Medical Ethics and the Externalization of Agency

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ABSTRACT: In this paper I position recent controversies regarding conscience protection for healthcare workers as part of a more general trend in medicine – I call it the "externalization of agency." Agency is externalized when the perspective of one agent (in this case, a healthcare worker) on her own actions is subverted to the perspective of another agent or group (e.g., a patient, employer, or professional or legal body). After illustrating this phenomenon with a recent case in which a midwife was fired and effectively blacklisted for refusing to perform abortions, I examine other cases to which it applies, including euthanasia. I note the similarities between the externalization of agency and the seemingly opposite phenomenon of excessive paternalism. In each case one agent's perspective is entirely coopted by another. The remedy to both problems is collaboration and respect for the agency of all parties.

1. Conscience Protection: Some Striking Case Studies

Ellinor Grimmark, a midwife and mother of two, recently – and reluctantly – left her native Sweden for nearby Norway in order to practice her craft. Why? Because her pro-life beliefs led to her being effectively blacklisted from employment as a midwife in her own country. Despite Sweden's shortage of midwives – a shortage that led to Ms. Grimmark's being paid a stipend of $1900/month while studying midwifery – and despite the fact that midwives are seldom called upon to perform abortions anyway, she suffered revocation of her stipend and of three employment offers because of her intention not to participate in abortions, as we read in this account:

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> In spring 2013, with one term left in her studies, she asked supervisors at the hospital where she planned to work to accommodate her conscience rights. She received a furious call from one manager. "How could you even think of becoming a midwife with these opinions?" Ms. Grimmark recalls the manager screaming. "What would you do if a patient who'd had an abortion came to you bleeding?" Ms. Grimmark tried to answer that she would help a woman in that condition, but the voice on the phone kept screaming. Ms. Grimmark was told she wasn't welcome. A few days later a text message informed her that her stipend would be cut off.[1]

Amazingly, after a two-year legal battle, her claims of discrimination have been rejected at the local and national level by a discrimination ombudsman, a district court, and Sweden's national labor court. Sweden's Health Professionals, an association of midwives and other medics, welcomed the high court decision. Its Vice-President, Ann Johansson, said: "People seeking care should not have to think about your own opinions."[2] Apparently, what Ms. Grimmark would describe as "exercising my conscience rights" or "practicing midwifery but not abortion," her potential employers and professional association called "having unacceptable opinions" and "making patients think about them." Their perspective won out, at least for the moment. Grimmark plans to appeal her case to the European Court of Human Rights.[3]

While American and Canadian midwives are not subject to this particular policy, conscience protections are eroding at an alarming rate in these countries as well. Although the 2015 Canadian Supreme Court ruling that permits assisted suicide specifies that it does not require physicians to participate in this practice, the College of Physicians and Surgeons of Ontario *does* require "effective referrals." As human rights lawyers Deina Warren and Derek Ross point out, this policy development – a world first – is deeply disturbing:

> Demanding that physicians participate in MAID [medical assistance in dying, i.e., assisted suicide] imposes state-approved morality on physicians, enforcing moral conformity. It...eliminates any room for dissenting and independent views on deeply

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[1] "Sweden Blacklists an Anti-Abortion Midwife," *The Wall Street Journal* (April 10, 2017), https://www.wsj.com/articles/sweden-blacklists-an-antiabortion-midwife-1491768904.

[2] "Swedish Anti-Abortion Midwife Loses Court Case," *BBC News (*April 13, 2017), http://www.bbc.com/news/world-europe-39587154.

[3] "Swedish Midwife to Take Abortion Beliefs Fight to Higher European Court," *Fox News* (April 24, 2017), http://www.foxnews.com/world/2017/04/24/swedish-midwife-to-take-abortion-beliefs-fight-to-higher-european-court.html.

contested moral principles, and it does so with the weight and authority of the state, meaning that the state has the ability to impose sanctions for falling outside the scope of what it deems permissible.[4]

In the United States conscience protection has been in serious jeopardy at least since the advent of Obamacare. Despite several rounds of negotiation regarding accommodations, Obamacare has required objecting business owners to facilitate employees' obtaining contraceptives. Recently Ronit Stahl, along with Ezekiel Emanuel, one of Obamacare's principal architects, has co-authored an article in the prestigious *New England Journal of Medicine* arguing that conscience protection in the medical field should not be allowed at all: "Objection to providing patients interventions...that the profession deems to be effective, ethical, and standard treatments...is unjustifiable."[5] Stahl and Emanuel favor allowing physicians to opt out of participating directly in procedures to which they object, but they insist that "conscientious objection still requires conveying accurate information and providing timely referrals to ensure patients receive care."[6] They are fully aware of the harsh alternatives generated by their proposed policy: "Healthcare professionals who are unwilling to accept these limits have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession."[7]

