

QUALITATIVE META SYNTHESIS OPEN ACCESS

Conscientious Objection in Euthanasia and Voluntary Assisted Dying From the Perspective of Stakeholders: A Meta-Synthesis

Rosa Pérez-Capellades^{1,2}  | Sergio Ramos-Pozón¹  | Daniel Pasten-Araya¹  | Anna Falcó-Pegueroles^{1,3} 

¹Faculty of Nursing, University of Barcelona, Barcelona, Spain | ²Hospital Comarcal del Pallars, GSS, Tremp, Spain | ³Faculty of Nursing, Consolidated Research Group 353 Bioethics, Law and Society: Interdisciplinary Analysis of Ethical, Legal and Social Issues of Biomedicine, Biotechnology and Emerging Technologies (BIOELSi), UB – FSM Chair of Spiritual Health and Humanisation, University of Barcelona, Barcelona, Spain

Correspondence: Rosa Pérez-Capellades (rmperez@hospitalpallars.com)

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ABSTRACT

Aim: Analyse the meaning of conscientious objection to euthanasia and/or physician-assisted suicide from the perspective of health professionals, students, patients, family members and regulations.

Design: Qualitative systematic review. This review was informed by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).

Methods: The Joanna Briggs Institute Critical Appraisal Checklist was used to evaluate the included articles. Data were extracted and analysed using meta-aggregation.

Data Source: The CINAHL, PubMed, PsycINFO, Web of Science and Scopus databases were consulted between January and April 2024. The protocol was registered in PROSPERO (ID: 1007658).

Results: We analysed 15 articles, mainly published between 2019 and 2023, from Canada, Australia, the United States, Spain, and the Netherlands. Two main findings were identified: non-moral motivations (perceived competence, social context, and emotional reactions) and moral motivations (ethical principles, moral consciousness, and religious beliefs).

Conclusions: Conscientious objection is a complex phenomenon in which moral, emotional, and organisational factors converge. Differentiating between moral and non-moral motivations is essential to understanding this diversity of reasons for conscientious objection and avoiding oversimplifications. Clear institutional frameworks are needed to facilitate the handling of objections, balance the rights of professionals and patients, and foster a culture of ethical dialogue.

Implications: Healthcare professionals, patients, and families need clear tools and criteria to manage conscientious objection related to euthanasia and physician-assisted suicide. The findings can contribute to the creation of precise institutional guidelines on the referral procedure and mechanisms that ensure a balance between rights and duties.

Impact: This meta-synthesis provides an integrated view of conscientious objection from multiple perspectives. The results contribute to a better understanding of the ethical complexity of conscientious objection and the practical implications for health systems that are in the process of implementing euthanasia and medically assisted dying laws.

Reporting Method: PRISMA.

Patient or Public Contribution: No patient or public contribution.

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1 | Introduction

The end of life is an issue of great ethical, legal, and social complexity. One of the central debates concerns whether individuals have the right to decide the conditions and timing of their own death, which brings us to the topic of euthanasia and medically assisted suicide. In the international literature, these practices receive different names depending on the legal and geographical context. Terms such as ‘voluntary assisted dying’ (VAD), ‘physician-assisted suicide’ (PAS), ‘medical aid in dying’ (MAiD) or ‘physician aid in dying’ (PAD) are used to refer to forms of assistance in dying that share common elements, but that correspond to different regulatory frameworks (Mroz et al. 2021). While in euthanasia, a health professional administers the lethal medication, in medically assisted suicide the patient self-administers the medication, as prescribed by a physician (Emanuel et al. 2016).

In this article, the generic terms ‘euthanasia’ and ‘assisted suicide’ (EAS) are used to encompass these practices, while respecting the terminology used in the original studies when referring to specific national contexts. EAS has been legalised in several countries: Netherlands (2002); Belgium (2002); Luxembourg (2009); Colombia (2015); Australia (Victoria, 2017; Western Australia, 2019); Canada (2016); United States (Oregon, 1997; Washington, 2009; Montana, 2009; Vermont, 2013; California, 2016; Colorado, 2016; the District of Columbia, 2017; Hawaii, 2019; Maine, 2019 and New Jersey, 2019); Spain (2021); Switzerland (where assistance in suicide has been permitted under specific circumstances since 1942); Germany (2020); Austria (2022); Portugal (2023); New Zealand (2019) (White 2025). As more countries have made progress in regulating EAS, the issue has gained prominence in bioethical debate, clinical practice, and society (White and Wicclair 2024; Savulescu 2006; Wicclair 2011). EAS poses a contradiction between two fundamental rights: the right of patients to request a legally recognised procedure versus the right of professionals to exercise their profession without renouncing their personal convictions (Fujioka et al. 2018).

Conscientious objection (CO) in the context of EAS is usually defined as the right of the healthcare professional to refuse to perform certain legal interventions, where the motivations given are ethical, moral or religious, derived from beliefs about the sanctity of life or values of medicine and the principle of non-maleficence (Triviño-Caballero et al. 2023). In this sense, the issue of CO cannot be understood solely as an individual decision, but as an ethical, legal, relational, and institutional phenomenon that affects the therapeutic relationship and develops within organisational frameworks that condition its implementation. Consequently, CO can be approached from different perspectives that do not always coincide. In this study, we approach CO from the qualitative literature, rather than from specific legal frameworks. However, not all the reasons given for exercising CO have the same basis. Beyond genuine moral or religious values, factors such as prejudice, personal interests, fear of stigmatisation (Brown et al. 2021b), or, in the parallel case of abortion, the avoidance of administrative burdens (Autorino et al. 2020; Bo et al. 2015), may also influence this decision. Despite their impact on professional practice, these motivations do not constitute ethical grounds for invoking CO.

In this context, CO emerges as a complex phenomenon, influenced by personal, professional, emotional, and contextual factors (Brown et al. 2021b).

An analysis of the literature on CO in healthcare reveals three positions. The first defends the absolute protection of CO, arguing that healthcare professionals should never act against their conscience (Wester 2015; Weinstock 2014). Wicclair (2011) refers to this position as ‘conscience absolutism’, in which any form of participation in the context of EAS is interpreted as a form of complicity (Trigg 2017). In contrast, the ‘compromise approach’ (Wicclair 2011) seeks to balance the moral integrity of professionals with the rights of patients, requiring that objections be justified in some way, whether in terms of ‘genuineness’ (Card 2017) or ‘reasonableness’ (Zolf 2019). This position aims to prevent abuses in the exercise of CO and to ensure that it does not interfere with individuals’ equitable access to medical assistance in dying. In this sense, models have been proposed in which objecting professionals must refer patients to other professionals willing to provide assistance, in order to guarantee continuity and quality of care (Carpenter and Vivas 2020). A third position considers that CO should not be accepted in a request for help to die, since health professionals must prioritise the rights of patients over their personal convictions (Savulescu and Schuklenk 2017). Wicclair (2011) calls this position the ‘incompatibility thesis’, because denials based on one’s conscience are incompatible with the professional obligations of healthcare professionals. From this perspective, a professional’s refusal to perform a legally recognised intervention may violate the principles of equity and justice in access to healthcare services. A recent comprehensive systematic review of the ethical literature on conscientious objection in EAS (Gómez-Virseda and Gastmans 2025), synthesising 58 articles across multiple databases, has further clarified these key ethical positions.

