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RESEARCH ARTICLE

Conscientious objection - A vignette-based, pilot study of international pharmacists' perspectives

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Abstract

Background: Conscientious objection (CO) in healthcare has always been a controversial topic. Some healthcare professionals perceive CO as a freedom of conscience, others believe their duty-of-care overrides personal perspectives. There is a paucity of literature pertaining to pharmacists' perspectives on CO. This study aimed to inform the development of a proposed questionnaire exploring pharmacists' decision-making in complex scenarios around CO and reasons for their choices. **Methods:** This was a cross-sectional, mixed methods pilot study of international pharmacists, using an online, vignette-based questionnaire on scenarios related to medical termination, emergency contraception, IVF surrogacy for a same-sex couple and voluntary assisted dying (VAD). **Results:** Sixty-two FIP 2019 conference delegate pharmacists participated in this pilot study. Approximately half them believed pharmacists have the right to CO. Most pharmacists agreed to supply the prescriptions across all four vignettes. Regarding continuity of care, majority of pharmacists agreed (97%) it was necessary for equity of access. Strong self-reported religiosity had a statistically significant relationship with pharmacists' decisions not to supply for medical termination, IVF surrogacy and VAD. **Conclusion:** This pilot study revealed insights into the various perspectives of international pharmacists on CO in healthcare and informed the development of a survey for future administration.

Introduction

Conscientious objection (CO) is a controversial topic in healthcare. In many countries, CO is accommodated across various healthcare laws (New South Wales Parliament, 2022), with general statements indicating healthcare professionals may conscientiously object. However, there are no clear instructions about how to approach or manage such cases and no specificity towards pharmacists.

CO is described as "*a practitioner's refusal to provide a service primarily because the action would violate their moral or ethical values*" (Pharmaceutical Society of Australia, 2017). Some perceive CO as a freedom of conscience (Smith, 2006). Others deem it "*a burden… that patients should not have to shoulder*" (Cantor, 2009). In modern medicine, CO is relevant to many situations, e.g. termination of pregnancy, contraception, and voluntary-assisted-dying (VAD) (Lawrence & Curlin, 2009). From a patient perspective, CO by a healthcare professional can have far-reaching implications that may impact rightful access to treatment. Principles of justice and respect for patient autonomy are central tenants of healthcare ethics. Patients may feel these principles compromised when their provider objects.

The majority of existing literature primarily focuses on investigating CO held by physicians, nurses and midwives. Most investigated the topic from a women's health and end-of-life perspective (Fujioka *et al*., 2018; Blaschke *et al*., 2019). For example, a 2011 study of 1032 US physicians found doctors divided about CO, with almost half even disagreeing with referring for continuity of care, deeming referral as immoral (Combs *et al*., 2011). Another 2009 national survey of 1000 US primary-care physicians concluded that doctors believed respecting "*patient autonomy*" did not guide their decision-making (Lawrence & Curlin,

2009). In Australia, a 2019 qualitative study identified that most doctors would not allow their moral/religious beliefs to impact patient care (Keogh *et al*., 2019).

Many studies in the literature investigating the implications of CO for nurses identified that nurses needed support to address these issues (Lamb *et al*., 2019). Dobrowolska *et al*. (2020) compared literature from Poland and the UK, concluding that regulation for nurses in the UK is limited to reproductive health, while in Poland, there are no specific procedures to which nurses can apply an objection (Dobrowolska *et al*., 2020). Even medical students' views have been investigated across multiple studies (Hagen *et al*., 2011; Card, 2012; Strickland, 2012; Nordstrand *et al*., 2014; Darzé & Barroso-Júnior, 2018)

For pharmacists, despite being ever-more responsible for controversial medicines supply (Lee *et al*., 2015; Verweel *et al*., 2018), exploration of pharmacists' decision-making around CO has been limited (Griggs & Brown, 2007; Davidson *et al*., 2010; Piecuch *et al*., 2014; Verweel *et al*., 2018). The literature has yet to explore why pharmacists may conscientiously object to certain prescriptions.

This pilot study aimed to inform the development of a proposed questionnaire regarding conscientious objection in pharmacy and explore international pharmacists' decision-making in complex scenarios around CO and the reasons for their choices.

Methods

Questionnaire design

A cross sectional, self-administered, electronic questionnaire was piloted amongst a random selection of international pharmacists attending the International Pharmaceutical Federation (FIP) Congress of 2019 in Session C8, The Ethics Forum, "*What does it mean to exercise conscientious objection?*" The questionnaire was developed by the research team (SI, BC, AJM) based on scenarios identified from previous research and the general literature (Hanlon *et al*., 2000; Davidson *et al*., 2010; Piecuch *et al*., 2014; Isaac *et al*., 2019).

The online questionnaire consisted of 20 questions, including demographics and four key vignettes. The instrument consisted of mixed formats, including multiple-choice, dichotomous responses, Likert scale-type questions, and an open-ended, free-text response section (Appendix B). The four hypothetical vignettes portrayed challenging or ethically controversial issues in pharmacy practice, which may evoke CO. The vignette topics incorporated the dispensing of the following medicines: 1) MS-2 Step medical abortifacient (mifepristone+misoprostol); 2) Emergency contraception pill (ECP); 3) Clomifene (IVF therapy) for a surrogate for a same-sex couple; and 4) Pentobarbital for VAD (Voluntary Assisted Dying)–to the wife of a 75 years old man with terminal pancreatic cancer.

Respondents were required to select either "*Supply*", "*Conditional supply*", or "*Do not supply*". They were also asked to provide additional reasoning for their selection in a free-text response section before progressing through the questionnaire. The questionnaire programme prompted participants to complete mandatory questions prior to submitting that page. Participants could choose to go back through questions and change responses prior to submitting the final questionnaire. All responses were anonymous.

Sample size

For the purposes of piloting and survey construction, there was no set sample size target. However, based on previous expert recommendations (Sudman, 1976; Courtenay, 1978; Sheatsley, 1983), the aim for most pilot studies is between 12 to 100 participants.

Recruitment

Participants were recruited via direct convenience sampling. A QR code linking attendees of the C8 FIP Ethics session to the piloted survey was placed on the seats in the workshop room and projected onto the screen at the end of the session. Those interested in voluntarily participating could scan the QR code and access the link to the questionnaire, which was kept open for two months after the conclusion of the FIP Congress (i.e. September–November 2019). The only inclusion criterion was that participants were registered pharmacists attending the FIP Congress. The questionnaire was distributed through the web-based application Survey Planet (https://surveyplanet.com/). Consent was implied by the voluntary submission of responses to the anonymous questionnaire, as stipulated in the participant information statement (Appendix A), which was attached before the online questionnaire.

Analysis

Each question required an answer to progress to the next; therefore, partially-completed questionnaires could not be submitted and, therefore, not included in the analysis. Open-ended/free text responses were exported from Survey Planet to Excel to review any

suggestions to improve the questionnaire (i.e. minor changes to response options, display of the questionnaire, typographical errors) to establish face value and content validity of the proposed survey construct. To gain insight into participants' perspectives, open-ended question responses were thematically analysed using the software (NVivo QSR, 12.6.0-3841, 2019). For quality control, the research team or authors (SI, BC and AJM) independently reviewed respondents' comments, and emergent themes were discussed and reviewed until consensus was achieved. Thematic analysis was conducted for each vignette separately to identify trends and triangulate themes across the various responses (Yin, 2015; Green & Thorogood, 2018). The analytical technique of "*constant comparison*" (a component of grounded theory) (Glaser & Straus, 1967) was adopted to extract and code key themes.

A brief statistical evaluation of the quantitative data was conducted using the statistical software R (Version 3.6.0), with a series of bivariant and Chi-square analyses to compare responses to each vignette by participants from different demographics and to establish the construct validity of the proposed survey. Data analysis followed the Checklist for Reporting of Survey Studies (CROSS) and Standards for Reporting Qualitative Research (SRQR) checklists (O'Brien *et al*., 2014; Sharma *et al*., 2021)

Results

Section 1: Participant demographics

The questionnaire was completed by 62 eligible respondents. As mentioned above, there were complete responses. Respondents' demographics were summarised in Table I. The majority were female (76%, 47/62), with a range of practice experience between 4-48 years (M = 17, SD = 11.9) in various primary roles. More than half (53%) of respondents were from the United Kingdom; the rest were from various countries around the world.

