Nurses and Conundrums of Conscience

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Abstract

There is controversy today concerning conscience, conscientious objection, and health care professionals. Nurses reportedly have said that they are expected to "set aside" or "deaden" their conscience to work in health care. Given the morally serious work that nurses do, this expectation is puzzling and concerning. It suggests a misunderstanding of the meaning of conscience, a conundrum which could be contributing to the persistent problem of nurses' moral distress and to the chronic shortage of nurses. This conundrum may be confounding efforts by society to formulate coherent policy on conscience and conscientious objection by health care professionals.

In this essay I offer reflections on various understandings of conscience as they relate to nurses. I suggest that when conscience is conceptualized in terms of relativism and subjectivism, setting aside one's conscience may seem possible and even understandable in a morally pluralistic society. However, conscience may not be entirely subjective or relative but, rather, deep-seated and grounded in objective moral norms, and, as a result, it is difficult to completely ignore one's conscience and troubling to act contrary to it. Because persons of good will may disagree in their conscientious judgments, tolerance, or mutual respect for conscience, is needed. Thus, reasoned discussions are necessary to formulate policy on conscientious objection that is coherent, morally defensible and avoids misunderstandings. It is my hope that this essay contributes to the discussion and to clearing up the conundrums.

Nurses and Conundrums of Conscience

Conscience: The faculty or principle which pronounces upon the moral quality of one's actions or motives, approving the right and condemning the wrong
(Oxford English Dictionary 2008).

There is much confusion and controversy in health care today concerning conscience, conscientious objection, and conscience clauses as they relate to health care professionals and some of the activities that they may be asked to perform.[1] Nurses, in particular, have said that they are expected to set aside their beliefs and values and do what others tell them to do even if this would mean acting contrary to their conscience (Laabs 2009). Some nurses have said that they must "deaden" their conscience in order to work in health care (Juthberg et al. 2007). These statements are puzzling. The right of conscience has long been recognized as a fundamental human right. Consider, for example, that freedom of belief and the right of conscience have been codified in the Universal Declaration of Human Rights over sixty years ago and remains so today (Universal Declaration of Human Rights 1948).[2] Still, these statements by nurses indicate that, as nurses, they believe they are expected to suppress their conscience and, thus, may not avail themselves of this right.

This apparent belief raises a number of questions. Why would a particular segment of society be expected to relinquish a human right shared by all? What is even more baffling is why some nurses seem to accept this apparent expectation. To freely enter into a profession knowing that you will be stripped of one of your fundamental rights as a result of being in that profession is perplexing. Perhaps nurses are not aware of this "expectation" until after they have become nurses, or, perhaps this is not an expectation at all but, rather, an unfortunate misunderstanding. Whether expectation or misunderstanding, the setting aside or deadening of

conscience can have serious implications for nurses, patients who are cared for by nurses, and the health care system that employs nurses.

The expectation that nurses must set aside their conscience in order to work in health care may explain a problem that has plagued nursing and has been recognized recently in the literature as moral distress.[3] Although the literature may not use the word "conscience," *per se*, studies imply that violations of conscience are related to moral distress and to compromised moral integrity among nurses (Hardingham 2004; Kelly 1998; Laabs 2007), as well as other health care professionals, such as psychologists (Austin et al. 2005) and pharmacists (Sporrong, Hoglund, and Arentz 2006). Some propose that moral distress is unavoidable in health care (Sporrong et al.) and, thus, represents an occupational hazard for all health care professionals. Among nurses, moral distress and compromised moral integrity have been associated with nurses losing their capacity for caring, avoiding patient contact, failing to give good physical care to patients (Corley 1995; Davies et al. 1996; Kelly; Redman and Fry 2000), burning out, and leaving the nursing profession (Corley; Fowler 1989; Fry et al. 2002; Kelly). Given the chronic shortage of nurses, which is predicted to worsen and so far has defied a full explanation (Black, Spetz, and Harrington 2008; Rosenfeld and Adams 2008), the conundrums of conscience that confound nurses are in need of attention.

In this essay I offer some reflections on various understandings of conscience as they relate to nurses and the work they do. I then suggest that when conscience is conceptualized in terms of relativism and subjectivism, setting aside one's conscience may seem possible and perhaps even an understandable demand in a society with a wide range of moral points of view. However, such conceptions of conscience are not helpful to nurses who are often faced with decisions having serious moral implications, may contribute to nurses' moral distress, and may confound efforts by society to formulate a coherent and morally defensible policy on conscientious objection by health care professionals. I then suggest that conscience may not be entirely subjective or relative but, rather, deep-seated and grounded in objective moral norms, and, as a result, it is difficult to completely ignore one's conscience and troubling to act contrary to it. In an effort to ensure that the right of conscience is protected for all, and that no one is under the impression that they are expected to relinquish their right as a condition of employment, or for any other reason, discussions about the meaning of conscience are necessary. It is my hope that this essay contributes to the discussion.

Understandings of Conscience

Common Understandings

Conscience has been described in various ways, some of which may be vague and confusing. Conscience commonly is defined as "the sense or consciousness of the moral goodness or blameworthiness of one's own conduct, intentions, or character together with the obligation to do right or be good" (Merriam-Webster 2008). A common metaphor for conscience is "the voice within," one that pipes up when moral conflict arises and one must decide between good and bad, right and wrong. The assumption is that the voice somehow is

infallible, and, when one has acted contrary to how the voice directs, the person may feel guilty. This is sometimes known as judicial or retrospective conscience (Sulmasy 2008). On the other hand, if one acts in conformity with the voice, one typically feels good about themselves, something which nurses, among others, have referred to as having a sense of moral integrity (Laabs 2007). The voice within informs moral judgment before performing an action, and somehow the voice knows what the good and right action would be. However, it has been found, at least among nurses, that for exactly the same ethical problem, the action that one nurse feels would be the good and right thing to do and would preserve their moral integrity, another nurse claims that same action would violate their integrity (Laabs 2007). Apparently the "voice within" and its understanding of what is good and right for a particular situation can vary among individuals, even to the point of contradiction. When that happens, logic tells us that both voices cannot be correct, but the crucial question, which one is correct, remains unanswered, and, thus, this conception of conscience is not particularly helpful.

