of what is right can vary from person to person or from one workplace to another, such differences can create a gap between nurses' personal, ethical perspectives and others' perspectives, such as those enshrined in a profession or a legitimized practice such as MAID in socio-political contexts. Robert

noted that when empowered with ethical knowledge and a sense of conviction, staying true to an ethical notion of care provision was something that needed to be consistent in nursing practice, *“I realized as I was working with different teams some were better to do the analysis of what was going on in the work environment...if you don’t know, you check!”*

Balancing between pluralist perceptions of ethics and morality that arose from the nurses’ personal sense of what was right and wrong that clashed with inter-professional, disciplinary and socio-political as well as institutional perspectives in voicing a CO was something that all these nurses realized. Yet, their ethical perspectives transcended their work situations and when met with the ethical problems that they disagreed with on a personal level, there was an overall sense of registering these problems from a professional nursing perspective as well. Specifically, that as nurses many participants did not agree with aspects of professional care practice such as MAID or futile treatment. While their conflict arose from an internal sense of morality that drove their ethical conviction to make a CO, these nurses also believed that from a professional perspective, they would be causing harm to their patients if they followed through on futile treatment or some professionally sanctioned practices, *“just like the doctors, we are supposed to do no harm. Well, I mean, killing someone, knowing they’re going to die when you give them something, that, to me, that is causing harm”* (Nancy). Cognizant of the tensions between her professional and personal sense of self, Amy noted that:

I want nurse practitioners to practice to their full scope but in this case [MAID], it was just like ooohhh...nurse practitioners can do this, that’s actually a bit worrisome. I can do this but I’m not going to...because of my own conscience...[and] I couldn’t actively help someone kill themselves.

*“My natural conscience would probably tell me not to kill somebody”* shared Ruth and so voicing a CO over MAID generated a sense of alarm for her, since supporting patients to die in this way would be an action that was going against her conscience. Moreover, participating in an action that went against her conscience was a cause to voice a CO for Ruth because the ethical problem that she was encountering was a concern for her, personally, since it would involve her in doing something, professionally, that she perceived would harm others as well. In this sense, CO emerged as an experience for these nurse participants as an action that would allow them to be clear that they did not personally wish to harm others in a professional capacity. For example, participating in killing their patients through MAID was viewed as something unethical by several of these nurses not only for themselves, but by way of what it would have them professionally do to others.

***Influencers of moral beliefs.*** Influences of these nurses’ moral beliefs in declaring a CO was another subtheme that was abstracted from the theme of *knowing oneself*. For the nurses in this study, the influencers of their moral beliefs that guided their decision to make a CO were grounded in religion as well as philosophical or evidence-based clinical practice perspectives. *“It was my epiphany, like wow! This is a really big issue I might have to explain to a higher being”* Amy stated in reference to what it meant for her to come to the conclusion to voice a CO as a nurse practitioner. While Amy’s ethical convictions were reinforced as a consequence of her actions, she also deliberated from a standpoint of reason, which is not disparate from her religious beliefs:

You have to look at the other things involved...you go more even more micro...there are different decisions along the way...am I comfortable

giving information about it [MAID]? It would be the action, that I would be ending somebody's life...that I would be hastening rather than the palliative perspective...the big difference is that this is not natural, you're hastening somebody's death.

Nancy shared that her religious convictions informed her decision to voice a CO because she believed in an afterlife, where the way one lives in temporality affects how one will live eternally, *"I really struggle with this [MAID] because of my religion, we believe if someone commits suicide, they don't go to heaven...[although] we don't judge that"*. For Nancy, the distinction between supporting her patients to die naturally and assisting them to die compounded her struggle to care for patients who want MAID, not because of her discomfort alone, but from a sense of compassion for what this could mean for patients who request it. Kate shared that as a Catholic, her ethics are informed by her faith, but she noted that her faith is based on reason and working through ethical scenarios with deliberation, which is something that takes moral discernment and education:

As a Catholic I know where that knowledge base comes from...I know whenever I'm not sure I can go read up on or think about the deeper implications of whatever confusing feelings I'm having...I can see other people hitting a bit of a roadblock when they have no moral code...and so some people turn to whatever feels right.

But religion is not just about feelings or operating outside of a basis for reason. As Robert shared, while Catholic, he is motivated by evidence based practice, clinical reasoning and education to predicate his CO on Medical Assistance in Dying. He noted that religion has become conflated with ignorance and the idea that it lacks legitimacy:

I think it's a danger word right now to be associating it [CO] with religion...because when they neutralize us with the label 'religion', they say you should not work there, go elsewhere. But the problem is the same...if we don't provide good quality care I will object. It's nothing to do with religion.

Emphatic that euthanasia in the form of MAID is unethical because it is not giving patients the palliative care they deserve, Robert was frustrated with being labeled as religious which he perceived is something that others in the health care community at large use to cast HCP's perspectives aside when they do not agree with MAID from an ethical perspective. Additionally, he perceived the use of MAID as a lack of appreciation for clinical knowledge and expertise on alternative care measures, measures that he perceived from a clinical knowledge standpoint as being underdeveloped and underused:

I think people having pain they need to have pain control and they need to have the right pain control...there are people who are having pain and uncontrolled symptoms right now. It doesn't make sense. Because what I've seen from my clinical work, is clinical relentlessness on one side and poor pain control [on the other], well they go straight to euthanasia...I say excuse me? Let's not skip directly to euthanasia, let's go through pain control and symptom control and palliative care before we consider the other...we need to develop a national initiative on palliative care to educate more of the health care professionals about pain and symptom control. So, I object to euthanasia and assisted suicide.

*Knowing oneself* as a person and as a professional is also based on non-religious perspectives of morality and can extend from one's upbringing, cultural influences and

education. As Annie pointed out, she found it disappointing that in nursing scholarship, so much work has been done to address moral issues in practice. However, that research and knowledge do not translate into action in nurses' clinical settings, which prompted her to use CO to address her concerns as a last resort prior to changing clinical areas to address her ethical issues:

I find, you know, that nursing goes in phases, the new 'hot' concept and for so long it was moral distress and then burnout and now I feel this [CO] should be a new one! I feel like it has so much more power than moral distress....and you don't just have to accept that's the way it is...now, in practice...I won't be like oh I feel morally distressed, I am conscientiously objecting to this! Based on my informed decision.

As Annie expressed, she viewed CO as an ethical option that can carry some weight because it does not leave her feeling that she cannot voice her ethical concerns, that if she has a reason to address an ethical issue in her day to day practice, CO could be a positive, professionally sanctioned and legal solution.

***Connecting conscience to conscientious objection.*** For these nurse participants, conscience and CO were not mutually exclusive-conscience is about discerning what is right for one to do, and making a CO is based on one's conscience based perceptions of morality and then expressed as that right action (ethics). Annie meaningfully perceived CO as something powerful because it is an action, which she equated with change:

Adding the word objection to it I feel like it has so much more power...you know, kind of doing what is wrong and questioning what's right, but I feel like this has more positive connotation to it, like you have a choice, you're



not feeling this residual distress and you just have to accept that's the way it is. I think it almost, it's a little empowering.

Annie's perception of CO was not a power over anyone per se, but denoted a sense of empowerment for oneself to be a voice in the noise or silence and as a way to express her own ethical position. Annie noted that similar terms to CO, such as moral distress, have not brought about a means for change to the unethical situations that nurses face in their workplace. Beth shared that conscience for her, was a *compass* to guide her decision making, such as by way of making a conscientious objection.

Amy shared that CO was "*refusing to participate in an activity that goes against your own conscience*". Nancy relayed that following one's conscience and making a CO were about "*being comfortable*" about doing or not doing something and to object to doing so, if needed. Making such decisions arose from a sense of knowing what one will do subsequent to knowing one's moral or ethical self. As such, *knowing yourself* emerged as a theme leading to *taking a stand* for these nurses. *Knowing oneself* also consists of making one's moral positions known to a given situation that one has thought about, in the moment or over time, based on their conscience and/or influenced through religion, as well as education and clinical experience. Then, based on their moral position, one can reach a moral conclusion about it, which directs one to do what they perceive to be right action (ethics).

### **Taking a Stand**

The limits of the nurses' moral sense of self being tested by perspectives and practices external to their comprehension of morality and conscience drove them to *taking a stand* over their *encounters with a problem* in clinical practice. *Taking a stand* means lining oneself up with one's moral convictions and following through on what one

believes to be right regardless of what others think, and in view of consequences that might result in serious outcomes. A sense of *transparency* emerged as a subtheme to the theme of *taking a stand*. As the nurse participants relayed, their personal, moral views became paramount to express in the form of making a CO to address their ethical problems in practice. The nurses chose to respond this way because they thought that they were being asked to do something, collectively and individually, that went beyond their personal moral limits as well as their professional capacity as nurses by way of participating in care that they perceived to be unethical. Conscientious objection became the way for them to *take a stand* which meant making known what their convictions were. Standing up for their beliefs was to be open about them, and while for some it took courage to speak up, across their experiences, CO was an ethical way for them to be transparent about their personal views.

The nurse participants also acknowledged that they felt a sense of moral responsibility to others, namely, their patients and professions or a higher being. This responsibility was not a sense of owning up to doing something wrong, by way of violating a professional standard or merely presenting an opposing opinion, but through an open acknowledgement to refrain from doing something they perceived to be wrong from what they saw as an overarching, moral standpoint. Making a CO “*is consistent with my beliefs and values*” [Tracey]. Annie shared:

I didn't want to participate in that situation anymore because it went so against what I thought was right, because if I had known that the family was agreeable to this, she was the type of person that would want to go like this, then sure, let's keep going...but the fact that they didn't want to take a

second to find out what her wishes were with the family....I just couldn't participate in that anymore.

Referencing her decision to make a CO in the moment of a futile resuscitation experience, Annie's decision to *take a stand* and voice her CO arose in a moment in time where her inter-professional colleagues and nurse managers opposed and remained silent, respectively, to her request to question the benefits of continuing aggressive treatment. In addition to voicing her disagreement, Annie felt compelled to leave the room to fully register her CO to participating any further in what she considered to be unethical care provision, exceeding proportionate benefit to the patient:

I just kind of had to leave. At least, well, I wasn't there, but I was still outside, you could still hear everything they were saying and yelling out and you could hear them shocking [the patient]. I don't know how else to respond to that-you do what you try and voice your concerns.

