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Freedom of conscience and nursing in Manitoba

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Abstract

For the most part, the codes of ethics and standards of Manitoba's nurse regulators provide little insight into the regulators' approach to freedom of conscience for nurses, and frequent failure to distinguish between "care" and "treatment" often impairs discussion of conscientious objection. The College of Licensed Practical Nurses of Manitoba code and standards appear inclined to separate personal and professional integrity, giving priority to the latter at the expense of the former. This encourages the view that nurses must leave their personal integrity in the parking lot when they report for work.

The regulators' views about freedom of conscience for nurses are most clearly demonstrated in the joint publication *Duty to Provide Care* (2019). They recognize conscientious objection only to *providing* a service. They fail to recognize (or are unwilling to admit) that one can legitimately refuse to encourage or facilitate a service for reasons of conscience. Consistent with this, they demand that objecting nurses provide effective referral for all morally contested procedures, including euthanasia and accepted suicide. This would be unacceptable to anyone who believes that it is immoral to facilitate what one believes to be immoral.

Unlike earlier guidelines for euthanasia and assisted suicide, *Duty to Provide Care* (2019) fails to clearly distinguish between "care" and procedures or interventions, and it does not acknowledge the duty of employers (and regulators) to accommodate nurses in the exercise of freedom of conscience.

Introduction

Nursing has often been described as a "caring profession." For historical reasons associated with the development of nursing, it appears that most nursing guidance documents use the terms "care" or "nursing care" with respect to all nurse-patient interactions, including interventions or treatments ordered by attending physicians.

This puts objecting nurses at a rhetorical disadvantage. Objections are made to treatments or interventions, not to caring. However, in a nursing context this is more readily perceived or characterized as "refusing to care."

The failure to distinguish between "care" and "treatment" can introduce uncertainty into guidance about conscientious objection, which, for example, may insist that an objecting nurse continue to provide "care" for a patient until relieved, without specifying that the care does not include the treatment or intervention to which the nurse objects.

College of Registered Nurses of Manitoba (CRNM)

The College of Registered Nurses of Manitoba regulates the province's registered nurses and nurse practitioners. It has formally adopted the *Canadian Nurses Association Code of Ethics for Registered Nurses (2017)*, which includes detailed guidance about conscientious objection.[1] In addition, *Duty to Provide Care* (2019), jointly published by the three Manitoba nurse regulators, provides important information about CRNM's approach to freedom of conscience.

Code of Ethics (2017)

The protection of conscience provision in the 2008 CNA *Code of Ethics for Registered Nurses* was revised in 2017 by adding a sentence referring to a *Criminal Code* provision about EAS, highlighted in the passage below:

> G7. If nursing care is requested that is in conflict with the nurse's moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person's needs or desires. **But nothing in the Criminal Code compels an individual to provide or assist in providing medical assistance in dying**. If nurses can anticipate a conflict with their conscience, they notify their employers or persons receiving care (if the nurse is self-employed) in advance so alternative arrangements can be made.(emphasis added)[2]

Notwithstanding the added specific reference to EAS, this guidance pertains to all morally contested services. Objecting nurses are expected to notify employers or patients (preferably in advance) of a conflict of conscience so that they can arrange for a substitute, and continue to provide "care" in the interim. Assuming the interim "care" does not entail participation in the contested service, this is a satisfactory arrangement.

More detailed guidance is provided in an appendix to the *Code*.

Ethical Considerations in Addressing Expectations That Are in Conflict with One's Conscience [Code of Ethics (2017) Appendix B]

The additional guidance explains that objections for reasons of conscience "are motivated by moral concerns and an informed, reflective choice and are not based on prejudice, fear or convenience."[3] It also introduces the important distinction between nursing "care" and "procedures and practices," though in discussing the issue it does not consistently maintain the distinction.