Section 2: General personal perspectives

On average, approximately 70% of participants agreed to supply the relevant medicine across the four vignettes proposed (Figure 1). The remaining 30% either withheld access or chose to provide a conditional supply of the medications.

Table I: Demographic of participating registered pharmacists (n = 62)

Characteristics		n	%
Sex	Male	15	24
	Female	47	76
	I prefer not to answer	0	0
Age range	≤24	2	3
	25–34	21	34
	35–44	16	26
	45–54	16	26
	55–64	5	8
	65+	2	3
Primary roles† (participants indicated multiple roles hence n≠223)	Community pharmacists	34	N/A
	Hospital pharmacists	18	N/A
	Industry	3	N/A
	Academia	35	N/A
	Professional organisations representatives /Government	8	N/A
	Other	4	N/A
Degree type	Pharm.D.	10	16
	B.Pharm./Hons.	15	24
	M.Pharm.	22	36
	Ph.D.	15	24
Years experience	1–5 years	11	18
	6–10 years	13	21
	11–20 years	17	27
	21–30 years	15	24
	31+ years	6	10
Country	Canada	2	3
	Egypt	1	1.8
	Ghana	1	1.8
	India	2	3
	Ireland	1	1.8
	Japan	1	1.8
	Kuwait	1	1.8
	Lebanon	2	3
	Nigeria	2	3
	New Zealand	2	3
	Philippines	2	3
	Portugal	2	3
	Singapore	1	1.8
	South Africa	1	1.8
	Sri Lanka	1	1.8
	Syria	1	1.8
	United Arab Emirates	1	1.8
	United Kingdom	33	53
	United States	5	8
Extent religion shapes your decision making in practice	Not at all	20	32
	Somewhat	27	44
	Very much so	15	24

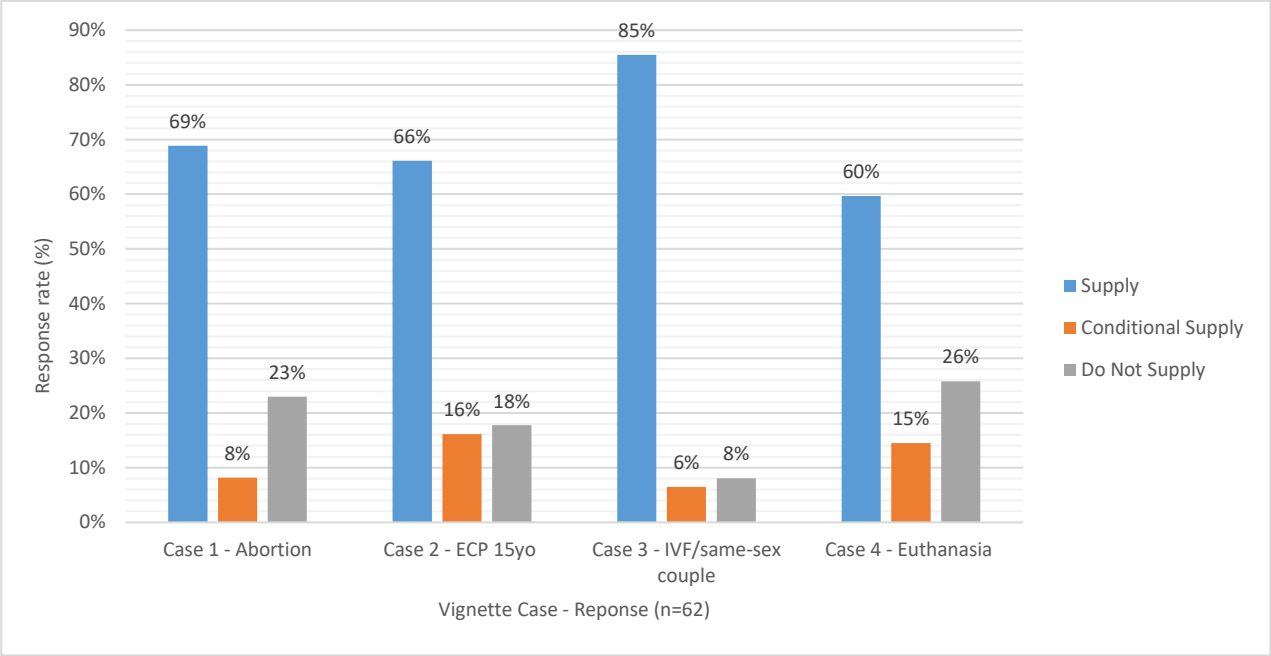

Figure 1: Response to vignette cases (n=62)

Findings (Table II) demonstrated a divided professional perspective on pharmacists' right to CO, with half (55%) of the respondents believing that pharmacists have the right to CO while a quarter disagreed (26%). Rather than asking about each participant's religion, this research posed the question regarding religiosity (i.e. "*To what extent do religious beliefs shape your decision-making in pharmacy practice?*"). The majority (44%) of respondents indicated that personal religious belief "*somewhat*" shaped their decision-making in practice, and 32% chose "*very much*", while the minority (24%) chose the "*not at all*" option (Table II & Table IIIA-D). Table II also illustrated that 44% of participants believed it is not ethically justifiable to enact CO if a patient is unable to access treatment. However, 22% of participants disagreed, irrespective of inconvenience, compromise of safety, or possible harm. The remaining 34% selected the conditional option of "*only if*", emphasising continuity of care.

> *"I do not agree with conscientious objection, but if it is permitted, they should have to consider continuity of care; nothing should compromise patient care." [Ph14]*

Some highlighted the importance of preserving individual morals and conscience as healthcare professionals:

> *"Professionals should not be forced to practice against their conscience. Legal & Professional frameworks should protect their faith and integrity to have a choice." [Ph28]*

Participants almost unanimously (89%) perceived continuity of care as a necessity (Table II), with only 11% indicating otherwise based on the concepts of professional autonomy, complicity via referral and patient autonomy to shop around.

> *"If I send someone to do wrong or do wrong myself, it is the same thing." [Ph22]*

> *"Everywhere in the world, there is a widespread distribution of pharmacies. Patients are free to choose another pharmacy whenever they dislike the service, or they cannot get their medication normally. Why should these patients be special?" [Ph61]*

Section 3: Vignette

Thematic analysis of the qualitative data collected from these vignettes yielded three major themes: 1) the role of the pharmacist; 2) ethical considerations; and 3) training/guidance. These emergent themes formulated the primary drivers, which were extrapolated into a driver diagram (Figure 2). The primary drivers were triangulated from secondary drivers from the thematic analysis of open-ended responses to each vignette. To clarify this process, the authors present the results of each case before categorising them into primary and secondary drivers.

Appendix C–G provide evidence in example quotes for each driver.

Case 1–Medical abortifacient
Supply:

For Case-1, 69% opted to supply (Figure 1)

> *"It is a valid prescription, no medicolegal reason why she cannot take the medicine." [Ph55]*

Some participants indicated the professional responsibility for patient care and that failing to fulfil such a request would be deemed unethical.

> *"Although I don't personally agree with abortion, I feel it's unethical to refuse." [Ph38]*

Others went as far as to challenge the career choices of fellow pharmacists who may choose to conscientiously object.

> *"I wonder if people who have conscientious objection should have chosen a different career path, where their beliefs would not impact others." [Ph23]*

Conditional Supply:

Some (8%) were concerned about safety and patient support around termination, therefore, would only provide conditional supply.

> *"I would have emotional difficulty with providing this supply and would see if a local colleague would do it. But I know ultimately it is not my business…." [Ph46]*

No supply:

For Case 1, 23% chose not to supply. Religiosity was not the only reason for their response.

> *"Abortion is a form of killing and killing is a sin." [Ph3]*

Some indicated their objection was based on the concept "*do no harm*". While others would not supply based on the need for registration and further training on MS-2-Step.