*Taking a stand*, for a nurse, could lead to losing one's job if they held a personal position that was not professionally supported, "*I just can't believe it, I never thought I'd see the day that this [MAID] happening to me, that this was the kind of nursing that I'd have to face...If I do get fired I'll be ok*" (Ruth). "*You can't snowball people with your own beliefs, but I do believe in hospice/palliative care as the option that is the right thing*", Beth related over her decision to make a CO, "*I told [my manager] I'm a conscientious objector to euthanasia, this law is poised to be passed, If I'm challenged in any way in my job I will not comply. I will walk from this job*" (Beth).

These nurses lived experiences of *taking a stand* brought language to the surface comprised of words that they used to indicate that they would "not" or "won't" and "can't" participate or comply professionally with acts that went against their conscience.

Across the nurses' narratives, these words were meaningful as the language of conviction and represented the strength of their moral perspectives that would limit their actions to be ethically transparent in their personal and professional practice. As Kate shared, it was important to her, as a nurse, to respond to her moral convictions and that motivated her to *take a stand* and make a CO:

I wouldn't say I come across too many morally ambiguous things that I have to make a decision about because it is nursing and at the end of the day a lot of what you do is good...but I think [MAID], that's [on] a larger scale where I am using my conscience...that's one of those things that I would [take] precautionary steps to let it be known that I would not participate in that.

Robert's decisions to address what he thought were unethical situations in practice by *taking a stand* resulted in his making a CO, which was "*quite stressful*", but he felt compelled to "*stand his ground*" when he perceived something was "*not right*", even to the point that he would have reported the physician he was standing up to, which would have been more stressful for him. Yet, he was willing to go that extent if ethically necessary, "*objecting professionally, I knew it [what the physician was doing], was wrong*" Robert stated, "*so, when you make a decision that is well grounded and the arguments are sound, the client agrees with you...then you know where we're going...because I would have reported [the physician], yeah, I was ready to report*". Robert's initial encounter with *taking a stand* over an ethical problem gave him confidence and it helped him to take a stand over current ethical issues of euthanasia as well. Kate explained:

CO for me is about saying I know that you guys think this is part of my professional responsibility and part of my professional obligation, but I'm not ok with this for reasons that are conscientious reasons. I mean, it is essentially objecting to participating or going a certain route of action because you know that it's wrong.

*Taking a stand* about her ethical position was something that Kate felt was the right thing to do, and believed she was “*absolutely*” making a CO in her nursing experience. Kate shared that voicing her CO was a positive experience and while it did not resolve her issue, she knew at that time that she had to speak up about it, “*I felt good afterwards, like that was the right thing, and if you're not going to speak up, then don't be surprised if people can't read your mind and don't know if you have a problem with it!*”

For Kate, *taking a stand* was about being heard, being consistent in her beliefs and moral reasoning, as well as making sure that she was not misunderstood. Doing the right thing was more important for her than being professionally involved in something she did not think was ethical or that her conscience did not agree with. Compromising her conscience was not outweighed by her professional obligation. Nancy also shared that after a meeting with her colleagues and the leadership at work over how MAID might be incorporated or play out in her workplace setting, Nancy sought out her manager to relay that she could not actively participant in MAID, and would not be present in either supporting or caring for patients who were requesting it, should the practice occur initiated in her workplace. Nancy *took a stand* as well when she clarified her position further, expressing that she also needed to know how and if MAID would occur at their facility, since she would quit if her only option was to be involved in it.

**Transparency.** Transparency is a subtheme in these nurses *taking a stand* to make their COs known. Being transparent is to be clear, and denotes a willingness to be open about one's views (OED, 2017). Ruth was *transparent* when she addressed her ethical concerns by making a CO to the problems she encountered in clinical practice that went against her conscience. She approached her nursing manager on two separate occasions to facilitate discussion with her manager and register her conscientious objections.

For Robert, ethical dilemmas present a transparent opportunity to bring clarity to challenging aspects of nursing practice. He noted that ethical concerns are common in health care practice and at various times he has had to advocate for being open with clients and other members of the health care team. To be transparent, Robert stated that open and frank discussion is necessary to flush out ethical concerns for clients and their caregivers, and to build knowledge through experience was an essential part of making a conscientious objection.

While the nurse participants all took varied approaches to making their COs known, which generated from a sense of personal conviction and a desire to be ethically transparent, their objections were met with varying degrees of support. Overall, while most of the nurse participants were not met with formal opposition to their COs, they did encounter a degree of uncertainty in that their COs did not motivate a change to the issues that they were objecting over. The next theme illustrates their post objection experiences.

### **Alone and Uncertain**

Alone is term that is defined as being on one's own, or not being accompanied (OED, 2017). Uncertainty means not being completely known or left vague and unclear (OED, 2017). Emerging from these nurses lived experiences with making a CO is that their decision left many of them feeling alone and uncertain, with some exception. A

sense of *futility* also emerged as a subtheme to the theme of *alone and uncertainty*. For those nurses that had more of an autonomous stance in their workplace settings, such as Amy who is a nurse practitioner and Robert a clinical nurse specialist, they expressed that they felt certain in their convictions and that their sense of being alone was the opposite to how most of the other participants felt in their objection experiences. For example, Amy related that because she knew she would receive support from her management team, she felt confident in making her CO and that she would not be isolated from her colleagues to do so. Robert's ability to address ethical concerns in his workplace due to his extensive education and comfort with ethics as a source of knowledge allowed him a strong degree of certainty and confidence to address ethical issues in his clinical practice. As such, while he was alone in his convictions that lead to his CO, he did not feel a sense of uncertainty about them.

For the other nurses, this was not the case. Tracey shared that she realized her position regarding MAID and objecting to it made her an "*outlier...because I thought it was unethical to facilitate our patients being killed and designing a policy that would allow that*". A policy that was otherwise held as the status quo in her workplace. Beth related that when the law for euthanasia was coming forward leading to her voicing a CO over it she felt like a "*lone soldier*" given that this was not an issue her colleagues agreed with her over. Beth shared how her colleague's views on euthanasia were so opposite to hers that this created a rift in how she felt as a part of her workplace and even her own profession, "*there is not that support around, in my colleagues. Everyone has compassion, typically in health care. But how they want to live it is like totally going...towards that idea [for euthanasia], so it's easier to see yourself in a conflict.*"

Pushing Beth to the outer rings of her nursing community, this sense of being alone was layered with uncertainty that became amplified after she made her COs on MAID known to her manager. While supported in voicing her CO, the fact that the practice of MAID will be moving into unanticipated areas of Beth's work was a shock for Beth. Beth related that she was not sure how much longer she could work at her facility, since new measures had been taken to make MAID available in hospice care, which initially Beth was under the impression would not happen, *"I was friends with all the people at x [place of work] and its, there's this division that I'm experiencing...am I becoming this person who is transparent or [am I] going underground to stay in my role to the last minute"*? Beth's uncertainty about how long she could practice nursing persisted after making her CO, since the issue she objected over was consistently being incorporated into more and more areas of nursing practice. This uncertainty was echoed by Nancy over her CO as well, *"I don't know what the end result will be I don't know whether the government will enforce something"* (Nancy). Even after seeking her nursing manager out to make her COs, Ruth was met with little support and no fixed plan over how to address the practices around the ethical problems she objected to, which continued to come up in her day-to-day nursing practice, leaving her feeling alone and uncertain:

This could happen again. I mean, we don't have to participate in the actual act, but this behind the scenes hurried death stuff, that can happen to me again! I still don't have any back up system to give me support.

Emerging from Robert's narrative is a sense of stigma associated with those who are religious and dismissing that influence as a reason to qualify a conscientious objection. Stigma arises from the Latin word for marking, or branding (OED, 2017).



Robert discussed encountering this stigma in the form of automatic dismissal for his perspectives based on other's instant assumption that he is religious, even though he himself does not offer that as a rationale. However, he indicated that he, in turn, counteracts this stigma by telling other HCPs that his clinical decisions are based on clinical facts, evidence and expertise. He shared that he puts on a white lab coat for his academic presentations and has a disclaimer slide to reinforce his position. Robert sees the coat as an outward sign of status to defend an inward conviction that he continuously justifies to others:

When it's [CO] based on religion...people dismiss you right away...and I object because usually it's a sign that people are not providing care that they should be providing...I neutralize it [the religious stigma against him] as soon as I can. I stop them as soon as I can because I say no...I put the white lab coat on when I start [a presentation] and I have a disclaimer that says it's not from a religious, traditional, historic or philosophical perspective. It is from my clinical experience working with people who are sick...this helps them to remember that I'm presenting from the clinical perspective of the health care professional.

Robert noted further that CO may be negatively perceived by nursing managers owing to their fear that nurses may object to everything, but he shared that he thinks nurses only object to what they think is wrong to do, leaving such a fear unfounded. When Kate voiced her CO to nursing educators at her workplace over MAID, she had the CO put back on her by being told that she had to do more to register her objection officially; for example, that she would also have to tell her manager and that her objections did not excuse her from her commitment to her patients and her obligation to

inform physicians of her patient's requests for Medical Assistance in Dying. This response was "*frustrating*" for Kate because it did not resolve her objection. The uncertainty of how to address her CO further, and to whom, may not be resolved for Kate even if she does share her objections more widely because she is not sure how MAID will surface in her day to day practice and what the right course of action would be to address it. She knows where she stands, morally, but there is no guarantee of how she can consistently address it in a professional context:

I hit a little bit of a roadblock in terms of them just not understanding where I was coming from with the whole referral thing...the worst part for me is being new and not knowing who to talk to...as a float nurse I have my own manager but then I have all the unit managers for all the places I'm floating to...the stress is partially due to just not knowing what to do or who to talk to...and it's a fear of the unknown...not knowing when it's going to happen and then also just not having a clear route of action.