Research on CO in healthcare has mainly focused on the positions and justifications of professionals, while less attention has been paid to the motivations underlying this decision and its impact on patients, families, and health organisations. Patients who encounter an objecting professional may experience difficulties in accessing assistance in dying, especially in areas with a shortage of professionals (Panchuk and Thirsk 2021). Although referral to non-objecting professionals may facilitate care, it is not always guaranteed equitably or within an optimal timeframe. In some legal frameworks, such as the Belgian one, this referral is a legal obligation aimed at ensuring access to the legally recognised service (Ayala and Collado 2023).

The exercise of CO affects various healthcare professionals, including physicians, nurses, and pharmacists (Kresin et al. 2021; Parra Jounou et al. 2024; Fovargue and Neal 2022). However, evidence on the motivations underlying CO remains limited, while attitudes towards EAS show considerable variability. Zenz et al. (2015) observed that only 5.3% of palliative care nurses would be willing to participate in euthanasia procedures, although they were more open to medically assisted suicide. Other studies report more favourable attitudes, such as among Canadian nurses (68.3%) (Lavoie et al. 2016) and Finnish nurses, where up to 73.7%

would participate (Terkamo-Moisio et al. 2019). Among physicians, attitudes are also heterogeneous: 50% of British physicians supported the legalisation of prescribing for self-administration, 39% opposed it, and 11% were undecided; regarding administration by professionals, 37% were in favour, 46% against, and 17% undecided (Twycross 2024). Pharmacists, who play a central role in the preparation and dispensing of lethal drugs, also face ethical issues related to participation, professional responsibility, and decision-making in potential objection (Hughes 2017).

Another controversial aspect is institutional conscientious objection (ICO). While some authors argue that healthcare institutions may refuse to provide EAS to preserve their identity and values, others maintain that conscience is an exclusively individual attribute and cannot be attributed to legal entities (Wester 2015). Some institutions invoke principles of self-governance to justify not offering EAS (Shadd and Shadd 2019), although this is considered ethically defensible only if access to legally recognised services is ensured through clear and transparent mechanisms (Hempton 2021). In this context, ICO may significantly affect access to assistance in dying, particularly through forced referrals and organisational barriers (Close et al. 2023).

Finally, although CO has been widely studied in bioethical, legal, and empirical national contexts, research has mainly focused on regulatory debates or quantitative assessments. Qualitative syntheses integrating the perceptions, experiences, and motivations underlying CO in EAS across different stakeholders remain limited. Accordingly, we conducted a systematic review of qualitative studies to address this gap and explore its implications for the different stakeholders involved. Specifically, this review sought to answer the following research question: How does the qualitative literature describe the perceptions, experiences, and motivations related to CO in the context of EAS?

2 | Aim

A1. Explore the perceptions, motivations, and experiences around CO related to EAS by health professionals, nursing students, patients, family members, and regulatory documents.

A2. Analyse the scientific quality of studies included in this review, published up to the end of 2023.

3 | Methods

3.1 | Design

This study is a qualitative systematic review with a meta-synthesis of studies aimed at exploring perceptions, experiences, and motivations in relation to CO in the context of EAS. To ensure transparency and methodological quality, we applied the recommendations of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al. 2021) and the Joanna Briggs Institute Manual for Evidence Synthesis (Aromataris et al. 2024). We used meta-aggregation to group the findings into categories based on similarities of meaning. This method is appropriate for researching complex phenomena to obtain findings with practical applicability (Munn

et al. 2014). The protocol of this meta-synthesis was registered in the International Prospective Register of Systematic Reviews (PROSPERO, ID: 1007658).

3.2 | Search Strategy

We structured our search following the PICoT system, adapted according to the Joanna Briggs Institute (Aromataris et al. 2024).

- *Population (population involved in the studies)*: Health professionals, students, family members, and patients. Documents created to guide professionals in the context of euthanasia and medically assisted suicide.
- *Phenomenon of interest*: The perceptions, experiences and motivations of health professionals, students, family members, and patients, in a context of CO and the contents related to CO contained in the regulatory documents of euthanasia and medically assisted suicide.
- *Context*: All levels of health care in which requests for euthanasia and medically assisted suicide occur.
- *Type of studies*: Any type of qualitative study.

The inclusion criteria were studies that used qualitative methodology to study the perceptions, experiences, and motivations of health professionals, students, family members, patients, and the contents of the regulatory documents of medical aid in dying. The search for articles was limited to 1998–2023. Studies that did not address the specific context of euthanasia or physician-assisted suicide were excluded; likewise, publications that addressed aspects related to euthanasia or the end of life but did not address CO were excluded. The search was conducted between January and April 2024 in PubMed, CINAHL, Scopus, PsycINFO and Web of Science (Core Collection). We employed three groups of keywords: (1) qualitative research, (2) conscientious objection, and (3) euthanasia and physician-assisted suicide (EAS). Boolean logic adapted to the syntax and topic headings of each database was used. We searched for the keywords in the title, abstract and body (File S1).

3.3 | Data Extraction and Synthesis

We used Atlas.ti to organise and manage the qualitative data (ATLAS.ti Scientific Software Development GmbH 2023). The studies that met the inclusion criteria were reviewed by three of the study authors (RPC, AFP and SRP) to determine their quality, using the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al. 2015). Two authors (RPC and AFP) independently extracted the data from the articles and prepared a table including socio-demographic data, study characteristics, and sample characteristics (Table 1). The search results were organised in three phases: in the first, the verbatim citations reported in the articles were extracted, as they had been presented and interpreted by the authors of the studies, selected with respect to our research aims. Two levels of codes were also identified that corresponded to the categories created by the authors of the studies based on verbatim citations. The first and second levels were identified

TABLE 1 | Characteristics of the included studies.

Author(s)	Country	Year	Study	Research design	Location and environment	Participants characteristics	
						Sample size	Sample characteristics
Bouthilier and Opatrny	Canada	2019	A qualitative study of physicians' conscientious objections to medical aid in dying	Semi-structured interviews. Thematic analysis	Hospital, long-term care, community	22 physicians	Physicians with CO to MAiD
Brown et al.	Canada	2020	Medical Assistance in Dying: Patients', Families', and Health Care Providers' Perspectives on Access and Care Delivery	Semi-structured interviews. Thematic analysis	All healthcare contexts	5 patients, 11 family members, 3 physicians, 4 social workers, 7 nurses	Health care with CO to VAD, patients and families which reported CO to MAiD
Brown et al.	Canada	2021	'What is right for me, is not necessarily right for you': The endogenous factors influencing non participation in medical assistance in dying	Semi-structured interviews. Thematic analysis	All healthcare contexts	17 physicians, 8 nurses	Physicians and nurses with CO to MAiD
D'Angelo et al.	United States	2019	Assessing genetic counsellors' experiences with physician aid-in-dying and practice implications	Semi structured interview	University medical center, others	15 genetic counsellors	Genetic counsellors with CO to PAD

(Continues)

TABLE 1 | (Continued)

Author(s)	Country	Year	Study	Research design	Location and environment	Participants characteristics	
						Sample size	Sample characteristics
Dumont and MacLure	Canada	2019	Conscientious objection to medical assistance in dying: A qualitative study with Quebec physicians	Semi-structured interviews. Thematic analysis	All healthcare contexts	20 physicians	Physicians with CO to MAiD
Haining and Keogh	Australia	2021	'I haven't had to bare my soul but now I kind of have to': describing how voluntary assisted dying conscientious objectors anticipated approaching conversations with patients in Victoria, Australia	Semi-structured interviews. Thematic analysis	All healthcare contexts	15 physicians, 1 nurse, 1 other	Health professionals with CO to VAD
Haining, Keogh and Gillam	Australia	2021	Understanding the reasons behind health care providers' conscientious objection to voluntary assisted dying in Victoria, Australia	Semi-structured interviews. Thematic analysis	All healthcare contexts	15 physicians, 1 nurse, 1 other	Health professionals with CO to VAD