Another common conception is that of two competing voices within the same individual. A familiar image is two small characters, one devilish and the other angelic, perched one on each shoulder whispering into a person's ears and advising the person which route to take or to avoid. However, on what grounds do these voices make judgments about right and wrong? How do we decide which of the two impish characters to heed and which to ignore? Should we take the advice of Shakespeare's Hamlet, for example, in his declaration that, "There is nothing either good or bad, but thinking makes it so" (act 2, scene 2)? According to this line of thinking, if the voice thinks that something is good or intuits that it is, then that makes it good. However, what do we do when one voice thinks one thing is good, and the other voice thinks the opposite? (After all, the two characters are, by nature, oppositional to each other and, thus, will give conflicting advice.)

This conception of conscience is not helpful to nurses who must make immediate decisions, often about matters of life and death. It leaves the nurse in a state of moral paralysis, often at the unfortunate time when the nurse does not have the luxury of deliberating with the two feuding characters and deciding which voice is the proper one to follow. Not only does this risk a misinformed conscience and the "voice within" leading the nurse astray, feuding voices may also result in no decision (which is a decision in itself) or a forced choice based on expedience rather than a free choice based on sound reason. Correct moral action would essentially be reduced to a matter of moral luck.[4] As a patient whose life depends upon the nurse choosing the good and right action, this is a risky predicament in which to be.

Academic Understandings of Conscience

Psychology has contributed to our understanding of conscience, most notably through the work of Sigmund Freud, the concept of the superego, and the feelings of moral approval or disapproval and associated feelings of reassurance or anxiety that originate from our relationship with our parents. Conscience is the result of conditioning and our spontaneous reactions, impulses, and feelings associated with a particular activity and, thus, are largely shaped by

factors that may not be based on rationality but instead on a desire to ward off anxiety if one acts contrary to the superego. Just as is the case of one "thinking" something into being good, acting on impulse or feelings rather than on reasoned premises can leave the individual at risk of condemning as wrong that which is right and approving as right that which is wrong. This possibility is worrisome when we consider that nurses are very much involved with activities, such as the removal of life-sustaining treatment, and the administration of nutrition and hydration where decision-making based on impulse or emotion may turn out to be arbitrary and illogical and may cost a patient their life.

Psychology also informs us that the sense of right and wrong develops in relationship to rules and regulations as they pertain to membership in a particular group. When one belongs to a particular group, or wishes to belong to it, one must abide by the rules of the group to be considered a good member. Here right and wrong are equated with meeting or failing to meet the standards of the group with which one identifies (e.g., the class, the team, the gang). For nurses, this would mean that the good nurse is the one who abides by the rules and regulations of the profession or of the institution in which the nurse is employed. However, similar to the question raised by Hamlet's declaration noted earlier, does the mere fact that a group deems something good or bad, necessarily make it so? How did the group arrive at its conclusion? Was it by consensus, positional rank, custom, flipping a coin, or something else? Conforming to a rule or regulation simply because it is a rule or regulation and even at the risk that the rule or regulation may be misguided suggests a legalistic notion of morality, which can be a dangerous way of thinking. One need not look any further than to the euthanizing of thousands of psychiatric patients during the late 1930's and 1940's in Poland and elsewhere at the hands of nurses who believed that the good nurse was the one who abided by the rule of unquestioning obedience to physician orders (Benedict, Caplan, and Page 2007).

Psychology further informs us that conformity to rules and regulations may develop into rebellion or resistance to the standard set by the group or authority figure, as is often seen in adolescence. Conscience may become a matter of individual self-assertion in which, rather than conforming to the rules of others, one makes one's own rules and the motto becomes, "*My* conscience is *my* guide." Although maximally autonomous on its face, the thinking remains legalistic in that one allows oneself only two alternatives – obey the rules of authority or rebel against them in favor of the rules that I choose. Either way, the grounds upon which rules are decided remain in question. We look to philosophy for possible guidance.[5]

Egoism, emotivism, and intuitionism have been suggested as guides to moral conduct, but their soundness as moral guides also has been challenged. Just as a rule or regulation may be morally misguided, so also might one's desires, feelings, or intuitions. John Stuart Mill (1986), for instance, believed that conscience was a complex set of feelings that prevented us from doing wrong. Consider, however, nurses whose conscience relies solely on their set of feelings when, for example, they feel compelled by emotion to relieve patients of suffering by relieving patients of their lives. Perhaps relying on the nurse's set of feelings may not always be in the best

interest of the patient who, for example, may not desire euthanasia, or the hospital who may not desire litigation as a result of the actions their employees feel compelled by emotion to take.

Less reliant on emotion, Heidegger described conscience as "a silent call to our potentiality for being ourselves" (Juthberg et al. 2007, 329). While this sounds lofty and inviting, for a nurse who must make an immediate decision, for example, about whether or not to attempt to resuscitate a newborn baby with a severe disability, it is vague and unhelpful. Upon considering Heideggerian philosophy as it pertains to nursing, Nelms (1996) sees the call of conscience as, "an authentic openness that transforms nurses' awareness of others" (368). Again, while appealing, I am not sure how helpful this is for the nurse who is caring for a comatose patient in need of a feeding tube and is being confronted by members of the patient's family engaged in a heated debate over what to do. Here I am quite sure that the nurse is aware of others.

Neither is Friedrich Nietzche helpful, as exemplified by his famous quote, "All credibility, all good conscience, all evidence of truth come only from the senses."[6] Should nurses rely on their senses when they must allocate limited resources among the many victims wounded in a natural disaster? It seems these understandings of conscience risk leaving the nurse in a predicament of arbitrariness and illogic while in the midst of pressing situations that demand a more robust moral defense than recourse to feelings, potentialities, and the senses. What guidance do professional organizations provide?