***Futility.*** Although most of the nurses felt uncertain and alone to varying degrees in making their COs known, for some of the nurse participants, their experience of voicing a CO also evoked a sense of futility in their relational lifeworld experiences. Futility means failure to bring about a desired result, of being useless, or a wasted effort (OED, 2017). As a subtheme to *alone and uncertain*, futility emerged as a feeling that some participants had after voicing their conscientious objection. Working with others and having nursing managers and a profession to answer to complicated some of these nurses' COs due to the lack of response their CO elicited from nursing managers, who were perceived as not providing some participants with any direction or little to no support. Arising from Annie's narrative is this sense of futility; Annie shared her

frustration by what she describes as being “*powerless*” as a nurse to speak up and drive change in practice over moral issues that she perceived needed to be addressed. In the moment of making her CO during a code, Annie recalled “*usually the [nursing] managers or coordinators are in charge of asking the families [about the code status] but for some reason they were...just watching and I don’t know whether they were just interested in what was going on*”?

Having tried to bring about change with her CO, and then seeing nothing result from it, caused Annie to feel that if she can’t change the situation, then she has to walk away from it and find some way to cope with it:

I find a lot of times I’m not included in the decision making and it just frustrates me to feel so angry and helpless...being unable to alter and even advocating and trying to make a difference and that didn’t do anything.

This negative experience shaped how Annie thinks that as a nurse her input for her patients is not valued by her physician colleagues or her nursing managers in her practice over issues that she finds morally frustrating. Over time she shared that because she has compromised over small things, such as giving in to family requests she does not always agree with, by not questioning moral aspects of care due to lack of time and feeling that she is not heard have made Annie consider leaving nursing. Ruth’s experience of making a CO on two occasions is one of uncertainty and futility where she is left largely unsupported by her nursing management. Recognizing that her ethical beliefs also make her a minority on her unit, Ruth does not have much in the way of professional support in her workplace even after voicing her COs:

It’s still an unresolved issue just kind of hanging over my head. If the situation comes up again...I’ll call the doctor on call and see what

happens...but...you're kind of at the mercy of whoever it is and whatever they say and think and their opinion... they might think euthanasia is awesome. So...I'm kind of left at the mercy of their opinion.

Ruth described herself as not feeling too “*emotional*” about having to fend for herself in her workplace, but she does feel “*unsafe...unsure, there's uncertainty I guess*”. Conversely, some nurse participants did not feel as uncertain in their decision to make a CO over MAID, but this was also because of the support that was openly offered by their management. Sharing this context for her decision to be a conscientious objector to MAID, Amy noted, “*it hasn't bothered me emotionally because I know that I would be supported if it came up*” because her managers are “*very supportive, of us as a staff and they've certainly been very open in saying anyone who has a CO to this [would be supported]*”. While across the participant's experiences there emerged a sense of being motivated to make a CO to register their moral convictions over ethical problems that they encountered to be true to themselves, regardless of how it was received, there was also a sense that they were inspired to object because of the compassion that they felt towards others, namely, their patients.

### **Caring for Others**

*Caring for others* was a quality that emerged across the nurses' stories. Caring, or being compassionate, particularly towards those who are sick (OED, 2017), came through Tracey's narrative in her concern for the well-being of her patients as well as her nursing colleagues and profession in her CO over Medical Assistance in Dying. Tracey viewed support of MAID and the perceived silence she received from others in her opposition to MAID as detrimental to patient's lives and her nursing colleagues who may not have had the opportunity to be informed about all sides of the issue. Tracey noted “*we don't have*

*the type of academic freedom in [health care organizations] that people have at a university to talk openly about their ideas....why isn't there more freedom of speech?*

Commenting on her efforts to write and share some of the information and reports from studies on euthanasia in Europe to disseminate a balanced approach to nursing and MAID has been *“very exhausting and draining....I feel like I have two full time jobs”* (Tracey).

Aware of all the provisions for nurses in the documents that emerged from regulatory nursing bodies on MAID, Tracey was concerned that the fundamental stipulation of not doing harm to patients became lost with the legalization of euthanasia. Beth's view of nursing practice was similarly multi-dimensional; she cared for those she worked for and she saw providing good care, such as appropriate palliative care and end of life treatment as practice that did not include assisting patients to die. Yet, she recognized that there are barriers to human and fiscal resources in providing compassionate care to patients as well, *“the doctors and nurses are totally burned out, the budgets are not there, the staff is not there and every person that walks in the door needs exactly the same thing the first person needed.”* Beth believed these constraints made advocating for ethical issues all that harder but even more necessary; she thought that the health care system in Canada is so resourcefully strained and ethically vacant from the onset of MAID that patients may even perceive themselves as a burden to their nurses and their families:

I think everyone is so burdened and so worn out and so frustrated with trying to manage the very increasing workload, the care load, the social implications that go on daily here with family meetings. I think we have really failed as a society...a society that does not care for the elderly, the sick...is a society that will not endure or last.

Compassionate towards her burdened colleagues despite their ethical differences, Beth shared that in her nursing practice she was exhausted at times and she worked over time consistently, arising out of the care that she had for others, such as her patients. However, she maintained that she believed in being present with her patients and noted that HCPs can place too much pressure on themselves when all they should do essentially is to be there, in the moment, for their patients, “*sometimes we over-care. Like we caregivers, we think we have to go too far...mostly they [patients] just want you to listen, right? That’s it. They don’t even care if you solve the problem, they just want to get it out.*” Beth referred to times when she pulled off the road on-route to visiting dying patients, reminding herself through self-talk that her patients just needed her to take on their pain; to listen to them; to give them of her time. She shared her impressions that many patients have pain and fear of pain, which is not just physical but emotional, and she questioned who will listen to that, who will be present with them if euthanasia becomes common practice?

Robert consistently addressed his *care for others* with respect to making ethical decisions and COs in practice. He felt compelled to inform clients and colleagues about what is right, for the sake of doing what is good for all involved. For example, he embraced conversations with clients at the end of life because he was concerned with assessing and understanding how they perceive their dying process and death, and wanted to ensure that everything was done to support them clinically without assisting them to die:

They’re [patients] afraid of death and sometimes it’s difficult to discuss...they’re afraid of dying and that’s why [they] want to be killed...and not deal with the fear of dying. I say, we can discuss that

together and I will go into details with you...usually it's because they're fearing to have pain or having symptoms that make them suffer and be alone.

Robert's ethical convictions were not for himself alone; he held his objector stance to MAID because he cared for the well-being of his clients. He has made a CO expressly out of concern for a client whose voice was being ignored by a physician when he was trying to assert that he wanted to cease futile treatment, which Robert perceived as abusive and asserted himself by conscientiously objecting to the physician's attempts to coerce the patient into continuing the treatment. Robert has also utilized his academic knowledge and clinical expertise in academic settings, by way of ethics committees and conferencing to advance ethical engagement and understanding of ethical care practice to inter-disciplinary audiences. In his teaching, he remains invested in caring about nursing students as well as supporting his nursing and inter-professional colleagues. He shared that he actively discusses ethical and clinical concerns with his students and colleagues as a means of mentorship and support:

People need to learn about things when they [situations] are not right, so, helping them to understand these things was part of being conscious about it...we are there to help and to advocate for the client, for the best of the things we can be providing them and help them in the process of getting better.

Kate acknowledged that for her, nursing was about being with patients, helping them heal, being patient and compassionate as well as "*loving*" her patients and looking at them as people who have dignity. Kate does not separate her personal moral convictions from her professional, moral practice owing to the care and love she has for

her patients and what they are going through. She viewed her patients professionally in a way that was not disparate from her personal, humane view of her patients. For example, when Kate was caring for a patient who was depressed and requesting MAID since the patient felt that they did not want to live any longer, Kate was concerned because she saw this patient as someone who was depressed and hopeless. Kate's response was to care about this patient's existence and what life could mean to this patient who was considering ending their life:

I heard the palliative consult from behind the curtain and she was crying and saying, I want to die! I want to die! Palliative's response was, 'well, I can't tell you whether or not you feel that your life is something you want to keep living, that has to be your decision'. And I was like, holy cow! That's not supportive at all! That just hit me in my nursing gut...I needed to be there with her and love her. It was one of the more human experiences...there was one point where she was just throwing up....and holding my hand so tight....and [saying]no, don't leave me! It was a very tender moment...she was definitely alone and...she needed a little bit more emotional support.

Nancy's concern over her ethical dilemma that prompted her CO was also stimulated by her care for her patients and a sense of solidarity for other nurses who might encounter a situation like hers and be unsure of what to do with it. Nancy revealed that when voicing a CO, it arose out of a deeper meaning of caring for patients and making ethical nursing decisions that need to be supported, which may only be revealed when a nurse is pressed into a problematic situation, *"to be able to help other people...even if the college gets some of this [sharing of her lived experience] they will know from a personal experience the struggle that is out there. And they need to support*



us.” For Beth, “*it would be nice to share this experience with somebody just to sort of say, ok, in the future, if what I tell can help other people*”. Nancy’s care for other nurses encountering an ethical problem and voicing a CO over it highlights the need for ethical issues be brought to light both to improve both patients and nurses lived experiences of encountering an ethical problem or dilemma in their day-to-day lives as nurses.

### **Perceptions of Support**

*Perceptions of support* came through the nurses’ stories as meaningful to their experience of making a conscientious objection. This theme was highlighted in their narratives as either a lack of support, presence of support and what support meant to them as conscientious objectors.

**Lack of support.** In Annie’s experience, concrete supports for making a CO did not exist. Instead, her experiences with addressing ethical conflict in her workplace environment had been a more passive-aggressive approach to standing up to inter-professional colleagues predominantly consisting of nurses against physicians and physicians not supporting nurses’ expressing patient wishes’, “*sometimes nurses will post articles about ethical issues...on futility and I think that’s their passive-aggressive way of getting back to the physicians*” Annie noted, and at times she would approach the physicians to ask them whether an aspect of treatment was ethical, saying “*is this right?* ...*and they’re [physicians] are like, ‘ok’ but just kind of ignore you and don’t necessarily listen*”.