(Continues)

TABLE 1 | (Continued)

Author(s)	Country	Year	Study	Research design	Location and environment	Participants characteristics	
						Sample size	Sample characteristics
Isaac et al.	Australia	2019	Australian pharmacists' perspectives on physician-assisted suicide (PAS): thematic analysis of semistructured interviews	Semi-structured interviews. Thematic analysis	All healthcare contexts	40 pharmacists	Pharmacists with CO to PAS
Koksvik	Canada	2020	Practical and ethical complexities of MAiD: examples from Quebec	Semi-structured interviews. Thematic analysis	Hospitals, clinics, education and hospice	9 physicians	Physician with CO to MAiD
Lamb and Babenko et al.	Canada	2019	Conscientious objection and nurses: Results of an interpretive phenomenological study	Semi-structured interviews. Interpretive phenomenology content analysis, phenomenological analysis. Heidegger approximation	All clinical practice environments	8 nurses	Nurses with CO to MAiD
Lamb and Evans et al.	Canada	2019	Nurses' use of conscientious objection and the implications for conscience	One-on-one in-depth semi-structured interviews. Content analysis, hermeneutic analysis	All clinical practice environments	8 nurses	Nurses with CO to MAiD
Ortega-Galán et al.	Spain	2022	Nursing students' perceptions of euthanasia legislation: A qualitative study	Descriptive qualitative study. Semi-structured, open-ended, focused interviews. Thematic analysis	Two universities	13 nursing students	Nursing students with a CO to euthanasia
Pesut et al.	Canada	2019	Medical assistance in dying: a review of Canadian nursing regulatory documents	Thematic surveys. Qualitative descriptive approach. Review of documents. Thematic analysis	All healthcare contexts for nurses	17 documents	Documents with guidance related to CO to MAiD

(Continues)

TABLE 1 | (Continued)

Author(s)	Country	Year	Study	Research design	Location and environment	Participants characteristics	
						Sample size	Sample characteristics
Van de Scheur and Van der Arend	Netherlands	1998	The role of nurses in euthanasia: a Dutch study	Semi-structured interviews. Thematic analysis	Hospitals	3 nurses	Nurses with CO to euthanasia
White et al.	Australia	2023	The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perceptions	Semi-structured interviews. Thematic analysis	Hospitals	32 family caregivers, 1 patient	Family caregivers which reported institutional objection to VAD

Abbreviations: CO, conscientious objection; MAiD, medical assistance in dying; PAS, physician-assisted suicide; VAD, voluntary assisted dying.

by the first author (RPC) and were reviewed together with the second author (AFP) to verify the correctness of each assigned code.

In the second phase, a third level of codes was created, based on similar concepts and ideas reported in the verbatim citations. In this process, we respected the interpretations given by the authors of the articles, following the guidelines established by Sandelowski and Barroso (2002) in the meta-aggregation method. The codes of the third level were identified by the first author (RPC) and reviewed together with the second author (AFP) to verify the adequacy of each assigned code.

In the third and final phase, the codes were grouped thematically based on similarities in reported experiences or situations. Examples of some of the groupings are 'Code A is merged with Code B because it is the same code with a different name'; 'Code A is part of Code B'; 'Code B is a consequence of Code A'. This last level of analysis was double reviewed by two researchers (RPC and AFP) to detect and minimise possible deviations in interpretation.

The coding and grouping process was carried out by two researchers independently and then by consensus to ensure analytical rigour and minimise interpretive biases.

3.4 | Ethical Considerations

This research was a meta-synthesis of published research, and no new human research participants were involved. It was therefore exempt from ethics committee review.

4 | Findings

Our search initially identified 55 articles. After removing 23 duplicates, 32 records were screened. Following title and abstract screening, 17 full-text articles were assessed for eligibility. Two articles were excluded, one because they did not address CO using qualitative methodology, and one because it did not focus on CO. Finally, 15 studies were selected for analysis. The PRISMA flowchart is shown in Figure 1.

4.1 | Quality Appraisal of the Included Studies

The quality assessment of the included studies was carried out using the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al. 2015; Aromataris et al. 2024). Eight articles scored at a high quality level and seven articles showed a moderate quality level. The main limitations identified were related to the researcher's values (item Q6) and the relationship between the researcher and the participating sample (item Q7). The quality assessment is shown in Table 2.

4.2 | Demographic Characteristics of Population

The 15 articles included data from regulatory documents and a total of 277 participants, including nurses, physicians, social

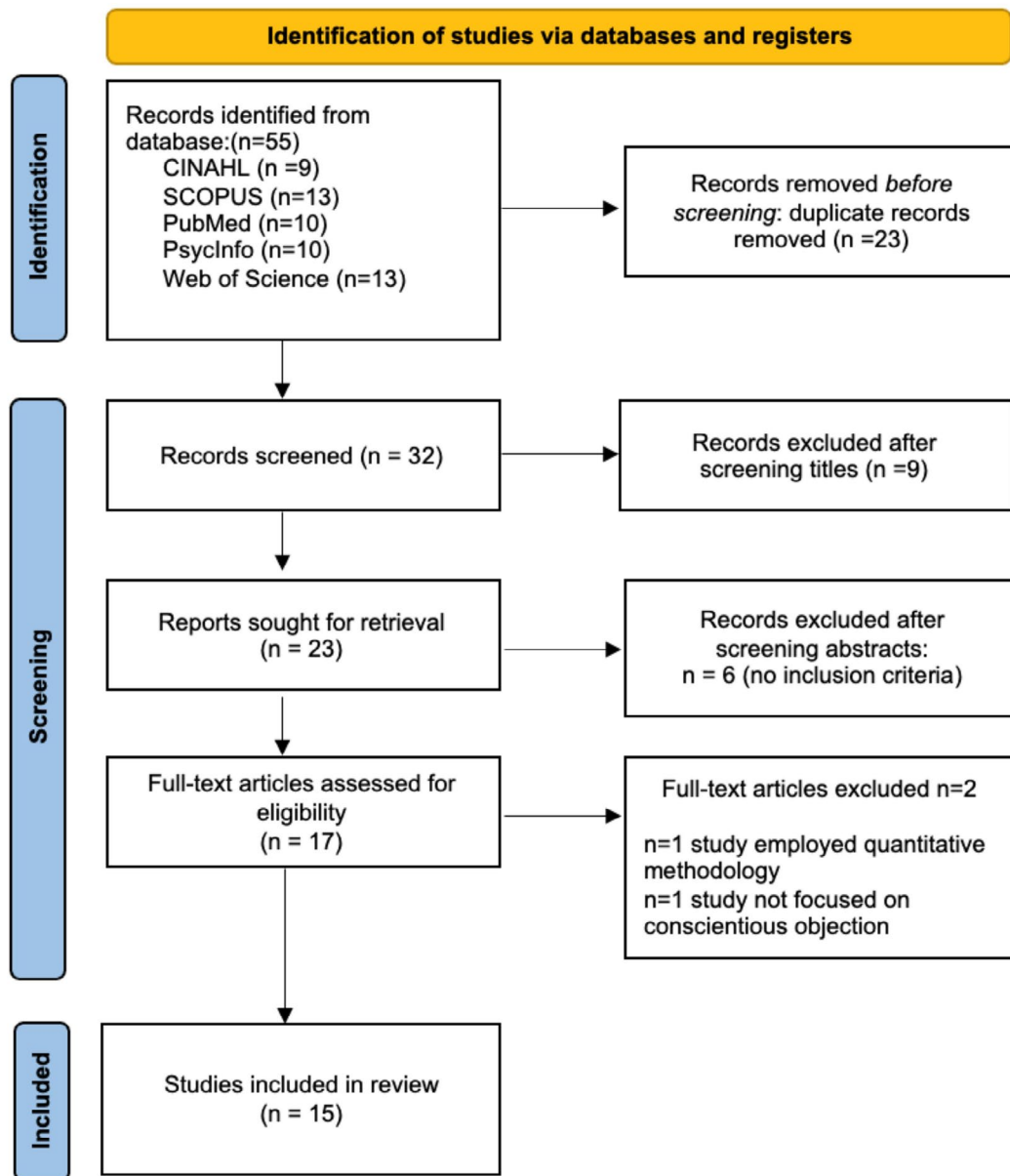


FIGURE 1 | PRISMA flow diagram. [Colour figure can be viewed at wileyonlinelibrary.com]