> *"I believe the child (foetus) has a much right to life as the mother." [Ph15]*

> *"Not registered for it. I would find out who is and refer her there." [Ph52]*

Table II: Response rates to remaining questionnaire questions related to personal perspectives (non-vignette questions)

Questions	Response options	No. of responses (n=62) *except*†	%
Q8. What does conscientious objection mean to you?	I know what it is about	38	61
	I have a vague idea what it is about	17	28
	I don't know anything about it	7	11
Q9. Pharmacists should have the right to conscientious objection?	Agree	34	55
	Neither agree nor disagree	12	19
	Disagree	16	26
Q10. Is it ethically justifiable to C/O if it means your patient cannot get treatment?	Yes	14	22
	No	27	44
	Only If (+ comments)	21	34
Q15. If a pharmacist has the right to conscientious objection, in your opinion should they ensure continuity of care?	Yes	55	89
	No (+ comments)	7	11
†Q16. Which of the following best describes how you would practice "*continuity of care*"? — (More than one option).	Referring the patient to try another pharmacy	33	N/A
	Referring the patient back to their doctor	21	N/A
	Providing the patient with information/resources of alternative pharmacies they can successfully access treatment	56	N/A
†Q17. Which of the following do you feel influences your views on conscientious objection? (More than one option)	Do no harm	35	N/A
	Patient autonomy	37	N/A
	Faith	28	N/A
	Professional & legal frameworks	36	N/A
Q18. How open are you to changing your views on conscientious objection?	Not going to change	27	44
	May or may not change	17	27
	Open to change	18	29

Table IIIA: Response groups vs characteristics for case 1 (Abortifacient)

Characteristic	Medical abortifacient			*p*-value[†]
	Do not supply, N = 15	Conditional supply, N = 5	Supply, N = 42	
Age, n (%)				0.090
24 years or less	1 (6.7%)	0 (0%)	1 (2.4%)	
25–34 years old	2 (13%)	1 (20%)	18 (43%)	
35–44 years old	3 (20%)	4 (80%)	9 (21%)	
45–54 years old	7 (47%)	0 (0%)	9 (21%)	
55–64 years old	2 (13%)	0 (0%)	3 (7.1%)	
65–74 years old	0 (0%)	0 (0%)	2 (4.8%)	
Sex, n (%)				>0.9
Female	11 (73%)	4 (80%)	32 (76%)	
Male	4 (27%)	1 (20%)	10 (24%)	
Degree, n (%)				0.095
B.Pharm./Hons.	7 (47%)	1 (20%)	7 (17%)	
M.Pharm.	4 (27%)	0 (0%)	18 (43%)	
Pharm.D.	2 (13%)	1 (20%)	7 (17%)	
Ph.D.	2 (13%)	3 (60%)	10 (24%)	
Religion, n (%)				0.018
Not at all	2 (13%)	2 (40%)	16 (38%)	
Somewhat	7 (47%)	0 (0%)	20 (48%)	
Very much so	6 (40%)	3 (60%)	6 (14%)	
Working years, median (IQR)	24 (16, 28)	15 (14, 15)	12 (6, 26)	0.2

[†]Fisher's test; Kruskal-Wallis rank sum test

Table IIIB: Response groups vs characteristics for case 2 (ECP)

Characteristic	Emergency contraceptive pill (15 yo)			*p*-value[†]
	Do not Supply, N = 11	Conditional Supply, N = 10	Supply, N = 41	
Age, n (%)				0.6
24 years or less	0 (0%)	0 (0%)	2 (4.9%)	
25–34 years old	3 (27%)	5 (50%)	13 (32%)	
35–44 years old	3 (27%)	3 (30%)	10 (24%)	
45–54 years old	5 (45%)	1 (10%)	10 (24%)	
55–64 years old	0 (0%)	0 (0%)	5 (12%)	
65–74 years old	0 (0%)	1 (10%)	1 (2.4%)	
Sex, n (%)				0.3
Female	7 (64%)	9 (90%)	31 (76%)	
Male	4 (36%)	1 (10%)	10 (24%)	
Degree, n (%)				>0.9
B.Pharm./Hons.	4 (36%)	2 (20%)	9 (22%)	
M.Pharm.	3 (27%)	4 (40%)	15 (37%)	
Pharm.D.	1 (9.1%)	1 (10%)	8 (20%)	
Ph.D.	3 (27%)	3 (30%)	9 (22%)	
Religion, n (%)				0.3
Not at all	1 (9.1%)	4 (40%)	15 (37%)	
Somewhat	5 (45%)	4 (40%)	18 (44%)	
Very much so	5 (45%)	2 (20%)	8 (20%)	
Working years, median (IQR)	20 (12, 26)	12 (9, 21)	14 (8, 29)	0.8

[†]Fisher's test; Kruskal-Wallis rank sum test

Table IIIC: Response groups vs characteristics for case 3 (IVF surrogacy to same-sex couple)

Characteristic	IVF surrogate to same-sex couple			*p*-value[†]
	Do not supply, N = 5	Conditional supply, N = 4	Supply, N = 41	
Age, n (%)				0.033
24 years or less	0 (0%)	1 (25%)	1 (1.9%)	
25–34 years old	0 (0%)	0 (0%)	21 (40%)	
35–44 years old	1 (20%)	1 (25%)	14 (26%)	
45–54 years old	3 (60%)	1 (25%)	12 (23%)	
55–64 years old	1 (20%)	0 (0%)	4 (7.5%)	
65–74 years old	0 (0%)	1 (25%)	1 (1.9%)	
Sex, n (%)				0.2
Female	3 (60%)	2 (50%)	42 (79%)	
Male	2 (40%)	2 (50%)	11 (21%)	
Degree, n (%)				0.7
B.Pharm./Hons.	2 (40%)	1 (25%)	12 (23%)	
M.Pharm.	1 (20%)	3 (75%)	18 (34%)	
Pharm.D.	1 (20%)	0 (0%)	9 (17%)	
Ph.D.	1 (20%)	0 (0%)	14 (26%)	
Religion, n (%)				0.8
Not at all	1 (20%)	2 (50%)	17 (32%)	
Somewhat	2 (40%)	2 (50%)	23 (43%)	
Very much so	2 (40%)	0 (0%)	13 (25%)	
Working years, median (IQR)	26 (15, 29)	22 (12, 34)	14 (8, 25)	0.5

[†]Fisher's test; Kruskal-Wallis rank sum test

Table IIID: Response groups vs characteristics for case 4 (VAD)

Characteristic	VAD			*p*-value[†]
	Do not supply, N = 16	Conditional supply, N = 9	Supply, N = 37	
Age, n (%)				0.3
24 years or less	0 (0%)	1 (11%)	1 (2.7%)	
25–34 years old	4 (25%)	4 (44%)	13 (35%)	
35–44 years old	3 (19%)	3 (33%)	10 (27%)	
45–54 years old	7 (44%)	0 (0%)	9 (24%)	
55–64 years old	2 (12%)	0 (0%)	3 (8.1%)	
65–74 years old	0 (0%)	1 (11%)	1 (2.7%)	
Sex, n (%)				0.6
Female	11 (69%)	8 (89%)	28 (76%)	
Male	5 (31%)	1 (11%)	9 (24%)	
Degree, n (%)				0.4
B.Pharm./Hons.	6 (38%)	1 (11%)	8 (22%)	
M.Pharm.	3 (19%)	4 (44%)	15 (41%)	
Pharm.D.	1 (6.2%)	2 (22%)	7 (19%)	
Ph.D.	6 (38%)	2 (22%)	7 (19%)	
Religion, n (%)				0.006
Not at all	0 (0%)	4 (44%)	16 (43%)	
Somewhat	9 (56%)	3 (33%)	15 (41%)	
Very much so	7 (44%)	2 (22%)	6 (16%)	
Working years, median (IQR)	25 (13, 29)	10 (3, 13)	15 (8, 25)	0.2

