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PHYSICIAN'S CONSCIENCE AND HECs: FRIENDS OR FOES?

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Introduction

The conscience of a physician has been one of the major determinants not only of the morality of specific acts of the physician, but also of the relationship between the physician and his patient. The practical importance of the physician's conscience requires a setting in which the physician has the authority to make appropriate medical decisions for his or her patients and to determine the ethical limits that form the boundaries for these decisions. As the basis for the authority for clinical decisions has changed from physician beneficence (paternalism) to patient autonomy (self-determination), mechanisms such as hospital ethics committees (HECs) have developed to assure attention to the patient's right to self-determination in the clinical setting. The tension that can result from a clash between the physician's conscience and the recommendations formulated by an HEC is the focus of this paper.

All areas in which there may be tension between the mandates of a physician's conscience and recommendations from an HEC cannot be explored here. Attention will be directed to the impact on the conscientious physician that HECs have when making recommendations concerning policy or patient care issues, and, conversely, the impact on HECs in their disagreements with physicians concerning ethical issues.

Conscience: What is it?

Martin Benjamin in *The Encyclopedia of Bioethics* (1, pp. 469-73) mentions three major conceptions of conscience: conscience meaning internal moral sense; conscience as internalized social norms; and conscience meaning integrity. According to Benjamin, the reliability of conscience as an internal moral sense can be attributed to its divine origin or to its being a reflection of our true moral self or some combination of the two. This absolutist definition of conscience is difficult to defend as

a moral force in today's clinical setting, since it leaves little room for internal or external conflicts or for compromise when considering these conflicts.

Conscience as internalized social norms is at the opposite end of the spectrum from conscience as an internal moral sense. In this view, conscience represents learned norms (particularly those learned in childhood). Consequently, any mandate from one's conscience can be overturned by learning a stronger appeal that contradicts the initial mandate. This concept of conscience has little if any internal normative import and therefore little moral authority. It is, however, the definition often used by those attempting to effect a rapid change in the moral climate (2).

The third conception of conscience, that it relates to a sense of integrity, is the one to which most in medicine would subscribe. This concept embodies reflection about both an act or moral position and one's conception of one's self as a moral being. This concept inexorably weaves integrity of the self with conscience. As Benjamin says, "the focus is not so much on the objective or universal rightness or wrongness of a particular act as on the consequences for the self of one's performing it" (1, p. 470). Conscience is, by this definition, a moral voice for an individual independent of ability to universalize its individual mandates. Conscience in this sense presupposes a thoughtful moral consideration of a particular act or at least of an analogous situation before pronouncing the act as "good" or "bad." If the act in question enhances integrity it is "good". If it decreases or overrides personal integrity it, by definition, "goes against" one's conscience.

Beauchamp and Childress (3, pp. 470-483) in discussing conscience propose a definition similar to the "integrity" definition proposed by Benjamin. They suggest that conscience is "an internal sanction calling attention to the actual or potential loss of a sense of integrity and wholeness in the self" (3, p. 476) and that a "good conscience is associated with integrity, psychological wholeness and peacefulness" (3, p. 476). They contend that an individual's conscience involves an awareness of and reflection on his or her acts in relation to his or her own standards.

Is the conscience of a physician a professional equivalent to her personal conscience, or is there a professional conscience, which directs the physician in her professional role, separate from personal conscience? If conscience is an internal moral sense derived in an *a priori* manner, then the admonitions of conscience are absolute in both personal and

professional activities, and are equivalent. If conscience is internalized social norms, the conscience of the professional might be more advanced and educated in the consideration of professional issues, but this is only an extension of the personal conscience through education.

If conscience is related to one's integrity, then, as professional education and socialization progresses, adding to the concept of self, the conscience of the physician will be expanded to include professional issues and attitudes. The ideals of right and wrong in medical practice depend upon this professional education and socialization. These ideals are continually influenced and reinforced by members of the profession during the physician's years of practice. In this manner professional ideals become integrated with personal ideals and the physician's conscience is reflective of this integration.

Although there are physicians who would likely define conscience in each of the ways suggested by Benjamin, I believe most would agree that professional conscience is not distinct from personal conscience in medical practice.

The idea of a *universal* professional conscience, which will not allow certain actions such as abortion or euthanasia, is called into question when members of the profession disagree on what the professional's conscience should tell him and even disagree on which issues are issues of conscience. Moral consensus concerning a specific issue may not convince an individual physician as to its rightness and worthiness of integration into his moral self and may therefore not be an issue of conscience for that physician.