> Nurses may not abandon those in need of nursing **care**. However, nurses may sometimes be opposed to certain **procedures and practices** in health care and find it difficult to willingly participate in providing **care** that others have judged to be morally acceptable. (emphasis added)[4]

Nurses are advised to "communicate their desires in appropriate ways" and

> a) to notify prospective employers of conscientious convictions likely to result in workplace conflict;

> b) to anticipate and avoid workplace conflicts by seeking accommodation in advance of need from supervisors and employers, which allows time for alternative arrangements to be made for patients;
>
> c) if confronted by a conflict of conscience, notify supervisors, employers or patients of the need for accommodation, meanwhile continuing to provide "appropriate care to meet the person's needs."[5]

Assuming the interim "appropriate care" does not entail participation in the contested service, the additional guidance is thus far satisfactory.

However, the 2017 CNA *Code* adds a statement specific to nurse practitioners:

> In the specific case of medical assistance in dying, nurse practitioners who object to participation **may have a professional duty to make an effective referral.** (emphasis added)[6]

An "effective referral" is understood to mean making arrangements for the patient to see someone willing and able to provide the service an objecting professional refuses to provide for reasons of conscience. An indeterminate number of objectors would be unwilling to do this because they believe it entails unacceptable moral complicity in an immoral act. However, in the joint 2019 document *Duty to Provide Care*, the CRNM agreed that all nurses have a duty of effective referral for all morally contested procedures (see below). Thus, it appears that CRNM is willing to force Manitoba nurse practitioners unwilling to personally kill patients or help them commit suicide to arrange for someone else to do so.

Two further statements in Appendix B to the CNA *Code* warrant attention:

> Employers and co-workers are responsible for ensuring that nurses and other co-workers who declare a conflict of conscience receive fair treatment and do not experience discrimination.
>
> Nurses need to be aware that declaring a conflict of conscience **may not protect them against formal or informal penalty.** (emphasis added)[7]

The second statement conflicts with the first. Imposing penalties for the exercise of freedom of conscience — especially "informal" penalties — is discriminatory. The second statement is troubling because it suggests that the CNA may be unprepared to defend nurses who are penalized for exercising freedom of conscience.

On the other hand, negotiating accommodation of freedom of conscience may entail accepting some disadvantages, such as accepting an unpopular or inconvenient shift, and this should not necessarily be construed as a "penalty."

College of Licensed Practical Nurses of Manitoba (CLPNM)

CLPNM Code of Ethics (2014)

The CLPNM *Code of Ethics* does not address freedom of conscience. However, statements in the Code can be understood to introduce a division between personal and professional integrity that

lends itself to the restriction or suppression of practitioner freedom of conscience.

The *Code* refers specifically to "professional integrity" describing it as "act[ing] with integrity and [being] mindful of professional conduct."[8]

To maintain "professional integrity", LPNs must identify their "personal values and beliefs" and ensure that they do not have "any negative impact on client care, nursing practice and the practice environment,"[9] which might be understood to imply that LPNs must leave their "personal" beliefs and their "personal" integrity at the door.

The *Code* directs LPNs

- to disclose "any unavoidable personal interest, value or belief that could conflict with, or appear to conflict with, the interests of the client"
- to "avoid any real or perceived conflict between the nurse's personal interests and those of the client"
- to place " the interests of the client above the nurse's own" in "professional nursing practice."[10]

The requirement for disclosure should help to avoid or minimize conflicts between a client seeking a service and an objecting LPN. However, objecting LPNs may be significantly disadvantaged if the College understands personal integrity to be merely an "interest" to be subordinated to the demands of "professional" practice, and not a fundamental human good.

The *Code's* first ethical standard is identified as a "people-centred approach" reflecting service to others: "Nurses empower and enable people to maintain, promote, and protect their health and well-being."[11]

The first element of the people-centred approach is a requirement to recognize and respect "the inherent worth of each person." The second is direction to express "regard for individual uniqueness" and eschew discrimination, including discrimination based on creed or political or spiritual beliefs.[12] Here the *Code* is referring to patients/clients, but it is not clear that the College understands that these statements apply equally to the treatment of nurses themselves *within the scope of professional practice*.