Other people in her workplace perceived Annie’s CO with support but did so by making negative comments about the physician (fellow nurses), silence (nursing managers not saying or doing anything when she made a CO in front of them), delayed apology but no admittance of wrong (physician), and delayed support (nursing

managers). Annie shared that overall these indirect actions were negative and did not advance a resolution to the ethical issues permeating her workplace environment:

Our unit's terrible for situations like that [dealing with ethical issues around futility], and it's something I've talked to my manager and educator about repeatedly...so, no, there's really nothing to help...sometimes my manager will say here is EAP, which is the employment assistance program, if you ever want to talk to a professional for help, but...it's not that I can't deal with it, I just want things to be different on the unit.

Noting there were no supports in place from colleagues, policies or guidelines to making her CO, Annie shared in retrospect of her experience of making a CO that in seeing the recruitment flyer for this study which included a definition of CO was the first time she was conceptually aware of the term, although her CO resonated for her experientially to mean conscientious objection. Any supports Tracey thought she had for her CO largely came from colleagues external to her workplace and who shared some of her concerns on the issue of Medical Assistance in Dying. While she felt initially she was met with some support from the nursing organizations she belonged to over her written COs to MAID, when, over time, they did not respond to her queries and concerns about MAID she felt that from a professional perspective that she was not being supported to voice her concerns over euthanasia, *"I can voice my opinions but it might be restricted on where they could be published and then they're met with silence"*. Moreover, Tracey did not feel that politicians were concerned about her issues from the lack of response she received in writing to her Member of Parliament (MP) and from the political meetings that she attended on Medical Assistance in Dying:

I went to that consultation meeting on the 43 recommendations for assisted death legislation and basically it fell on deaf ears. One of the co-author's of the recommendations sat behind me and said 'this group really has one-sided opinions'. I said...if all 43 recommendations are implemented, I won't be able to practice as a nurse. She said, 'oh that's not true'. I said, it is true. You're in a box where, I mean, nobody has clearly said what's going to be the repercussion if you refuse to transfer or refer a patient who asks for assisted suicide. But, you know, it's in the document that the nurse must transfer.

Robert did not have support from any guidelines or policies to make his CO apart from his own ethical knowledge. Kate has had a similar experience. An overarching problem arising for Kate in voicing her CO was maneuvering within her workplace to do so, since there was no established process for doing it. As such, there was no clear way forward for Kate to determine how she was going to voice her CO in clinical practice. Moreover, Kate found that as a newly practicing nurse, there was little time in her workday to sort out how to address her ethical concerns. She noted that while there were various human resources available in terms of ethicists, spiritual care and social workers as well as nursing managers she could talk to, she needed to find some way of making her CO understood by those who could guide her in making this kind of objection amidst other stressors such as being newly practicing:

It's not that there is no one to talk to, I [just] haven't talked to anyone who gets it about the whole referral thing yet. So, maybe I should actively scope out bioethicists....the other stressful thing is I literally just started as a new employee, I don't know if it looks bad to put in my own preferences....my

manager is just really scary...but I need to get on that because I know that's my professional obligation to let your manager know.

While she has had to take the initiative to source out what her rights are by way of going through her college guidelines with respect to making a CO, Kate has not encountered anyone specifically in her professional life that could assist her in this regard.

**Presence of support.** In voicing her CO, Tracey mainly received support from like-minded colleagues external to her workplace. Apart from that, Tracey has largely relied on her own ethical convictions with minimal support from some of her professional colleagues. Beth shared that she has supports from her husband, community, spiritual and social circles.

Robert related that his colleagues initially gave him support through discussion before he made his first CO in nursing practice. Robert has had ethics education throughout his formal nursing ethics education which support his clinical practice and vice versa. Robert indicated that he has several supportive colleagues in his workplace as well as the ethics committee he is on to discuss ethical concerns for professional practice. Amy found her professional and management team to be a source of support in making her decision to be a conscientious objector. She related that knowing she worked in a place where MAID was openly discussed and knowing ahead of time that she would have her manager's support to make a CO over it made the decision easier for her. Amy's understanding of CO also provided her with a meaningful understanding of what the concept is in terms of religion and historical significance. Due to her prescriptive role, Amy had also informed herself about the legislation around MAID and her knowledge as well as self-identification from a religious perspective were supportive means for Amy's

experience of being a conscientious objector. In voicing her CO, Nancy indicated that her supports largely came from some of her colleagues, her husband, family and one of her managers. Nancy did not have any specific guidelines that supported her professionally to make a CO, but she did go on to her professional nursing website to explore what her options were in making her CO as well as identified that one of her managers seemed to be up to date on college regulations about CO as well.

**Meaningful support.** Support that some of the participants voiced would be meaningful to them emerged as a subtheme to *perceptions of support*. Since concrete professional supports are largely absent from these nurses' narratives in making a CO, some of the participants shared what support would mean to them, as conscientious objectors. Nancy relayed:

You have to have the support. From your management, right? If you've got management that comes up and says, no, you don't want to rock the boat....then of course that is going to put more fear in you...but if you've got more supportive management...and has the same ethics, then it makes it a lot easier to make those decisions and feel comfortable about them.

Ruth shared that in her view, some sort of protection for freedom of conscience needed to be implemented for front line nurses who make conscientious objections. She also noted that public awareness is needed to illustrate that not all nurses are ethically amenable to certain practices that are part of the status quo, such as MAID, and that it seems to be the public's perception that whatever changes occur in health care provision, that all HCPs agree with it:

There will be some nurses who can't participate, so let the public know...I think the public assumes anyone who walks in, assumes we are all there for

it. We have to have our protection too...just because you [patient] want it you can't expect me to do it and put me in that position and report me if I don't do what you say.

Ruth further noted that nursing management needs to be supportive for nurses when they make a CO and one way to do this could be by way of developing a protocol of sorts, *“just a little protocol lined up for nurses who don't want to practice that...some kind of a plan laid out, maybe have them assigned...to one side of the floor?”*

### **Summary**

Amongst and across these nurse participant's narratives of living with an experience of making a CO, six themes with sub-themes emerged to illustrate what those experiences were meaningfully like for them in professional practice. What can be learned from this thematic analysis as well as implications of this research with recommendations relevant to nursing education, practice, policy and future research will be discussed alongside the study limitations, strengths and conclusion in the next and final chapter.

## CHAPTER SEVEN

### What can be Learned?

In my phenomenological study, I explored the lived experiences of nurses who made a CO in their practice setting. Sharing what these experiences meant for the nurse participants offers an opportunity to deeply engage with understanding the phenomenon of CO in the context of practicing nurses. Insights gleaned from my research provide a new way of perceiving how CO is relevant to nursing practice, education, policy and research. The six themes uncovered in the participant's collective stories illustrate how nurses make sense of ethical issues in the context of their professional practice. In this chapter I will discuss how these themes can be further appreciated for the nursing profession, relate the limitations and strengths of the study as well as implications and recommendations for nursing and further research to conclude this dissertation.

#### **Encountering the Problem**

In *encountering the problem*, nurses shared that when they were faced with an issue in their professional practice that amounted to an ethical problem for them, it was contextualized in time. Temporality, in the phenomenologically perceived lifeworld of time, was evidenced in how these nurses each *encountered the problem*; for some the realization that they were facing an ethical issue that they needed to address occurred in a moment, expressed as a revelation or an epiphany (Van Manen, 2014). For others, the realization to address their ethical problem emerged through a sense of corporeal (clocked) time and subjective or lived time, in that they took time to absorb, process and work through an understanding of needing to address their ethical problem with a CO over the process of days or weeks (Van Manen, 2014). Time surfaced with this theme as a significant factor for nurses when facing an ethical issue. For example, insights gleaned

from this theme offer an opportunity to appreciate how nurses may not fully articulate their ethical problems in the midst of their day-to-day experiences, which can be compounded by the constraints of time as well.

Nurses today work in medically complex, fast paced settings that may leave them little time to address their ethical problems outside of the demands of patient care needs (Hamric et al., 2012). As such, nurses need to work in supportive environments that appreciate the ethical concerns nurses may have. In addition, nurses in my study revealed that their proximity to patients and ethical issues can become more complex over time, such as was experienced by some of the nurse informants who expressed mounting concern over ethical issues that evolved into their everyday lives. This evolution lead to increasing the practical problems of how to go about their everyday care practice compounded by worry over moral complicity and job security as opposed to a resolution once they had made their COs known. In order to address the ethical issues that nurses may encounter, nurses need a sense of self-knowledge that explicates their subjective ability to navigate the context of their corporeal temporality abstracted in my study as *knowing oneself*.

### **Knowing Oneself**

While all the nurse informants expressed ethical persuasions, most were largely influenced by their religious beliefs and all of them held a strong sense of personal conviction. Being strongly convicted in terms of one's ethical perspectives to make a CO is reflected in nursing codes of ethics and resonates with findings from Davis et al.'s (2012) study where nurses reported that their use of CO was influenced by religious, socio-political, cultural beliefs, lack of set beliefs and codes of ethics. Much of the scholarship around CO is made up of theoretical articles that discuss philosophical



positions for or against nurses and other HCPs making a CO in practice settings. Predominantly, the scholarship to date has failed to reveal how nurses themselves are informed about their decisions to conscientiously object and, specifically, if their decisions stem from being informed by their conscience. What the theme of *knowing oneself* adds to the literature on CO is a perspective that nurses who do make a CO can be motivated, as self-reported, on the basis of their conscience, giving rise to the sub themes of *influencers of moral beliefs* and *connecting conscience and conscientious objection*.

Nurse participants' narratives converged to reveal that their moral beliefs were influenced by ethics education, religious precepts and their own conscience to follow through on their personal convictions to address their ethical problems by way of making a conscientious objection. For most of the participants, their conscience was individually and collectively associated with a sense of right or wrong, a belief that they could inform their conscience, and that it was something that needed to be acted upon to stay true to their inner sense of morality. In contrast to previous studies conducted by Dahlqvist et al. (2007) and Jensen and Lidell (2009) where nurses reported varying perceptions of what conscience could be, in this research nurses relayed what conscience meant to them, and then shared experiences where they acted upon their conscience to make a CO to an issue that they conscientiously perceived to be wrong to follow through on.

