Provincial Health Services Authority

Navigating Conscientious Objection in Healthcare:

Support for Care Professionals, Staff & Leaders

Prepared by:
Provincial Health Services Authority Ethics Service
October 2025

ethics@phsa.ca

Navigating Conscientious Objection in Healthcare: Support for Care Professionals, Staff & Leaders

Table of Contents

Acknowledgements

This resource was informed by the work and insights of the Provincial Health Services Authority (PHSA) working group and UHN Women's College Hospital Abortion Care: An Ethics Guide to Providing Conscientious Care, prepared by Ruby Shanker (June 2, 2022).

Introduction

The PHSA Ethics Service has identified a need for guidance on navigating issues related to conscientious objection in the healthcare environment in response to increased inquiries on this subject. As reflected in its North Star Priorities, PHSA is committed to delivering the highest quality of patient care and supporting the well-being of its staff and healthcare providers by enabling an anti-racist, safe, and discrimination-free culture that respects and reflects the diversity of patients and the workforce. This resource was created with these priorities in mind, in collaboration with subject matter experts from across PHSA's various clinical programs and corporate services including BC Cancer, BC Children's Hospital, BC Women's Hospital + Health Centre, BC Mental Health and Substance Use Services, BC Emergency Health Services, BC Centre for Disease Control, and PHSA's provincial clinical programs and health improvement networks. We are thankful for their time and expertise.

The Coast Salish Teachings, gifted to PHSA by Musqueam Knowledge Keeper, Shane Pointe, Siem Te Ta-in, offer important guidance to health care professionals in the effort to create an inclusive work environment that is free from Indigenous-specific racism and discrimination and experienced as culturally safe by Indigenous peoples. The teachings offer important grounding for how we show up every day and can help us navigate situations where conscientious objections arise, inviting self-reflection on how to do our best as human beings and ensure humanity is centered in every interaction.

Purpose

The purpose of this resource is to offer guidance and practical tools to support healthcare professionals, staff, and leaders in understanding and discussing conscientious objection in a healthcare context. The goal is to support teams in creating a safe, inclusive environment where everyone can explore and discuss their values while upholding Indigenous rights to self-determination and protecting the human rights, dignity, and continuity of care for patients, clients, families, and the public.

Understanding Conscientious Objection

Definitions

Freedom of Conscience

Freedom of conscience is the ability of a person to act according to their deeply held personal values or moral beliefs, whether those beliefs are religious or secular.[1] In Canada, this freedom is protected as a fundamental right under the Canadian Charter of Rights and Freedoms. It ensures everyone is free to practice and live according to their views and values and make decisions in their personal life as they see fit. Additionally, it helps safeguard individuals from being compelled to act in ways they believe to be morally wrong. In healthcare, many professional standards recognize this right by allowing for conscientious objection (defined below) in certain situations. However, like all rights, freedom of conscience is not absolute. It must be balanced with a healthcare professional's legal, ethical, and professional responsibilities, and with the rights of patients.[2]

Conscientious Objection

Conscientious objection in western healthcare is defined as "the refusal by a health care professional to provide a legal, patient-requested medical service or treatment that falls within the scope and qualifications for their field, based on their personal or religious beliefs."[3] It is a measure that may be used to protect freedom of conscience from unfair interference where no other remedy alleviates that interference.

Conscientious objections must be grounded in conscience and moral integrity and require an examination and appreciation of one's own values and moral perspective.[4]

Clarifying Misconceptions

Conscientious objections must be based on personal values or moral convictions. Conscientious objections are not based on:

- convenience,
- lack of resources,
- discomfort,
- lack of education or familiarity with a procedure,

---

[1] Government of Canada, Department of Justice. (2024, August 13)
[2] Canada. (1982)
[3] Fiala et al. (2025)
[4] Lamb (2016); Zolf (2019)

- scientific or political misinformation,
- bias or discrimination toward certain populations or individuals, or
- mere disagreement with patient's choices.

These reasons for refusing to provide a service are not supported by professional practice standards or PHSA policies.

Misuse of requesting an accommodation based on conscientious objection can arise from prejudice and discrimination including but not limited to racism, sexism, cis-heteronormativity, anti-trans bias, ableism, and classism. Conscientious objection should only be used as a tool to help healthcare professionals act ethically within their own boundaries of moral integrity, and justifying conscientious objection using these precursors cannot lead to a just or ethical result.[5] Objections based on prejudicial and discriminatory beliefs or views will not be accommodated because doing so would be an unfair interference of individuals' rights to live free of discrimination.

Practically speaking, conscientious objection should relate strictly to the service, not the person seeking it. For example, a surgeon who regularly provides breast augmentation surgery to cisgender women but refuses to do so for transgender women may not claim they have a conscientious objection because the grounds for their objection is based in discrimination against a certain group of people (transgender women), not the surgery itself.