As in the case of the Swedish midwife, physicians under the policy devised by Stahl and Emanuel would be subject to re-definition of their own actions by an external agent. For a physician opposed to sterilization, for example, declining to participate in it would no longer be called "practicing medicine but not sterilization" or "following my conscience" but would instead be labeled "failing to provide effective, ethical[!], and standard treatments" or perhaps even "dereliction of duty." In the remainder of this article I argue that the denial of conscience protections is part of a more general trend in medicine

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[4] Deina Warren and Derek Ross, "Physicians, Conscience, and Assisted Dying," *Policy Options* (May 4, 2017).

[5] Ronit Y. Stahl and Ezekiel J. Emanuel, "Physicians, Not Conscripts: Conscientious Objection in Health Care," *New England Journal of Medicine* 376 (2017): 1380–85. For helpful commentary, see Wesley J. Smith, "Pro-Lifers: Get Out of Medicine!" *First Things* web exclusives (May 2017), https://www.firstthings.com/web-exclusives/2017/05/pro-lifers-get-out-of-medicine.

[6] Ibid.

[7] Ibid.

that I call the "externalization of agency." I examine other cases to which externalization applies, including abortion. I conclude by noting the similarities between the externalization of healthcare workers' agency and the seemingly opposite phenomenon of excessive paternalism, and I suggest ways in which both problems can be addressed.

2. Externalized Agency: Definitions and Difficulties

Before we go on to examine additional cases of what I am calling externalization of agency, a definition is in order. As I am using the term, agency is "externalized" when one agent's perspective on her own actions is entirely subverted to the perspective of another agent or group – e.g., a patient, an employer, or a professional or legal body. As we saw, that is what happened to Ellinor Grimmark. Her perspective on her midwifery practice was supplanted by the perspective of her potential employers and, eventually, that of the lawyers opposing her in court. That is, the unique and *prima facie* veridical perception that she had of her actions – as the one who was performing them – was systematically denied and replaced with a perception that another agent or group of agents external to the action were able to impose.

This sort of externalization is deeply problematic for both theoretical and practical reasons. On the theoretical side, as I just noted, an agent's first-person perspective on what she is doing is *prima facie* veridical. Normally, what someone thinks she is doing is what she is in fact doing. Contrast the less-straightforward process of external observation for generating knowledge of what an agent is doing. For example, suppose that I find a colleague crouched under his desk, muttering in a language that I do not understand. Even though I can see and hear him, I do not know what he is doing. I can imagine many possibilities. He may be searching for his lost contact lens while reciting Latvian poetry, trying to repair his computer using a manual written in Korean, or hiding from his students and attempting to cast an invisibility spell on himself.[8] To know what he is in fact doing, I have to ask him. If he says, "I'm talking on the phone with my Iranian aunt and the reception is much better down here," I normally have no good reason to tell him that he is not in fact talking with his aunt but doing something else.

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[8] I borrow this example from my earlier paper, "The Limits of Double Effect," *Proceedings of the American Catholic Philosophical Association* 89 (2015): 143-57.

That is not to say that agents are infallible regarding their own actions. One can occasionally be ignorant or mistaken or self-deceived about such things. Sometimes such mistakes are detectable by external observers. For example, if instead of "I'm talking to my aunt," my colleague says "I'm fighting in World War II" or "I'm winning the Olympic slalom ski race," I can point to objectively verifiable evidence that his description of his action is incorrect. It is not possible to do either of those things by crouching under one's desk. But the fact that such responses could call for immediate psychiatric evaluation serves to show that the normal, expected state of things is that an agent's description of her own action will be correct. Absent evidence of confusion or deception, it is epistemically irresponsible simply to replace an agent's own characterization of her act with someone else's.

An agent's characterization of her act could, of course, be correct but incomplete, as occurs when we engage in rationalization. We present only the most favorable descriptions of our actions while ignoring less positive but equally relevant descriptions. Sometimes other agents can point out – or at least suggest – additional accurate descriptions of our actions. That sort of thing is well and good and does not count as externalization of agency. Again, agency is externalized when one's perspective on her own actions is entirely subverted to another's perspective – generally without explanation (and often without even a claim) regarding some unreliability of the agent's process of introspection. Unlike pointing out the rationalization of others, the externalization of agency is primarily and fundamentally an exercise of will (the will to power, we might say) rather than of intellect. So, to return to Grimmark's case, her screaming manager told her that she held "unacceptable" opinions (i.e., opinions that the manager chose not to accept) incompatible with midwifery and then refused to listen to Grimmark's own characterization of her beliefs and actions.