In the empirical nursing literature, the prevailing conceptualization of conscience is that conscience cannot be universally defined, owing to a dominant belief that conscience itself is a construction based on individual perceptions, although professionally there is a broadly shared consensus that conscience is a relevant idea in relation to nursing ethics (Dahlqvist et al., 2007; Glasberg et al., 2006; Jensen & Lidell, 2009). Moreover, CO has been disparately viewed as a phenomenon that is both an

extension of conscience and unrelated to conscience given the lack of belief that conscience is, itself, an objective principle (Emerson & Daar, 2007). However, as the subthemes to *knowing oneself* revealed, the nurses in my study largely held that their COs were meaningfully made as arising from their conscience.

Although influenced by various beliefs, ultimately conscience emerged consistently as a phenomenon that held meaning for these nurses as forming the basis for their conscientious objections. In the philosophical literature and in the works of primary authors on conscience, such as Aquinas (1998), the idea that conscience is inherent to humankind has been stipulated for centuries. While post-enlightenment and modern day approaches to conscience reductively subtract any notion of conscience as an objective principle whereby everyone possesses a conscience, across these nurses' experiences of CO, conscience held true as a common phenomenon that lent meaning to their COs as something that existed for each nurse, to hold each nurse accountable to right action.

Something to be gleaned from this insight is a consideration that conscience may be objectively rendered but subjectively perceived and subsequently developed, which could support both an overarching notion of conscience, objectively, in need of a personal systemization to inter-subjectively connect one nurse with morality and with one nurse to another. This intersection could create a shared cultural appreciation of a common experience in the context of conscience-driven nursing practice and render a deeper understanding of conscience in the context of nurses ethical decision making. As the central locus for their perceptions of right and wrong, conscience also supported these nurses' conviction to action by way of making a CO by their *encountering the problem* and *knowing themselves*, which gave rise to these nurses *taking a stand*.

## Taking a Stand

Nurses who encounter ethical problems and dilemmas often do so in the context of health care practice related to conflicting viewpoints with other HCPs and professionally sanctioned practices that fundamentally differ from individual as well as collective nurses' moral and ethical perspectives. For example, most of the nurse participants had a mutual objection to MAID, although the circumstances surrounding their experiences were individually contextualized. To bring their conflicting perspectives to light and to face their ethical problems or dilemmas in practice can require nurses to act with moral courage (LaSala & Bjarnson, 2010). Conscience has been discussed as an antecedent to moral courage in nursing (Numminen, Repo & Leino-Kilpi, 2016). In a conceptual analysis by Numminen et al. (2016), researchers found that conscience can be a positive force, driving nurses to question the status quo, adhere to their values, address challenging situations and debate dominating perspectives. Nurses in my phenomenological study shared that their commitment to adhering to what they valued to be moral and be ethically transparent about their decisions was part of how they balanced their personal beliefs with their professional obligations.

Catlin et al.'s (2008) hybrid conceptual analysis and descriptive study revealed that nurses can come into conflict with other HCPs, such as physicians, over patient health care decisions which may result in nurses voicing a CO to assert their ethical perspectives on what they consider to be appropriate treatment options. At times, nurses in Catlin et al.'s (2008) study revealed that they voiced a CO when their attempt at discussing ethical treatment options with physicians resulted in their declaring a conscientious objection. Essentially, their CO's were made to remove themselves from a

situation or advocate for their patients, due to conflict with those physicians with whom they had reached a moral impasse.

The scenarios reported in Catlin et al.'s (2008) study highlight the importance of inter-professional communication, where nurses' voices can be discounted in discussions with physicians that end with a lack of agreement owing to nurses' role restrictions in not being able to make what they perceive to be the ethical treatment and/or care decisions. This is an area that needs to be further brought to light; while it is proper to the role of nurses, (outside of the nurse practitioner position), to not make decisions about treatment options, how nurses contribute to patient care decisions bears further consideration. In some cases nurses may simply disagree with treatment options but when it comes to a serious ethical disagreement, nurses may end up having to advocate for patients and be left feeling powerless to alter the situation because they are not in a position of authority to do so (Baker, 1996). This feeling of powerlessness can generate the need for a nurse to make a CO, such as in the case of the CO expressed by Annie.

The relevance for nurses expressing their ethical concerns also necessitates better dialogue on ethical issues amongst disciplinary team members such as front line nurses and nurse managers, since nurses at the bedside can shed light on various aspects of an ethical situation that nurse managers may be removed from (Ford et al., 2010). For example, as nurse participants revealed, at times they felt involved and morally complicit in aspects of MAID even after they had voiced their COs to refrain from participating in such practice to their managers. This left some nurses having to seek out their managers repeatedly for support and to suggest supports themselves, involving them in *taking a stand* on multiple occasions to address a single problem. What can be learned from these lived experiences is that there are layered issues involved in nurses' making a CO,

indicating that support and discussion is needed for nurses who act to address their ethical problem in declaring a CO in professional practice. Moreover, voicing such a concern can be made in the patient's interest, and is not only associated with a nurses' personal, ethical beliefs as is often indicated in the literature to date on CO for nurses and HCPs across health care practice (Kane, 2009; McHale, 2009; Shaw & Downie, 2014). For example, all the nurse participants conveyed a sense of *caring for others* that motivated their COs to address ethical problems they perceived to be relevant to their patients, as well as themselves. In such instances, nurses may even be exhibiting moral courage to follow their conscience and question the status quo. At the least, the use of CO by nurses bears further understanding than deciding at the outset that HCPs who make a CO are steeped in religious bias, or have no personal right within their professional obligations to declare their ethical concerns, which has become a recent stipulation across the current, bioethics literature (Schucklenk & Smalling, 2016).

Rather, the knowledge around nurses who make COs is an emerging area of scholarship and one that bears further understanding to mitigate the pluralizing, moral contexts of contemporary health care practice (Lamb et al., 2017). The emphasis on CO might be better placed at further understanding the context of conscientious nurses since conscience has been shown in research to be a positive driving force in nurses' day to day practice (Gorbanzadeh et al., 2015; Jensen & Lidell, 2009). Moreover, nurses who cannot follow their conscience over what they consider to be quality patient care provision or from a personal, ethical standpoint have reported a 'deadening' or silencing of their conscience in care practice. This deadening or silencing can result in nurses leaving their practice areas and refrain from playing an active role in ethical care provision due to a thwarted sense of conscience (Juthberg et al., 2007). Finally, while an antecedent to

moral courage, conscience should not have to become a precursor to addressing ethical issues in practice from such a heroic perspective. Instead, conscience and CO could be better understood as supports to nurses' ethical transparency in practice which serve to facilitate morally sensitive work environments (Ford et al., 2010).

### **Alone and Uncertain**

Addressing ethical problems in practice through CO left nurses feeling alone and uncertain. As previous research indicates nurses have reported being silenced when attempting to address ethical issues in practice (Newton et al., 2012). This silencing can occur in the form of choosing to be silent to not upset the prevailing norm, fear of being stigmatized, lack of comfort around articulating challenging ethical situations and being dismissed or ignored by physicians and managers even when nurses attempt to vocalize their concerns over ethical issues in practice (CNA, 2003; Ford et al., 2010; Ford, 2012; Newton et al., 2012). Nurses can even be involved in concerted actions such as making efforts to engage in discussion with other team members and still feel silenced or be met with silence, further perpetuating their ethical concerns and road blocking their attempts to clarify or resolve ethical issues in practice (Newton et al., 2012).

Resonating with the literature, nurses voiced feeling uncertain about their future as professionals after making their COs, and a lack of power in driving change, being dismissed, and missing a sense of common, collegial, ethical perspectives which made them feel alone in their nursing communities. In the case of MAID, Tracey felt unheard in her attempts to discuss the issue with governing nursing bodies; Ruth had repeatedly tried to engage her nursing manager and doctors in discussion to advocate for herself to refrain from participating in MAID and a hurried death; Annie was met with silence when she voiced her CO to her nursing managers; Nancy and Beth worked with

colleagues who predominantly disagreed with their fundamental positions on MAID which made them feel uncomfortable in discussing their moral viewpoints in their workplace. Most of the nurse participants voiced a concern with losing their jobs or reconciling themselves to the possibility of doing so, since they held a moral position against practice that differed from the status quo. Making a CO can be hard for nurses to voice in the first place, and they need supports to be able to discuss their issues without having to feel that they need to hide who they are or fear losing their jobs (as voiced by nurses in this study) to share their ethical perspectives.

Notably, the experience of making a CO by staff nurses differed significantly compared to the nurses who were in positions of authority in their own roles. For example, Robert and Amy both expressed confidence and a sense of security in making their viewpoints known, because they shared that they knew that they would be supported and were confident in their professional autonomy to make care decisions against Medical Assistance in Dying. In the sole case of Robert, having extensive ethical knowledge enabled him to effectively engage in difficult situations where he has conveyed his perspective with self-reported, consistent success. Conversely, most of the other participants were in front line staff roles and needed the support of their managers to be able to voice their COs and refrain from participating in practice they perceived to be unethical. They voiced feelings of being alone and uncertain after making their COs, which contrasted with the lived experiences of other participants with more autonomy in their workplace settings. As Ford et al. (2010) conveyed, front line nurses often need the support of nursing managers to make COs, and nursing managers may not be adequately equipped themselves with the knowledge and skills needed to effectively engage in having those supportive conversations with staff nurses.

Given that the nurses in my study had to seek out information about CO themselves, or did not know they were making a CO until after the fact, the findings resonate with Lamb et al.'s (2017) assumptions that nurse managers as well as front line nurses, may not be currently informed about CO as stipulated in their Canadian Nursing Code of Ethics (CNA, 2008). Moving forward, the experiences of these participants reinforce the need for dialogue and the facilitating role that nurse managers need to engage in with their front-line staff to authentically support staff nurses' ethical concerns and conscientious objections.

Lack of nurse educators formally educated in ethics has also been identified as an issue for nurses (Laabs, 2015). Nurses in my study who reported confidence in making COs apart from a strong sense of personal conviction were those that had an extensive ethics background and one who was already conceptually well versed in CO before having to make one. Again, nurses who did not have as staunch a background in ethics were more uncertain about broaching their ethical issues in practice. Moreover, all but one participant reported formal ethics education in their nursing education and none of the nurses had a conceptual understanding of either conscience or CO from their formal nursing education experiences.

