Bioethics Outlook

Plunkett Centre for Ethics

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Respect for conscientious objection in healthcare:

Two views in current debates

Imagine that paediatricians are asked by the parents of a child with severe developmental disabilities to perform a hysterectomy and mastectomy on their daughter and give her hormones to restrict her growth. Imagine that, though the paediatricians sympathetically appreciate the motivation of the parents for this request – that restricting her growth will enable them to continue to care for her themselves, they think that they cannot do these things to the child. Should we compel them to provide the procedures? Or should we accommodate their conscientious judgment? Or again. Imagine that a doctor is willing to provide a first trimester termination but is reluctant to terminate a pregnancy in the third trimester. Should we compel the doctor to provide the procedure? Or should we accommodate the doctor's conscientious judgment? The general question to be considered is whether it is ever justifiable to compel performance by a doctor in violation of his or her conscience. Or, to put the question another way: What scope – if any at all - should be given to conscientious judgment in healthcare?

In this issue:

The Honourable Paul Brereton KC addresses the subject of moral distress at the first PM Glynn Ethos Event for 2023.

Notice of the Annual Plunkett Lecture to be given by John Haldane on Confusions about the Common Good.

ACU
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PLUNKETT CENTRE FOR ETHICS

Annual Plunkett Lecture

The Plunkett Centre for Ethics, a joint centre of Australian Catholic University (ACU) and participating partner hospitals, welcomes you to its annual lecture.

Date
Thursday 9 November 2023
at 6pm
Refreshments from 5:15pm

Venue
Peter Cosgrove Centre
Level 18,
Tenison Woods House
8-20 Napier Street,
North Sydney

Register
For catering purposes, please register your attendance at
plunkett@acu.edu.au

For more information
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Common confusions about the common good:
What is it? How is it relevant to health care? What is its meaning in a pluralist society?

PRESENTER

Professor Haldane is Emeritus Professor of Moral Philosophy at the University of St Andrews, a Fellow of the Royal Society of Edinburgh and Chair of the Royal Institute of Philosophy in London. He is a Visiting Professor at ACU.

John Haldane will distinguish between different senses of the term 'common good' and set out the conditions for having and pursuing it. He will query whether modern, socially and morally diverse states can really employ substantive notions of the common good. He will also discuss the challenges facing Catholic health care in a society that not only lacks moral cohesion but is increasingly hostile to the Catholic understandings of this great idea.

The participating partners of the Plunkett Centre are Sydney's St Vincent's Public Hospital, St Vincent's Private Hospital and the Mater Hospital, as well as St Vincent's Private Community Hospital, Griffith, Calvary Healthcare, the Mercy Hospital in Melbourne and Cabrini Hospital in Melbourne.

Last year, when the New South Wales Parliament legalised 'voluntary assisted dying' – VAD is the term that is used in Australia for assisted suicide or euthanasia - it refrained from compelling doctors to provide (or facilitate access to) this service in violation of their conscience. [1]

Though there is now an enormous literature on the subject, most views sit on the range between, on the one hand, 'there ought to be little or no scope for conscientious judgment in healthcare' and, on the other, 'there ought to be wide scope for conscientious judgment in healthcare'. Classic expressions of these two views were given some time ago by Julian Savulescu and Daniel Sulmasy respectively. Though there are now other contributors to the discussion, and other points of view, a grasp of the early claims of these two doctor-philosophers will orient a newcomer to the shape of the debate.

Savulescu argues that

> *'[a} doctor's conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's good and the patient's informed desires. If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.'* [2]

This view was further elaborated in a 'consensus statement' adopted by a group of philosophers and bioethicists (Savulescu among them) who met at the Brocher Institute in Geneva in 2016. According to them,

> *'[h]ealthcare practitioners' primary obligations are towards their patients, not towards their own personal conscience. When the patient's well-being (or best interests, or health) is at stake, healthcare practitioners' professional obligations should normally take priority over their personal moral or religious views.'*[3] When practitioners have a conscientious objection, they ought to refer their patients to another practitioner who is willing to perform the treatment, and in emergency situations perform the treatment themselves. When they have a conscientious objection to providing treatment, they should be required to explain themselves. The burden of proof of the reasonability and sincerity of the objection should be on the practitioner. Reasons offered could be

[1] That said, it is a pity that Australian parliaments adopted the euphemism 'voluntary assisted dying' for a practice more accurately described as 'assisted suicide'.

[2] Savulescu, Julian. Conscientious objection in medicine. *BMJ,* 2006: 332; 294-297 https://www.bmj.com/content/332/7536/294

[3] Consensus Statement on Conscientious Objection in Healthcare: http://blog.practicalethics.ox.ac.uk/2016/08/consensus-statement-on-conscientious-objection-in-healthcare/ accessed 22.7.22

assessed by tribunals who could test their reasonability and sincerity. Hiring authorities should generally be allowed to make hiring decisions on the basis of whether the possible employees are willing to perform procedures to which others have a conscientious objection. Practitioners who are exempted from performing procedures on conscientious grounds should be required to compensate society for their failure.to fulfil their professional obligations. Medical students should not be exempted from learning how to perform basic procedures they consider to be morally wrong. Practitioners should be educated to identify the basis of their objections and to reflect on the influence of cognitive bias in their objections.