HECs: Their role and activities in today's healthcare organization

It may be valuable to consider briefly the present position of the HEC in the healthcare institution before discussing tensions between mandates from a physician's conscience and the educational, policy, and patient care recommendations of an HEC.

HECs began in the late 1970s and early 1980s as an outgrowth of the burgeoning field of contemporary bioethics. Members of early HECs saw as their mission the protection of the patient as a person while in the clinical setting, and therefore paid a great deal of attention to issues of "patient rights." Many HECs have evolved beyond the "patient rights" stage. They now see themselves as the institution's secular "conscience," which defends the integrity of the institution as a moral entity. HECs may

also act as a bridge (relating to ethical issues) between the institution and the wider community (4, Chap. 14).

Essentially all HECs are considered advisory. HECs have a membership which represents the major clinical areas of the healthcare organization (HCO) and includes one or more members not directly affiliated with the HCO. These non clinical "community members" are there to broaden any discussion within the HEC so that it includes considerations of socio-economic, cultural, ethnic, legal, and regulatory issues. Because of the diverse nature of HEC membership and its limited advisory role, an HEC's functions depend mainly on discussion and consensus-building rather than on authority and expertise (5, Chap. 8).

HECs: Threat to a physician's integrity (conscience)?

Since HECs have a broader perspective and agenda than the conscience of the individual physician, it stands to reason that there may be areas of conflict between these markedly different approaches to ethical determinations in the clinical setting.

The approach to "ethics" by an HEC is by nature secular and strives to consider and represent the prevalent societal views on the issue in question. Discussions within an HEC often include articulation of specific parameters sanctioned by society in the form of laws, regulations and court decisions. Its mechanism for deciding on an appropriate ethical position is consensus-building and its position may or may not fully represent the moral views of all, or of any one, of its members.

It is this attempt at maintaining a broad perspective that has enhanced HECs' ability to take on the role of "interested third-party" in important ethical discussions; to be less concerned about outcomes of contentious issues than about maintaining an appropriate process for consideration of these issues; to be non-judgmental in its relationships except when society at large has already made a judgement concerning the issue at hand; to respect ethical and religious positions of the participants in an ethical problem without embracing or even agreeing with those positions; to remain committed to helping appropriate decision makers work through a problem without embracing the agenda of any one of the participants; to act as a means of clarification of the problem at hand without advocating for a particular outcome; and to inform and educate about the issues at hand or to mediate if indicated and desired.

HEC members bring their values and individual consciences to

discussions within the committee, but as members they must be willing to accept actions and positions which are antagonistic to these values. By their very nature, HECs have no conscientious positions other than those of society and the known and articulated values of the parent institution.

In contrast, the ethical position of the physician, when based on conscience, is informed by long-standing, traditional "medical ethics." This tradition reaches back to Hippocrates for its base and considers beneficence toward the patient as its primary goal. The HEC often needs to consider the physician's conscientious position in its deliberations, but it will usually be concerned with a much broader analysis of the issue at hand.

Physicians, who see their role as more authoritarian and whose consciences support this role, may perceive that the necessarily secular outlook of the HEC is a constraining force that does not allow for adequate consideration of their conscientious positions. These physicians may therefore consider HECs a serious threat to their integrity.

Consider the issue of refusal of life sustaining treatment by a patient when the treatment in question would usually be curative with little risk to the patient (Jehovah's Witness cases come to mind). Many physicians have stated that their conscience will not allow them to do nothing while a patient under their care dies when he could easily have be saved. This occurs even though the physician may recognize that present laws and a number of important court decisions support the patient's right to make this decision without outside interference. An HEC would be remiss if it did not use its knowledge of law and court precedents in recommending specific institutional policies supporting this right or in supporting the authority of the patient in particular cases of this type, even though these positions may diametrically oppose the conscientious position of the attending physician.

In these cases the physician continues to retain the authority to withdraw from the care of the patient after assuring appropriate transfer to another physician. But, for many, this "out" is less than satisfactory, since the physician may believe that integrity has been compromised by the assault on his conscientious position (6). In discussing integrity Beauchamp and Childress suggest that *moral* integrity actually has two aspects; a coherent integration of all aspects of one's life over time, and a faithfulness and willingness to defend the moral values upon which one's life depends (3, p. 471, note 4). Many physicians believe, rightly or wrongly, that this ability to maintain fidelity and defend fundamental

moral values in situations of this type have been taken from them while leaving them with the moral responsibility to do "what is best for the patient".