Conscience and Professional Organizations

The descriptions of conscience by professional organizations, when present, tend to be vague and limited in scope. For example, the American College of Obstetrics and Gynecology (2007) defines conscience as ''the private, constant, ethically attuned part of the human character'' (2). The American Medical Association (AMA 2008) does not define conscience, mentions it only as it relates to medical students, and takes no official position on conscientious objection. While AMA Policy H-295.896 on conscience clauses has been commended for recommending that conflicts be discussed in medical school, it has been criticized for vagueness and problems with interpretation (Protection of Conscience Project 2008). In regard to practicing physicians, Opinion 9.12 of the AMA Code of Medical Ethics is referenced which states that the patient-physician relationship is contractual in nature and that both parties are free to enter into or decline the relationship, but the physician must not decline services for discriminatory reasons (AMA 2006, 296; Parsi 2007).

Similarly, the American Nurses Association (ANA) does not define conscience. The ANA Code of Ethics, however, defines conscientious objection as "the moral or religiously based refusal to participate in an activity otherwise required, perhaps even by law" (Fowler 2008, 67). Specifically this refers to a refusal to participate categorically in a specific intervention, such as abortion, or in a particular intervention with a specific patient such as discontinuation of life-sustaining treatment, or to a moral objection to a pattern of behavior such as habitual short staffing that result in substandard nursing practice that endangers the well-being of patients (Fowler 68). Considered a matter of duty to self, conscientious objection provides nurses a way

out of conflicts by affording them the opportunity to make a strenuous objection on moral grounds. Nurses are said not to be merely instruments of the orders of others, whether physicians, employers, or patients, but moral persons who are responsible for their own decisions (Curtin 2008, 85).

The ANA description of conscientious objection is helpful for nurses because it specifies that it is an *activity* in which the nurse unconditionally objects to participating, and not the *patient* for whom the nurse objects to providing care, and, thus, reduces the risk of discrimination. Nurses are rightly recognized as having moral agency and accountability for their actions. However, the code of ethics notes that conscientious objection does not insulate the nurse from the negative consequences of having exercised one's conscience. This caveat may be problematic because it sends a message to nurses that they leave themselves open to retribution should they exercise their conscience, and, moreover, their professional organization may not support them. Thus, while conscientious objection is recognized as valid by the professional organization, support of conscience may depend on the nature of the objection. In short, while nurses are free to exercise their conscience, they do so at their own risk.

Professional nursing organizations outside of the United States also vary in the degree of helpfulness to nurses. The Royal College of Nursing (2007) website does not mention the word "conscience" or the phrase "conscientious objection." The Code of Ethics by the International Council of Nurses is also silent (ICN 2006). Although the Nursing and Midwifery Council Code of Conduct does not mention conscience or conscientious objection *per se*, the Council does have an "advice sheet" on conscientious objection (2008a; 2008b). This document, while it does not define conscience, explains that there are only two areas of care to which nurses have the right to object, direct abortion and assisted reproduction procedures, and that nurses are accountable to the law in justifying their objection. The Canadian Nurses Association (CNA) Code of Ethics acknowledges the possibility of a conflict of conscience and defines conscientious objection as "a situation in which a nurse requests permission from his or her employer to refrain from providing care because a practice or procedure conflicts with the nurse's moral or religious beliefs" (CNA 2008, 23). The CNA Code of Ethics goes on to provide a step by step procedure for the conscientiously objecting nurse to follow when declaring a conflict of conscience. Like the Nursing and Midwifery Council Advice Sheet and the ANA Code of Ethics, the CNA code reminds nurses that declaring a conflict of conscience may not protect them against formal or informal penalty (43-46).

Thus, while professional organizations may offer some support of conscientious objection in their codes of ethics or related documents, they do not define conscience, *per se*, and advise nurses who exercise their conscience that they take a risk and should not depend on the organization to back them up. This is borne out by a stinging commentary by Tadd (1995) in which he admonishes the Royal College of Nursing for apparently threatening nurses with professional negligence who conscientiously objected to participation in a measles vaccination campaign,[7] and for barring a nursing student from taking his final exams who refused to

participate in electroconvulsive therapy for patients on the grounds of conscience and, thus, ending his nurses training.

Confusing messages are given to nurses and to the public about nurses' right of conscience and the role it plays for them. For example, in response to a recently proposed regulation that would increase awareness of and compliance with existing laws in the United States that protect federally funded health care providers' right of conscience and prevent discrimination toward those who exercise their right of conscience (United States Department of Health and Human Services 2008), a representative of the ANA and the ANA Code of Ethics, was interviewed by Cable News Network (CNN). Expressing opposition to the regulation, the ANA response was as follows:

> We [nurses] don't go to school to learn how to make god-like decisions. That's not what it's about for us. It's about trying to get to where the patient is and helping the patient make their own decisions. Nobody appointed us the ultimate person to pass judgment (ANA 2008).

This is a curious response to the regulation, and suggests a misunderstanding of conscience, seeing it as something that one imposes upon others rather than something one imposes upon oneself. Any judgment that takes place is by the nurse upon himself should he fail to follow his conscience, not a judgment passed upon the patient by the nurse. The response seems to miss the point that the purpose of the regulation is to protect nurses from discrimination in the exercise of their fundamental right to object to participation in activities that are contrary to their conscience, not a means to allow nurses to discriminate against or condemn patients. Because it misses the point, the ANA response might be viewed as an unfortunate and regrettably inadvertent endorsement of discrimination against the very persons the organization claims to represent. I seriously doubt that was the intent. Yet, while it is widely known that televised interviews are often edited and, thus, may not reflect the interviewee's full response, the ANA appears to be sufficiently satisfied with the interview clip that the ANA has posted it on its website without qualification.

To add to the confusion, the response appears to contradict provision five of the ANA Code of Ethics which reads, in part, "The nurse owes the same duties to self as to others, including the responsibility to preserve integrity…." (Fowler 2008, 158). Interpretive statements of the provision go on to address moral self-respect, wholeness of character, the duty to express one's own moral point-of-view in practice even when one's view may differ from that of others and even when one's view may not prevail. Nurses are encouraged to compromise only if the compromise preserves their integrity and does not jeopardize the dignity or well-being of the nurse or others (Fowler 160). However, the ANA response to CNN, by opposing proposed regulation in support of conscience, almost seems to discourage nurses from having their own moral point of view and, instead, to encourage nurses to ignore their conscience. The result would be that the actions of nurses would be directed solely by others. This is a troubling possibility. One cannot help but wonder if this line of thinking may have contributed inadvertently to the findings reported in a recent analysis by the ANA comparing nursing

education in 1965 and 2002 in which the authors concluded that despite efforts to increase levels of education, nurses continue to be governed by the decisions of others (Donley and Flaherty 2008).