The CLPNM has also adopted its own Standards of Practice, which deal very briefly with ethical practice, noting obligations to adhere to the College's *Code of Ethics* and to recognize the "impact of own values and beliefs."[13]

CLPNM Practice Direction: Duty to Care

The practice direction *Duty to Care* updated by the CLPNM in 2020 provides guidance not found in the *Code of Ethics* and *Standards of Practice* to assist LPNs when their ability to provide services may be compromised. It offers specific suggestions for responding to unilateral, unplanned extension of nursing shifts by employers.

More generally, the Direction notes that an LPNs may feel compromised in their ability to provide "safe, competent and ethical care" because of "lack of resources, unreasonable employment

expectations, lack of individual competence or a conscientious objection."[14] Note that the Direction presumes that conscientious objection, like unreasonable employment expectations, is an impediment or obstacle ethical "care."

In these circumstances, LPNs are expected to notify the employer or client to find a resolution, "and, if necessary, refer the client to another qualified health professional." They are required to continue providing "care" to the best of their ability until the problem is resolved and/or a replacement has been found.[15]

This expectation is problematic, since LPNs who decline to participate in a procedure for reasons of conscience may also be unwilling to facilitate it by referral if they believe that would entail complicity in the act. Nonetheless, the College went further in the 2019 document *Duty to Provide Care*, jointly published with other Manitoba nurse regulators. There the CLPNM agreed that all nurses have a duty to provide effective referrals for all morally contested procedures. Thus, it appears that CLPNM is willing to force objecting Manitoba LPNs to arrange for someone else to provide procedures or treatments they consider immoral.

College of Registered Psychiatric Nurses of Manitoba (CRPNM)

Registered psychiatric nurses in Manitoba are advised to understand and be attentive their own "values and culture" and how they affect their practice,[16] and to prevent or resolve conflicts they may engender.[17] The CRPNM *Code of Ethics* and *Standards of Practice* do not address conscientious objection, but the College's position on freedom of conscience demonstrated in *Duty to Provide Care* (2019). The College believes that nurses are obliged facilitate services or procedures they believe to be immoral by effective referral: by arranging for them to be provided by someone else. Objecting nurses who believe this entails complicity in immoral acts would find this unacceptable.

CRNM, CLPNM, CRPNM: Duty to Provide Care (2019)

In 2019 the three nursing regulators jointly issued *Duty to Provide Care*. It is described only as a "document," so it does not appear to have official status as a practice directive or guideline. Even if the regulators do not treat it as such, it demonstrates how they understand their codes of ethics, standards of practice and practice directions, which, they say, underpin it.[18]

Two definitions are critical:

> **Duty to provide care**: a nurse's professional and ethical responsibility to provide safe and competent nursing care to a client, for the time-period that the nurse is assigned to provide service.
>
> **Abandonment**: When a nurse discontinues care after receiving a client assignment without:
>
> - Negotiating a mutually acceptable withdrawal of service with the client;
> - Arranging for suitable alternative or replacement services; or
> - Allowing the employer a reasonable opportunity to provide for alternative or replacement service[19]

The first point to note is that "nursing care" appears to be understood as assigned services, making no distinction (for example) between helping patients use the bathroom and inserting an IV line for lethal injection. Discussion of a duty to provide care within the context of conscientious objection is hampered by the failure to distinguish between the former (accurately described as "care") and the latter (accurately described as an intervention or procedure).

It appears that the duty to provide care is understood to apply only during a nurse's shift, including shifts that have been unilaterally extended by an employer. Nurses might be understood to be more clearly "on duty" and "off duty" than physicians, whose duty of care may not be limited to specific working hours.

With respect to abandonment, conflicts can be avoided or resolved by negotiating mutually acceptable solutions or by alternative arrangements made by employers or supervisors. However, conflict likely be triggered or exacerbated by forcing objecting nurses to arrange for others to provide services they consider morally unacceptable.