At first glance, Stahl and Emanuel may seem to fare better than Grimmark's manager. They appear to offer objective criteria for overriding some conscientious objection when they say it is "unjustifiable," for they are claiming to object to treatments "that the profession deems to be effective, ethical, and standard." But that appearance is superficial. In addition to being hopelessly vague (how effective? how is "ethical" defined? at what point does a treatment become "standard"?), their criteria are not objective at all. "The profession" – that is, the sort of people currently in power in professional associations – decides what treatments count as "effective, ethical, and

standard" and thus what treatments less-powerful professionals must offer. To avoid the charge of advocating the externalization of dissenting professionals' agency, Stahl and Emanuel would have to offer and defend criteria that actually were based on objective ethical norms and standards of effectiveness. For example, one might reasonably argue that it is unjustifiable (because unjust) to refuse to participate in providing treatments that are immediately necessary to preserve patients' lives or treatments that one has already agreed to provide for a particular patient. But Stahl and Emanuel offer no such objective norms, standards, or criteria. As with Grimmark's manager, they simply assert that the perspective of those in power should prevail over that of the agent performing (or declining to perform) the act in question.

This theoretical problem with externalization of agency substitutes a description based on a less-reliable external point of view for one based on a more-reliable first-person perspective on an action. Thus it is related to a more practical problem, viz., the situation in which the external characterizers do not just form *beliefs* about the agent's actions but form *policy* – often with serious consequences. As we saw with both Grimmark's case and with the proposal by Stahl and Emanuel regarding conscience rights for healthcare workers, they try to redescribe the action of someone declining to participate in activities that violate the person's conscience by labeling them as "failing to provide adequate care." On this basis they want to force practitioners out of their countries or professions. Alternatively, if the externalization is sufficiently successful, the practioners could decide to adopt the external perspective by silencing their own consciences, but this is hardly a promising technique for fostering high standards of ethics and integrity among healthcare professionals.[9]

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[9] As we have noted, I am not claiming epistemic infallibility for conscientious objectors. People are occasionally mistaken about the nature of their own actions. Importantly, conscience protections – the ability to decline to do what one considers unethical – do not constitute a claim of *ethical* infallibility on the agent's part either. I can, without inconsistency, acknowledge that it is deeply problematic to force a Hindu to cook or eat beef while I happily munch my own burger. Similarly, especially given the abundance of alternative providers, even those who believe that contraception is God's gift to women can recognize that it is a serious ethical violation to force conscientiously objecting Catholic business owners to participate in providing that "gift."

3. Abortion and Externalization

As we saw at the beginning of this paper, Canadian physicians are suffering from the externalization of their agency in the matter of assisted suicide. Refusal to provide "medical assistance in dying" (as it is labeled) threatens their ability to practice medicine in Ontario. The fact that participation would be violating their consciences is ignored in favor of a description under which participation is the "standard of care" and thus more inviolable than one's "personal morality." Similarly, in Sweden a Christian midwife's unwillingness to perform abortions is not called "integrity" or "conscientious objection" but "failing to provide essential care." Thus firing her for this failure is not "discrimination" or "violating free exercise of religion" but "upholding professional standards." Such phenomena, while certainly distressing, are not particularly surprising when we consider that agency has long been distorted and denied in political discussions of both abortion and euthanasia. So as to focus our discussion here, I will examine abortion in this section, but the parallels with euthanasia are not difficult to see.

In the case of abortion, it has long been observed that what the fetal human "is" (and thus what may be done *to* him or her) seems to depend on what another agent – the mother – *thinks* he is and *wants* done to him. According to American law, the killing of a fetal human may be properly labeled "medical care" or "murder," depending upon the mother's beliefs and desires. The fetal human is presumed to have no agency, and physicians are expected to externalize theirs by adopting the beliefs and desires of a woman who is seeking either abortion or prenatal care. In one of the rare articles still capable of shocking my undergraduate students, abortionist Lisa Harris describes in striking terms the conceptual and practical difficulties with this way of defining humans and their actions:

> As a third-year resident I spent many days in our hospital abortion clinic. The last patient I saw one day was 23 weeks pregnant. I performed an uncomplicated D&E procedure.... Then I rushed upstairs to take overnight call on labor and delivery. The first patient that came in was prematurely delivering at 23–24 weeks. As her exact gestational age was unknown, the neonatal intensive care unit (NICU) team resuscitated the premature newborn and brought it to the NICU. Later, along with the distraught parents, I watched the neonate on the ventilator. I thought to myself how bizarre it was that I could have legally dismembered this fetus-now-newborn if it were inside its mother's uterus, but that the same kind of violence against it now would be illegal, and

unspeakable.[10]