[†]Fisher's test; Kruskal-Wallis rank sum test

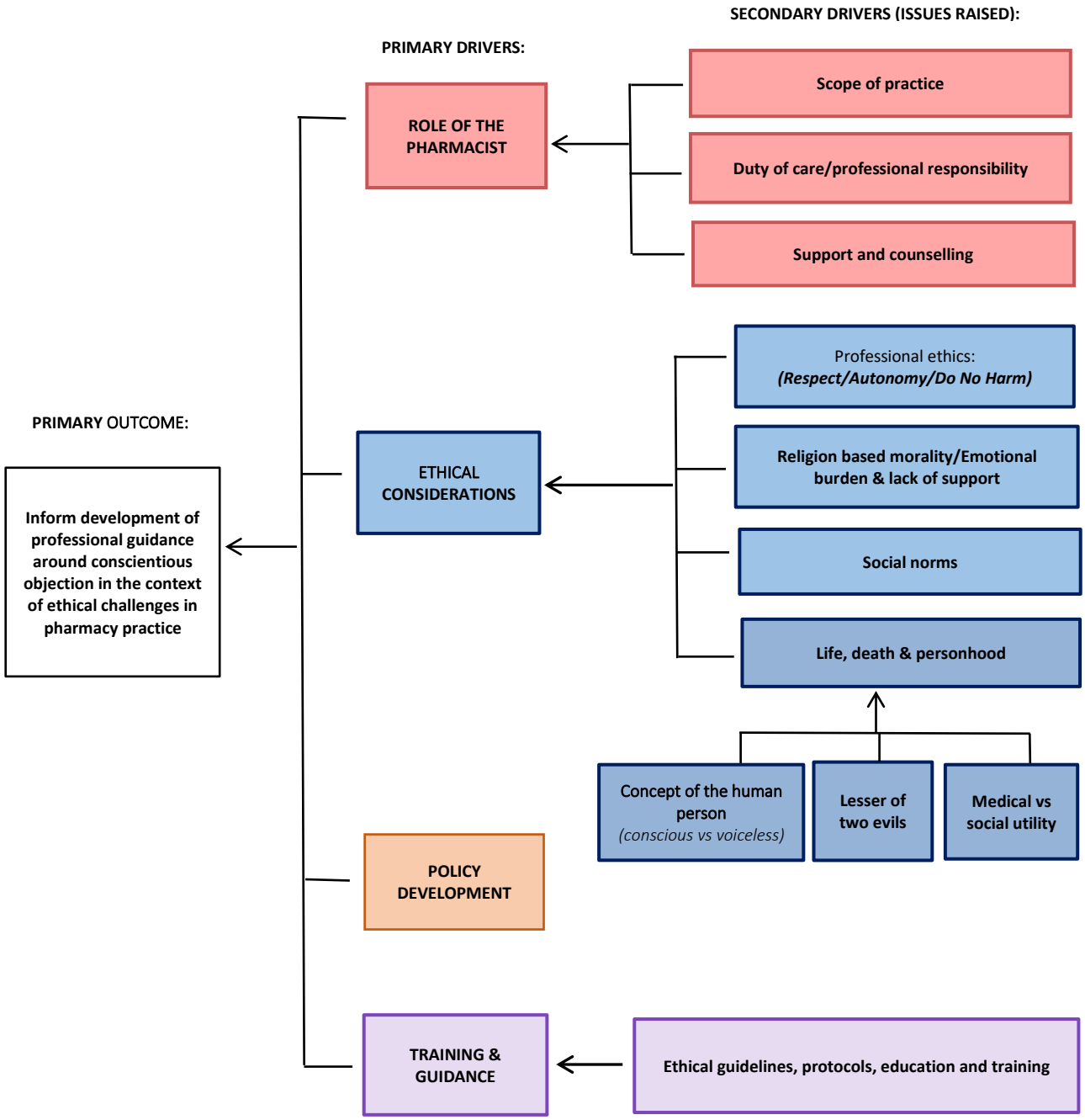

Figure 2: Driver diagram

Case 2 – Emergency contraception (ECP)

Supply:

ECP has been available for legal supply since 1999 (Munro *et al*., 2015), yet it still poses some ethical challenges for many. Most participants chose to supply (66%). They highlighted the importance of respect for autonomy in women's health.

> *"It is her body and her right to make a decision, I will only provide accurate information about the pill and let her make her decision." [Ph43]*

Many identified that as a legally valid and safe medication, it would be unethical not to supply the ECP.

> *"Absolutely the appropriate thing to do (from public health, rights-based & professional responsibility perspective." [Ph2]*

Some participants who indicated a high level of religiosity justified their choice to supply the ECP in Case 3 but not the abortifacient in Case 1 by distinguishing between ECP, contraception and termination.

"Because I do not believe this is an abortion" [Ph9]

Conditional Supply:

Despite being–in most countries–a non-prescription product, the ECP had the highest level of conditional supply (16%). Most had safety concerns for the patient, who was a minor. This was primarily based on the legal age of consent (Australian Government Institute of Family Studies, 2017).

"This is a safeguarding issue, depending on consent and decision-making power of the 15 year old." [Ph55]

Interpretation of the law around Gillick competence around sexual intercourse is complex, and supplying the ECP varies between countries, which was apparent in the responses.

"I would not supply if I thought the 15 year old does not have the capacity, and I would refer to sexual health centres." [Ph45]

Referral was a recurrent caveat to ensure appropriate support:

"Provided 15yo would have the capacity to make such decisions and would refer to sexual health centres." [Ph45]

Do not supply:

Some chose not to supply ECP, indicating it violated their religious beliefs.

"Extramarital sexual relationship is punishable in my religion. Aiding and abetting is equal to committing the sin." [Ph28]

Other participants would not supply purely based on concern for safety and risk of abuse or legal frameworks, which varied from country to country.

"In the Philippines, the ECP is not readily available, and the initial use of the common contraceptive pill must be given with a prescription first." [Ph3]

For some, their responses indicated the need for further "*training and guidance*" around legislation as well as how to manage cases of CO as well as the legislative.

"Tell them we don't have it and refer her to the three pharmacies down the street." [Ph52]

Case 3 – IVF

Supply:

Most pharmacists felt this was the least ethically concerning case, with 85% agreeing to supply the medication. They cited the autonomy of the surrogate woman and the same-sex couple's rights.

"It is her right to choose to be a surrogate, and my job is only to be concerned with the clinical appropriateness of the script and dose." [Ph5]

Those who held a personal objection yet supplied indicated that it did not implicate anyone and was not a matter of life or death.

"Whilst it may not be the way I choose to bring a child into the world, it is her right to do so." [Ph19]

As societal norms have progressed, pharmacists' views seem to have evolved with the times to incorporate inclusivity and anti-discrimination.

"Supply I wholeheartedly believe that LGBTQ+ people should have the same opportunities as heterosexual people." [Ph16]

Conditional Supply:

Not many participants had conditions for the supply of Clomifene. The condition stemmed from objection to IVF itself, which would lead to a referral for access.

"I would try to avoid the supply of IVF medication where possible, as I don't agree with freezing embryos." [Ph15]

Do Not Supply:

Few participants had any strong objections for which they would deny supply (8%). These participants refused supply based on religious objections to homosexuality.

"Basically, on religious grounds. Marriage is for two opposite sex: male and female. If she's doing it for a normal couple (male and female) who are infertile, I'll have no objection." [Ph18]

Case 4 – Voluntary Assisted Dying (VAD)

Supply:

Most participants (60%) reported they favoured dispensing a prescription for VAD for stage 4 pancreatic cancer. The primary reason for supply was respect for patient autonomy.

"I don't agree with euthanasia, but the patient has the right to choose." [Ph2]

Many compared the right to die for humans with that provided for pets, exploring the notion of "*Life, Death & Personhood*".

"I believe that it's ridiculous that we would make someone suffer if they are unwilling to keep surviving." [Ph9]

Participants identified the need to "*do no harm*" by reducing patient suffering and also the legal validity of the prescription.

> *"It's a valid prescription. I would supply without judgement and try to ensure to the best of my ability that the drug is being used for the purpose described." [Ph26]*

Conditional Supply:

Those who chose to provide conditional supply (15%) did so to preserve patient autonomy and ascertain their intentions.