The practice environment

The regulators assert that nurses and employers share responsibility for maintaining practice environments in which nurses can discharge their duty to provide care. To this end, they identify a number of important employer responsibilities:

- maintaining adequate staffing levels
- considering individual skills, qualifications and limitations when assigning work;
- ensuring efficient distribution of skills and experience;
- supporting nurses to work within their level of competence;
- informing nurses of their roles and expected levels of service;
- providing policies , procedures, guidelines, orientation, education and training for nurses

asked to work in unfamiliar fields or settings;

- collaborating with nursing staff when human resources are limited or not optimal for meeting client need. [20]

These sound administrative measures can contribute substantially to the accommodation of freedom of conscience for nurses, provided accommodation is also recognized as an employer's responsibility, and provided objecting nurses give advance notice of their concerns whenever possible. This was emphasized in earlier guidelines about euthanasia and assisted suicide (see below), but *Duty to Provide Care* fails to draw attention to this.

Parameters for conscientious objection

Conscientious objection is defined as refusal to provide a service "within the competence" of the objector.[21] Note that the regulators recognize conscientious objection only to *providing* a service. They fail to recognize (or are unwilling to admit) that one can legitimately refuse to encourage or facilitate a service for reasons of conscience.

Leaving that aside, conscientious objection is described as generally acceptable if three conditions are met:

> a) it is based on "a longstanding and deeply held belief that the requested intervention is morally wrong and/or would compromise the nurse's personal moral integrity";
>
> b) "the situation is not urgent or emergent";
>
> c) another healthcare provider can safely provide the required care in a timely manner.[22]

Condition (a) could mean that a regulator will *refuse* to recognize conscientious objection by nurses who decide, upon reflection, that they can no longer provide a service for reasons of conscience. A belief that is the product of such a conversion (religious or otherwise) would not be "longstanding."

What constitutes an "urgent or emergent" situation (condition (b)) is often tendentiously defined by activists for the purpose of compelling objecting health care workers to provide morally contested services they demand, such as "emergency contraception." Regulators may be tempted to use the same approach in some circumstances.

If regulators will recognize conscientious objection (i.e., refusal) *only* if someone else is available to perform a procedure or intervention (c), it is especially important for employers and institutions to ensure that willing professionals are available.

Duties of objecting nurses

Discussion of the duties of objecting nurses is garbled by persistent failure to distinguish care from interventions or procedures. The sentence opening the discussion is especially unhelpful.

> The duty to provide care for a nurse with a conscientious objection does not include withholding client care.[23]

Rendered according to the document's earlier definitions (care = any assigned service, conscientious objection = refusal to provide a service) this becomes:

> The duty to provide a service for a nurse who refuses to provide the service does not include withholding services.

The regulators impose the following duties upon objecting nurses, numbered here for convenient reference:

i)	Acknowledging the client's request and assuring the client that their request will be conveyed;
ii)	Informing both their supervisor and employer about the client's request;
iii)	Making a timely referral, in good faith, to a non-objecting provider who is able to carry out the client's request, and following up on that referral
iv)	Maintaining a therapeutic relationship with the client;
v)	Continuing to provide care unrelated to specific request;
vi)	Informing the employer about their conscientious objection; and
vii)	In accordance with professional standards and organizational policy, documenting in the client health record any request for information related to the client's request, the interaction with the client, the care provided and/or any resources given to the client. [24]

Two of the requirements, while acceptable, warrant comment.

First, objecting nurses should give employers and supervisors advance notice of their views to facilitate accommodation of both nurses and patients and avoid conflicts, so one would expect this to be the first duty listed, not the sixth, unless the situation is unanticipated.

Second, it seems unnecessary to require an objecting nurse to inform both a supervisor and an employer about a request (ii), especially one received on a night shift or weekend. In the absence of other direction from an employer, informing the supervisor ought to be sufficient.

Taking these comments into account, most objecting nurses would be willing to comply with all but one of the requirements imposed by the regulators. The single exception is the demand for effective referral (iii).