Nurses' Notions about Conscience

Little is known about what nurses, as individuals, think about conscience. What is known suggests that there may be some confusion and misunderstanding of conscience as it applies to the role of nurses. To illustrate this point I offer a few anecdotes from my experience as a clinician and as an educator of nurses, and from a modest research study that I conducted among nurses who had recently graduated from a baccalaureate program in nursing (Laabs 2009).

The following comments are from an experienced nurse about a situation in which she was to provide care for a Jehovah's Witness patient who was refusing a life-saving blood transfusion. (The nurse herself was not a Jehovah's Witness.)

> I would have to set aside my conscience in that case and honor the patient's wishes [i.e., not transfuse the patient]. I would not, however change my beliefs or values to match his.[8]

Without the benefit of further explanation by the nurse, it seems the nurse is saying that to honor the refusal of a blood transfusion by a competent adult patient would require her to ignore her conscience. Does this suggest that her conscience ordinarily requires her to transfuse a patient in need of blood even if this would mean doing so against the patient's will? I doubt that she was implying a willingness to force treatment on an unwilling patient. Such an action would be considered unjust, as the right of the competent adult patient to refuse treatment is firmly established in law and ethics.[9]

Perhaps what the nurse means by her conscience are the values and beliefs that inform her judgment about what would be the good and right thing to do in this situation. While she is willing to "set aside" or not act on her judgment that a blood transfusion would be good for the patient and her desire that the patient should accept a blood transfusion, she is not willing to change her values and beliefs such that her judgment conforms to that of the patient. However, the implication that nurses might be expected to change their values, beliefs, or conscience, such that they would be congruent with that of the patient is odd. In a world of moral pluralism where, theoretically, every patient could have a different moral point of view, changing one's conscience to fit each patient would be an impossible task, or, it would necessitate that nurses have no conscience at all.

Respecting a patient's right to conscience need not require nurses to act contrary to theirs. Yet, strangely, this may be exactly what is happening. In the words of another nurse commenting about assisting with an abortion or other procedure to which she morally objects, "But if someone's beliefs …required me to take an action I consider against my beliefs, then I would be forced to set aside my conscience and provide the care."[8] Coercion is implied in this statement, along with a directive to ignore one's conscience and do what one is told. Why would nurses accept such a directive? Perhaps it has to do with how nurses understand conscience.

If conscience is equated with mere personal values and beliefs, such as personal preferences or agreement, to act contrary to one's conscience would be no more problematic than deferring one preference for another or agreeing with someone for the sake of expediency or courtesy. Such an understanding would trivialize conscience and reduce ethical decision-making to a matter of etiquette rather than morals. This line of thinking, whether intentional or not, may be supported in the literature on nursing ethics and professional responsibility, which, at the same time, acknowledges that acting contrary to one's conscience is an assault on one's integrity and an affront to one's identity. Grace (2009) explains.

> Our ethical responsibilities for good care may often include following the considered wishes of patients for something with which we don't agree or for which we wouldn't wish. However, it is important to keep in mind that the healthcare decision is not based on our preferences but ideally on the lifestyle, culture, beliefs, and values of the person that it will most affect. Thus, we must understand whether we have the facts straight, to what extent we are likely to be affected by going against our conscience, and how enduring the insult to our sense of identity is likely to be (87).

Besides understanding conscience as a matter of preference or agreeableness, the willingness to set aside one's conscience seems to be related to one's sense of duty to others. One nurse comments, "It is so important for the nurse to support a patient's decision even when it is not in line with his/her own beliefs. The best we can do is to educate patients, so that they can make informed decisions."[8] Another nurse has this to say, "Yes, I think it is important for the nurse to always work as an advocate for the patient, even if patient wishes contradict the nurse's beliefs [of what is the right thing to do]."[8] Again, without the benefit of further explanation by the nurses, these comments suggest that it is the duty of the nurse to advocate for the patient understood as a directive to back the patient's decision simply because it is the patient's decision and regardless of the nature of the decision. This seems to be a rather literal, legalistic understanding of advocacy which, in a complex health care environment, often calls for a more reflective and studied approach.

Interestingly, a willingness to set aside one's conscience for the sake of duty is not limited to nurses. A physician who, despite both his public moral opposition to capital punishment and the AMA prohibition of physician participation in executions, takes part in lethal injections of condemned prisoners. He remarks that:

> I strongly feel that this [capital punishment] is an end-of-life issue, and my duty to care for a patient in a humane way and to address the pain and suffering at death far outweighs any other of my personal ethical or moral choices as a physician" (Gawande 2006a, 3).

This suggests that conscience is a choice of one option among others, and adherence to one's conscience carries less moral weight than performing one's duty, and, thus, one's duty may trump one's objection to participating in an activity one is convinced is morally wrong.

Even if conscience is viewed from a perspective of extreme individualism, "I make my own rules of conscience," one's conscience might be overridden by a strong sense of duty. A physician who participates in executions and who sees it as his job to follow the law comments:

> if I live in a state [where capital punishment is legal] then I would see it as being an obligation to be available [to assist with executions]…[and] I think that if I had to face someone I loved being put to death, I would want that done by lethal injection, and I would want to know that it is done competently" (Gawande 2006b, 1226).

These sentiments were shared by a nurse who also participated in executions despite the prohibition by the ANA. "As a …nurse…,I hope I will never become someone who has no problem taking another person's life. But society had decided the punishment and had done so carefully" (Gawande 1227). These comments suggest that these professionals felt a stronger sense of duty to society than to their professions and the long-standing traditions of those professions that object to participation in executions, or to their personal objections to it. Thus, a choice had been made between competing authorities – the law of the land (that condones executions), the prisoner as patient (who we can assume would rather not be executed), one's professional organization and tradition (that prohibits participation in executions), and one's conscience (that morally objects to executions).