Therefore for many conscientious physicians the HEC truly does represent a threat to integrity and this issue needs further discussion and clarification by these physicians and HEC members in each HCO.

HECs as defenders of physicians' integrity

On the other hand, HECs may become the last bastion for defending the conscience of the physician as an important moral factor in clinical decisions within the rapidly changing healthcare arena. As managed care and other business-based mechanisms are applied to the delivery and payment for healthcare, the position of the physician faced with conflicting obligations has become more troubling from an ethical perspective. Physicians directly affiliated with certain managed care organizations have had to compromise on conscientious positions and modify actions in ways that they consider ethically problematic. Professional organizations are attempting to address the professional issues associated with managed care, but specific problems faced by particular physicians may not lend themselves to being resolved by general principles and guidelines developed and advocated by large professional organizations.

In the future, a strong, highly-regarded HEC may be able to help the physician maintain his integrity and allow his conscience to be heard. Few if any HECs are actively addressing professional ethics issues, presently. But with the necessity for greater attention to "organization ethics" (7) in the HCO of the future and the possibility (likelihood?) that the HEC will take on this task, attention to professional ethical issues in this context may fall to the HEC.

Physician's conscience: Threat to HECs?

Members of HECs have voiced complaints about physicians who denigrate or overrule their recommendations concerning specific cases or who contradict their efforts at appropriate policy development and ethics education for the HCO. Physicians have been accustomed to holding significant power in making decisions concerning patients and concerning the operation of the entire HCO. In spite of recent changes, they

continue to command respect and, in many HCOs, are at the top of the decision-making pyramid.

When there is a disagreement between a physician and an HEC relating to the morality of an act or position, the physician may attempt to ignore the HEC and its recommendations. More commonly, the physician will be willing to discuss the issue with members of the HEC. But, if after discussion, that physician's conscientious position is not compatible with recommendations from the HEC, subsequent support of the HEC and its activities may well decrease. If a physician perceives that the HEC is a mechanism for erosion of his legitimate moral authority with patients, he may become an outright opponent of the HEC and attempt to neutralize its authority.

It can be argued that the HEC only represents decision-making parameters promulgated by the larger society. Accordingly the HEC may actually prevent potential problems for the physician who might do something which, although sanctioned by his conscience, is against the law or counter to the presently prevailing mores of the community. This argument, although logical, does not consider the important emotional reaction to a threat to one's integrity and so may not allay the physician's negative feelings toward the HEC. Powerful physicians in the past have been able to block the formation of HECs in a number of HCOs and, within others, to rob them of their proper position.

HECs have little inherent power so, to do their appointed task, they must have the support of physicians. HEC members should attempt to understand the physician's conscientious objections to certain ideas and interventions and should be willing to deal with these objections in an informed and open manner. As they are being formed and before beginning their work, HEC members need to explain to the medical staff and to particular individual physicians (critical care physicians, ICU directors, others in areas where ethical dilemmas are likely to surface and where HECs are likely to become involved) exactly what they do, thus assuring physicians that the HEC can be helpful in acknowledging issues of conscience even when they run counter to generally accepted societal positions. An attitude of openness and the knowledge that the societal parameters monitored by the HEC may change with a new law or a new court decision or a new community wide consensus will help in defining for the conscientious physician exactly what the HEC is and assure her that the HEC will consider her legitimate moral authority in all of its dealings with her and her patients.

Summary

No matter the future of healthcare financing and management, physicians of conscience and integrity must still be an important force in the consideration of ethical issues. The traditional role for the conscientious physician — being the only or even the major determinant of the morality of specific clinical decisions — is, for better or worse, no longer in effect. Much of this authority now belongs to patients and HECs are the mechanism within HCOs to help maintain this authority and to observe, comment on, recommend, and occasionally "regulate" the ethics of the healthcare arena.

It is natural that these mechanisms for addressing areas of moral uncertainty create a certain tension. This tension should be acknowledged by conscientious physicians and HEC members. Total agreement on all moral issues in the clinical setting is impossible and should not be a goal. However, the respectful recognition of the importance of each perspective by both HEC members and conscientious physicians, and cooperation in developing effective mechanisms to address real differences, are possible and desirable. All who are interested in the ethics of healthcare now and in the future should support these endeavors.

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