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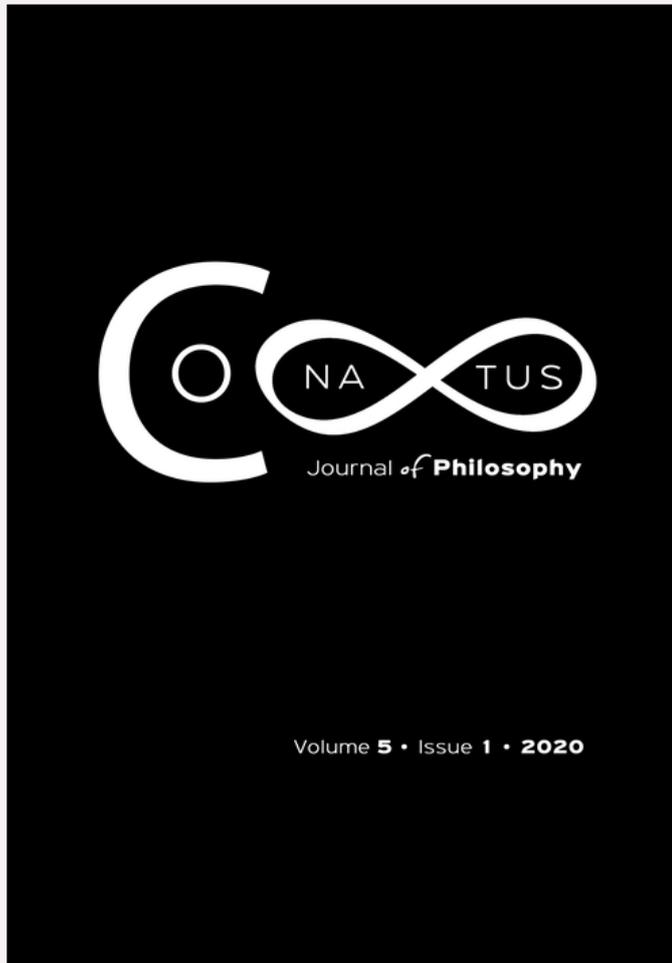
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Balancing Conscience: A Response to Fernandes & Ecret*

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Abstract

*There are many lessons that bioethics can learn from the Holocaust. Forefront are the lessons from the Nuremberg trials and the formation of research ethics. An often-overlooked lesson is how the Nazi regime was able to construct a hierarchy in such a way that influenced people to act in horrendous ways. Fernandes & Ecret, writing in *Conatus – Journal of Philosophy* 4, no. 2 (2019), highlight the influence of hierarchy on the moral silence of nurses and physicians within the Nazi regime. While we greatly enjoyed the paper, and think it is an important contribution, we find several misrepresentations of current bioethical discourse. There is not a global acceptance of euthanasia or medical aid in dying, the contemporary position in bioethics does not favor removal of conscience-based protections, and the lack of personal conscience-based protections was not the main factor in the analysis of Nazi medical hierarchy. The authors' overall conclusion that their analysis suggests the importance of strengthening personal conscience-based objections to prevent medical hierarchy from influencing immoral behavior misses the more significant issue of institutional behavior. Instead, we argue, that the lessons from the analysis of Nazi nurses and physicians speak to the importance of protecting patients from institutional conscience-based objections that violate patient rights of access to legal medical services. This paper will respond to the misrepresentations. We highlight the growing threats to health care access from religious affiliated institutions, the threats to professional ethics and physician and nurse scope of practice. We conclude that the analysis by Fernandes & Ecret does point out an important lesson, but rather than showing the importance of individual conscience protections, it speaks to the importance of protecting patient rights.*

Key-words: *conscientious objection; patient rights; bioethics; organizational ethics; professional ethics*

*A. Fernandes, and D. Ecret, "The Effect of Hierarchy on Moral Silence in Healthcare: What Can the Holocaust Teach Us?" *Conatus - Journal of Philosophy* 4, no. 2 (2019): 21-43.

We read with great interest “The Effect of Hierarchy on Moral Silence in Healthcare: What Can the Holocaust Teach Us?” by Fernandes & Ecret, which presents a powerful and important discussion of hierarchy and moral silence in healthcare.¹ In the article, the authors highlight the dangers of silence in the face of ethical violations, encourage the moral voices of nurses and physicians, and believe the lessons of the Shoah should be better materialized in professional education. We agree!