The famous Stanley Milgram experiments remind us of the difficulty many people have breaking with authority even when they are totally convinced of the wrongness of the actions the authority is asking them to take.[10] They also remind us of the rationalization that can take place to reduce the sense of complicity with the wrong done. Interestingly, although people may not derive any satisfaction from the actions they take, they derive satisfaction from having pleased the authority, proud of having done a good job and having obeyed authority under difficult circumstances. Milgram (1973) comments on accountability and obedience to authority:

> The essence of obedience is that a person comes to view himself as the instrument for carrying out another person's wishes, and he therefore no longer regards himself as responsible for his actions. Once this critical shift of viewpoint has occurred, all of the essential features of obedience follow. The most far-reaching consequence is that the person feels responsible to the authority directing him but feels no responsibility for the content of the actions that the authority prescribes. Morality does not disappear – it acquires a radically different focus: the subordinate person feels shame or pride depending on how adequately he has performed the actions called for by authority (76-77).

When nurses come to view themselves as instruments for carrying out the wishes of others, they may no longer see themselves as responsible for their own actions. This may be a reflection of a culture within nursing, still present today, in which nurses continue to be governed by the decisions of others (Donley and Flaherty 2008), even to the point of sacrificing their integrity and identity. Historically nurses have been governed by the decisions of physicians and institutional administration but, based on the comments of the nurses above, it may be that patients have been added to the list. Within such a culture, respecting patient autonomy would require subjecting nurses to heteronomy such that good nurses are the ones who ignore their conscience and do what others request even if it may require them to act contrary to their conscience. Still, even though one might try to set aside one's conscience, complicity with or participation in the wrongful act of another may continue to be a concern of conscience and

result in moral distress. As bemoans a physician who participates in executions, "I agonize over the ethics of this every time they call me to go down there [to the execution chamber]" (Gawande 2006b, 1226).

Although participation in capital punishment is not the everyday experience of nurses, "stress of conscience" does occur in their everyday work, and emotional exhaustion and depersonalization can result (Glasburg, Erikksson, and Norburg 2007). The source of this 'stress of conscience' can be related to a lack of time to provide the care nurses feel the patient needs, the demands of work negatively influencing one's home life, not being able to live up to the expectations of others, and having to lower one's aspirations to provide good care, resulting in nurses feeling that they must deaden their conscience in order to keep working in health care (Glasburg et al.). As one nurse commented, "I also feel that nurses sometimes ignore their 'voice of reason' and continue to work in troubling conditions for job security."[8] Loss of a sense of self and compromised personal moral integrity have been associated with moral distress, and these experiences can lessen the nurse's confidence and resolve related to decision-making (Grace 2009). As one nurse reflects:

> I think I have been timid about 'pushing' things. I would bring it up, but if even another peer who knows the physicians better than me would say, it's not worth even bringing it up to the Doc.., I would have dropped it (I am ashamed to say!), but it would bother me for a long period of time. Sometimes the unspoken word is 'not to stir things up'- after all, we are 'just nurses.' Sometimes the path of least resistance looks awfully tempting.[8]

Despite the apparent willingness to set aside their conscience, some nurses say they eventually draw a line. For example, an experienced nurse who related how she had "set aside" her conscience to provide care for a patient that was acceptable to the patient relative to his culture but morally unacceptable to her, drew the line at one activity in particular, but, at the same time, appeared to qualify her objection. "I could not take part in euthanasia…I could never do something like that regardless of another person's beliefs. [But] I guess it depends on what it [the request] is."[8]

The message that nurses are expected to set aside their conscience may be delivered inadvertently during nursing school. Even so, a new graduate insists that there are limits:

> Of course we are asked to set aside our values for the sake of economics, politics, patients' "rights," doctors' wishes, administrators' desires, etc. It's up to the individual nurse to determine how far they are willing to give up their values/beliefs and how much are they willing to accept whatever consequence (guilt, post-job stress, etc.) (Laabs 2009).

One wonders how much a nurse is able to withstand in such an environment. In a study comparing new graduates and experienced nurses, Ham (2004) found that new graduates had higher level principled thinking than experienced nurses and concluded that, while new graduates initially act based on individual moral codes, they gradually abandon personal beliefs of right and wrong and slowly succumb to environmental pressures to conform.

Toward Clearing up the Conundrums

If conscience is understood as a matter of taste, preference, feeling, intuition, or a desire for approval, and if what is good and right is subjective, changeable, and relative to person, time, or place, then one can see how one's claim of conscience can be difficult to defend and can risk arbitrariness and bias. It is understandable, then, that professional organizations would hesitate to say that they will support nurses when they exercise their conscience. It would not be unreasonable to expect nurses to set aside their conscience, and it would be understandable that nurses might accept the expectation, lest they be accused of bias or insubordination.

Is conscience really a matter of subjectivism and relativism? If it were, nurses should not be the least bit troubled when they feel they must ignore their conscience. It would be ridiculous to speak of conscience in terms of one's integrity and identity, as we commonly do. Yet, studies continue to demonstrate the persistence of moral distress among nurses and the seemingly perpetual nursing shortage. A recent study by Jensen and Lidell (2009) confirms that nurses consider conscience to be an important factor in the exercise of their profession, a driving force, as well as a restricting factor, and a source of sensitivity and awareness of the vulnerability of human beings. To expect nurses to set aside their conscience is to endorse an unfeasible stance of value neutrality toward the moral work of nursing, a perilous stance that risks indifference toward patients who have placed their lives in the hands of persons they count on to care for and about them.

The conundrums of conscience as experienced by nurses in the work they do suggests that conscience, understood as relative and subjective, is problematic for individuals and society. If conscience can mean whatever anyone wishes it to mean, then conscience can mean anything and it can mean nothing. It essentially is meaningless. If conscience is meaningless, any claim to a right to the exercise of conscience would be meaningless as well.

Conscience must be something other than purely subjective or relative. There must be some grounding in an objective moral norm that is apparent to more than just the individual making the claim. Without an appeal to an objective, unchanging moral norm, as the literature and the words of nurses illustrate, the nurse is left without a claim that is sufficiently compelling and, thus, finds no recourse but to submit to the will of others which may be based on personal preference, consensus, permission, or, in the case of duty and unquestioning obedience to authority, the demands of the figure who wields power over the nurse. How can nurses protest an injustice toward a patient, for example, if nurses cannot invoke some objective claim regarding the nature of justice?