The Impact of Conscientious Objection

If not appropriately communicated to leaders and balanced with competing rights and obligations, conscientious objections can lead to harmful outcomes for patients, healthcare staff, organizations, and potentially erode trust in the governance of public institutions. The ongoing experience of colonialism makes this particularly true for Indigenous patients, healthcare staff, and organizations.

There are power dynamics inherent in healthcare that systematically disadvantage patients, who are more susceptible to situational or systemic vulnerability than those working in the system. In addition to duty of care, obligations to patients exist because healthcare in Canada is a universal, publicly funded service. Without discounting staff experiences and wellness, patients' rights must be prioritized.

Improperly managed conscientious objections disproportionately affect people who have experienced and continue to experience marginalization, including women, racialized communities, Indigenous peoples, disabled individuals, and members of the 2SLGBTQIA+ community who are already at higher risk of experiencing barriers to care and harmful interactions with the healthcare system.[6] For example, patients may experience additional and unfair barriers to the care they need and would otherwise

[5] Lamb (2016); Downie & Bayliss (2017)
[6] Fry-Bowers (2020)

receive, including delays or no care at all. They may also experience fear, misinformation, and abandonment.[7]

Improperly managed conscientious objections also have the potential to negatively impact staff. The person with a conscientious objection and their non-objecting colleagues may experience disagreements and moral distress, which can affect the team's dynamics including judgment, stigmatization, and resentment.[8]

For these reasons, it is essential to understand how to properly identify a conscientious objection, understand how exercising a conscientious objection may impact patients, teams, and the system, and consult with leaders and support services to determine whether an accommodation is possible.

[7] Fiala et al. (2025)
[8] Shanker (2022)

Conscientious Care

Defining Conscientious Care

Conscientious objection is often framed as an absolute concept in that if an individual has an objection, they can opt out of providing the care insofar as that care infringes on their values, beliefs or morals. However, we are faced with a duty to uphold patients' rights to access the care they need and want without stigma or discrimination, while promoting diversity amongst staff and creating a safe and inclusive workplace. Framing conscientious objection as less absolute helps us to balance these priorities in ways that help meet the needs of patients and healthcare professionals. A "conscientious care" approach can help navigate this shift in framing.

Conscientious Care is a person-centred approach that supports healthcare professionals in participating in parts of care they find personally morally challenging, while aligning with their professional duties. It represents a middle ground between full participation and complete refusal, which can help enable person-centered care and staff wellness while mitigating barriers to access for patients, operational difficulties, and moral distress.

Conscientious care also requires leaders and organizations to support their staff. Success depends on an environment that welcomes open communication about conscientious objection without fear of judgment or negative consequences, including assurances that conversations will be confidential.

An example of conscientious care can be found in scenario 1 at the end of this document.

Navigating Practical Limits

Conscientious objection exists within a context of legal, professional, organizational, and ethical requirements and responsibilities. Engaging in conscientious care requires healthcare professionals to be aware of and practice within the limits of these requirements and responsibilities while balancing the limits of their own moral comfort with a particular care act.

Legal Accountabilities

PHSA is accountable to the legislative obligations related to Indigenous Rights as outlined in the Declaration on the Rights of Indigenous Peoples Act (DRIPA), the DRIPA Action Plan, and the United Declaration on the Rights of Indigenous Peoples (UNDRIP).[9] All patients have a right to dignity and equitable access to healthcare.[10] They also have the right to exercise their autonomy, while safeguards must be in place when it is determined they lack the capacity to make their own decisions. This includes

[9] British Columbia (2019); United Nations (2007).
[10] *Canadian Charter of Rights and Freedoms* (1982); *Canada Health Act* (1985); *BC Human Rights Code* (1996)

a right to consent to and decline medical interventions. This includes abortion and abortion-related care and MAiD, provided they are eligible.

Patients also have a right to freedom of conscience, including the right to choose care that aligns with their moral integrity, values, and beliefs.

Professional Standards

Conscientious objection is mentioned in professional college standards for nurses & midwives, physicians & surgeons, and pharmacists. Please refer to these professional college standards for more information. More information can be found in the Resources section.

Commonalities among these practice standards include:

- Continuity of care and duty of non-abandonment, including ensuring timely and effective referrals where required and continuing to offer care unrelated to the conscientious objection
- Non-judgment
- The objection must be based on beliefs and values to be considered a conscientious objection

As outlined in the College of Physicians and Surgeons of BC Practice Standards, physicians in BC do not have an obligation to effectively refer directly to another willing provider but do have a duty of care that is continuous and non-discriminatory.[11] The lack of a clear duty to refer creates an environment where a patient may face significant barriers to care.