> *"Only after I talk to her to make sure she's talked with him since it's his decision. As long as that's their choice, I would serve my patients." [Ph4]*

Concern for misuse and/or diversion of the medication was apparent, as well as the training and guidelines to protect all involved.

> *"I would want to ensure that a system is in place that protects both the patient and myself before supplying." [Ph32]*

Do Not Supply:

The largest proportion (26%) of "*do not supply*" responses was in this scenario. Reasons not to supply were consistent with existing literature (Isaac *et al*., 2019).

> *"I am not comfortable with the idea that the medication will be used to end another person's life and would ask for the prescription to be taken to another pharmacist." [Ph41]*

For some, the magnitude of ending another person's life was emotionally burdening.

> *"I cannot. I would feel like I was part of murdering a patient." [Ph22]*

For many, religious belief was the sole reason to object.

> *"Ending the life of another is not allowed in my religion." [Ph28]*

One participant supplied the abortifacient in Case 1 but refused the supply of VAD in Case-4, showcasing the theme and secondary driver of "*life, death and personhood*".

> *"I am not comfortable with the idea that the medication will be used to end another person's life and would ask for the prescription to be taken to another pharmacist." [Ph41]*

For many, this study encouraged self-reflection and evaluation of the reasons behind their decision-making and thought processes, whether for or against.

> *"It gave me more information and self-insight on the issue." [Ph18]*

It also strengthened their existing views and ignited questions regarding potential responses from professional organisational bodies for the new, widespread "*policy development*".

> *"I do not agree with conscientious objection, but if it is permitted, they should be policies that ensure pharmacists consider continuity of care; nothing should comprise patient care." [Ph14]*

> *"It would be interesting to see if FIP would be willing to consider developing policy in this regard." [Ph5]*

> *"Professionals (Pharmacists in this case) should not be forced to practice against their conscience. But there needs to be the development of Legal & Professional framework to protect their faith and integrity to have a choice as well as the patient." [Ph28]*

Discussion

Statement of principal findings and comparison to existing literature:

This pilot study identified that most participating international pharmacists when presented with controversial and ethically challenging clinical situations, would supply medicines or do so irrespective of their personal beliefs. The pilot study helped inform the development of questions which explored pharmacists' decision-making in complex scenarios around CO.

The data from this pilot showed interesting perspectives from the participants. A significant minority reported they would conscientiously object in several contexts, at times irrespective of implications to patients, however, with signposts to refer elsewhere. The pilot findings identified four primary drivers (Figure 2) that shed light on the salient concerns of participating pharmacists around CO. The need to clarify the role of the pharmacists, consider the ethical challenges they may face, provide clear guidelines on how CO can be managed safely and development of policies around CO where identified.

Driver 1: The role of the pharmacist

An interesting perspective expressed by some was regarding pharmacists' scope of practice and professional responsibilities. Many indicated that a pharmacist's role is to dispense a legally valid prescription and simply ensure it is safe and appropriate for the patient. This was mirrored in a 2007 article which

discussed a pharmacist's role as "*not to second-guess an adult's decisions regarding the use of an approved pharmaceutical but is to provide convenient and safe access to medications*" (Card, 2007). Nevertheless, pharmacists, like any healthcare profession, should not forsake their morals and right to CO because a medical practitioner has deemed a prescription valid (Cantor & Baum, 2004). The right to CO must be balanced by the accepted duty to refer and ensure continuity of care. Hence, why having clear professional protocols/guidelines to follow would enable CO to be enacted safely, without discrimination to the objector.

There is also a professional responsibility/accountability for patient care. There is an innate power imbalance associated with being a healthcare professional who has an expert level of health literacy and education. According to Shanawani (2016), the challenge of CO amongst healthcare professionals is the "*monopoly of knowledge, skills, and resources*" that may impact patient care. The most reasonable solution may be providing an extension of the conscience clause with a step-by-step protocol, which according to Hanlon *et al*. (2000), would allow for "*the efficient provision of the pharmaceutical service, whilst at the same time respecting the personal beliefs of those who object*".

Driver 2: Ethical considerations

For some, the case studies generated a multitude of difficult ethical dilemmas between principles of "*respect for patient autonomy*", "*beneficence*", "j*ustice*", and "*do no harm*." These dilemmas are possibly best resolved with clear guidelines and standards of practice.

Non-denominational religiosity was a key ethical challenge that had a significant influence on participants' decision-making against the supply of abortifacients, emergency contraception and VAD, as indicated in the findings. This is similar to existing literature (Davidson *et al*., 2010), indicating certain religious affiliations significantly predicted pharmacists' willingness to dispense medicines that evoke CO.

Religion-based reasoning was also influenced by the degree of harm perceived to be associated with dispensing CO-evoking medicines. Findings indicated a greater proportion of refusal-to-supply was for the abortifacient and VAD, both of which were deemed too consequential, resulting in the death of a human entity. These findings shaped the secondary drivers: life and death, human personhood, the lesser of two evils and medical versus social utility. These issues highlighted that despite the conundrum of life and death that will always baffle human beings, they also indicated the need for professional guidance/protocol relating to the duties of healthcare providers towards patient care and safety in the case of CO.

Interestingly, findings indicated a greater objection to supplying the euthanistic (Case 4) than for the abortifacient (Case 1). Some pharmacists changed their CO, with the bases likely due to their personal perception of when they deem a foetus a human being. Ethically and medico-legally, the definition of when the human person begins to exist is not without contention, with varying termination laws in different countries contributing to the ongoing contention and moral discomfort around abortions.

Intriguingly the same participants who objected to the cases of life and death were not as objects in other scenarios, which may be attributed to the power of social norms and relativity. For example, the acceptance from most participants for IVF surrogacy for a same-sex couple was at least in part influenced by a shift in social norms. This same social acceptance and shift in societal norms may also gradually evolve for bioethical issues concerning life and death, especially as practices of VAD increase around the world.

Driver 3: Training and guidance

The need for training and guidance about CO for pharmacists remained an important theme in this pilot. There was also some misguided understanding of their country's legislation and/or principles of Codes of Ethics around Gillick competence. For example, in the UK, teenagers aged 13-16 years deemed to have competency can gain access to the ECP Ulipristal without a prescription (National Health Service, 2021).

While the request for training and guidance for emerging practices/services like VAD (Isaac *et al*., 2019) was clear, protocols and guidance around what should be done at a time when one chooses to enact conscientious objection are non-existent, consequently placing not only the consumer at risk of lack of access but also places the objector at risk of moral conflict, workplace pressures and ostracisation. A clearly validated framework also has the potential capacity to simultaneously address the other two drivers of "*the role of the pharmacists*" and "*ethical considerations*".

Driver 4: Policy development

The development of policy that is robust, overarching and timeless in its ability to cover the future ethical challenges of advancements to come is crucial. Participants indicated the necessity of having policies that would guide pharmacists around CO. FIP has developed a code of ethics (International Pharmaceutical Federation, 2014a) and has published a reference document titled "*Pharmacist ethics and professional autonomy: Imperatives for keeping pharmacy aligned with the public interest*" (International

Pharmaceutical Federation, 2014b). Both pieces provide guidance around the challenges of professional ethics; however, the notion of CO is yet to be explored to its fullest. The only true mention of CO was referencing the renowned ethicist Nancy Berlinger (2008), who states that "*healthcare providers with moral objections to providing specific services have an obligation to minimise disruption in deliver of care and burdens on other providers*" (International Pharmaceutical Federation, 2014b).

The need for a policy, framework or statement around the challenges of CO for both pharmacists and their patients is important and would help to elevate concerns around liability, continuity of care and patient safety. With the evolution of legislation around CO worldwide, this may be a timely opportunity for pharmacy professional organisations–like that of FIP, which is a global leader in pharmacy education and policy–to develop CO specific guidelines.

This pilot study is the first to offer valuable insight into the ideas of international pharmacists/FIP delegates around CO in pharmacy and the potential gaps that may be expanded upon in the primary research paper. The pilot study highlighted some issues in the survey that required finetuning and, based on qualitative analysis, aspects that need to be explored.