While Harris seems to find this tension a bit unsettling, she immediately goes on to toe the party line by claiming that the "vital difference" between the baby in the abortion clinic and the one in the NICU was the mothers' "hopes and wishes" for these babies. (I do not think that she meant the word "vital" to be taken in the literal sense that would have made her claim obviously correct.) Like Harris, feminist writer Naomi Wolf attempted – more successfully, I think – to acknowledge the moral tensions surrounding the pro-choice perspective. She expressed frustration with the incoherence of external definitions of fetal human beings based on the "hopes and wishes" of others:

> Any happy couple with a wanted pregnancy and a copy of *What to Expect When You're Expecting* can see the cute, detailed drawings of the fetus whom the book's owner presumably is not going to abort, and can read the excited descriptions of what that fetus can do and feel, month by month. Anyone who has had a sonogram during pregnancy knows perfectly well that the four-month-old fetus responds to outside stimulus – "Let's get him to look this way," the technician will say, poking gently at the belly of a delighted mother-to-be. *The Well Baby Book,* the kind of whole-grain, holistic guide to pregnancy and childbirth that would find its audience among the very demographic that is most solidly pro-choice, reminds us that: "Increasing knowledge is increasing the awe and respect we have for the unborn baby and is causing us to regard the unborn baby as a real person long before birth." So, what will it be: Wanted fetuses are charming, complex, REM-dreaming little beings whose profile on the sonogram looks just like Daddy, but unwanted ones are mere "uterine material"?[11]

Under the incoherent theory long associated with the pro-abortion movement, then, the mother's perspective on both the fetal human and its killer's actions reigns supreme. If she wants the baby, he is in fact a baby and killing him is murder; if she does not, then "it" is "uterine material" and "terminating" its existence is "medical care."

But matters are not so simple in practice. As so many post-abortive mothers and those who counsel them know, that description often does not reflect women's own experience. They do not experience the empowerment that could be expected to come with determining another human's moral status

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[10] Lisa Harris, "Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse," *Reproductive Health Matters* 16 §31 (2008): 74–81 at p. 77.

[11] Naomi Wolf, "Our Bodies, Our Souls," *The New Republic* (October 16, 1995), pp. 26–35 at p. 32.

or shaping the agency of a medical professional. They do not even necessarily persuade themselves that fetal humans are "tissue" rather than "babies." They feel intensely pressured by partners, parents, poverty, immaturity – in short, external agents and circumstances. There are many stories of this sort, but let us consider just one here. For another project, I conducted a set of two-hour life-story interviews of several apparent moral exemplars: people who had won national awards for their community service. In response to a question regarding the greatest interpersonal loss she had ever experienced, one of my interviewees, a woman now in her fifties, recalled an abortion that she had had during her first year of college:

> I was doing pretty great, but...I didn't have all the life tools, meaning skills of right and wrong. So I had a boyfriend at that time, and he was just magical to me, and he would come up every weekend or I would come back home. And eventually what happened was I got pregnant, and I was freaking out. And he told me, "We're gonna get married, and it's gonna be okay, and everything's gonna be awesome," and I believed it. But...he picked me up from the train on a weekend and said, "I can't be there. My parents want more for me, and my father would kill me, literally kill me." He was being very scared and serious. And he was, like, "You've got to have an abortion"; and I had no other choice, in my mind. Now I know I had a choice. But in my mind, when I was 18, I thought I had no other choice, because there's nobody around that could've helped me. At that time they had group homes for pregnant girls, and I went to all these group homes and none of them had a place for me, and they all just turned me away. Literally, I was left to fend for myself. So I made an appointment and went ahead and had the abortion. It was a clean facility and it was a legit facility, but the experience itself was horrifying. And they literally had to hold me down, three nurses had to hold me down and I was saying, kind of in the beginning, "I don't want to do this," and they said I was kind of already in it. So I feel like I was forced to have it and it was just a whole horrible, horrible, horrible thing.[12]

Clearly, that is not the story of an overly-empowered agent who has coopted the agency of everyone else involved. Even before the part involving physical restraint, her experience is one of seeming to have no choice – no agency – in her own actions. Despite her hopes and wishes, her agency is seemingly externalized too. First it was forfeited not to any specific individual or group

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[12] Life-story interview with author, January 12, 2017. The project was made possible through the support of a grant from the Beacon Project at Wake Forest University and the Templeton Religious Trust. The opinions in this publication are those of the author and do not necessarily reflect those of the Beacon Project, Wake Forest University, or the Templeton Religious Trust.

but to a combination of other agents and circumstances, and then, at least as she perceived it, forcibly overtaken by the nurses at the clinic.