PHSA physicians and all staff who have identified that they have a conscientious objection are encouraged to follow the Recommended Process in addition to consulting with professional colleges to ensure they are meeting requirements.[12]

PHSA Organizational Requirements

All healthcare professionals and staff at PHSA are required to ensure access and continuity of patient care and uphold professional standards of conduct. PHSA is also committed to maintaining a safe and transparent work environment, balancing respect for diversity of staff worldviews with system-wide care responsibilities.

Importantly, PHSA is a signatory of the Declaration of Commitment on Cultural Safety and Humility in Health Services[13], and has implemented the Indigenous-Specific Anti-Racism and Discrimination Staff Policy.

[11] College of Physicians and Surgeons of British Columbia (2025).
[12] Abortion Rights Coalition of Canada (2018, August).
[13] British Columbia (2015).

Ethical Requirements

Healthcare professionals must abide by professional codes of ethics which typically require non-abandonment and acting for the good of the patient. In certain scenarios, it is expected that care will be provided regardless of a conscientious objection. For example:

- During a medical emergency or time sensitive event where a patient is or appears to be at imminent risk of sustaining serious harm if treatment is not administered promptly, or where treatment options will be precluded if not provided promptly. This includes situations where a patient's access to care would be unreasonably delayed in the absence of prompt action.
- When the decision to opt out of care would place an unreasonable burden on the patient, other employees, or the organization/system at large.

A burden is unreasonable if it leads to barriers to care that cannot be reasonably managed in a way that is acceptable to the patient and to the organization. In assessing reasonableness, it is essential to consider individual patient circumstances and equity, recognizing that some patients experience inequities that may decrease their ability to overcome barriers to care.

Recommended Process

The following section is the recommended process for healthcare professionals and staff to follow when they think they have a conscientious objection. Early identification and engaging in these steps as soon as possible is encouraged to facilitate continuity of care. Whether a conscientious objection can be accommodated may be case specific but a plan should be put in place in advance whenever possible.

1. Access Educational Information and Engage in Self-Reflection

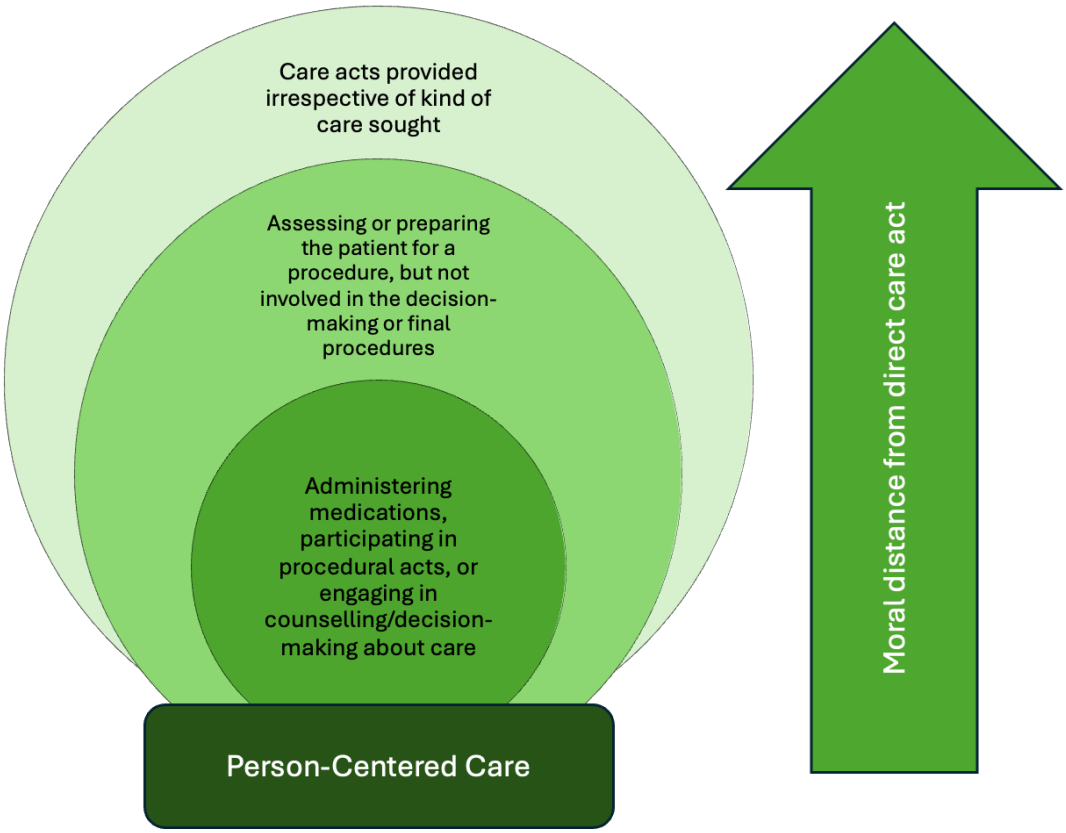
- Identify if you have a conscientious objection to certain types of care within your area/scope of practice. Use this guide for information on what constitutes a conscientious objection and what does not.
- Assess legal, professional, organizational, and ethical limits to conscientious objection in your situation. Consult with your professional college, professional codes of ethics, or professional practice teams as applicable for advice and role clarity if needed.
- If you identify that you have a conscientious objection, reflect on your level of comfort with different aspects of the relevant care. Using the conscientious care approach, determine what level of involvement and care you might be comfortable providing. Use reflective tools such as the Circles of Conscientious Care suggested below.
- Ensure that the objection does not result in abandonment of the patient, delays in care that may result in poor health outcomes or suboptimal patient experiences, unfair added burdens for a patient, inequitable care, or the patient being exposed to risks of harm/unsafe care.
- Consult with available resources such as PHSA Ethics Service, Psychological Health and Safety, Spiritual Care, Risk Services, Human Resources, the Sanya'kula team, professional standards of practice and codes of ethics, and your professional regulating body (if applicable) for support as needed.