Conscience calls for decisions to be based on an accurate understanding of the particular facts of the issue at hand, an awareness of objective moral norms, and sound reasoning. This requires the use of one's intelligence to seek the truth in forming one's conscience. The result is a prudential judgment which is an act of the intellect, not merely subjective feelings, preferences, or a sense of duty. This is not to say that affect has no place in making judgments, but only that judgments must not be directed solely by feelings or preferences and must be in accord with moral standards. Conscience is one's best judgment about what one ought to do or ought not to do in this particular situation. The fundamental question for the conscience is, "What is the good

and wise thing to do in this situation?" Because it is one's best judgment, one's integrity demands that one abide by it.

Judgments about the good and wise thing to do depend on an understanding of the facts of the issue in question and a general level of awareness of objective moral norms and knowledge of the basic principles of morality. These serve as the starting points for moral deliberation and to which one can appeal to show the truth of the particular conclusion reached after moral deliberation. Such starting points are moral truths that one is to do good and avoid evil, good being not only what is morally good, but also whatever truly perfects the human person and evil being whatever deprives human persons of their perfection or fullness of being (May 2003, 94). From these arise ways in which we can pursue the good and avoid evil. For example, we ought not to kill people, or lie, or take things that do not belong to us, and we ought to treat others with the same measure of respect that we would like them to provide to us. These are core values that are shared by all morally serious persons and are consistent with the values and traditions of nursing. They provide more defensible action guides than one's feelings, preferences, sense of duty, or one's search for potentialities of being. Granted, there can be genuine disagreement about the meaning of good, evil, objective moral truth, norms, and the fullness of human persons, but that should not translate to there being no place for these concepts in serious and sincere discussions about conscience and conscientious objection. It may be the lack of such discussions that contributes to the conundrums.

Conscience is a person's final judgment of the goodness or badness of the options available to them. People feel a sense of obligation to follow their conscience, and to act in accordance with their best judgment of what is right or wrong in a given situation. Because conscience is the awareness of oneself as a moral being, as a person having a deep-seated desire to seek and to know the truth and to act in accordance with the true and the good, one must form one's conscience carefully. Hence, one is responsible for working to inform one's conscience both with respect to the adoption of moral principles and with respect to accurate knowledge of the particulars necessary to decide a case correctly (Sulmasy 2008). To accomplish this, prudence requires that we engage in discussions, seek counsel, and consider the advice of others or of established sources of wisdom in coming to a sound moral decision. This implies a social and communal dimension to the process of moral decision-making. This stands in contrast to individualism in which, as isolated individuals, we must decide for ourselves according to our own subjective consciences and, thus, tempting us to justify and act upon self-interest, making each of us, through our own judgments of conscience, the arbiters of good and evil (Beauregard 1996). Making prudential judgments of conscience is something nurses need to be able to do and be allowed to do for their good and for the good of patients who depend on nurses to act in good conscience.

Conscience and Implications for Policy

To expect nurses to set aside their conscience and simply do what they are told would change nursing education, philosophy, and practice in a fundamental way. For example, it would

require teaching nurses not only how to prevent a patient from committing suicide, but also how to assist the patient in doing so, as long as one's assistance is permitted by law in the jurisdiction in which one is practicing. It would necessitate preparing nurses to remain silent when the lack of sufficient staff compromises patient care or risk dismissal for insubordination. It would call for the teaching of value neutrality to the extent that nurses would support and provide the highest quality prenatal care to an expectant mother and at the same time be ready to assist with her abortion should the mother suddenly change her mind and decide to terminate the pregnancy. It would further require disclosure by nursing schools to prospective students of the expectation that they must be willing to set aside their conscience. This would be needed lest schools be accused of deception and a bait and switch tactic of sorts intended to draw unsuspecting individuals into a profession in which freedom of conscience presumably is respected only to later reveal the true philosophy and actual requirements of the work they are expected to do. It would require similar disclosure by employers of nurses not only to the nurses considering employment with them, but also to the recipients of nursing services at their facilities. Codes of ethics that include statements that support nurses' right to practice according to conscience and to preserve integrity would have to be rescinded.

To say that, as policy, nurses should set aside their conscience and do only what others direct would be to say that, as policy, it is permissible to deprive a certain segment of society of the exercise of a right that is otherwise protected by the Universal Declaration of Human Rights. It would be to say that if one chooses nursing as a profession, one must be willing to relinquish the exercise of conscience and forfeit the opportunity to fulfill the deep-seated human desire to seek and to know the truth through the work one does. This is a devaluation of nurses and an assault on their dignity as human beings. To deprive one segment of society of a fundamental human right is to devalue that right and all human beings deserving of that right. If a fundamental human right can be so easily manipulated, no human right is immune and all segments of society would be at risk.

None of this is to say that the right of conscience is a limitless right. The risk of abuse of the right of conscience arises when it is understood as a right that is limited only by that which each individual deems good or bad on subjective grounds. While one may still err in conscience due to ignorance of facts or of moral rules, faulty reasoning, or emotional imbalance, this only behooves the morally serious to strive diligently to form one's conscience correctly (Sulmasy, 2008). Thus, reasoned discussions are needed to form policy on conscience and conscientious objection that is morally defensible and avoids abuse and misunderstandings.

Concluding Thoughts

Conscience understood as a matter of preference, feelings, or intuition is not helpful to nurses who often must make decisions having life and death consequences for patients. Nurses sense this deeply or they would not be troubled when the formation and exercise of their conscience is frustrated by subjectivism and relativism, dictated by authority figures or set aside in deference

to others. Such conceptions of conscience likely contribute to moral distress and compromised moral integrity, which in turn, contribute to poor patient care and nurses leaving the profession.