With abortion we see that externalization can go both ways. In theory the pregnant woman determines the status of the fetal human and the nature of doctors' actions upon him, but in practice she may not herself be freely exercising her agency and may be unduly influenced or even coerced by the very medical professionals who are supposedly adopting her perspective. That latter phenomenon – paternalism, or the ceding of the agency of patients to that of doctors – has been around for a very long time.

4. Conscience Denial and Paternalism: Two Sides of the Same Coin?

At first glance, paternalism and the plight of the Swedish midwife with whom we began look like opposites. Paternalism involves excessive authority and influence on the part of a healthcare worker over a patient. Grimmark was allowed too little authority over even her own actions. With paternalism, the caregiver's judgment regarding treatments and the information offered her patients is accepted uncritically. In Grimmark's case, her professional judgment was given no consideration at all. But in light of our analysis in this paper, we can see paternalism and the denial of conscience protection as flip sides of the same coin of agency externalization: the denial of the legitimate, first-person perspective of the agent regarding his or her own actions and decisions. This externalization of agency, whether that of the patient or that of a dissenting healthcare worker, is often well-meaning. Usually, the justification given for overriding agency is the good of patients – a desire to protect them from decisions that could threaten their well-being, even at the expense of their own agency or that of others.

The fundamental problem with both paternalism and denial of conscience protections seems to be lack of trust: in patients, in health-care workers, and ultimately in oneself. The lack of trust in others is manifested by a failure to listen to the priorities and concerns of the non-expert patient or the dissenting professional. His or her judgment is assumed to be inadequate to ensure the patient's well-being. Rather than considering how those priorities and concerns might be addressed – either by satisfying them through accommodating actions or by revising and resolving them through dialogue and rational persuasion – another individual or body simply dismisses the judgment of the patient or of a healthcare worker in favor of her own, more trusted, judgment. In some cases the explanation may dead-end there – that is, the decision-making agent really

may harbor a general distrust of the person whose agency he or she externalizes. But I suspect that more often the deeper issue is that the externalizing individual or body does not have sufficient self-trust or trust in the available processes. That is, the individual or the body cannot be confident of finding a solution that both preserves everyone's agency and promotes the patient's well-being. A medical professional or body then tends to feel obligated to give the patient's well-being first priority.

If I am correct, the externalization of agency, while deeply problematic, is perfectly understandable and not likely to respond to simple solutions. On that cheery note, I will close by noting some possibilities for beginning to address it.

5. Some Partial Solutions

The most obvious and perhaps most efficient solution to denial of conscience protection is simply to forbid such denial: to pass laws requiring healthcare bodies and employers to accommodate those healthcare workers who conscientiously object to providing particular substances or procedures. There appears to be a bit of irony in such an approach. Doesn't it just add another, more remote, layer of agency externalization that will override the perspective and decisions of the more-immediately-involved individual or body? I think that the answer to that question is "not necessarily." Preventing a second party from overriding the agency of a third party can be distinguished reasonably from overriding the second party's agency over his or her own actions. Further, we can appeal to a distinction between positive and negative requirements. The second party is attempting to require a third party to *perform* an action that he or she finds morally problematic, while a law of the sort that we are discussing would merely tell the second party to *refrain* from requiring particular people to perform such actions in violation of their conscience. Further, since that leaves open the possibility of the action's being performed by someone else, it does not amount to requiring that the second party *not* facilitate an action that this second party thinks to be important or obligatory.

As is perhaps obvious, an essential part of the solution, whether or not we pass the sort of laws that I just described, is to gain trust through respectful dialogue and creative problem-solving. As we have learned with the decline of paternalism over the last few decades, the best course of treatment – the one most conducive to a patient's overall well-being – takes his or her goals, values, and resources into account. That is, failing to listen to the patient's

priorities and instead imposing one's own judgment regarding how to achieve his or her well-being is often counterproductive. We need to recognize that a lack of dialogue between authoritative bodies and conscientious objectors is likely to be similarly counterproductive. It will result in evasion of the requirements, loss of integrity, and/or the exit of individuals with integrity from the profession, none of which are desirable outcomes. To avoid them, we must find ways to encourage and facilitate meaningful dialogue and good-faith efforts to find solutions acceptable to all parties. While I can make general suggestions toward this goal – for example, representation at meetings of policy-making bodies and agreements regarding up-front disclosure of the limitations of one's practice – I must leave the details to those with boots on the ground in the medical field.