The authors primarily hypothesize how ingrained hierarchy had a role in shaping moral actions during the Holocaust. They are right that it is foolish to ignore these lessons, giving way to the complacency that it couldn’t happen here or now. We agree that hierarchy of the Nazi regime worked to ensure physicians and nurses stayed silent and were complicit. We, however, challenge the authors’ concluding assumptions that:

- i. there is a global acceptance of euthanasia and assisted suicide in the “medical profession” for conditions such as depression, schizophrenia, autism, addiction, and transgenderism.
- ii. “contemporary” literature in bioethics favors removal of conscience protection laws.
- iii. lack of individual conscience protections was the main factor in complicit behavior in the Shoah.

The authors conclude that these assumptions support the argument for strengthening individual provider conscience protections against the dangers of medical hierarchy, preventing moral silence. Ensuring protections are important. The more prescient threat is not medical hierarchy but religious affiliated organizations holding institutional conscience-based refusals against offering medical services.

Hospitals that hold restrictive conscience-objections prohibit staff from providing or discussing care with their patients. The US government, instead of strengthening patient protections, is seeking to expand protections for those entities.²

We will address our criticism of the three assumptions that Fernandes & Ecret base their conclusion on. We will then show how the lessons

¹ Ashley K. Fernandes, and DiAnn Ecret, “The Effect of Hierarchy on Moral Silence in Healthcare: What Can the Holocaust Teach Us?” *Conatus - Journal of Philosophy* 4, no. 2 (2019): 21-43.

² Ian D. Wolfe, and Thaddeus M. Pope, “Hospital Mergers and Conscience-Based Objections – Growing Threats to Access and Quality of Care,” *The New England Journal of Medicine* 382 (2020): 1388-1389.

from Fernandes & Ecret's analysis seem to point towards the dangers of an institution setting a specific conscience and overriding clinician conscience and ethics against the rights of patients.

Assumption I

Assisted suicide, now referred to as medical aid in dying (MAID), is fairly accepted in some medical professions, but there is by no means "global" acceptance.³ Although MAID is certainly gaining momentum, it is legal in only seven US jurisdictions, for limited indications, and a rigorous process for access.⁴ The American Medical Association still considers it "fundamentally incompatible with the physician's role."⁵ The American Nurses Association only recently changed their policy around MAID that recognizes it as a legal and ethical right, highlights the obligation of the nurse to support their patient in that choice and through the process, but still maintain that nurses are ethically prohibited from administering medications for that purpose.⁶ Further, euthanasia, which is different and distinct from MAID, remains illegal in the United States, and most other countries. One or two instances in history do not equate to accepted practice.

Assumption II

The authors' claim that contemporary bioethical literature supports removal of conscience protection laws is false and is a mischaracterization of this debate. The authors misrepresent Stahl & Emmanuel's argument by claiming it called for an end to conscience protection laws.⁷ The argument Stahl & Emmanuel make is that a clinician should not be allowed to utilize conscience protection laws to violate a patient's right to access of a legal and medically accepted treatment, particularly when the clinician is federally funded or practices in an organization that receives public funds. Patient rights must be the primary concern. Clinicians with conscience-based objections have a duty to disclose this to their employer so they can accommodate patient access.

³ Bob Roehr, "Assisted Dying in US and Canada: Controversy Subsides after Legalization," *The British Medical Journal* 360 (2018): k503.

⁴ Thaddeus M. Pope, "Legal History of Medical Aid in Dying: Physician assisted Death in US Courts and Legislatures," *New Mexico Law Review* 48, no. 2 (2018): 267.

⁵ American Medical Association, "Physician-Assisted Suicide," November 14, 2016, <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide>

⁶ ANA Ethics Advisory Board, "ANA Position Statement: The Nurse's Role When a Patient Requests Medical Aid in Dying," *The Online Journal of Issues in Nursing* 24, no. 3 (2019).

⁷ Ronit Y. Stahl, and Ezekiel J. Emanuel, "Physicians, not Conscripts-Conscientious Objection in Health Care," *The New England Journal of Medicine* 376, no. 14 (2017): 1380-1385.

Savulescu & Schuklenk make a similarly nuanced argument that speaks to the importance of the discussion.⁸ While they do call for an end to conscience protection laws, they do so by demonstrating that objections are often better grounded in professional codes of ethics and scope of practice provisions. Their point, we believe, is not to silence professionals, but rather to protect patients by putting the focus on individual patient rights before a right to conscience-based objections by clinicians. Their approach puts the burden onto the clinicians, who have more power than a patient, by requiring them to base their objection in professional practice and code of ethics rather than the more ambiguous reference to “conscience.” We believe that individual conscience-based objections are a legitimate and necessary moral exercise but that careful balance is needed to ensure that patient rights are not overridden by the same type of mistaken medical morality that led to faulty medical ethics by the Nationalist Socialists in Nazi Germany.