How nurses are educated in ethics is also worth considering in light of these nurses' stories, as is appreciating the way in which nurses are supported to augment their feelings of being alone and professionally uncertain due to lack of communication and processes in place to support nurses on the ground when making a conscientious objection. As Ruth related in her narrative, she was the one to suggest to her manager that some sort of protocol be put into place for nurses who make COs; for most of the other nurses, although they followed through on addressing their ethical problems with COs,



the problematic effects of making those COs could have been mitigated with support from nursing managers. Moreover, cultural awareness over diverse opinions on ethical issues within the nursing community itself would have been supportive in making a conscientious objection. For example, Tracey felt as though she was completely alone in her nursing community and was met with silence when she tried to engage in dialogue from an opposing view of MAID with her nursing regulatory college and interest groups.

Public awareness could also be heightened to enlighten potential patients that not all nurses agree with certain practices, such as the socio-cultural majority stance on MAID in Canada. As Beth put it, even amid conflicting ethical viewpoints with others, nurses at large are trying to do what is good for their patients and for themselves, as morally integral agents, and this is not necessarily apparent in the public's perception of nurses. Increasing public awareness of the ethical situations of nurses, as expressed by Ruth, could be another strategy for supporting nurses who make COs in professional practice.

### **Caring for Others**

Expressed by Heidegger (2010) as a concept that lends meaning to human existence, care was a motivating factor for nurses living with making a CO in their professional practice. Most importantly, their expression of this motivating factor was levied towards others and materialized as a sense of compassion for the suffering of their patients and a desire to see that suffering decreased either through the cessation of futile treatment or as re-directed with palliative care as an alternate to Medical Assistance in Dying. Suffering is a part of the human experience and may be described as needing a cooperative approach in which people as care providers and care receivers can appreciate the suffering of one another (Lamb, 2009). In this sense, suffering has been perceived as

something that is relational, and a way to connect one human to another by way of considering the fundamental implications of what it means to be, fully human (Frankl, 1985). In a break from the Cartesian duality of the cognitive essence of existence, Wojtyla (1979) noted that the fundamental characteristic of humanity is to act, which is expressed ethically as doing that which one considers to be right, not only for oneself, but as an existential extension of what it means to be, in relation of oneself to another. Suffering is that common human condition, and care, or the motivating factor to live a meaningful existence, or compassion, can be the bridge to supporting those experiencing it (Heidegger, 2010).

As the nurses in my study shared, they were motivated by a sense of care that caused them to voice a CO that would not only maintain their sense of moral integrity, or congruence between one's personal and professional sense of self (Lamb, 2016), but that evoked a concern that they had for the well-being of their patients as well. For most of the participants, they put aside their fears and apprehensions and advocated for a sense of what they perceived to be a common good for their patients, nursing communities and society. Appreciated as that which is good for each and every person in a society, the common good principle is a notion that can be further abstracted through this theme of *caring for others*, since it rests on a sense of fulfilling a moral requirement that elicits right actions are undertaken at the cost to self for the sake of others (Lamb, 2016; Maritain, 2011). However, what the common good principle does not allow is that what is good be compromised by one for the sake of others. This is meaningfully expressed by nurses who were opposed to MAID, since they were opposed to being asked to support taking the lives of their patients which would have compromised their moral appreciation of what it meant to be a good nurse, an ethical human being and a departure from a

common, human experience of support for others who were suffering in a relational context.

The theme, *caring for others*, reveals that those who make a CO may do so to challenge what might otherwise signal an erosion of what can be perceived to be good for individuals and a society at large. In my research, MAID was perceived as such an example in which nurses would not participate in a practice that would both harm the patient who requested it, the nurse who assisted in it and a society who had sanctioned that taking someone's life could be a social good.

### **Perceptions of Support**

For the most part, nurse participants felt professionally unsupported in making their conscientious objections. Canadian regulatory bodies to date have stipulated that nurses be transparent in making their COs known, but outside of that occurring, little direction exists on how to integrate CO into nurses' practice or to direct nursing managers on how to support themselves or other nurses when COs occur (College of Nurses of Ontario, [CNO], 2016). While some nursing codes of ethics are more informative in some countries than others in delineating a process for CO, such as the American Nurses Association's Code of Ethics (2015), there also needs to be a balance in not being too prescriptive about how to make a conscientious objection. An underlying assumption regarding CO in the theoretical, nursing and bioethics literature is that COs are predictable or only made over issues of abortion, contraception and euthanasia (Cannold, 1994; Giubilini, 2014; Kane, 2009; Schuklenk & Samlling, 2016). As Annie and Ruth revealed, COs can be made for other reasons as well.

Notably, researchers in the Canadian context have been heavily involved in restricting the COs of HCPs across the country predicated on the sense that patients are

not being provided enough access to services such as abortion, contraception and euthanasia (Kantymir & McLeod, 2014; Schuklenk & Smalling, 2016; Shaw & Downie, 2014). However, the work of these researchers has extensively failed to address the rights of and reasons for HCPs to stay true to their chartered right to freedom of conscience (Charter, 1982) as expressed by HCPs themselves.

Health care professionals are also entitled to freedom of speech to articulate an ethical position that both expresses their fundamental, values frameworks and subsequently, what it means for HCPs to be fully human. Moreover, CO has been largely overlooked by contemporary, Canadian advocates against COs by HCPs such as Kantymir and McLeod (2014), Shaw and Downie (2014) and Schuklenk and Smalling (2016), over what the experience of nurses are in relation to voicing a CO, as well as why. This is problematic considering nurses dominate the health care work force (Canadian Institute for Health Information [CIHI], 2011) and make a significant contribution to the Canadian health care system at large.

Nurses already face problems in practice with being silenced over ethical issues which could be further complicated if nurses feel they cannot address, or find they are not being supported in addressing, their ethical problems by way of COs in practice settings (CNA, 2003; Newton et al., 2012). This lack of voice has been shown to result in nurses becoming removed from ethical aspects of health care practice, which is detrimental to patient's well-being and is corrosive to the ethical mainstay of nursing care provision, since nursing is a moral endeavour (CNA, 2008; Carnevale, 2013; Newton et al., 2012). To ensure that ethical issues are freely expressed is relevant to just and tolerant societies. As revealed in the lived experiences of nurses making COs, while contentious, ethical issues need to be brought to light in nursing practice for the sake of moral integrity,

transparency and the preservation of moral agency in nursing care contexts since quality patient care necessitates ethical nursing practice.

### **Limitations**

Perspectives on ethics and ethical concepts in nursing can vary greatly with scholarship advancing from various sectors on a frequent basis, posing a challenge to capturing all the nuances that exist in association with ethical concepts. While my research focused on the nursing context for conscience and CO, my study also focused on addressing what meaning could be explicated to appreciate a different way of understanding what it is like for nurses to use CO in nursing practice. Most of the nurses shared an experience related to MAID, which is a very current and controversial topic in the Canadian social and health care context. As such, this research may be limited in relation to revealing the range of issues that can prompt a nurse to make a CO or, may have simply attracted participants based on the currency of an issue as opposed to eliciting varied responses from nurses. In addition, recruitment was a challenge and while the recruitment strategies for this research were chosen to maximize reaching potential participants in a confidential manner, it may have proven less of a challenge if more informal methods were used such as word of mouth or advertisements in local newspapers. More phenomenological studies may glean further insights across a more diverse participant demographic to understand more fully what it is like for nurses to make conscientious objections. For example, a study specifically exploring the experiences of nursing managers may offer yet another side to the phenomena in question and present a fuller appreciation of the nuances involved in supporting nurses who make COs in professional practice.

## **Strengths**

Strengths of my study include initiating an understanding of what it is like to be a nurse voicing a CO in clinical practice. Insights into the intricacies of being an ethical nurse in today's morally pluralistic practice settings were generated to shed light on how to support nurses facing ethical problems that could lead to their objections based on their conscience. Suggestions for nursing practice, education, policy and further research into CO and conscience are presented to increase knowledge in these areas and to better support nurses from an ethical context.

## **Implications and Recommendations for Nursing**

**Nursing practice.** At a time when patient care needs are increasing and becoming more technologically and ethically complex, nurses need strong ethical knowledge to effectively respond to the practical and ethical demands of their profession. My phenomenological study supports a way forward to expand on ethical nursing practices regarding conscience and conscientious objection. The nursing perspective shared on these concepts in my study signal a greater need to address issues of conscience and ethical problems that nurses can encounter and address by way of making a conscientious objection. Relevant to nursing practice, awareness of, and commitment to, an ethical orientation is a requisite for contemporary nurses, made possible by their ability to address conscience issues through transparency of conscientious practice. Ways in which nursing practice can be enhanced by the findings from this study and recommendations for nursing practice include:

- Adopt a professionally inclusive approach to nurses who use CO and develop supportive measures in clinical areas with frontline nurses and nurse managers to ensure that nurses are able to voice their ethical concerns in workplace settings.

- Incorporate information sessions into professional nursing practice settings to support nurses who may need to ethically refrain from participating in practices such as MAID and offer these sessions to nursing managers and inter-disciplinary teams as well.
- Support the creation of conscience protection policies into workplace settings and nursing regulatory bodies to inclusively address nurses' conscience rights with respect to ethically contentious practices, such as Medical Assistance in Dying.
- Dissemination of findings via policy briefs to nursing regulatory bodies, interest groups, nursing executive officers across the country, Members of Parliament and the Minister of Health to inform nursing and health care leaders in Canada that nurses' voices are relevant to ethical problems that they encounter in their practice settings.
- Disseminate findings with additional policy briefs to nursing regulatory bodies and Members of Parliament on nurses' experiences relevant to Medical Assistance in Dying legislation in practice.