A nurse practitioner who refuses to kill a patient for reasons of conscience may well be unwilling to arrange for the patient to be killed by someone else. That is what (iii) requires in relation to euthanasia and assisted suicide, no less than for other morally contested procedures. This would be unacceptable to anyone who believes that it is immoral to facilitate what one believes to be immoral. The President and Director of the Collège des Médecins du Québec explained this to Quebec legislators studying the province's proposed euthanasia law:

> [I]f you have a conscientious objection and it is you who must undertake to find someone who will do it, at this time, your conscientious objection is [nullified]. It is as if you did it anyway.
>
> Parce que, si on a une objection de conscience puis c'est nous qui doive faire la démarche pour trouver la personne qui va le faire, à ce moment-là, notre objection de conscience ne s'applique plus. C'est comme si on le faisait quand même.[25]

Nonetheless, it appears that the demand for effective referral in *Duty to Provide Care* (2019) overrides guidance specific to euthanasia and assisted suicide published by the three nurse regulators the previous year, which did not.

Medical Assistance in Dying: Guidelines for Manitoba Nurses (2018)

MAiD Guidelines for Manitoba Nurses (MGMN) was published by the province's three nursing regulators in 2018.[26] Much of the discussion of conscientious objection in the document was later incorporated into *Duty to Provide Care* (2019) in the section addressing the parameters of conscientious objection.

Distinction between care and intervention

Since it was dealing with two specific procedures of short duration that were understood to be highly controversial (euthanasia and assisted suicide), MGMN clearly distinguished between nursing care and the contested interventions, specifying that "[r]outine or daily care and other care unrelated to the request for an assisted death remains within the scope of nursing practice,"[27] since (as later explained) "many other elements of care that must continue uninterrupted."

> A nurse may object to participating in medical assistance in dying; however, a nurse may not refuse or withhold care for a client that has requested medical assistance in dying. For example, a nurse is still expected to provide medications, answer a call-bell, respond to family concerns or requests and/or provide after death care. . .[28]

This clarity is notably lacking in *Duty to Provide Care* (2019).

Importance of advance discussion

MGMN emphasizes that nurses should consider their position on EAS in advance and not simply avoid the issue, a point stressed in a scenario about a nurse who calls in sick on the day a patient is scheduled for EAS because of her discomfort about the procedure. The document associates this to the need for collaboration to enable the accommodation of objecting nurses.

> It is also a shared responsibility between the nurse and employer to ensure they are aware of those nurses who may have a conscientious objection and to find ways to work with nurses to balance the duty to provide care while allowing them to morally object to the medically assisted death. [29]

Requirement to accommodate freedom of conscience

The requirement for employers to accommodate objecting nurses is clearly stated in MGMN, which stresses the importance of encouraging dialogue to ensure that employers are aware of issues associated with the procedures.

> ...The nurse must let their employer know they have a conscientious objection so that the employer can make accommodations for the nurse while assuring care for the client continues (e.g. staff scheduling on the day of the assisted death).
>
> . . . It is the responsibility of the employer to acknowledge and address any conscientious objections raised by nursing staff and to accommodate these requests as much as reasonably possible.[30]

These points are notably absent in discussion of the shared responsibility of nurses and employers in *Duty to Provide Care* (2019), even though they apply to every morally contested procedure or service, not just euthanasia and assisted suicide.

No "effective referral"

Unlike *Duty to Provide Care* (2019), MGMN does not assert a duty on the part of an objecting nurse to provide an effective referral. However, it advises nurses responding to requests for information to guide people "directly to the provincial medical assistance in dying clinical team (or adhere to organizational policies that provide alternate directives), and ensure that clients are aware of all additional supports that may be available to them including palliative care or spiritual support."[31]

Some objecting nurses may be unwilling to directly connect a patient with EAS providers, though they would be willing to connect them to health care providers generally or a service enabling access to a range of services, including EAS.

Summary

For the most part, the codes of ethics and standards of Manitoba's nurse regulators provide little insight into the regulators' approach to freedom of conscience for nurses, and frequent failure to distinguish between "care" and "treatment" often impairs discussion of conscientious objection. The College of Licensed Practical Nurses of Manitoba code and standards appear inclined to separate personal and professional integrity, giving priority to the latter at the expense of the former. This encourages the view that nurses must leave their personal integrity in the parking lot when they report for work.