There are certainly bioethicists calling for removal of individual conscience objections, but not all.⁹ The debate in bioethics is not one of consensus for blanket removal of conscience protections rather it is more nuanced and is over the balance between patient access to legal and professionally accepted care and respect for the individual conscience of their healthcare provider in order to avoid morally tenuous scenarios.

Assumption III

Fernandes & Ecret’s conclusion that the Nazi regime indoctrinated physicians and nurses to act immorally provides an important and valuable lesson. It does speak to an element of individual conscience protections. However, we believe that discussion of hierarchy and moral silence by health professionals in the Nazi regime is more aptly analogized to the dangers of institutional conscience-based protections and institutional power, namely that a hierarchal structure such as a hospital can force its ideological beliefs on the community it serves, even coopting employees as morally apathetic agents of that hierarchy. Nazi physician’s and nurse’s individual objections were not made because they were willful participants in the regime’s belief structure.

Institutional conscience protections allow healthcare institutions to decline provision of certain services based on their mission and values, even

⁸ Julian Savulescu, and Udo Schuklenk, “Doctors have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception,” *Bioethics* 31, no. 3 (2017): 162-170.

⁹ Mark R. Wicclair, “Is Conscientious Objection Incompatible with a Physician’s Professional Obligations?” *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 171-185.

if such therapies are considered medically indicated. Institutional conscience protections are widely supported by both federal and state laws.¹⁰

Fernandes & Ecret's arguments make the case for why institutions should not promote a particular "conscience" that might override individual conscience. This becomes particularly important, and relevant, when individual hospitals can promote conscience-based objections. Hospital conscience-based objections interfere with patients' rights to standard and legally authorized treatments similar to the way in which the Nazi regime reduced the rights of segments of the population, ensuring compliance from their clinicians.

I. Institutional Conscience

Individual conscience protections do not seem to have been the problem in the Holocaust, they could have spoken up, likely would have been punished. The absence of these laws does not seem to have been the main culprit in getting clinicians to act out their bidding. Rather, their analysis highlights the dangers being a part of a collective entity that encroaches on the rights of those they are supposed to serve in the name of an institutional belief structure, engaging in group think and moral silence. Fernandes & Ecret are correct that nurses and physicians have an obligation to speak up against institutional practices they conscientiously and morally object to.

Clinicians who many find themselves working in a, for instance, Catholic health care facility, are not constrained by objections to care, but rather they are constrained by the inability to provide care.¹¹ These are problems of institutional restrictions to care, the provider can voice their objection about a hospital not providing a legal medical service, but the patient still suffers a denial of rights, delays in care, and sometimes inadequate treatment. In fact, in some facilities a clinician cannot even counsel or advise a patient on how to access a service outside of the institution without a risk of employment violations.¹²

Fernandes & Ecret present an important and powerful analysis. But their analysis supports the conclusion that patient rights and protections are paramount. The ethical violations of Nazi physicians and nurses was not

¹⁰ Nadia N. Sawicki, "Protections from Civil Liability in State Abortion Conscience Laws," *Journal of the American Medical Association* 322, no. 19 (2019): 1918-1920.

¹¹ Maryam Guiahi, "Catholic Health Care and Women's Health," *Obstetrics and Gynecology* 131, no. 3 (2018): 534-537.

¹² Debra B. Stulberg, Rebecca A. Jackson, and Lori R. Freedman, "Referrals for Services Prohibited in Catholic Health Care Facilities," *Perspectives on Sexual and Reproductive Health* 48, no. 3 (2016): 111-117.

a failure of conscience-based protections but a violation, by omission and commission, of people because of the “conscience” of the institution, or regime. They were complicit while the rights of those they were supposed to serve were reduced and eliminated. It is faulty to believe that one could have achieved justice through conscience protections in a wholly unjust society.

The reason this distinction is important, and why these lessons are relevant today is that conscience-based objections in healthcare have risen to the level of social discussion. However, there is a distinction that is getting lost in the discourse. This distinction is between the conscience of an individual clinician (nurse, physician) and the conscience of an entity such as a hospital (institutional conscience).