Interestingly, it also provided insight into the nature of individual pharmacists' responses which can have a direct impact on individual patient care. Each response was meaningful in that patient-related impact, even if minor in quantity, would be deemed significant in effect for that patient. This aligns with findings from US studies (French *et al*., 2016; Holt *et al*., 2017; Homaifar *et al*., 2017; Green & Thorogood, 2018) and a recent paper on CO in women's health in Australia (Keogh *et al*., 2019). When interpreting the results from this study, the following limitations should be considered. As a pilot study, the sample size of our cohort is relatively small, which predisposes the data to chance finding or coincidence and correlation, leading to increased bias. However, this is the premise of a pilot study which is aimed at developing the questions for future studies with larger sample sizes. Additionally, the recruitment style of convenience sampling of FIP delegates at the 2019 FIP Congress in Abu Dhabi may lead to sampling bias. Therefore, the data is by no means generalisable to the entire pharmacy profession. However, despite these limitations, the authors feel the results from this study provide useful outcomes to justify further investigations and future research, which is in keeping with the aim of a pilot study.

Conclusion

This pilot study helped inform the development of a proposed questionnaire regarding CO in pharmacy and explore international pharmacists' decision-making in complex scenarios around CO and the reasons for their choices. Indicative findings suggested that the majority of pharmacists would not exercise CO in most cases. However, for the minority who chose to exercise CO, their reasons and approaches varied. For some, it was for religious values; for others, it was mostly due to the ethical tension between "*do no harm*" and "*respect for patient autonomy*". These preliminary findings highlighted the need for further research to help investigate a large population of pharmacists and identify the key challenges around CO in practice.

Conflict of interest

The authors have no competing interests to declare that are relevant to the content of this article.

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Appendix A: Participant information statement

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Introduction to survey on conscientious objection
Thank you for opening the link to this survey.
We invite you to share your valuable opinions about the principle of conscientious objection in pharmacy.

QUESTIONS YOU MAY HAVE BEFORE COMMENCING THE SURVEY:

1. What is this study about?
   Conscientious objection is defined as: "[A] practitioner's right to refuse to engage or provide a service primarily because the action would violate their deeply held moral or ethical values about what is right and wrong."
   Our aim is to explore this notion to inform future formulation of guidelines and policies for our profession; as it is becoming ever more engaged in healthcare services that may be morally challenging such as the recent legislation of assisted dying (Victoria).
   This study involves the conduct of a de-identified survey of your opinions about conscientious objection in pharmacy. You will not be asked for your identity. We are presenting you with a few scenarios for your comments.

2. Who is running the study?
   Mr Sami Isaac, Prof. Andrew McLachlan & Assoc. Prof. Betty Chaar from the University of Sydney School of Pharmacy, Faculty of Medicine and Health

3. How much of my time will the study take?
   We anticipate less than 5 minutes

4. Who can take part in the study?
   Any registered pharmacist.

5. Do I have to be in the study? Can I withdraw from the study once I've started?
   Your participation in this de-identified survey is completely voluntary.
   Once you have started the survey you may withdraw at any time by closing your browser, however once submitted it is not possible to retrieve or remove your submission.

6. Are there any risks, costs or direct benefits associated with being in the study?
   We believe there are no risks, costs or benefits associated with this study.

7. What will happen to information that is collected during the study?
   Study findings may be published, but you will never be identified in these publications.

8. Can I tell other people about the study?
   Yes, you are welcome to tell other people about the study and share the link to this survey.

9. What if I would like further information about the study
   Please contact the researchers (contact details in letterhead above) for any further information.

10. What if I have a complaint?
    If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number. d
    The Manager, Ethics Administration, University of Sydney:
    • Telephone: +61 2 8627 8176
    • Email: ro.humanethics@sydney.edu.au
    • Fax: +61 2 8627 8177 (Facsimile)

Appendix B: Survey questions

THE UNIVERSITY OF SYDNEY

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School of Pharmacy
Faculty of Medicine and Health

Mr Sami Isaac | B Pharm. (Hons) PhD Candidate

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Q1. Please select your age group:
o 24 years or less
o 25 – 34 years old
o 35 – 44 years old
o 45 – 54 years old
o 55 – 64 years old
o 65 – 74 years old
o 75 years old and above

Q2. Please select your sex:
o Male
o Female
o Other

Q3. To what extent does religion shape your decision making in pharmacy practice when it comes to controversial issues (e.g. life and death)
o Not at all
o Somewhat
o Very much

Q4. Please identify your occupational role and how many years you have been working as a registered pharmacist:
o Pharmacist (How many years have you been registered?)
_____

o Other
_____

Q5. Please select the option that reflects your educational degree:
o B. Pharm/ B. Pharm (Hons)
o M. Pharm
o PharmD.
o PhD.
o Other

Q6. Country of Practice (If Australia please indicate the State/Territory you practice in):

_____

Q7. Pharmacy Field (Community, Hospital, Industry, Academia etc.)
- o Community Pharmacy
- o Hospital Pharmacy
- o Academia
- o Industry
- o Government Position
- o Heads of Professional Bodies
- o Other _____

Q8. What does "conscientious objection" mean to you?:
- o I don't have a clue
- o I'm not sure, I've not experienced it
- o I have a vague idea what it is about
- o I know what it is all about
- o Would you like to add anything here? _____

Q9. A pharmacist should have the right to conscientious objection? (conditional and/or unconditional):
- o Strongly agree
- o Agree
- o Neither agree nor disagree
- o Disagree
- o Strongly Disagree

Q10. Is it ethically justifiable to conscientiously object if it means your patient cannot get the treatment?
- o Yes
- o No
- o Only if… (please explain below)

Q11. If a pharmacist has the right to conscientious objection, in your opinion should they ensure continuity of care? (e.g. refer patient to alternative pharmacists)
- o Yes
- o No (Why?)

_____

Q12. Which of the following best describes how you would practice "continuity of care"?
- o Referring the patient to try another pharmacy
- o Referring the patient back to their doctor
- o Providing the patient with information/resources of alternative pharmacists they can successfully access treatment

Q13. Which of the following do you feel influences your views on conscientious objection?
- o The principle of "Do No Harm"
- o The principle of "Patient Autonomy"
- o Faith
- o Professional & Legal Frameworks
- o Other_____

Q14. [Please regard Q14- 17 as hypothetical even if they may not be legal in your country yet]
CASE 1: Mrs Stevens (29 years old) is 9 weeks pregnant. She has chosen to terminate her pregnancy where her foetus was diagnosed with Down Syndrome (Trisomy 21) but otherwise healthy. She has been provided her with a valid prescription for the abortion tablet MS-2 Step (RU486 - mifepristone and misoprostol combination). What would you do?*

- o Supply (Why?)

_____

- o Don't Supply (Why?)

_____

- o Conditional Supply (Why?)