workers, patients, family members, genetic counsellors, pharmacists, nursing students, and other stakeholders. In this review, the term ‘other stakeholders’ refers to additional professionals involved in the discussion or regulation of EAS, as described in the original studies. Also, some of the data analysed are derived from regulatory documents that address professional guidance on EAS and CO management.

Eight studies took place in Canada; four in Australia; one in the United States (participants from California, Colorado, Montana, Oregon, Vermont, Washington, and Washington, DC); one in the Netherlands; and finally, one in Spain (Table 1).

4.3 | Summary of Findings

Most of the 15 studies were published between 2019 and 2023. In the first phase of the synthesis, we identified 223 verbatim

quotations related to the phenomenon of interest; most of these citations were from nurses and physicians, followed by students, patients, families, and, to a lesser extent, pharmacists, genetic counsellors, other stakeholders, and regulatory documents.

In the first phase of initial coding, these quotations were grouped into 39 first-level categories of analysis and into 83 second-level subcategories. In the second phase of the synthesis, 123 third-level codes were identified. In the third and final phase of the synthesis, these third-level codes were grouped into 15 final codes.

Based on our thematic analysis and grouping of codes, two categories of reasons were identified for declaring oneself a conscientious objector: (1) *non-moral motivations* and (2) *moral motivations*. Each of these categories had three themes.

Non-moral motivations included (1) perceived professional competence and bureaucratic requirements; (2) factors related to the

TABLE 2 | JBI quality appraisal checklist.

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Value	
Bouthillier and Opatrny (2019)	Green	Green	Green	Green	Green	Yellow	Red	Green	Green	Green	8.5	Moderate-quality
Brown et al. (2020)	Green	Green	Green	Yellow	Green	Red	Yellow	Green	Green	Green	8	Moderate-quality
Brown et al. (2021)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	10	High-quality
D'Angelo et al. (2019)	Green	Green	Yellow	Green	Green	Red	Yellow	Green	Green	Green	7.5	Moderate-quality
Dumont and Maclure (2019)	Green	Green	Green	Green	Green	Red	Red	Green	Green	Green	8	Moderate-quality
Haining and Keogh (2021)	Green	Green	Green	Green	Green	Red	Red	Green	Green	Green	8	Moderate-quality
Haining et al. (2021)	Green	Green	Green	Green	Green	Red	Yellow	Green	Green	Green	8.5	Moderate-quality
Isaac et al. (2019)	Green	Green	Green	Green	Yellow	Green	Green	Green	Green	Green	9	High-quality
Koksvik (2020)	Green	Green	Green	Green	Green	Green	Yellow	Green	Green	Green	9.5	High-quality
Lamb, Babenko-Mould, et al. (2019)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	10	High-quality
Lamb, Evans, et al. (2019)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	10	High-quality
Ortega-Galán et al. (2022)	Green	Green	Green	Green	Yellow	Red	Yellow	Green	Green	Green	8	Moderate-quality
Pesut et al. (2019)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	10	High-quality
Van de Scheur and Van der Arend (1998)	Green	Green	Green	Green	Green	Yellow	Green	Green	Yellow	Green	9	High-quality
White et al. (2023)	Green	Green	Green	Green	Green	Yellow	Yellow	Green	Green	Green	9	High-quality
Yes	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		
No	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red		
Unclear	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow		

Note: quality criteria

Note: Q1 = Congruity between the stated philosophical perspective and the research methodology; Q2 = Congruity between the research methodology and the research question or objectives; Q3 = Congruity between the research methodology and the methods used to collect data; Q4 = Congruity between the research methodology and the representation and analysis of data; Q5 = There is congruence between the research methodology and the interpretation of results; Q6 = Locating the researcher culturally or theoretically; Q7 = Influence of the researcher on the research, and vice-versa, is addressed; Q8 = Representation of participants and their voices; Q9 = Ethical approval by an appropriate body; Q10 = Relationship of conclusions to analysis, or interpretation of the data. High-quality paper = scores 9–10; moderate-quality paper = scores 7.5–8.5; low-quality paper = less than 7.5; exclude: less than 6. Cell colours indicate the JBI appraisal outcome: Green = Yes; Red = No; Yellow = Unclear.

social context in which EAS requests occur; and (3) emotional reactions.

Moral reasons included (1) ethical and bioethical principles used in the bioethical literature in the field of EAS; (2) aspects expressed by professionals that were related to moral consciousness itself; and (3) expressions of religious belief (Figure 2).

Note that our distinction between moral and non-moral motivations derives from the analytical criteria used in the process of coding and synthesis and is not intended to establish a normative hierarchy between them. We categorised as moral motivations those that the participants gave as explicit justifications linked to values, ethical principles, or religious convictions, while the motivations classified as non-moral were related to context, professional competence, or emotions, without reference to explicit normative arguments. Importantly, this distinction does not deny the possibility that factors such as emotions or workload may have relevant ethical implications. Rather, it reflects the ways in which these experiences and circumstances were expressed and conceptualised by the participants in the analysed studies (Table 3).

4.3.1 | Non-Moral Motivations

The motivations included in this category are not grounded in ethical or religious convictions, nor in moral principles or values that guide individuals in distinguishing between what is considered right or wrong. While moral motivations are articulated as a defence of integrity based on religious values, principles, or convictions, non-moral motivations are described primarily as contextual or protective of personal well-being. For these professionals, these reasons are not a breach of CO guidelines, but a legitimate way to protect their personal and professional integrity. This separation does not deny the ethical dimension of emotions but rather makes it possible to differentiate clinically between clashing values (which require bioethical dialogue) and psychological or technical impact (which requires institutional responses based on support and training).

This main theme comprises three sub-themes.

4.3.1.1 | Theme 1: Perceived Competencies and Bureaucratic Procedures. This theme is composed of two sub-themes. The first is perceived professional

Typology of Motivations for Conscientious Objection in End-of-Life Care



FIGURE 2 | Themes and subthemes. [Colour figure can be viewed at wileyonlinelibrary.com]

competence. Sometimes, physicians and nurses turn to CO when they feel that the theoretical training they have received is insufficient for assisting a person in dying. Professionals report that they do not have the necessary knowledge, despite recognising that they are not authentically conscientious objectors (Bouthillier and Opatrny 2019). The lack of specific psychological training is also used as an argument for not having participated in EAS (Ortega-Galán et al. 2022; Haining and Keogh 2021) and even serves as an excuse to avoid participating in EAS in the future (Haining and Keogh 2021).

The second subtheme expresses, at the same time, how professionals experience added administrative or bureaucratic burdens that also have an influence on the decision of the objecting professional. Both physicians and nurses point out that the tasks derived from these procedures lead to an increase in professionals' care burden (Bouthillier and Opatrny 2019; Isaac et al. 2019).