Savulescu gives four reasons for the view that there should be little scope for conscientious judgment in healthcare. Respect for conscientious refusal is inefficient because it causes patients to waste time, energy and money; it is inequitable because some patients, less informed of their entitlements, will fail to receive a service which they should have received; it is inconsistent with other practices in healthcare where doctors are not permitted to act on their own views; and it is unprofessional because '*… to be a doctor is to be willing and able to offer appropriate medical treatments that are legal, beneficial, desired by the patient, and part of a just health care system'.*[4]

Savulescu's practical recommendation is straightforward. If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.[5]

Sulmasy defends a very different view. He argues that '… *one should not readily empower the state to compel its physicians to alienate themselves from their deepest moral convictions'.*[6] Rather, we should exhaust every available alternative before requiring a doctor to act against his or her deeply held, self-identifying moral beliefs. Without claiming that conscientious objections can never be trumped by other considerations, he recommends that we set a very high bar before compelling performance in violation of conscience.[7]

Sulmasy's view is grounded in his account of the nature, and (from which account it follows) the primacy, of conscience itself. Conscience, he says, is the disposition to act in accordance with a commitment to *uphold one's deepest, self-identifying moral beliefs*. It is an expression of moral agency. Of course, a person's conscience can err, so acknowledging its primacy does not

[4] Savulescu, J. ibid
[5] Savulescu, J. ibid
[6] Sulmasy, Daniel. What is conscience and why is respect for it so important? *Theoretical Medicine and Bioethics,* 2008, 29: 135-149 https://pubmed.ncbi.nlm.nih.gov/18758994/
[7] Sulmasy, D. ibid

imply a belief in its infallibility. We can expect general agreement about some moral items of moral knowledge because they are so obviously true (for example, 'it is wrong to inflict unnecessary pain'). But given the imperfect nature of our moral knowledge and reasoning, moral disagreements between us are inevitable. Thus, because we are all moral agents, we owe each other mutual respect, both in the practice of healthcare and in the rest of life.

How, then, does Sulmasy think we should go about determining whether it is legitimate for a state, a profession or an institution to compel performance by a doctor against his or her conscientious judgment? Sulmasy suggests that we decide the matter, in particular circumstances, by asking three questions about the practice – that is, the action or the refraining from action - for which a doctor seeks tolerance.

First, we should consider whether the doctor's practice undermines or contradicts the principle of tolerance itself. If it does, then the practice does not deserve tolerance. So, for example, if a doctor were to refuse to treat a Jehovah's Witness for pneumonia simply because of the doctor is hostile to people of that religious persuasion, her refusal would hardly deserve tolerance. But if she refused to operate on a patient because the patient would not allow blood transfusions, her refusal would deserve our tolerance.

Second, we should consider whether the doctor's practice entails a substantial risk of serious illness, injury, or death for those who do not share the belief that is said to justify the practice. A serious risk of injury or death to a patient would constitute grounds for compelling the doctor's performance. But (and here's the nub of the current controversy) inconvenience, psychological distress or mild symptoms on the part of a person seeking a service would not constitute grounds for compelling the doctor's performance. For '*mutual respect for conscience demands that we ought to be willing to be inconvenienced, if necessary, for each other's sake.'*[8]

Third, we should consider whether the practice for which the doctor seeks tolerance is an action or a refraining from action. Greater moral justification should be needed to compel a doctor to *perform* an action than is, in general, required to compel a doctor to *refrain* from an action. No one would object if an institution compelled a doctor to *refrain* from proselytizing her patients. But a much stronger ethical justification should be needed if an institution wanted to compel a doctor to *perform* a procedure to which she had a conscientious objection.

It is clear that there is some common ground between the two positions, in particular that an emergency which threatens a serious risk of injury or death to a patient would constitute grounds for compelling a doctor's performance. It is also clear that there are profound differences between the two positions, differences explained or at least reinforced by differing

[8] Sulmasy, D. ibid

views about (on the one hand) the nature and goals of medical practice and (on the other) about the nature and *modus operandi* of conscience itself. Savulescu's view treats conscience as a mere personal preference. Sulmasy's view treats conscience as a self-identifying commitment to personal integrity.

Since doctors are increasingly being asked to intervene in situations which have little or nothing to do with treating disease, the profession, and indeed the wider society, needs to work out a principled way of resolving disputes about the proper scope of, and proper limits to, respect for conscientious judgment in healthcare.

My hunch is that we will not be able to do this unless we clarify three things. First, the exercise of conscience is not to be understood as an expression of a mere personal preference (like a taste in food or wine): rather it is a matter of integrity, that is, a serious self-identifying moral commitment. Second, the role of doctor is not to provide whatever the patient ('or consumer') wants: rather it is to (offer to) treat injury or disease. Third, in a well-ordered society the state's authority over doctors does not extend to compelling them to violate their consciences: on this particular matter, it is to preserve that kind of individual liberty which is at the heart of everyone's flourishing.