Reflective Tools

Self-reflection is a critical step in exploring discomfort and feelings of potential conscientious objection. Values are not static and may change based on life experience. Practice also changes and new services may become available that cause some discomfort. It is recommended to engage in self-reflection regularly, especially after major life changes or introduction of new practices and procedures.

Circles of Conscientious Care is a visual representation of conscientious care that is meant to assist with self-reflection. Resting on a foundation of person-centered care, each circle represents the level of involvement in a care act, with decreased involvement in each step further from the centre of the circle. The outermost circle represents care that is furthest removed from the care act that is causing moral discomfort, such as blood draws, or administering pain medications, for example. Each circle includes actions one could take on based on moral comfort level. See Figure 1 below.

Figure 1. Circles of Conscientious Care.[14]



Other reflective guides that may support exploration of values:

- Values Exploration: Values Worksheet
- Abortion-related Care: Values Clarification Guide 1 ; Values Clarification Guide 2
- MAiD-related Care: Reflective Guide

[14] Figure 1 has been adapted from Shanker (2022).

2. Communicate with Leader or Supervisor

- If you identify that you have a conscientious objection, communicate this information with your leader or supervisor in advance of care delivery (i.e., upon onboarding or orientation to the program or service area when possible). Your professional regulating body, professional standards of practice, or professional codes of ethics may have requirements regarding how and when this information should be shared.
- Describe what aspects of care you are comfortable, and not comfortable, providing in relation to your conscientious objection.

3. Make a Plan for Continuous Care

- Follow your professional college requirements (if applicable), standards of practice, or code of ethics for ensuring continuous care in the context of conscientious objection.
- To ensure continuous care, consider referring the patient to a non-objecting, available professional. It is important to inform the patient about available options so they can make decisions that align with their priorities and values.
- Ensure patients are safe, not abandoned or stigmatized, and do not experience delays in care. If it is not possible to plan ahead, make reasonable efforts to find an alternate professional as early as the conscientious objection becomes apparent. Ensure patients do not experience adverse clinical outcomes due to delayed care or lack of continuity.
- Refrain from communicating conscientious objections to patients. If a change to the care team or care plan must be made to accommodate a conscientious objection, you may consider communicating this information if it is aligned with person-centered care and will not lead to harm to the patient.
- Request support from your leader if needed.
- Uphold your duty of care to your patients, which includes non-abandonment, acting for the benefit of patients and promoting the good of the patient. In instances where no alternative to care is available, particularly in times of medical urgency or time sensitivity, be prepared to provide care that may be outside of the limits of your moral comfort despite your conscientious objection.
- Consider referring the patient to other supportive services if needed. Appendix 4: Resources includes is a list of services that are available to patients in need of referrals.

Support for Leaders

Leaders can promote a culture of conscientious care by supporting those who report to them through open conversations and taking supportive action where needed. There are three timepoints or phases that raise different considerations for leaders: preparation, planning, and initial conversations (before a concern is raised), when a concern is raised, and team reflection after a concern is raised. This section includes suggested prompts for conversations during each phase.

Phase 1: Preparation, planning, and initial conversations

Staff need to feel confident in expressing their concerns and boundaries early to help facilitate planning, and leaders are expected to cultivate a safe environment that promotes honest conversations and proactive action without fear of stigma or negative consequences.[15] Supporting staff in having these conversations means prioritizing respect, care, humility, non-judgment and wellness.

Initial communication about possible conscientious objection ideally occurs during onboarding and orientation. Communication processes could include one on one conversations between the person with an objection and their leader. This may be followed by an open team discussion if it is appropriate and necessary for planning purposes (see Team Reflection below).