**Nursing education.** While clauses and codes of ethics protect CO for nurses in various countries, stringent attributes in the literature stipulate that nurses need to be willing to give up their jobs as a consequence to making a CO, which does not reflect many of the current codes and guidelines supporting nurses' appropriate objections (Catlin et al., 2008; Lamb et al., 2017). In addition, nurses in my study, for the most part, did not have a conceptual understanding of conscience or CO by way of formal nursing education. This lack of conceptual understanding may be further compounded by the lack of ethically educated educators in nursing, which is problematic given that ethics is a standard of nursing practice. Consequently, strategies for nursing ethics education are

needed to support conceptual awareness and understanding of CO for practicing nurses as well as nursing students to ensure their awareness of the ethical options available to them in professional practice, should the need arise where they would consider making a conscientious objection.

Potential educational strategies include incorporating formal and ongoing education into schools of nursing and across nursing health care sectors on conscience and CO to increase nursing knowledge over relevant strategies to address ethical issues in nursing practice. For example, creating and disseminating information pamphlets on conscience and CO for practicing nurses across Canadian care settings could enhance knowledge and awareness on conscience and CO across health care sectors. Supporting the need for ethics educated nursing educators through publications on the topic as well as establishing my program of research in this area would integrate more knowledge about conscience and CO into academic institutions.

**Nursing policy.** Relevant to the Canadian nurse experience the findings from my study indicate that nurses' perceptions of conscience and lived experiences of making a CO are not receiving adequate support from their managers and regulating bodies on how to make a CO in their professional settings. Empirical studies further indicate that nurses who cannot address their conscience issues in practice may result in silencing, or not responding to, their conscience (Ford, 2012; Juthberg et al., 2007). Increasingly, ethical dilemmas are becoming part of nurses' everyday practice experience, adding layers of moral complexity to nursing care already burdened with financial and human resource constraints. Critically relevant to patient's care experiences, nurses play a crucial role in supporting patient well-being, yet their own welfare is often neglected due to their not being able to express their conscience concerns and address the ethical dilemmas



frequenting their daily work lives. The findings from my research advance the need to explore the space between nurses' encounters with ethical issues and making COs to create resolutions to their ethical practice issues through policies, public awareness and professional recognition that support conscience clauses for nurses' ethical health care practice. Specifically, this need could be addressed by increasing public awareness on nurses varied, ethical stance to practices such as MAID through public press conferences, workshops and newspaper publications.

While codes of ethics exist in Canada that offer protection for nurses' use of CO, given the lack of formal knowledge and manager's ability to proactively address nurses' COs in my research, policies on freedom of conscience as well as protection for CO could be a useful tool to engage front line nurses, nurse managers and inter-disciplinary professionals in professional practice settings on how to clinically navigate and address solutions to nurses' conscience concerns. Establishing a work force with relevant stakeholders across the country is an initial step to creating and disseminating a workplace policy for nurses' protection of conscience that reinforces the option to make a CO as already outlined in the Canadian Nurses Association Code of Ethics (2008).

### **Further Research**

Appreciating conscience and CO as ethical components for nursing care is an opportunity to advance nursing ethics through future research. Further research that could emerge from this study's findings include:

- A mixed-methods, three-phased research study to identify: 1) the meaning of conscience for nurses, 2) develop, implement and evaluate a conscience based educational intervention with student and practicing nurses, and 3) outline a conceptual framework of conscience-driven care provision.

- Studies on how conscience has been epistemologically addressed by nurse educators in schools of nursing across Canada to appreciate if nursing ethics educators could be further supported to teach on conscience and conscientious objection.
- A national study looking at nurses' and stakeholders' (public, institutional, political) awareness surrounding conscience based health care and implement as well as evaluate educational interventions that foster conscience awareness in health care practice.
- Establish a conscience-based conceptual framework for practice and implement and test it in schools of nursing, health care institutions in Canada and internationally.

While research on conscience related issues are becoming more apparent in the nursing literature, the meaning of conscience and CO individually and in relation to each other are minimally, empirically researched. A grounded theory study is needed to generate empirical knowledge on conscience with respect to CO to more fully explicate how nurses and other HCPs respond to conflicts of conscience. More research is warranted to practically support and evaluate nurses' theoretical understanding and actual encounters with conscience and conscientious objection. Given the relevance of conscience and CO to nursing ethics, evidence is needed to shed light on how conscience related concepts can be positively incorporated in today's ethically diverse practice settings. Efforts are needed to reduce the negative implications conscience issues can hold for nurses and to begin to formally address the conflicts that could give rise to their conscientious objections.

## **Conclusion**

The results of my study reveal that there are substantial gaps in the literature related to the meaning of conscience and CO for nurses as voiced by nurses themselves, and how CO is taken up in nursing practice. My research study demonstrates an initial appreciation of conscience and CO for nurses to date, as meaningfully lived through and voiced by nurses themselves. Conscience is an essential component of ethics as well as moral nursing practice, offering a medium for nurses to think through and act on what they perceive to be right. Conscientious objection is an option that can proactively address nurses' conflict of conscience over personal, ethical concerns and patient care issues, which can be taken up by nurses accompanied by supportive guidelines and knowledgeable leadership. Exploring the phenomena of conscience and CO as meaningful to the context of nurses bridges a gap between research and practice by explicating what is known and what needs to be clarified further. My phenomenological study offers an initial way forward by providing insights for advancing nursing ethics centered on addressing what conscience and CO mean for nursing practice, and outlining implications for further research. The search for meaning continues.

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## Appendix A. Recruitment Flyer



### **Are you a Registered Nurse working in Ontario?**

Have you ever had a time at work where you said you would not provide care or participate in practice because you thought it was wrong to do so?

This is known as conscientious objection, and protects your right as a nurse working in Ontario to object at work to doing something you think is seriously wrong to do.

I am a PhD in nursing student, and I would like to hear more about your experience for my doctoral research through one or two interviews held face to face or over the telephone. Each interview will take an hour to an hour and a half, or a total of three hours of your time.

If you are interested in having a confidential interview to discuss your experience with me, please email me, Christina, at:

**Co-Principal Investigator/Supervisor**

Dr. Marilyn Evans  
Associate Professor  
Arthur Labatt Family School of  
Nursing  
Western University, London, ON

**Co-Principal Investigator/Supervisor**

Dr. Yolanda Babenko-Mould  
Associate Professor  
Arthur Labatt Family School of  
Nursing  
Western University, London, ON

## Appendix: B. Research Ethics Board Approval



Research Ethics

### Western University Health Science Research Ethics Board HSREB Delegated Initial Approval Notice

**Principal Investigator:** Dr. Marilyn Evans

**Department & Institution:** Health Sciences/Faculty, Western University

**Review Type:** Delegated

**HSREB File Number:** 107793

**Study Title:** Exploring the Food Experiences of Concentration Checkers for Nurses in Ontario

**HSREB Initial Approval Date:** April 29, 2016

**HSREB Expiry Date:** April 29, 2017

#### Documents Approved and/or Reviewed for Information:

| Document Name                   | Comments  | Version Date |
|---------------------------------|---|--------------|
| Other                           | References  |              |
| Recruitment Items               | Recruitment flyer   | 2016/03/22   |
| Recruitment Items               | Facebook Recruitment Strategy   |              |
| Other                           | Letter for other Facebook Domain Users                                      | 2016/03/22   |
| Recruitment Items               | "Participant Information Clip" video text for Facebook Recruitment Strategy | 2016/04/27   |
| Western University Protocol     |   | 2016/03/23   |
| Letter of Information & Consent |   | 2016/04/27   |

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submissions and acceptance of HSREB Continuing Ethics Review.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice Practices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Ethics Officer, on behalf of Dr. Joseph Gilbert, HSREB Chair

Ethics Officer is Content of Further Information:

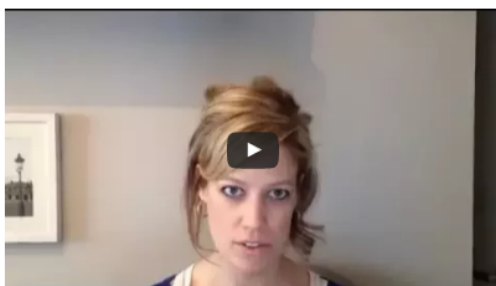
## Appendix C. Recruitment Website

### Website Recruitment Page: Screen Shots with Content Description

## Nursing Ph.D. Research

Study: Exploring the Lived Experience of Conscientious  
Objection for Nurses in Ontario.

Christina Lamb, RN, PhD Candidate, Arthur Labatt Family  
School of Nursing, Western University.



### Hello and welcome to my Nursing, Doctoral research webpage.

If you are an English speaking, Registered Nurse currently working in Ontario who has made a conscientious objection in your professional practice, then this page might be of interest to you!

Conscientious objection is objecting to doing something that you think is seriously wrong to do.

Please view the video for an explanation of my doctoral research and contact me, Christina Lamb, Registered Nurse and PhD student at: [clamb4@uwo.ca](mailto:clamb4@uwo.ca) if you are interested in participating in my research study.

Please watch the video for more information on this study!  
Thank you for your time.

- Christina Lamb

\*These are screen shots from the website recruitment page.

I had this page created to use as a recruitment strategy for this research. The page is populated with information on the research: what it is, the inclusion criteria, my name and status, how to contact me through my school email and the names and contact information for both my doctoral supervisors and the Research Ethics Board at Western.

The page also contains a short, personal information clip (using the script from the approved appendix B which was also modified for this ethics amendment). The video is linked to You Tube to be able to play this type of video file. However, only those who see this website link will be able to watch the video, and comments have been disabled for the video. Viewers are able to 'like' or 'dislike' the video, but it does not identify the viewer in any way, and only the administrators of the webpage can see the like/dislike results to understand the impact of the viewer reach for the video.

Viewers of the website will be able to send me an email to my school address off of the website, but in no way can they contribute to any discussion or online presence on the

webpage. As such, there is no possibility for a public forum or communication via this webpage recruitment strategy.

Additionally, I am able to ensure that there is no personal information about me on this page for my personal safety and also ensure that there is no way to see those who view the page. The link to the website is: . It is currently online, but has not been pushed out to any search engines, so, those who know the link can view it, but until there is ethics approval, this website recruitment strategy is not being utilized as a recruitment strategy in any way.