Bernadette Tobin

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The Plunkett Centre for Ethics is a joint centre of the Australian Catholic University,
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Cabrini Hospital, Melbourne, and
Mercy Hospital, Melbourne.

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The ethical challenges of responding to catastrophes

Paul Brereton KC

Catastrophes pose enormous moral and ethical challenges: not only to victims and their families, but also to those who respond to them. In these opening remarks I will focus on what I think is the major sequelae of catastrophes, namely moral injury.

Catastrophes are a moral minefield. It is now well established that exposure to trauma can initiate PTSD. But there is also the serious risk that sustained exposure to suffering can have a more insidious effect: it can breed indifference, and this can be exacerbated if the environment is geographically and/or culturally remote from one's moral home. The moral compass can waver, if it not constantly checked and calibrated.

Then, there is the ethical dilemma that constantly inevitably arises in the context of catastrophe, because the circumstances and constraints will demand decisions about whose interests and welfare is to be prioritised, and at what cost to others? How these ethical dilemmas are resolved can have devastating implications for those making such decisions: later regret at an act or decision perceived to have been wrong – whether contemporaneously or retrospectively – and recognition that one's moral compass may have strayed, can inflict moral injury, with potentially lifelong consequences.

Moral injury differs from PTSD. Moral injury arises from perpetuating, failing to prevent, bearing witness to, or learning about, acts that transgress one's deeply held moral beliefs and expectations; this can be deleterious in the long term emotionally, psychologically, behaviourally, spiritually and socially[1]. These transgressions can be individual acts of commission or omission, the behaviour of others, or bearing witness to intense human suffering. Because the experience is at odds with core ethical and moral beliefs, it results in serious internal conflict, associated with guilt and shame.[2][3]

In this way, it differs from PTSD, where that association is with fear. While naming the condition is new, its existence is ancient.[4] There is evidence of it in a Sophocles tragedy, through the

[1] Brett Litz et al, Moral injury and moral repair in war veterans: A preliminary model and intervention strategy' (2009) 29 Clinical Psychology Review 695, 700.
[2] Shira Maguen and Brett Litz, 'Moral Injury in Veterans of war' (2012) 23 PTSD Research Quarterly 1,1.
[3] Brett Litz et al, 'Moral injury and moral repair in war veterans: A preliminary model and intervention strategy' (2009) 29 *Clinical Psychology Review* 695, 698.
[4] Maggie Puniewska, 'Healing a Wounded Sense of Morality', *The Atlantic* (online, 3 July 2015) https://www.theatlantic.com/health/archive/2015/07/healing-a-wounded-sense-of-morality/396770/

American Civil War, and among World War II airmen tasked with bombing civilians.[5] In a memoir of his experience in Vietnam one author reflects:

> *'I watched a man die on a trail near the village of My Khe. I did not kill him. But I was present, you see, and my presence was guilt enough.'*[6]

While most studies of moral injuries arise from war and warlike experiences, other catastrophes are likely to be fertile ground for moral injury. So how is this to be addressed?

Treatment for moral injury presupposed that anguish, guilt and shame are signs of an intact conscience and expectations about goodness, humanity and justice. In other words, moral injury is only possible if acts of transgression produce dissonance; and dissonance is only possible if the subject has an intact if impaired moral belief system. Put simply, psychopaths do not incur moral injuries. This means that underlying beliefs remain available, but they are less accessible due to the consequences of moral injury (in particular, shame and withdrawal), and there is conflict, confusion, and black-and-white thinking about whether one can be good and moral and meritorious after having experienced severe transgressions. So, those who genuinely seek help are struggling, but still capable of reclaiming goodness and moral directness, and forgiveness and repair is possible.[7]

There are two routes to moral repair and renewal: (1) psychological – and emotional – processing of the memory of the moral transgression, its meaning and significance, and the implications for the individual, and (2) exposure to corrective life experience.

The first involves the individual disclosing and thinking deeply about what they did (or failed to do); breaking through experiential thought which entails shame and expectations of mortification and rejection, and examining and challenging negative beliefs and expectations.

The second corrective element, exposure to corrective life experience, involves increasing the accessibility of positive self-judgement by doing good deeds, and positive judgements about the world by seeing others do good deeds, as well as by giving and receiving love and care. It also involves an element of atonement. This counters self-expectations of moral inadequacy and the belief of being tainted by past acts.[8] So, to cope ethically with catastrophes and their sequelae, we need to constantly check and calibrate our moral compass, and to understand moral injury, and support those who have them to obtain support.

[5] *Ibid.*
[6] Tim O'Brien, *The Things They Carried*; quoted in *Ibid*.
[7] Brett T Litz, Nathan Stein, Eileen Delaney, Leslie Lebowitz, William P Nash, Caroline Silva, Shira Maguen, "Moral injury and moral repair in war veterans: A preliminary model and intervention strategy", *Clinical Psychology Review 29* (2009) 695-706 at 701.
[8] Ibid.