Conscience is rooted in a fundamental commitment to the truth and the good and one's deep-seated desire to act in accordance with that fundamental commitment and, thus, to preserve one's moral integrity. It unifies the cognitive, conative, and emotional aspects of the moral life by a commitment to moral wholeness (Sulmasy 2008, 138). It involves a commitment to uphold fundamental moral principles and, through the use of sound reasoning, arrive at a prudential judgment, and to freely act on that judgment. Thus, conscience is the most fundamental of all moral duties - the duty to unite one's powers of reason, emotion, and will into an integrated moral whole based upon one's most fundamental moral principles and identity (Sulmasy 138).

Persons of good will may disagree in their conscientious judgments. Thus, tolerance, or mutual respect for conscience, is needed. However, respect does not necessarily mean agreement, and a nurse does not have to agree with the patient's beliefs to respect the patient and provide good nursing care. Tolerance requires that we should be willing to be inconvenienced and to accommodate, if necessary, out of respect for one another's right to conscience. However, no one should be compelled to perform an action that is contrary to their conscience. That would be intolerance, which risks totalitarianism and would be especially troubling when objective truth is denied. In a morally pluralistic society, self-interest would inevitably set individuals in opposition to one another, until made to surrender to the force of power.

From a practical standpoint, conundrums of conscience, confused and conflicted by subjectivism and relativism, and expectations that nurses must set aside their conscience are simply bad for business. As an employer, one should expect low morale, high rates of error, high turnover of staff, poor performance and poor patient satisfaction. As employees, nurses should ask themselves to what extent they are willing to work where their rights are disregarded and they are expected to function as indifferent, unthinking, automatons rather than as respected, autonomous, professionals. As patients or potential patients, we should ask, in whose hands would I rather place my life? In the hands of a nurse whose conscience is sound, heeded, and freely acted upon, or in the hands of a nurse whose conscience is stunted, ignored, or dictated by others? As Thomas Jefferson aptly advised, "It behooves every man who values liberty of conscience for himself, to resist invasions of it in the case of others: or their case may, by change of circumstances, become his own."[11]

References

American College of Obstetricians and Gynecologists Committee. 2007. Opinion No. 385, November 2007: The limits of conscientious refusal in reproductive medicine. *Obstetrics and Gynecology* 110*,* 1203–1208.

American Medical Association. 2006. *Code of medical ethics of the American Medical Association: Current opinions with annotations* 2006-2007 edition*.* Author.

American Medical Association. 2008. *Medical ethics*. Retrieved January 5, 2009 from http://www.ama-assn.org/ama/no-index/physician-resources/2416.shtml

American Nurses Association. 2008. ANA weighs in on provider conscience on CNN.

Retrieved January 5, 2009 from http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/MediaBackgrounders/Provider-Conscience-video.aspx

Austin, W., Rankel, M., Kagen, L., Bergen, V., and Lemermeyer, G. 2005. To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. *Ethics & Behavior* 15 (3):197-212.

Beauregard, D. N. 1996. What is conscience anyway? *Ethics & Medics* 21 (1):1-3.

Benedict, S., Caplan, A., and Page, T. L. 2007. Duty and 'euthanasia:' The nurses of Meseritz-Obrawalde. *Nursing Ethics* 14 (6):781-794.

Black, L., Spetz, J., and Harrington, C. 2008. Nurses working outside of nursing: Societal trend or workplace crisis? *Policy, Politics & Nursing Practice* 9 (3):143-157.

Canadian Nurses Association 2008. *Code of ethics for registered nurses*. Ottawa Ontario: Canadian Nurses Association.

Corley, M. C. 1995. Moral distress of critical care nurses. *American Journal of Critical Care* 4 (4):280-285.

Curtin, L. L . 2008. Ethics in everyday language for nurses in everyday practice. In W. J.Ellenchild Pinch, & A.M. Haddad (Eds.) *Nursing and health care ethics: A legacy and vision*. Silver Spring, MD: American Nurses Association. 83-89.

Davies, B., Cook, K., O'Loane, M., Clarke, D., MacKenzie, B., Stutzer, C., Connaughty, S., and McCormick, J. 1996. Caring for dying children: Nurses' experience. *Pediatric Nursing* 22 (6):500-507.

Donley, R., and Flaherty, M. J. 2008. Revisiting the American Nurses' Association first position on education for nurses: A comparative analysis of the first and second position statements on the education of nurses. *The Online Journal of Issues in Nursing* 13 (2) retrieved January 5, 2009 from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/vol132008/No2May08/ArticlePreviousTopic/EntryIntoPracticeUpdate.aspx

Fowler, M. D .M. 1989. Moral distress and the shortage of critical care nurses. *Heart & Lung* 18, 314-315.

Fowler, M. D. M. 2008. *Guide to the code of ethics for nurses: Interpretation and application*. Silver Spring, MD: American Nurses Association.

Fry, S. T., Harvey, R. M., Hurley, A. C., and Foley, B. J. 2002. Development of a model of moral distress in military nursing. *Nursing Ethics* 9 (4):373-387.

Gawande, A. 2006a. When law and ethics collide: Why physicians participate in executions. Supplement transcript. 1-4. *New England Journal of Medicine* 354 (12):1-4.

Gawande A. 2006b. When law and ethics collide: Why physicians participate in executions. *New England Journal of Medicine* 354 (12):1221-9.

Glasburg, A. L., Erikksson, S. and Norburg, A. 2007. Burnout and 'stress of conscience' among health care personnel. *Journal of Advanced Nursing* 57 (4):392-403.

Grace, P. J. 2009. *Nursing ethics and professional responsibility in advanced practice*. Boston: Jones and Bartlett.

Ham, K. 2004. Principled thinking: A comparison of nursing students and experienced nurses. *The Journal of Continuing Education in Nursing* 35 (2):66-73.

Hardingham, L. B. 2004. Integrity and moral residue: Nurses as participants in a moral community. *Nursing Philosophy* 5 (2):127-134.

International Council of Nurses. 2006. The ICN code of ethics for nurses. Geneva Switzerland: International Council of Nurses. Retrieved January 5, 2009 from http://www.icn.ch/icncode.pdf

Jensen, A., and Lidell, E. 2009. The influence of conscience in nursing. *Nursing Ethics* 16 (1): 31-42.