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clearly distinguish between "care" and procedures or interventions, and it does not acknowledge the duty of employers (and regulators) to accommodate nurses in the exercise of freedom of conscience.

Notes:

1. "Practice Expectations", *College and Association of Registered Nurses of Manitoba* (website), online: <https://www.crnm.mb.ca/support/quality-practice-consultation/practice-expectations>.

2. The Canadian Nurses Association, *Code of Ethics for Registered Nurses 2017 ed.*, Ottawa: CNA, 2017, online: <https://nurses.ab.ca/practice-and-learning/nursing-practice-information/document-library> [*CNA-2017*].

3. *Ibid* at 37.

4. *Ibid* at 35.

5. *Ibid* at 36.

6. *Ibid* at 37.

7. *Ibid.*

8. The College of Licensed Practical Nurses of Manitoba, *Code of Ethics,* Winnipeg: CLPNM, 2014 at 10, online: <https://www.clpnm.ca/wp-content/uploads/CLPNM-Code-of-Ethics-Approved-June-2-2014.pdf>

9. *Ibid* at 11.

10. *Ibid*.

11. *Ibid* at 5.

12. *Ibid.*

13. The College of Licensed Practical Nurses of Manitoba, *Standards of Practice*, Winnipeg: CLPNM, 2004 at Standard IV: Ethical Practice, online: <https://www.clpnm.ca/wp-content/uploads/standards.pdf>.

14. The College of Licensed Practical Nurses of Manitoba, *Practice Direction: Duty to Care*, Winnipeg: CLPNM, 2020 at 1, online: <https://www.clpnm.ca/wp-content/uploads/PD-Duty-to-Care.pdf>.

15. *Ibid* at 2.

16. The College of Registered Psychiatric Nurses of Manitoba, *Code of Ethics 2017*, Winnipeg: CRPNM, 2017 at 4, online: <https://www.crpnm.mb.ca/wp-content/uploads/2019/03/CRPNM-Code-of-Ethics-Adopted-May-2017-1.pdf>.

17. The College of Registered Psychiatric Nurses of Manitoba, *Standards of Pscyhiatric Nursing Practice* 2019, Winnipeg: CRPNM, 2019, at Standard 5, article 3, online: <https://www.crpnm.mb.ca/wp-content/uploads/2019/12/Standards-of-Psychiatric-Nursing-Practice-FINAL-October-2019-RS.pdf>

18. The College of Licensed Practical Nurses of Manitoba, College of Registered Nurses of Manitoba, College of Registered Psychiatric Nurses of Manitoba, *Duty to Provide Care*, Winnipeg: CLPNM, CRNM, CRPNM, 2019, at 2, online: <https://www.crpnm.mb.ca/wp-content/uploads/2019/12/Duty-to-Provide-Care-Final.pdf>.

19. *Ibid* at 2.

20. *Ibid* at 2–3.

21. *Ibid* at 4.

22. *Ibid*.

23. *Ibid*.

24. *Ibid* at 4–5.

25. Quebec, Assemblée Nationale, la Commission permanente de la santé et des services sociaux, "Consultations particulières sur le projet de loi n° 52 - Loi concemant les soins de fin de vie (1)", in *Journal des débats* , CSSS-34 (17 September 2013) at 13. online: <http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_81797&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz >.

26. The College of Licensed Practical Nurses of Manitoba, College of Registered Nurses of Manitoba, College of Registered Psychiatric Nurses of Manitoba, *Medical Assistance in Dying: Guidelines for Manitoba Nurses*, Winnipeg: CLPNM, CRNM, CRPNM, 2018, online: <https://www.crpnm.mb.ca/wp-content/uploads/2019/02/MAID-guideline_feb19.pdf>.

27. *Ibid* at 7.

28. *Ibid* at 8.

29. *Ibid* at 10.

30. *Ibid* at 19.

31. *Ibid* at 7.