Recommended process for leaders:

- Determine an acceptable process for communication about conscientious objection for each department or team and share the communication process with staff.
- Ensure conversations are held consistently with all staff.
- Maintain confidentiality to the extent possible. Share information about conscientious objections as appropriate when staff and leaders transition between departments and teams.
- Revisit discussions about conscientious objections when there is a relevant change in practice or scope, or a new care pathway becomes available.
- Ensure processes uphold applicable laws and regulations and meet applicable professional requirements. Reassure staff that these discussions will not impact their employment or role.
- Ensure conversations are safe, trauma and violence informed, and inclusive.

Suggested facilitation questions:

General values awareness	"Are there aspects of your role that you feel strongly aligned with, or uncomfortable with, from a values perspective?" "If a situation arose where you felt moral discomfort, what would help you feel safe raising that with me?"

[15] Lamb (2016).

Specificity related to a potential objection	"Are there any procedures or situations that may arise in your practice that you're unsure about participating in?" "How can we work together to respect your boundaries and ensure continuity of care for patients if a situation like that arises?"

Phase 2: When a concern is raised

When a situation occurs that raises concerns related to conscientious objection, leaders may need to clarify boundaries, explore possible accommodations, and provide support. Normalizing value-based dialogue and respectful disagreement are helpful strategies to promote productive and safe conversations. Staff do not need to justify their values/morals or provide reasons for their conscientious objection, but leaders should encourage self-reflection, as well as consultations with support services when needed. Leaders should remind staff that ethics, spiritual health, and psychological safety support are available at any time.

If you are unsure about whether a particular situation is a conscientious objection or not, refer to Clarifying Misconceptions, as well as the scenarios in Appendix 1.

Appendix 4: Resources includes is a list of services that are available to patients in need of referrals.

Recommended process for leaders:

- Explore the individual's moral concerns and clarify what aspects of care they are willing and not willing to engage in.
- Encourage engagement with the recommended process for staff and reflective tools.
- Help to arrange alternate care provision when appropriate.
- Communicate with staff when accommodation of a conscientious objection is not feasible or appropriate.
- Provide support as needed, including connecting the individual with resources.

Suggested facilitation questions:

Understanding moral concerns	"Can you help me understand what specifically is causing moral discomfort for you in this situation?" "Which of your beliefs, values, or professional standards feel challenged in this situation?"
Clarifying boundaries	"What parts of the care process feel outside your moral comfort zone?" "Are there elements you are still comfortable participating in?"
Accommodation	"What would a respectful accommodation look like from your perspective?"

	"We have tried to accommodate your request, but cannot because [specify reasons]. I acknowledge this is difficult for you. How can we support you?"
Support & next steps	"What kind of support would be most helpful to you right now? I can help to put you in touch with available PHSA resources if you like." "Would you like help finding someone who can take over for this patient?" "How can I help to ensure this patient receives the care they need while upholding your moral integrity?"

Phase 3: Team reflection

Leaders may need to address conflicts related to differing values/morals and conscientious objections that arise within teams, including ethical challenges, moral distress, and organizational issues such as staff and human resource availability. Leaders are encouraged to facilitate team discussions to prepare for future situations, but may also find them useful as a debriefing opportunity when a difficult situation has arisen that has led to conflict or distress within a team.

Suggested facilitation questions:

Collective preparedness	"How can we work together when team members have different comfort levels?" "What does respecting a conscientious objection look like in practice while ensuring seamless patient care?" "What structures could we put in place now to help us respond well if an objection arises?"
Building culture of openness	"What does a safe space for discussing values look like to you?" "How can we proactively support one another when values may differ?"

Leaders are strongly encouraged to seek support from the resources available, including the PHSA Ethics Service, Spiritual Care, Psychological Health and Safety, relevant professional regulating bodies, Human Resources, Risk Services, Indigenous Health, Sanya'kula, and Diversity, Equity and Inclusion. These services are available to consult prior to speaking with staff to help facilitate these conversations in well ways.

Appendix 1: Scenarios

Scenario 1: Exploring how to provide conscientious care

Amrita is a nurse in the emergency department of a small rural hospital. She holds a deeply rooted moral belief that prevents her from directly participating in abortion procedures. Until now, she has not been involved in cases involving abortion.

Amrita knows that patients seeking abortion-related care may present to the emergency department, and she is aware that, due to the hospital's limited staffing, she might be the only nurse available at a critical moment. Concerned about the potential for conflict between her beliefs and her professional responsibilities, Amrita takes time for self-reflection and reviews relevant professional standards and ethics resources. She identifies that she is comfortable providing emotional support and coordinating aspects of care not directly related to the abortion procedure but feels unable to participate in the abortion itself.

Amrita's supervisor proactively asks all of their staff about their values and whether they have any conscientious objections. During a conversation with her supervisor, Amrita clearly outlines the care she is and is not able to provide, and decides she is comfortable sharing this information with her team to support proactive planning and ensure continuity of care.