## Appendix D. Letter of Information and Consent



### Letter of Information for Study Participants

**Study Title:** *Exploring the Lived Experience of Conscientious Objection for Nurses in Ontario*

**Phd Candidate:**

Christina Lamb, BScN, RN, MA,  
PhD Candidate  
Arthur Labatt Family School of Nursing  
Western University  
London, ON.

**Principal Investigator/Supervisor**

Dr. Marilyn Evans  
Associate Professor  
Arthur Labatt Family School of  
Nursing, Western University  
London, ON

**Principal Investigator/Supervisor:**

Dr. Yolanda Babenko-Mould  
Associate Professor  
Arthur Labatt Family School of Nursing  
Western, University  
London, ON

**Purpose of the Study**

This is a study to interpret what it is like for nurses who use their right to object to doing something that they think is unethical in practice. I am interested in understanding more about nurses who make conscientious objections in professional settings. You are invited to participate because you have used your right to object to providing care because you thought it was the right thing to do (conscientious objection).

**Procedures for this Study**

You will be asked to take part in at least one or two interviews, which will be held face to face or on the telephone, whichever you prefer. Each interview will be held at a time and place that is convenient for you and will last about an hour to an hour and a half, or three hours at the most, in total. I will audio-record each interview so that I can type up the recordings for analysis. If there is something that you do not want me to record, I will stop recording it.

If there is something that you've told me that you don't want included in the study, it doesn't have to be included and will be removed from the study. I can show you a copy of the typed interview if you choose. I will ask you to fill out a demographic

questionnaire at the first interview, but none of the information will identify you in any personal way.

The findings will be used for publication in peer reviewed journals and in my doctoral defense at Western University. I may use the typed interviews for future studies, but only if you agree that I can.

### **Risks and Benefits to You if You Participate in the Study**

There are no known direct risks to participating in this study. You may become emotional or upset if you relate a time that was stressful to you. I will have a name of a counselling service for you to speak to if you decide you need support and you may wish to have a loved one to contact should you become upset. You may stop the interview at any time, you do not have to answer questions and if you withdraw from this study it will not impact your employment in any way whatsoever.

The benefits of this study include you potentially having positive feelings from sharing your experiences and knowing that other nurses may benefit from your experiences through the publications of this study's findings. You may feel that you have benefited from finding meaning in sharing your experiences and what these experiences mean to you. Society could benefit from understanding the ethical challenges that nurses can face in making ethical decisions and voicing objections to something that nurses think is unethical to do in practice.

### **Confidentiality and Privacy**

Your confidentiality and privacy will be respected at all times. No personal identifying information will be associated with this study. I will use a code to name your typed interviews. The only data that will be reported in the results of this study will be anonymous. There will be no data publicized that could identify you and your individual responses and the data will only be published in peer reviewed journals and used in my doctoral defense at Western University.

All the interview tapes, typed interviews, demographic questionnaires and any information about you will be stored on a password protected laptop and in a lockbox that only I will have access to. The tapes, typed interviews and questionnaires will only be shared with my doctoral supervisors and doctoral research committee. I cannot guarantee complete confidentiality but will make every effort to maintain it to the utmost of my ability. All the data will be destroyed after five years in keeping with Western University's policy and all hard copy data will be shredded, and any electronic data will be deleted and wiped off from the electronic devices used. I will have a master list of all participant's names and contact information for the purpose of setting up interviews, but the list will stay in a locked box in my locked office at home and no participant will have access to it.

I may publish the results of this study, but there will be no identifying information about you in the publication. Quotes may be used in the publication of the study but there will be no identifying, personal information.



**Voluntary Participation and Withdrawing from the Study**

Before you decide to participate in this study, you should be aware that your participation is voluntary. You do not have to participate in this study and you may refuse to answer any questions or withdraw at any time. If you decide to withdraw after data is pooled with data from other participants, I will use your data for data analysis and publication, but there will be no personally identifying information used with it at any time. If you decide to withdraw from the study after the data has been pooled, it will not be possible to remove it from the study at that time. You do not waive any legal rights by consenting to this research.

**Contacts for Study Questions or Problems**

If you have any further questions about this study, please feel free to contact me, Christina Lamb, at my contact information enclosed in this letter. You may also contact my doctoral supervisors, Dr. Evans and Dr. Babenko-Mould at their numbers listed above. If you have any questions about your rights as a research participant or the conduct of the study, you may contact the Office of Research Ethics, Western University, London, ON. Representatives of The University of Western Ontario Non-Medical Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

## Consent Form

**Study Title:** *Exploring the Lived Experience of Conscientious Objection for Nurses in Ontario*

**Phd Candidate:**

Christina Lamb, BScN, RN, MA,  
PhD Candidate  
Arthur Labatt Family School of Nursing  
Western University  
London, ON.

**Principal Investigator/Supervisor**

Dr. Marilyn Evans  
Associate Professor  
Arthur Labatt Family School of  
Nursing, Western University  
London, ON

**Principal Investigator/Supervisor:**

Dr. Yolanda Babenko-Mould  
Associate Professor  
Arthur Labatt Family School of Nursing  
Western, University  
London, ON

**Participant Consent**

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I give my permission for the data from this study to be used in future studies:

**NAME OF PARTICIPANT:** \_\_\_\_\_

**SIGNATURE OF PARTICIPANT:** \_\_\_\_\_

**DATE AND TIME:** \_\_\_\_\_

**SIGNATURE OF PERSON OBTAINING CONSENT:**  
\_\_\_\_\_

**DATE:** \_\_\_\_\_

### Appendix E. Demographic Questionnaire

**Study title:** *Exploring the Lived Experience of Conscientious Objection for Nurses in Ontario*

**Please fill in the blanks or check the space next to the appropriate questions below.**

\*Note: this questionnaire is asking demographic questions only and will not be used in any way to reveal your identity. It will only be used to identify group characteristics in this study.

1. What is your level of education?  
 Diploma \_\_\_\_  
 Bachelor of Science of Nursing \_\_\_\_  
 Masters \_\_\_\_  
 Other (please describe) \_\_\_\_\_
2. Did you receive ethics education in your nursing education? Yes \_\_\_\_ No \_\_\_\_
3. Have you ever received any ethics education? Yes \_\_\_\_ No \_\_\_\_
4. If you answered yes to question 2 or 3, please describe the ethics education you received: \_\_\_\_\_  
 \_\_\_\_\_
5. Please list the area of nursing you practice in:  
 \_\_\_\_\_
6. How many years of nursing experience do you have?  
 \_\_\_\_\_

## Appendix F. Semi-Structured Face-to-Face and Telephone Interview Questions

**Study title:** *Exploring the Lived Experience of Conscientious Objection for Nurses in Ontario*

1. What made you want to go into your area of clinical practice?
2. Can you share with me what the term conscience means to you?
3. Tell me about an experience you had where you had to voice an objection to something you thought was unethical in practice, (CO)?

*Prompt: tell me more about that....*

*Prompting questions: what was that experience like for you?*

4. What was it like for you to respond?

*Probe: initially, support from others....?*

5. What are some guidelines or policies that you used in your decision to make a CO?

6. Is there anything you would have done differently?

*Tell me more about that...*

7. What does conscientious objection mean to you?

*Probe: do you think you were using CO? Why/why not?*

*Prompt: how did you come to know about it?*

8. Is there anything else that you would like to say/share with me today that I have not asked you about?

9. What has this interview experience been like for you?

10. Why did you decide to participate in this study?

## CURRICULUM VITAE

**Name:** Christina Lamb

**Post-secondary Education and Degrees:** Western University  
London, Ontario, Canada  
2001-2005 BScN

St. Mary's University  
London, England  
2007-2009 MA (Bioethics)

Western University  
London, Ontario, Canada  
2012-2017 Ph.D, Nursing

**Honours and Awards:** Province of Ontario Graduate Scholarship  
2015

Irene E. Nordwich Foundation Doctoral Award  
2012, 2013

Edmund Burke Fellowship Award  
2013

**Related Work Experience** Lecturer, University of Ottawa, Ottawa, Ontario  
School of Nursing  
2014-15; 2016

Lecturer, St. Paul's University, Ottawa, Ontario  
Faculty of Philosophy  
2014

Teaching Assistant, Western University  
London, Ontario  
School of Nursing  
2012-2017

Graduate Research Associate  
Western University, London, Ontario  
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Clinical Ethics Fellow  
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**Publications:**

**Lamb, C.**, Evans, M., Babenko-Mould, Y., Wong, C. & Kirkwood, K. (2017). Conscience, conscientious objection and nursing: A concept analysis. *Nursing Ethics*, (E-Pub Ahead of Print, April 12, 2017). doi: 10.1177/0969733017700236.

**Lamb, C.** Conscientious objection: Understanding the right of conscience in health and health care practice. *The New Bioethics*, 22(1), 33-44. doi: 10.1080/20502877.2016.1151252.

**Lamb, C.** *The conscientious nurse: Exploring conscience in nursing education and care practice*. 18<sup>th</sup> Nursing Ethics Conference & 3<sup>rd</sup> International Ethics in Care Conference. 'Present and Future Challenges and Opportunities for Ethics in Nursing and Care', September 14-16, 2017 Leuven, Belgium. Role: Confirmed Presenter.

**Lamb, C.** *Conscientious objection: Understanding the right of conscience in health and health care practice*. Von Hugel Institute, St. Edmund's College, University of Cambridge. 'Navigating Impasses in Bioethics: Rethinking Ill/Health', Cambridge, UK, December 4, 2015. Role: Presenter.

**Lamb, C.**, Evans, M., Babenko-Mould, Y., Wong, C. & Kirkwood, K. *Conscience, moral distress and conscientious objection: Implications for nursing education*. 1st International Care Ethics Observatory and 16th Nursing Ethics Conference, University of Surrey, Guildford, UK, July 18, 2015. Role: Presenter.

**Lamb, C.** *Conscientious Objection in Inter-Religious Dialogue amongst Nursing Health Care Professionals: Does Moral Philosophy Have a Say?* Presented at the Canadian Jacques Maritain Association Annual Symposium-Conference on Jacques Maritain and Interreligious Dialogue, Toronto, ON. November, 2013. Role: Presenter.