_____

Q15. CASE 2: An 15 year old girl comes into your pharmacy and asks to speak to you about the emergency contraceptive pill (Levonorgestrel) to prevent her from falling pregnant after having sexual intercourse the night before with her boyfriend. What would you do?

o Supply (Why?)
_____

o Don't Supply (Why?)
_____

o Conditional Supply (Why?)
_____

Q16. CASE 3: Miss Smith is a 32 year old who will be undergoing IVF treatment as a surrogate mother to bear a child for her friends, a homosexual couple. She explains her circumstances and comes in with a prescription for Clomiphene (as part of IVF procedures) What would you do?

o Supply (Why?)
_____

o Don't Supply (Why?)
_____

o Conditional Supply (Why?)
_____

Q17. CASE 4: You are a pharmacist working in a country where euthanasia has been legalised. Mrs Peters brings in a valid prescription for ("Nembutal" = Pentobarbital) for voluntary euthanasia for her husband. He is a 75 year old male patient of yours who is terminally ill with Stage 4 pancreatic cancer. What would you do?

o Supply (Why?)
_____

o Don't Supply (Why?)
_____

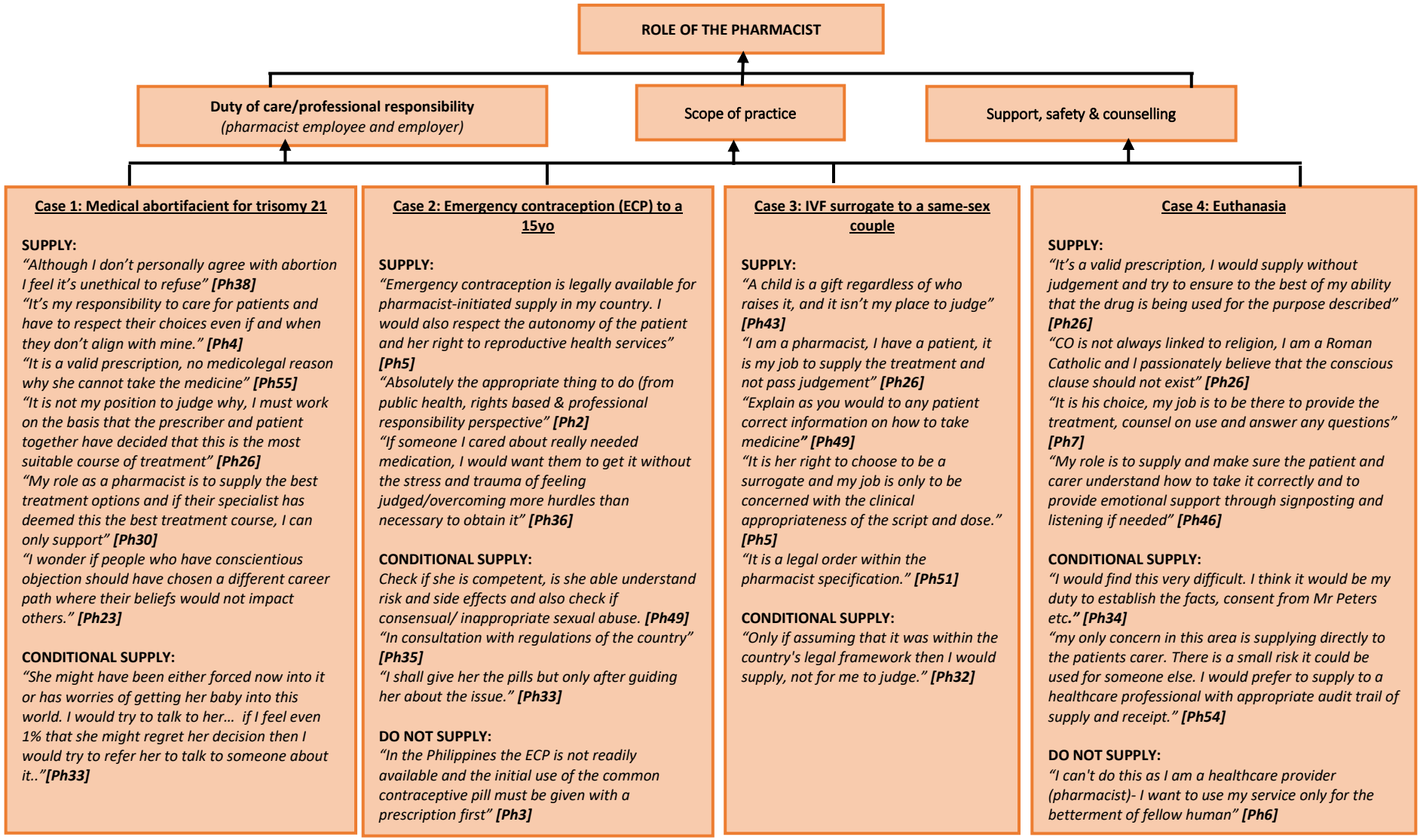
o Conditional Supply (Why?)
_____

Q18. How open are you to changing your views on conscientious objection?
Willingness for views to change:
o 1 = Never going to change
o 2
o 3
o 4
o 5 = Open to Change

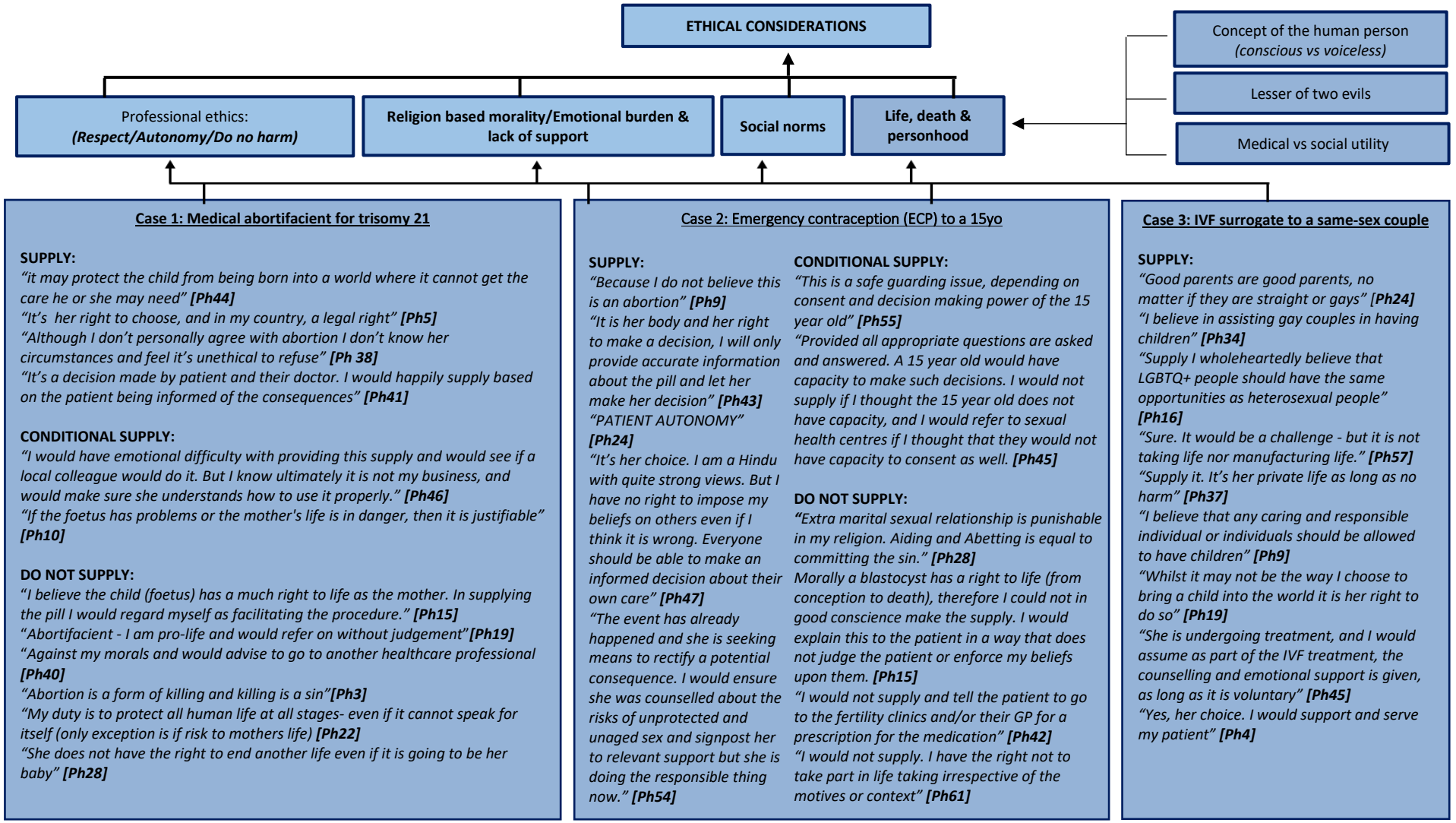
Q19. If you attended the FIP session (C8 - Ethics Forum on Conscientious objection) did you find it useful? If not, please move to the next question. [For PILOT only]
_____