Several months later, a patient presents to the emergency department with symptoms of severe early-onset preeclampsia at 20-weeks gestation. The patient is in significant medical distress, and the clinical team determines that urgent termination of the pregnancy is required to prevent serious harm or death. Amrita is the only nurse immediately available. The charge nurse, who is aware of Amrita's conscientious objection, asks her to complete the initial assessment while she arranges backup. Amrita agrees and conducts the assessment, ensuring the patient receives timely care. When a surgical abortion is identified as medically necessary, the charge nurse steps in to assist with the procedure. However, due to ongoing staffing constraints, Amrita is needed to support pre- and post-operative care.

Though uncomfortable with her proximity to the procedure, Amrita agrees to stay involved, recognizing the urgency of the situation and her professional responsibility not to abandon the patient. She does not disclose her feelings to the patient, and prioritizes the patient's wellbeing while still maintaining as much alignment with her moral limits as the situation allows.

After the event, Amrita debriefs with her supervisor and the charge nurse. She experiences some moral distress and reaches out to her local Spiritual Care and Psychological Health and Safety teams for support in processing the experience. Her supervisor affirms her actions and encourages continued reflection and use of support resources.

Scenario 2: Is it a conscientious objection or something else?

Linda is a medical oncologist who knows that some of her patients have accessed Medical Assistance in Dying (MAiD) through their local MAiD care coordination office. She supports MAiD in principle and is comfortable providing accurate information to patients. While she is not comfortable providing MAiD herself, she has done eligibility assessments for patients with advanced cancer in the past.

One of Linda's patients, Gary, has been diagnosed with early-stage prostate cancer. His prognosis is excellent, and with treatment, he is likely to have good long-term outcomes. However, Gary also lives with severe PTSD and chronic, non-cancer-related pain that is poorly controlled. After discussing treatment options for his cancer, Gary declines treatment and asks Linda about MAiD. He explains that his decision is largely driven by his unrelenting pain and emotional suffering.

Although Linda wants to support Gary, she does not feel prepared to assess him for MAiD. She is concerned that his request may be influenced more by his mental health and chronic pain than by his cancer diagnosis, and worries that not all options for relieving his suffering have been explored. She is also unsure whether her discomfort stems from a moral objection or from uncertainty about her scope of practice related to MAiD for those whose death is not reasonably foreseeable due to cancer.

Linda reflects on her role and consults her local ethics service. Together, they explore the nature of her discomfort. The ethics team affirms that Linda's situation likely does not constitute a conscientious objection, as she is not morally opposed to MAiD. Rather, her hesitation relates to uncertainty about her knowledge and confidence in managing this type of request.

The ethics team encourages Linda to refer Gary to the MAiD care coordination office, where trained assessors can evaluate his eligibility and support a comprehensive exploration of his options. They also recommend offering Gary a referral to palliative care or a pain and symptom management team to address his suffering, regardless of whether he proceeds with a MAiD request. Linda agrees with this approach and explains to Gary that she would like to refer him to the local MAiD office for support but confirms that she will continue to treat him if he chooses, and will provide other referrals as needed.

Common scenarios that are not conscientious objection:

- A physician has a very busy clinic with appointments that are supposed to be kept to approximately 15 minutes each. They decline to see patients requesting MAiD assessments because they do not think they have time to accommodate the complexity of these conversations. This is not a conscientious objection because the refusal is based on resourcing and convenience, not a moral or ethical objection to MAiD itself.
- A pharmacist regularly fills prescriptions for emergency contraception but will not dispense the same mediation to a specific person who has requested it on several occasions, citing personal disapproval of the person's lifestyle. This is not a conscientious objection because the refusal is based on biases and prejudice resulting in discriminatory care, not a moral objection to the medication itself.

For more information, see the Clarifying Misconceptions section.

Appendix 2: Foundational Principles[16]

Organizational Commitment

The Coast Salish teachings are a means of self-reflection and can be used to guide how we work together, deliver care, and show up as our whole selves.

Reflecting the Coast Salish teachings and PHSA's North Star priorities, PHSA commits to:

- Supporting an environment that is free of discrimination, racism and oppression, including taking steps toward eradicating Indigenous specific racism
- Upholding professional standards of conduct
- Ensuring access and continuity of patient care
- Maintaining a safe, diverse, inclusive, and transparent workplace
- Balancing staff accommodations with system-wide care responsibilities

All patients have the right to dignity and safe, equitable access to healthcare. They also have the right to exercise their autonomy and make decisions about their healthcare when determined to have the capacity to do so. PHSA prioritizes person-centered care, focusing on the individual's needs, preferences, and values in healthcare decision-making. Further, upholding the legal rights of First Nations, Métis and Inuit peoples to access healthcare and traditional practices without discrimination is a fundamental commitment as affirmed in Article 24 of UNDRIP.[17] Upholding the principles below help ensure that patient rights, access to care, and person-centered care are also upheld.