II. The Balance of Conscience and Rights

The balance between conscience and rights has been shifting in the US, as Catholic hospitals are merging with and acquiring hospitals around the country.¹³ Problematic institutional consciences are not isolated to religiously-affiliated hospitals, this is our point. They are only currently emblematic of the dangers around allowing institutions to push particularly restrictive belief structures. One could imagine a secular institution employing some other restrictive conscience. As major policy initiatives are being attempted through the expansion of federal conscience rules that would expand what services and to whom services can be denied.¹⁴ These policies favor institutional conscience over that of patient rights to access basic, standard, and legally accepted healthcare services, even when their own insurance policies allow for access. A clinician should maintain the right to refuse participation in controversial procedures, but not ones considered basic or urgent care. Institutional conscience policies also place physicians and nurses in a compromising position, one that can lead to moral distress in the face of concerns for employment violations.¹⁵ This becomes the problem that Fernandes & Ecret warn of, institutional silencing of individual morals and professional codes of ethics leading to the harm of patients.

The shift towards institutional conscience protections also impacts the professional ethics of the clinical staff within the organization, just as Fernandes & Ecret detail in their account of Nazi physicians and nurses. While the authors

¹³ Maryam Guiahi, “Religious Refusals to Long-Acting Reversible Contraceptives in Catholic Settings: A Call for Evidence,” *American Journal of Obstetrics and Gynecology* 222, no. 4 (2019): S869.e1-S872.e5.

¹⁴ Lawrence O. Gostin, “The ‘Conscience’ Rule: How will it affect Patients’ Access to Health Services?” *Journal of the American Medical Association* 321, no. 22 (2019): 2152-2153.

¹⁵ Guiahi, “Religious Refusals,” S870.

make the argument that the lessons of the Shoah speak to the importance of individual conscience protections for physicians and nurses, we believe the more compelling and prescient argument is the protection of patients, and citizens, from institutional power. If hospitals have more power over patients, patients' rights may be violated, even making nurses and physicians complicit. The balance is recognizing the rights and responsibilities in both patients and clinicians without overly endowing power to the institution. The lessons from the Shoah, in Fernandes & Ecret's analysis, are that moral silence is unjust and institutional power needs to be checked. Individual clinician conscience regulations are too easily corrupted by institutional power. Without the dissolution of institutional conscience protections or the acceptance of conscientious provision protections, institutions will have too much power over patients and clinicians, and it is likely that history will sadly continue to repeat itself.

References

- American Medical Association. "Physician-Assisted Suicide." November 16, 2020. <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide>.
- ANA Ethics Advisory Board. "ANA Position Statement: The Nurse's Role When a Patient Requests Medical Aid in Dying." *The Online Journal of Issues in Nursing* 24, no. 3 (2019).
- Bob Roehr. "Assisted Dying in US and Canada: Controversy Subsides after Legalisation." *British Medical Journal* 360 (2018): k503.
- Fernandes, Ashley K., and DiAnn Ecret. "The Effect of Hierarchy on Moral Silence in Healthcare: What Can the Holocaust Teach Us?" *Conatus – Journal of Philosophy* 4, no. 2 (2019): 21-43.
- Guiahi, Maryam. "Catholic Health Care and Women's Health." *Obstetrics and Gynecology* 131, no. 3 (2018): 534-537.
- Guiahi, Maryam. "Religious Refusals to Long-Acting Reversible Contraceptives in Catholic Settings: A Call for Evidence." *American Journal of Obstetrics and Gynecology* 222, no. 4 (2019): S869.e1-S869.e5.
- Gostin, Lawrence O. "The 'Conscience' Rule: How Will it Affect Patients' Access to Health Services?" *Journal of the American Medical Association* 321, no. 22 (2019): 2152-2153.
- Pope, Thaddeus Mason. "Legal History of Medical Aid in Dying: Physician Assisted Death in US Courts and Legislatures." *New Mexico Law Review* 48, no. 2 (2018): 267-301.

Savulescu, Julian, and Udo Schuklenk. "Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception." *Bioethics* 31, no. 3 (2017): 162-170.

Sawicki, Nadia N. "Protections from Civil Liability in State Abortion Conscience Laws." *Journal of the American Medical Association* 322, no. 19 (2019): 1918-1920.

Stahl, Ronit Y., and Ezekiel J. Emanuel. "Physicians, Not Conscripts-Conscientious Objection in Health Care." *New England Journal of Medicine* 376, no. 14 (2017): 1380-1385.

Stulberg, Debra B., Rebecca A. Jackson, and Lori R. Freedman. "Referrals for Services Prohibited in Catholic Health Care Facilities." *Perspectives on Sexual and Reproductive Health* 48, no. 3 (2016): 111-117.

Wicclair, Mark R. "Is Conscientious Objection Incompatible with a Physician's Professional Obligations?" *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 171-185.

Wolfe, Ian D., and Thaddeus M. Pope. "Hospital Mergers and Conscience-Based Objections – Growing Threats to Access and Quality of Care." *The New England Journal of Medicine* 382 (2020): 1388-1389.