Q20. Please provide any additional comments or views in the field below
_____
_____

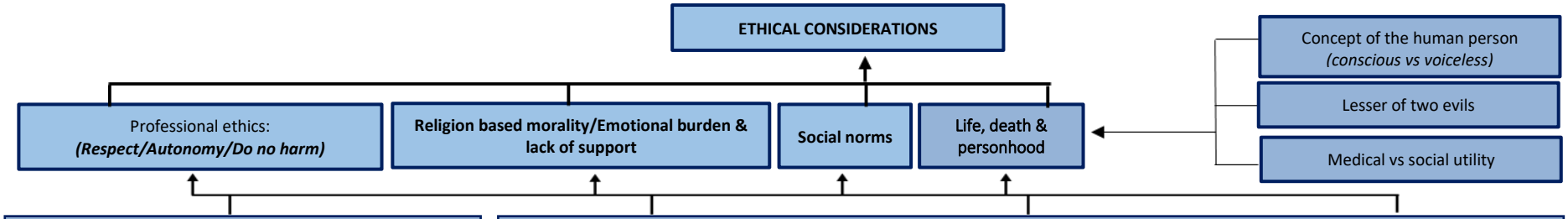
Appendix C: Example quotes for driver 1



Appendix D: Example quotes for driver 2



Appendix E: Example quotes for driver 2 (Continued)



Case 3: IVF surrogate to a same-sex couple

CONDITIONAL SUPPLY:

"I would try to avoid the supply of IVF medication where possible as I don't agree with freezing embryos ***[Ph15]***
"Tell her all the risks of pregnancy and its effect on her body. I would just state facts without trying to convince her of changing her decision . She has the right to know everything then decide if she would do such a sacrifice" ***[Ph31]***

DO NOT SUPPLY:

" Basically on religious grounds. Marriage is for two opposite sex: make and female. If she's doing it for a normal couple (male and female) who are infertile, I'll have no objection." ***[Ph18]***
"Because of circumstances of a homosexual couple I would pass on to next pharmacist" ***[Ph48]***
"Don't agree with gay marriage" ***[Ph11]***
"This may cause and ethical dilemma for some. But ethics are the foundation of civilization and it prevents us from doing things against our most profound human convictions. And ultimately, we too must be free to decide on what we ourselves are just not willing to do. Freedom." ***[Ph6]***

Case 4: Euthanasia

SUPPLY:

"I believe that it's ridiculous that we would make someone suffer if they are unwilling to keep surviving." ***[Ph9]***
"I don't agree with euthanasia but the patient has the right to choose this legal option" ***[Ph2]***
"Respect patient autonomy" ***[Ph62]***
*"The patient is suffering, and would probably have a very decreased quality of life and as a pharmacist I would assume that the patient has had all the relevant counselling and a psych evaluation."[****Ph45]***
"Do away with pain and suffering, let him pass away in peace" ***[Ph60]***
*"Although I recognise the challenges and need to ensure access to quality palliative care, I also support the right to access assisted dying services"****[Ph5]***

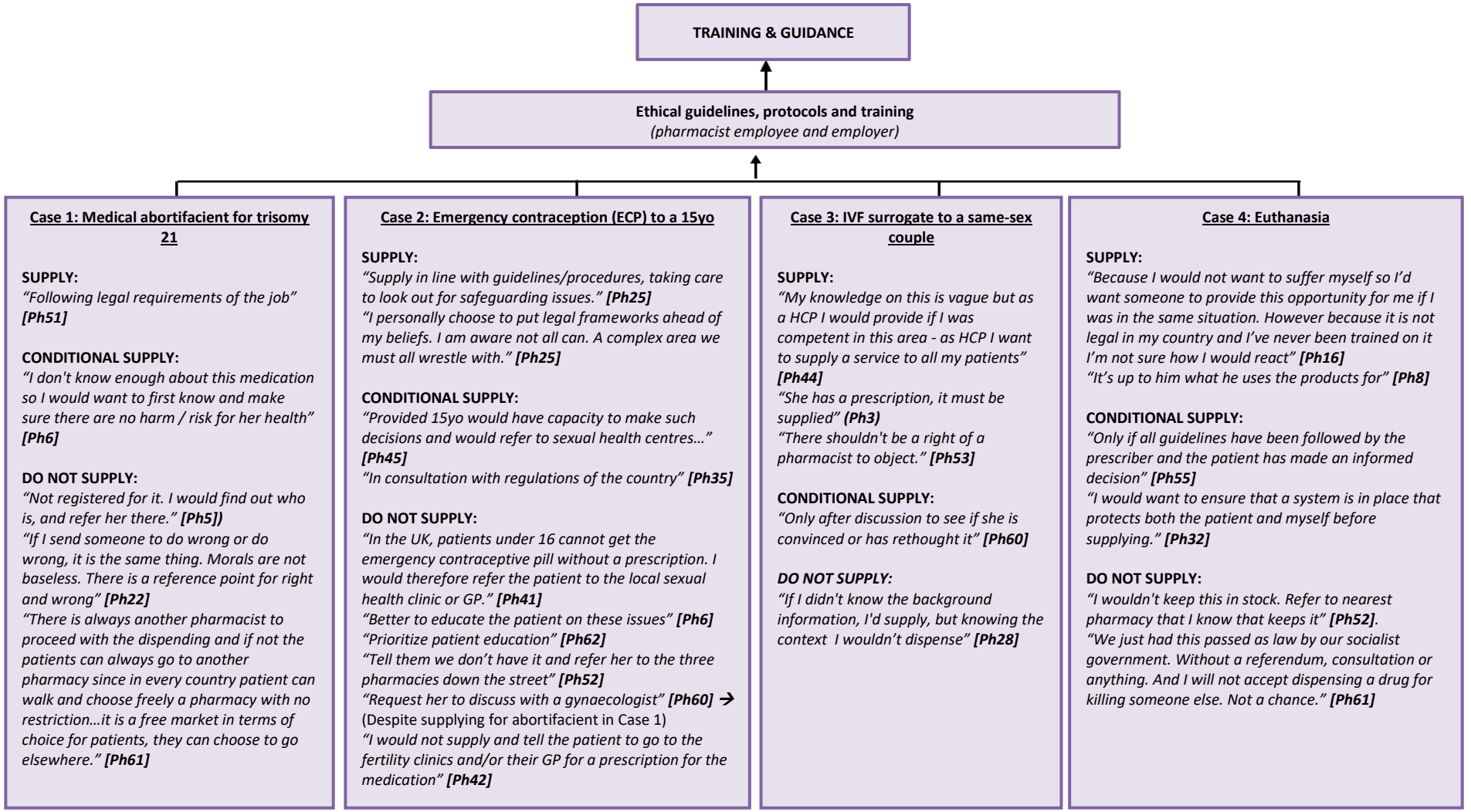
CONDITIONAL SUPPLY:

*"Only after I talk to her to make sure she's talked with him since it's his decision. As long as that's their choice, I would serve my patients"****[Ph4]***

DO NOT SUPPLY:

"A difficult one. I'll not supply because I fundamentally object to euthanasia." ***[Ph18]***
"Against my morals, would signpost elsewhere" ***[Ph40]***
"Because I believe that we would never know if this is the patient's will and can never live with such a thing." ***[Ph31]***
"Don't supply, simply too emotional and religious" ***[Ph37]***
"Ending the life of another is not allowed in my religion." ***[Ph28]***
"I am not comfortable with the idea that the medication will be used to end another person's life and would ask for the prescription to be taken to another pharmacist." ***[Ph41]***
"People can feel coerced (e.g. feeling a burden upon their relatives). I went into a caring profession to look after people with dignity… Good end of life care involves the relief of pain, and medical, social and spiritual support for patients and their relatives and friends. Pentobarbital doesn't achieve this." ***[Ph15]***
"I cannot. I would feel like I was part of murdering a patient" ***[Ph22]***
"I don't agree with euthanasia although it may prevent one from suffering, I would feel wrong for supplying a route to end a life" ***[Ph43]***

Appendix F: Example quotes for driver 3



Appendix G: Example quotes for driver 4