Care involves demonstrating kindness, concern, attention and empathy in providing what is necessary for health and wellbeing. Wellbeing is a state of wholistic health, comfort and life satisfaction. It is our duty as healthcare professionals to engage in caring relationships with the individuals, families, communities in whose health journeys we are partnering, as well as with our colleagues. This includes approaching these relationships with humility and curiosity so that we can learn and respect what care and wellbeing means to them.

Respect refers to our regard for the dignity, feelings, wishes, rights, choices, lived experience, and traditions of others. We demonstrate respect through relational and narrative ethical practice, and by honouring privacy, autonomy, self-determination, worldviews and rights to make decisions about health and healthcare. We work to build trust in healthcare systems and to promote respect by welcoming inclusion and engaging in best practices, Wise Practices, relational practices, trauma-informed care and harm-reduction approaches.

Humility refers to acknowledging our own limitations and having a willingness to learn from others. We work in partnership and seek consensus wherever possible. We remain modest about our role in the

[16] PHSA Ethics Service (2025). *Ethical Practice Guide.*
[17] United Nations (2007).

healthcare journeys of those we serve. We recognize the dignity, wisdom and diverse worldviews of patients, clients, families, communities and colleagues.

Cultural Humility[18] is a life-long process of self-reflection and self-critique to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. It is foundational to achieving a culturally safe environment.

Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification. Health equity implies that all individuals have an equitable opportunity to reach their full health and wellness goals. Health equity can be impacted by a variety of factors including a person's culture, geography, and socioeconomic status.

Anti-Racism[19] is more than just "not being racist." It involves taking action to create conditions of greater inclusion, equality, and justice. It is the practice of actively identifying, challenging, preventing, and eliminating racist ideologies, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism.

Anti-Discrimination aims to prevent people from being treated unfairly or unjustly because race, sex, gender identity, disability, religion, sexual orientation, age, or other protected characteristics. It is grounded in the principle that all individuals deserve equal rights, opportunities, and respect, regardless of their identity or background.

Diversity among our workforce reflects the diversity of the patients we serve. We welcome diverse cultures, beliefs, and lifestyles among our staff by creating a safe and inclusive workplace.

Inclusion and supportive leadership is essential to enable diversity and safety within the workplace, where everyone feels a sense of belonging.

[18] Health Standards Organization (2022).
[19] Health Standards Organization (2022).

Appendix 3: Definitions[20]

Best Practices are western approaches to care that have been shown by research and experience to produce optimal results and that are established or proposed as a standard suitable for widespread adoption.

Wise Practices are effective and culturally appropriate actions, tools, principles, or decisions that contribute significantly to the development of sustainable and equitable conditions and practices and, in doing so, produce optimal results for Indigenous Peoples.

Trauma-informed Care is an approach that takes into account an understanding of trauma in all aspects of care and places priority on patient safety, choice and control.

Harm Reduction is an approach that minimizes and prevents undue health and social harms (e.g., HIV, hepatitis C, illness, infection, overdose) related to substance use and sexual activity both for people who use substances as well as communities.

Narrative Ethics recognizes the importance and power of story-telling about health and healthcare journeys when engaging in conversations about ethics. These narratives can organize information, connect values to actions, and reveal potential resolutions to ethical challenges. A narrative approach may involve asking people to reflect on how their healthcare journey has unfolded and then explore the best path forward based on the information, perspectives, context and values revealed through the telling of the story.

Relational Ethics focuses on the ways in which we act and respond within interpersonal relationships, with understanding that people are dependent on one another and should not be viewed in isolation. Caring relationships should be present in every interaction, through respectful engagement, transparency, and attending to the needs, perspectives and experiences of those engaged in care. Relational ethics also describes our collective, social responsibility to provide care with humility and in ways that address inequities.

Moral Distress is the experience of psychological and emotional harm as a result of being unable to make decisions or act according to their personal and professional values, or what they perceive as ethical.[21]

[20] All definitions sourced from the PHSA Ethical Practice Guide unless otherwise cited.
[21] PHSA Ethics Service (2025). *Moral Distress: A Strategy Building Guide*.

Appendix 4: Resources

Professional Resources:

- British Columbia College of Nurses and Midwives. Duty to provide care.
- Canadian Nurses Association. *Code of Ethics for Nurses.*
- College of Physicians and Surgeons of British Columbia. Access to medical care: Professional standard.
- British Columbia College of Pharmacists. How does conscientious objection work in pharmacy practice?