I will never do the training that will make me eligible to assist ... so, therefore, I would just say to the patient, 'I do not have adequate training. You'll have to see somebody else.'

(Health professional. Australia. Haining and Keogh 2021)

There is a significant administrative burden that comes with providing medical aid in dying. It is not the main reason for my refusal, but it is definitely a

contributing factor. It is already difficult enough for physicians to keep their heads above water, especially the new ones. And don't know how I could make it.

(Physician. Canada. Bouthillier and Opatrny 2019)

4.3.1.2 | Theme 2: Social Context. The social context in which euthanasia and assisted dying take place is often the point of origin of professionals' CO. This theme consists of four sub-themes: (1) the role of the media in informing society; (2) the opinion of professionals on the necessary requirements described by law; (3) the insufficient economic and human resources allocated to palliative care; and (4) the circumstances reported by family members when there is an ICO.

The first sub-theme includes the opinions of professionals in relation to the media. Some participants disagree with the way the media report on professional care in end-of-life situations, providing partial or inadequate information (Haining et al. 2021). Along the same lines, some professionals also report feeling criticised and judged by the media (Haining et al. 2021).

I don't believe that people die in agony, and I think that the prominent people in the media, who say that people have these horrible, undignified deaths, are just talking complete rubbish ... they obviously don't work in hospitals and see what we do.

(Health Care Provider. Australia. Haining et al. 2021)

TABLE 3 | Detailed description of identified main themes and subthemes.

Examples	Subthemes		Main themes
I will never do the training that will make me eligible to assist ... so, therefore, I would just say to the patient 'I do not have the adequate training. You'll have to see somebody else' (Haining et al. 2021) Although all of the documents reviewed recognised the right of nurses to conscientiously object to participating in MAiD, there was a lack of acknowledgement of how nurses grow into these decisions over time, and the moral work required for that growth.... Without this knowledge and confidence, nurses may decline to participate, even if they are not conscientious objectors (Pesut et al. 2019)	Professional competence	Competence and bureaucracy	Non-moral motivations
There is a significant administrative burden that comes with providing medical aid in dying. It is not the main reason for my refusal, but it is definitely a contributing factor. It is already difficult enough for physicians to keep their heads above water, especially the new ones. I don't know how I could make it (Bouthillier and Opatrny 2019)	Administrative requirements		
There are still grey zones in the law. It would help if some criteria were better defined (Bouthillier and Opatrny 2019)	Euthanasia legislation	Context	
Until we have access across Victoria everywhere on the ground ... to quality palliative care ... this debate about, in inverted commas, suffering, is actually premature (Haining et al. 2021)	Limited palliative care		
The staff member said, 'I can't, because of my role, there's nothing I can do to help you, I can't do anything'. But she said, 'I'm here for you' (White et al. 2023)	Institutional objection		
But if you're in a place like [city] where you have one hospital which has a religious foundation ... then you might have had a problem getting access, and I do not regard it as morally justifiable. Let's put it this way, there are limits [to MAiD] and the limits are set by secular beliefs, not by religious beliefs' (Brown et al. 2020)			
I don't believe that people die in agony and I think that the prominent people in the media, who say that people have these horrible, undignified deaths, are just talking complete rubbish... they obviously don't work in hospitals and see what we do (Haining and Keogh 2021)	The role of the media		
As long as they were able to respectfully refer out and say that this is not something that they typically handle. It's important that person is not being perceived as passing judgement (D'Angelo et al. 2019)	Professional discomfort	Emotional reasons	
It's been very divisive, it's been very difficult, it's not easy. People don't understand. They will very often try to explain this as another expression of medical power (Koksvik 2020)			
I would like to see the data that comes forward in the next five or ten years on these practitioners who drive around from place-to-place, just to give these provisions to people. I would like to see some data about whether any psychological adversity occurs or if there is any evidence of PTSD (Post Traumatic Distress Disorder) (Brown et al. 2021a)	Psychological concerns		

(Continues)

TABLE 3 | (Continued)

Examples	Subthemes		Main themes
Even though I support PAS, I can tell you if I was sitting at home right now knowing the drugs I supplied will be used to kill somebody, I would be an emotional wreck (Isaac et al. 2019)			
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 (Lamb, Babenko-Mould, et al. 2019)	Moral consciousness	Moral consciousness	Moral motivations
When autonomy has been stated as a bioethical principle with the other three. Even these people didn't say it's supreme. Beneficence, for example. There are many areas in life in which our autonomy is limited (Dumont and Maclure 2019)	Bioethical Principles	Ethical Principles	
'I will do everything to relieve suffering. I will not unduly prolong the agonies. I will never deliberately cause death' (Dumont and Maclure 2019)	Hippocratic Oath		
'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) (Lamb, Evans, et al. 2019)	Do no harm		
I have become concerned morally with the slippery slope. Now I know our Victorian legislation says that there is checks and balances, and that this is the most thorough legislation. Every country that I have read about has gone on a slippery slope with this incremental change, and I am concerned about twenty or thirty years time when I am at that age [that I will be] devalued (Haining and Keogh 2021)	Slippery slope		
In this case I didn't do it. In fact I did it in the past but I noticed that it does not come across at all in the experience of the patient. I can imagine this very well. People are not expecting me to tell them my problem and conflict or to say something like: 'I really do not agree with it at all' or, 'I think God has forbidden it' (Van de Scheur and Van der Arend 1998)	Divine authority	Religious beliefs	
I'm totally against euthanasia. For religious reasons ... life is most sacred in our religion, so the one who gave you life is the one who should take it away from you. You have no right to take your own life. If I chose to be euthanised, which amounts to suicide in my religion, I would go straight to hell (Ortega-Galán et al. 2022)	Sanctity of life		

If you say, "I am a conscientious objector," they say, "oh well you're a religious bigot; you're judgmental; you think you're above others" ... nothing could be further from the truth ... that's my perception of the way the public debate is handled on these things.
(Health Care Provider. Australia. Haining et al. 2021)

The second sub-theme includes the motivations that describe healthcare professionals towards the laws regulating EAS; in this sub-theme, some professionals report that the law does not offer the necessary guarantees to ensure that all possible treatment routes have been exhausted and that the patient requesting EAS is fully determined in their decision (Haining et al. 2021).

In these circumstances, professionals feel that laws regulating EAS have unresolved legal aspects and do not sufficiently guarantee that it cannot be administered by mistake (Bouthillier and Opatrny 2019).

There are still gray zones in the law. It would help if some criteria were better defined.
(Physician. Canada. Bouthillier and Opatrny 2019)

The third sub-theme includes the circumstances in which the professional rejects EAS when they feel that properly administered palliative care, including palliative sedation, provide a dignified death that would prevent patients from requesting euthanasia (Bouthillier and Opatrny 2019; Dumont and Maclure 2019; Lamb, Babenko-Mould, et al. 2019). In this

context, some professionals report that resources for palliative care are insufficient (Haining et al. 2021) and that professionals need more support after becoming conscientious objectors (Lamb, Evans, et al. 2019).

Some physicians and nurses report a view of death as a beautiful part of life, which, even within suffering, can provide endearing moments between patients and family (Brown et al. 2021a; Dumont and Maclure 2019).

There are so many other options other than “let us just refer to MAID”. I have been in some very beautiful deaths in the palliative care approach. It is not just about the person dying. It is about the experience and what it brings to the family. If you do the MAID program, maybe that’s not going to happen.

(Health Care Provider. Canada. Brown et al. 2021a)

The advantage of palliative sedation is that it is not the doctor who decides when the patient will die. He dies when he dies. We watch him, we stay by him, we hold his hand, then at some point he leaves. And I like that it’s not the doctor who decides.

(Physician. Canada. Dumont and Maclure 2019)

The fourth and final sub-theme includes the experiences described by patients and families in situations of ICO. These stakeholders report feelings of anguish and suffering when they see that they will have to be referred to another centre, with the stress that this can entail at the end of life (Brown et al. 2020; White et al. 2023). However, some family members report having received displays of support from members of the care team when a patient was referred to a non-religious centre (Brown et al. 2020).

ICO affects both professionals who work in the objecting institutions and patients and their families when they cannot be cared for near their residence or in the region where they live. In rural settings, the lack of options can make it even more difficult to manage the request and condition the patient to modify their initial choice, accepting the self-administration of lethal medication when they initially preferred it to be administered in an institutional setting (Brown et al. 2020).

But if you’re in a place like [city] where you have one hospital which has a religious foundation ... then you might have had a problem getting access, and I do not regard it as morally justifiable. Let’s put it this way, there are limits [to MAiD] and the limits are set by secular beliefs, not by religious beliefs.

(Patient. Canada. Assessed and approved for MAiD, Brown et al. 2020)

That was a significant challenge and just created a whole lot of stress on what was her last day. You know, it was this frantic rush and ... then having to wheel

her out and she couldn’t say goodbye to people ... you get to the top of the mountain and then you’ve got that last big, huge boulder to climb over. It will always be a great sadness for me that the last few precious hours on Mum’s last day were mostly filled with stress and distress, having to scurry around moving her out of her so-called “home”.

(Family caregiver. Australia. White et al. 2023)

It wasn’t an option in [rural town]. So it was only ever available as self-administered. If Dad had to have practitioner assisted, he had to be transported to [major city].

(Family caregiver. Australia. White et al. 2023)

4.3.1.3 | Theme 3: Emotional Reasons. This theme covers the emotional reactions that influence the decision of professionals not to participate in EAS practices and includes two sub-themes.

The first sub-theme is professional discomfort, in which some professionals express feeling uneasy about an EAS request (Haining and Keogh 2021; Haining et al. 2021; Isaac et al. 2019; Lamb, Babenko-Mould, et al. 2019) when they do not feel emotionally prepared to carry it out or feel pressured to participate in EAS (Lamb, Babenko-Mould, et al. 2019). However, the emotional reasons can lead to the decision to declare oneself a conscientious objector, even if the objector is not against euthanasia (Bouthillier and Opatrny 2019).

In some situations, participants express not feeling emotionally prepared and describe feelings of discomfort in the face of death (Brown et al. 2021a; Dumont and Maclure 2019; Haining and Keogh 2021; Lamb, Babenko-Mould, et al. 2019; Koksvik 2020) or fear of possible future psychological repercussions (Bouthillier and Opatrny 2019; Brown et al. 2021a; Ortega-Galán et al. 2022).

Similarly, some genetic counsellors describe professional discomfort that prevents them from addressing the request, while stressing the need to provide an appropriate response and refer the patient to another professional who is more comfortable with the issue (D’Angelo et al. 2019).

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

(Physician. Canada. Bouthillier and Opatrny 2019)

It’s been very divisive, it’s been very difficult, it’s not easy. People don’t understand. They will very often try to explain this as another expression of medical power [given in the original as an example of how professionals feel ‘pressured’].

(Physician. Canada. Koksvik 2020)

I think that, even if I'm in favor of it, it could lead to me becoming depressed ... In the end, even if you are a healthcare professional, you're a person above all.

(Student. Spain. Ortega-Galán et al. 2022)

As long as they were able to respectfully refer out and say that this is not something that they typically handle. It's important that person is not being perceived as passing judgment.

(Genetic counsellors. United States. D'Angelo et al. 2019)

The second sub-theme, psychological concerns, includes situations in which professionals experience both physical and psychological manifestations, such as burnout or moral distress, as a result of participation in decisions related to EAS (Brown et al. 2021a; Haining and Keogh 2021). In some accounts, professionals describe emotionally intense experiences, expressed in terms of feeling 'emotionally wrecked' (Isaac et al. 2019). From a different perspective, some family members of patients also describe experiences of high emotional burden in ICO contexts related to the difficulty of accessing the service (White et al. 2023).

In these circumstances, professionals also express the need to feel supported by the institutions where they work and describe situations in which the lack of institutional support increases their reluctance to get involved in this process (Lamb, Babenko-Mould, et al. 2019; Lamb, Evans, et al. 2019). In these situations, professionals point out that CO can act as a strategy to protect their psychological well-being.

I would be worried about physician burnout ... I think it [MAiD] could be harder emotional work than one foresees it being at the start. That would be something that would concern me.

(Health Care Provider. Canada. Brown et al. 2021a)

That sounds very hopeless, but that is my true and honest belief. We already have so much ethical and moral distress, to put ourselves in that [MAiD participation] situation, I just cannot see it happening.

(Health Care Provider. Canada. Brown et al. 2021a)

Even though I support PAS, I can tell you if I was sitting at home right now knowing the drugs I supplied will be used to kill somebody, I would be an emotional wreck.

(Pharmacist. Australia. Isaac et al. 2019)

4.3.2 | Moral Motivations

The category of moral motivations includes situations in which the decision not to participate in EAS is based on convictions

that are part of the professional's moral identity and guide their judgement on what they consider right or wrong.

4.3.2.1 | Theme 1: Moral Consciousness. This theme includes professionals' appeals to their conscience or moral consciousness as a personal and subjective dimension that allows them to distinguish between right and wrong and act accordingly (Lamb, Evans, et al. 2019). For some professionals, appealing to their conscience implies a process of reflection and deliberation on what they consider right and wrong, even if this may entail high professional costs, such as having to choose between professional duty and fidelity to one's conscience (Lamb, Evans, et al. 2019).

In this sense, they report that their conscience acts as a 'compass' or as 'an inner voice' to guide the decision-making process when faced with the possibility of objecting (Lamb, Evans, et al. 2019; Lamb, Babenko-Mould, et al. 2019).

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.

(Nurse. Canada. Lamb, Babenko-Mould, et al. 2019)

Conscience for her, was a "compass" to guide her decision-making, such as by way of making a CO.

(Nurse. Canada. Lamb, Evans, et al. 2019)

4.3.2.2 | Theme 2: Ethical and Bioethical Principles. This theme is composed of four sub-themes. The first, bioethical principles, includes the reasons why professionals justify their position, in terms of professional ethics and applied bioethics. In these accounts, the decision not to participate in EAS is often articulated with the principle of beneficence. In this line, some professionals think that the legislation has not taken into account the opinion of physicians, who will always ensure these principles, guiding their professional action to avoid harm and promote the well-being of patients. For them, the principle of beneficence should prevail over that of patient autonomy (Bouthillier and Opatrny 2019; Dumont and Maclure 2019; Haining et al. 2021; Lamb, Babenko-Mould, et al. 2019; Lamb, Evans, et al. 2019).

The second sub-theme, Hippocratic Oath, describes the motivations of professionals to maximise benefits and avoid harm, as reflected in the Hippocratic Oath, as well as the codes of professional ethics (Dumont and Maclure 2019; Haining et al. 2021). In this sense, the results show that CO can be interpreted as a way to preserve consistency with the ethical principles that govern the profession.