PHSA Resources:

- Diversity, Equity and Inclusion: https://pod.phsa.ca/our-phsa/diversity
- Ethics Service: https://pod.phsa.ca/our-phsa/browse-by-department/Pages/Ethics-Service.aspx
- Human Resources: https://pod.phsa.ca/our-phsa/browse-by-department/Pages/Human-Resources.aspx
- Professional Practice: https://pod.phsa.ca/quality-safety/professional-practice
- Psychological Health and Safety: https://pod.phsa.ca/our-phsa/browse-by-department/Pages/Health-Promotion.aspx
- Spiritual Care: https://pod.phsa.ca/quality-safety/spiritual

Resources for patients in need of referrals:

- PHSA MAiD Care Coordination Office – maidcco@phsa.ca
- Pregnancy Options Service - 1-888-875-3163 (offers short-term telephone confidential counselling throughout BC)
- Sex Sense - https://www.optionsforsexualhealth.org/sex-sense/ or by phone at 1-800-739-7367 throughout BC or 604-731-7803 in the Lower Mainland.

Reflective guides that may support exploration of values:

- Values Exploration: Values Worksheet
- Abortion-related Care: Values Clarification Guide 1 ; Values Clarification Guide 2
- MAiD-related Care: Reflective Guide

Appendix 5: References

Abortion Rights Coalition of Canada. (2018, August). *Appendix: Policies on conscientious objection in healthcare* (Position Paper No. 95). https://www.arcc-cdac.ca/media/position-papers/95-appendix-policies-conscientious-objection-healthcare.pdf

British Columbia. (2015). *Declaration of Commitment on Cultural Safety and Humility in Health Services.* https://www.fnha.ca/Documents/Declaration-of-Commitment-on-Cultural-Safety-and-Humility-in-Health-Services.pdf

British Columbia. (2019). *Declaration on the Rights of Indigenous Peoples Act,* SBC 2019, c. 44. https://canlii.ca/t/544c3

British Columbia. (1996). *Human Rights Code*, RSBC 1996, c. 210. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96210_01

British Columbia College of Nurses and Midwives. (n.d.). *Duty to provide care*. https://www.bccnm.ca/RN/PracticeStandards/Pages/dutytoprovidecare.aspx

British Columbia College of Pharmacists. (n.d.). *How does conscientious objection work in pharmacy practice?* https://www.bcpharmacists.org/faq/how-does-conscientious-objection-work-pharmacy-practice

Canada. (1982). *Canadian Charter of Rights and Freedoms*. Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), c. 11. https://laws-lois.justice.gc.ca/eng/const/page-15.html

Canada. (1985). *Canada Health Act*, R.S.C., 1985, c. C-6. https://laws-lois.justice.gc.ca/eng/acts/c-6/

Canadian Nurses Association. (2025). *Code of Ethics for Nurses.* https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics/2025-coe

College of Physicians and Surgeons of British Columbia. (2025). *Access to medical care: Professional standard*. https://www.cpsbc.ca/files/pdf/PSG-Access-to-Medical-Care.pdf

Downie, J. & Baylis, F. (2017). A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms: Regulating and Litigating Conscientious Refusals in Health Care. *McGill Journal of Law & Health,* 11(1), S1. https://mjlh.mcgill.ca/wp-content/uploads/2017/09/webfinal_mjlh-11-1-downie-2017-09-06.pdf

Fiala, C., Arthur, J., & Martzke, A. (2025). Origin of “conscientious objection” in health care: How care denials became enshrined into law because of abortion. *Journal of Law, Medicine & Ethics*, *2025*, 1–14. https://doi.org/10.1017/jme.2025.46

Fry-Bowers, E. K. (2020). A matter of conscience: Examining the law and policy of conscientious objection in health care. *Policy, Politics, & Nursing Practice*, *21*(2), 120–126. https://doi.org/10.1177/1527154420926156

Government of Canada, Department of Justice. (2024, August 13). *Section 2(a) - Freedom of religion*. In *Charterpedia*. https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/check/art2a.html

Health Standards Organization. (2022). HSO 75000:2022 - British Columbia Cultural Safety and Humility Standard.

Lamb, C. (2016). Conscientious objection: Understanding the right of conscience in health and healthcare practice. *The New Bioethics*, *22*(1), 33–44. https://doi.org/10.1080/20502877.2016.1151252

PHSA Ethics Service (2025). *Ethical Practice Guide.* http://www.phsa.ca/our-services-site/Documents/PHSA-Ethical-Practice-Guide.pdf

PHSA Ethics Service (2025). *Moral Distress: A Strategy Building Guide*. http://www.phsa.ca/our-services-site/Documents/Moral%20Distress_A%20strategy%20building%20guide.pdf

Shanker, R. (2022). Women's College Hospital abortion care: An ethics guide to providing conscientious care. Women's College Hospital.

Zolf, B. (2019). No conscientious objection without normative justification: Against conscientious objection in medicine. Bioethics, 33, 146–153. https://doi.org/10.1111/bioe.12521

United Nations. (2007). United Nations Declaration on the Rights of Indigenous Peoples. https://www.un.org/esa/socdev/unp/