In the third sub-theme, do no harm, professionals frequently appeal to the principle of non-maleficence, often expressed in the form of 'do no harm', which they identify as a central element in their academic training and professional ethics. According to the participants, this principle is incompatible with participation in EAS procedures (Bouthillier and Opatrny 2019; Dumont and Maclure 2019). In this context, professionals believe that governments impose actions on professional associations,

making legislation prevail over the expert criteria of the members (Dumont and Maclure 2019)

Our job is not to determine when someone dies and how they die. We're supposed to support them and assist them. We are not supposed to be ending their life ... it is contrary to the doctor-patient relationship, and I would argue that is contrary to Hippocratic Oath ... it devalues doctors' role in society and what they are supposed to do.

(Health Care Provider. Australia. Haining et al. 2021)

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.

(Nurse. Canada. Lamb, Evans, et al. 2019)

It's collusion with the College of Physicians, but basically it was imposed by the Government of Quebec. It's not medicine. It is not up to them to define what medicine is. It's not for the Supreme Court of Canada to define what medicine is.

(Physician. Canada. Dumont and Maclure 2019)

Finally, in the fourth sub-theme, some participants express concern about a 'slippery slope'. This argument is frequently used as a bioethical reason, because it leads to the discrediting of healthcare professionals who, in specific contexts, could gradually extend this practice to people who do not meet the requirements, such as minors, the mentally ill, or people without an illness. In this sense, professionals argue that their refusal to participate in EAS prevents the progressive expansion of these scenarios in the future (Dumont and Maclure 2019; Haining et al. 2021).

The terminally ill is just how they start off getting it in, and then they want to introduce it to all the involuntary, the demented ... the whole illness range to the healthy elderly, all the way to people who have had enough.

(Health Care Provider. Australia. Haining et al. 2021)

4.3.2.3 | Theme 3: Religious Reasons. This theme includes motivations based on religious convictions. A significant part of the participants in the studies report that their religious values are the main motivation for being objectors (Dumont and Maclure 2019; Haining et al. 2021; Lamb, Babenko-Mould, et al. 2019; Ortega-Galán et al. 2022). This theme is composed of two sub-themes.

In the first sub-theme, divine authority, some participants indicate that decisions about the moment of death belong to a higher power, formulated in theistic terms. In this view, God is the only agent who may legitimately determine the moment of death (Van de Scheur and Van der Arend 1998).

However, the extracts analysed show that religion does not always operate in isolation, but is often articulated with a broader moral, professional, and civic framework, which influences their decision not to participate in EAS (Dumont and Maclure 2019).

In this case I didn't do it. In fact, I did it in the past, but I noticed that it does not come across at all in the experience of the patient. I can imagine this very well. People are not expecting me to tell them my problem and conflict or to say something like: 'I really do not agree with it at all' or 'I think God has forbidden it'.

(Nurse. Netherlands. Van de Scheur and Van der Arend 1998)

And that, I cannot accept that ... as a doctor. As a citizen first of all, as a doctor second, and finally as a Catholic.

(Physician. Canada. Dumont and Maclure 2019)

In the second sub-theme, we identified the 'sanctity of life' as a reason for rejecting an EAS request. This expression refers to the idea that human life has an intrinsic value that cannot be interrupted by human decision, even when this decision corresponds to the expressed will of the affected person (Isaac et al. 2019; Ortega-Galán et al. 2022).

I don't believe that it's our place to decide when we die; God decides that.

(Pharmacist. Australia. Isaac et al. 2019)

I'm totally against euthanasia. For religious reasons ... life is most sacred in our religion, so the one who gave you life is the one who should take it away from you. You have no right to take your own life. If I chose to be euthanised, which amounts to suicide in my religion, I would go straight to hell.

(Student. Spain. Ortega-Galán et al. 2022)

4.4 | Findings From the Analysis of Regulatory Documents

Unlike the qualitative studies based on the experiences and perceptions of the different stakeholders, the analysis of Canadian regulatory documents on Medical Assistance in Dying (MAiD) and the exercise of CO conducted by Pesut et al. (2019), identified that the documents emphasise the importance of nurses engaging in an active process of reflection on their own values when considering participation in MAiD. This process of moral reflection, consistent with Theme 1: Moral consciousness, highlights the need for decisions regarding participation in MAiD to be preceded by reflection on one's own values and professional responsibilities.

This qualitative meta-synthesis provides an integrative analysis of the perceptions, experiences and motivations, and contextual factors underlying conscientious objection (CO) in the context of euthanasia and assisted dying (EAS), incorporating the perspectives of different stakeholders involved. The fact that most of the included studies were published between 2019 and 2023 reflects the emerging and growing relevance of this phenomenon at the international level, in parallel with the progressive regulation of EAS in different contexts. However, the inclusion of the study by Van de Scheur and Van der Arend (1998) is particularly relevant due to its pioneering contribution to the conceptualisation of healthcare professionals as moral agents in this field. Overall, the findings highlight the complexity of the phenomenon, which cannot be understood solely from a normative or legal perspective but requires a multidimensional approach.

One of the main contributions of this study is the analytical distinction between moral and non-moral motivations in the justification of CO. Although the literature has traditionally associated objection with deeply held moral convictions linked to professionals' moral identity (Sulmasy 2008), our findings show that a substantial proportion of justifications are not articulated in these terms. This categorisation, aligned with Wicclair's (2011) theoretical framework, allows for a more precise operationalisation of the phenomenon in real clinical contexts. In this regard, the identification of non-moral motivations—of an emotional, organisational, or contextual nature—suggests that not all instances of CO arise from irreconcilable value conflicts, but may instead be mediated by factors that are amenable to intervention. This interpretation helps to move beyond dichotomous approaches based on the 'thesis of incompatibility' and opens the door to compromise-based approaches aimed at balancing professionals' moral integrity with patients' right to access legally recognised services.

Regarding non-moral motivations, the findings are consistent with previous studies (Triviño-Caballero et al. 2023; Byrnes et al. 2025) and highlight the role of professional, contextual, and emotional factors. One of the most recurrent elements is the perceived lack of competencies, both technical and psychological, among physicians, nurses, and students in addressing EAS requests (Bouthillier and Opatrny 2019; Haining and Keogh 2021; Ortega-Galán et al. 2022). This lack of preparedness is further reinforced by the perception of insufficient training and limited specific institutional guidance (Pesut et al. 2020). These difficulties are also observed in other professional groups, such as pharmacists and genetic counsellors, where lack of knowledge and experience likewise contributes to reluctance to participate (D'Angelo et al. 2019; Isaac et al. 2019). Additionally, factors related to the legal and social framework also emerge as relevant. Some professionals express distrust towards legislation, particularly when they perceive ambiguity in eligibility criteria or insufficient safeguards for patient protection (Haining et al. 2021). Similarly, the preference for alternatives such as palliative care is often associated with the perception that these services are insufficiently developed or funded, which may indirectly

influence the demand for EAS (Dumont and Maclure 2019; Lamb, Babenko-Mould, et al. 2019). In this context, social and media discourses may also shape perceptions of end-of-life care, generating expectations that do not always reflect the complexity of healthcare provision in these situations (Brown et al. 2020; White et al. 2023).

Emotional responses constitute another central dimension within non-moral motivations. Professionals frequently describe experiences of discomfort, distress, or uncertainty when confronted with EAS requests, which in many cases do not result in absolute refusal but rather in doubts about their own position and tensions within teams (Haining et al. 2021; Isaac et al. 2019; Lamb, Babenko-Mould, et al. 2019). In other situations, more intense forms of moral distress or psychological impact are reported, particularly in the absence of adequate institutional support (Brown et al. 2021a; White et al. 2023; Lamb, Evans, et al. 2019). These findings highlight the relevance of the emotional dimension in CO, which is often underrepresented in predominantly normative debates.

With regard to moral motivations, these are primarily articulated around established ethical frameworks that shape professional identity. In line with Jensen and Lidell (2009), moral consciousness emerges as a central element guiding clinical practice. In this sense, the findings of our study show that moral motivations function as a true *ethical compass*, guiding professional action and reinforcing the need to act in accordance with one's own values and principles (Lamb, Evans, et al. 2019; Lamb, Babenko-Mould, et al. 2019). Within this framework, the principles of bioethics formulated by Beauchamp and Childress (1999) emerge as key references in the justification of conscientious objection, particularly in relation to the tension between autonomy and beneficence, as well as the centrality of the principle of non-maleficence. For many professionals, participation in EAS procedures is perceived as incompatible with the fundamental duty to do no harm, reinforcing the central role of the principle of *do no harm* in the justification of CO (Dumont and Maclure 2019; Isaac et al. 2019). Other arguments include references to the Hippocratic tradition, which frames medical practice as oriented towards care and the alleviation of suffering (Haining et al. 2021), as well as the *slippery slope* argument, in line with Marcos and de la Torre (2019), which warns of a potential progressive expansion of the criteria for the application of EAS.

Finally, religious beliefs constitute another relevant dimension within moral motivations. In line with Pesut et al. (2020), when CO is linked to religious principles, it cannot be understood in a rigid or decontextualised manner, but requires careful reflection on the underlying values, such as the sanctity of life and the potential consequences for professionals, patients, and society (Isaac et al. 2019; Ortega-Galán et al. 2022). In this regard, some professionals, particularly nurses, base their objection on faith, while describing the associated emotional impact, including feelings of loneliness, sadness, or frustration, as well as the need for family, social, and institutional support to sustain their decision (Lamb, Babenko-Mould, et al. 2019; Van de Scheur and Van der Arend 1998), in line with findings reported by Bellens et al. (2020).

Beyond professionals' motivations, and in agreement with Close et al. (2023), this study highlights the relational consequences of CO for patients and families. Several studies show that refusal to participate in EAS procedures may generate experiences of frustration, powerlessness, and deterioration of trust in the therapeutic relationship (White et al. 2023; Brown et al. 2020). This impact is particularly significant in rural settings, where access to EAS may be seriously compromised (Panchuk and Thirsk 2021). These findings suggest that CO cannot be understood solely as an individual decision, but rather as a relational phenomenon that redistributes the burden of moral conflict onto patients and their families, generating a relational cost that extends beyond the strictly professional domain.

Finally, these findings have relevant implications from both clinical and organisational perspectives. First, the distinction between moral and non-moral motivations allows for the design of more tailored responses: while the former require spaces for ethical deliberation and respect for professional integrity, the latter may be addressed through training strategies, institutional support, and improvements in organisational processes. Second, it is necessary to ensure effective referral mechanisms that guarantee patients' access to EAS without compromising professionals' rights. Finally, the creation of structured spaces for ethical reflection may contribute to managing the complexity of these situations in everyday clinical practice, thereby strengthening both the quality of care and the well-being of professionals.

5.1 | Strengths and Limitations

Around 90% of the included studies show high methodological quality, supporting the reliability of the findings and their potential transferability to similar care contexts. This robustness is particularly relevant considering the wide range of perspectives captured across the studies, and contributes to a relatively underexplored topic, CO in the field of medical assistance in dying. The resulting knowledge can inform the development of health policies and training strategies that support ethically grounded and context-sensitive clinical practice, respect moral plurality, and provide professionals and families with tools to make decisions regarding euthanasia and physician-assisted suicide.

However, this synthesis also presents some limitations. The number of included studies remains limited due to the limited availability of eligible studies. In addition, the scarce variability of methodologies used in the original studies, predominantly structured interviews, may have restricted the depth and diversity of perspectives collected. While the geographical diversity of the studies is a strength, it also introduces heterogeneity derived from cultural and legal differences, which should be considered when interpreting the findings.

Finally, although most included studies were published between 2019 and 2023, the review includes an earlier study published in 1998. This study is noteworthy due to its pioneering contribution to the qualitative exploration of nurses' roles in euthanasia. It was the first to conceptualise nurses as independent moral agents in the EAS process and to describe a four-phase intervention framework (request observation, decision-making, intervention, and post-intervention care) that has informed

subsequent literature. It also identifies early tensions between legal regulations and clinical practice, including professionals' roles under conditions of emotional commitment and limited institutional support, helping to contextualise the evolution of CO in contemporary healthcare systems.

5.2 | What Does This Paper Contribute to the Wider Global Clinical Community?

- This review shows that CO to euthanasia and medically assisted suicide can have both moral and non-moral motivations.
- The review shows that non-moral motivations include perceived lack of competence, bureaucratic burdens, social context, and emotional impact, while moral motivations derive from moral consciousness, ethical principles, and religious beliefs.
- The review shows that health organisations must have clear procedures that guarantee the rights of patients and objecting professionals, as well as promoting more research in different contexts to reinforce ethically sound decision-making.

5.3 | Implications for Training and Research

The results of this meta-synthesis suggest several implications for professional training, institutional management, and future research.

In relation to training, the results indicate that many refusals to participate in EAS procedures are related to factors such as the lack of specific training or the difficulty in managing the associated emotional discomfort. Training in bioethics that includes decision-making at the beginning and end of life, especially regarding euthanasia, assisted suicide and CO, should be given ample attention in training curricula and continuing education (Hewitt et al. 2022). This would better prepare professionals to face ethical problems, prepare them for the complexity of decision-making, reduce uncertainty, and promote coherence between personal values and professional responsibilities. In this sense, some pedagogical strategies such as the use of clinical simulation and structured ethical deliberation may be useful in addressing this complexity (González-Pérez et al. 2025).

Regarding institutional management, clear protocols must be established, including defined timeframes for patient referral when a professional invokes CO, in order to avoid delays in care (Byrnes et al. 2025). The creation of confidential, non-punitive registries is also recommended (España 2021). In addition, institutional agreements should be promoted to ensure internal referral of cases and the preparation of specific ethical guidelines that guide clinical practice, ensuring continuity of care and reducing potential conflict within teams.

Finally, further research should explore the diverse motivations underlying CO and promote qualitative and mixed-methods studies across different contexts to better understand its impact and inform balanced, rights-based clinical practice.

6 | Conclusion

The decision of health professionals to invoke CO to a request for help in dying is rarely based on a single motivation, but involves the interaction of ethical, emotional, personal, social, and institutional factors. This complexity shows the need to address CO not as an individual right, but as a multidimensional phenomenon with implications for access to legally recognised services, professional relationships, and care practice. Distinguishing between moral and non-moral motivations is particularly relevant, as it reveals the diversity of factors involved and cautions against simplistic or stigmatising interpretations. While moral motivations are grounded in ethical values and may open spaces for dialogue, non-moral motivations can generate uncertainty and hinder effective responses in clinical settings. In this context, developing clearer frameworks to guide the management of CO may support a more balanced consideration of the perspectives and responsibilities of the different stakeholders involved.

Author Contributions

Rosa Pérez-Capellades: conceptualisation, funding acquisition, writing – original draft, writing – review and editing. **Sergio Ramos-Pozón:** writing – review and editing. **Daniel Pasten-Araya:** software. **Anna Falcó-Pegueroles:** conceptualisation, methodology, writing – review and editing.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Research data are not shared.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **File S1:** Database search strategy.