Juthberg, C., Erikksson, S., Norberg, A., Sundin, K. 2007. Perceptions of conscience in relation to stress of conscience. *Nursing Ethics* 14 (3):329-343.

Kelly, B. 1998. Preserving moral integrity: A follow-up study with new graduates. *Journal of Advanced Nursing* 28 (5):1134-1145.

Laabs, C. A. 2007. Primary care nurse practitioners' integrity when faced with moral conflict. *Nursing Ethics* 14 (6):*795-809.*

Laabs, C. A. 2009. Perceptions of moral integrity among newly graduated baccalaureate prepared nurses. Unpublished manuscript, Marquette University, Milwaukee, Wisconsin, USA.

May, W. E. 2003. *An introduction to moral theology*. (2nd ed.). Huntington IN: Our Sunday Visitor.

Merriam-Webster. 2008. Retrieved December 31, 2008, from http://www.merriam-webster.com/dictionary/conscience

Milgram, S. 1973. The perils of obedience. *Harper's Magazine* December, 247 (1483):62-77.

Mill, J. S. 1986. *On Liberty*. Amherst NY: Prometheus Books.

Nelms, T. P. 1996. Living a caring presence in nursing: a Heideggerian hermeneutical analysis. *Journal of Advanced Nursing* 24 (2):368-374.

Nursing and Midwifery Council. 2008a. The code in full. Retrieved January 5, 2009 from http://www.nmc-uk.org/aArticle.aspx?ArticleID=3056

Nursing and Midwifery Council. 2008b. Conscientious objection. Retrieved May 19, 2009 from http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=4027

Oxford English Dictionary. 2008. Conscience. Retrieved December 31, 2008, from http://dictionary.oed.com/entrance.dtl

Parsi, K. 2007. Duty to treat: Conscience and pluralism. *Virtual Mentor: The American Medical Association Journal of Ethics* 9 (5), 362-364. Retrieved January 5, 2009 from http://virtualmentor.ama-assn.org/2007/05/hlaw1-0705.html

Protection of Conscience Project. 2008. American Medical Association Policy H-295.896 Conscience clause: Final report. Retrieved January 5, 2009 from http://www.consciencelaws.org/Conscience-Policies-Papers/PPPMedicalOrg05.html

Redman, B. K., and Fry, S.T. 2000. Nurses' ethical conflicts: What is really known about them? *Nursing Ethics* 7 (4):360-367.

Rosenfeld, P., and Adams, R. E. 2008. Factors associated with hospital retention of RNs in the New York City metropolitan area: An analysis of the 1996, 2000, and 2004 national sample survey of registered nurses. *Policy, Politics, & Nursing Practice* 9 (3):158-172.

Royal College of Nursing. 2007. The Royal College of Nursing. Retrieved January 5, 2009 from http://www.rcn.org.uk/

Sporrong, S. K., Hoglund, A. T., and Arentz, B. 2006. Measuring moral distress in pharmacy and clinical practice. *Nursing Ethics* 13 (4):416-427.

Sulmasy, D. P. 2008. What is conscience and why is respect for it so important? *Theoretical Medicine & Bioethic* 29*:*135-149.
Tadd, V. 1995. Moral objections. *Nursing Standard 8*(14):54.
United States Department of Health & Human Services. 2008. Regulation proposed to help protect health care providers from discrimination. Retrieved January 5, 2009 from http://www.hhs.gov/news/press/2008pres/08/20080821a.html
Universal Declaration of Human Rights. 1948. Universal Declaration of Human Rights Article 18. Retrieved January 5, 2009 from http://www.un.org/Overview/rights.html

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Endotes

1. Examples of recent controversies include the Statement by the American College of Obstetrics and Gynecology (ACOG) Committee Opinion on the Limits of Conscientious Refusal in Reproductive Medicine No 385 November 2007, the October 2008 passage of a law in Victoria Australia eliminating conscientious objection by physicians and other health care workers from participating in abortions (Gannene & Craven, October 6, 2008, "Deep irony in abortion bill," Heraldsun.com.au), and the June 2007 issue of the *American Journal of Bioethics* volume 7 number 6 devoted entirely to conscientious objection by health care professionals.

2. The collective conscience of mankind is referenced in the Preamble of the Universal Declaration of Human Rights, "Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people…" Article one refers to the conscience of the individual. "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." See http://www.un.org/Overview/rights.html

3. Moral distress among health care professionals is often defined in the literature, and is defined here as when one knows the right thing to do but constraints make it nearly impossible to pursue the right course of action. This is based on the definition by Andrew Jameton (1984) in *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice-Hall, Inc. page 6.

4. Moral luck – The phenomenon that the moral goodness or badness of some of our actions depends simply on chance. See for example http://plato.stanford.edu/entries/moral-luck/

5. Space does not allow for a more full account of the contributions of psychology and philosophy. While debatable, the authors selected for inclusion in this essay are those with whom nursing seems to be most familiar.

6. Friedrich Nietzsche. "All credibility, all good cons..." *The Columbia World of Quotations*. Robert Andrews, Mary Biggs, and Michael Seidel, eds, New York, Columbia

University Press, 1996. Retrieved January 5, 2009 from
http://www.bartleby.com/66/99/41599.html

7. Although it is not detailed in the article, presumably the nurses objected to participation in the measles vaccination program because the measles vaccine had been produced from cell lines derived from tissue from aborted fetuses.

8. Personal and informal communication from nurses in confidence

9. In the United States, the legal doctrine of informed consent is said to date back to the 1914 case of Schloendorff v. The Society of the New York Hospital, a liability case in which surgery was performed on a patient without her consent. Justice Benjamin Cardozo's classic statement in that case has become a mantra of sorts in the legal and ethics traditions of individual rights of liberty, self-determination, and privacy. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body...." See, for example, Dean M. Harris, *Healthcare Law & Ethics*, Health Administration Press, Chicago, 2008.

10. Stanley Milgram is a social psychologist who carried out controversial experiments on obedience to authority while teaching at Yale University in the 1970s. In the basic experiment, a "teacher" administered progressively stronger electric "shocks" to a "learner" upon the direction and in the presence of a researcher under the guise of a study of the effects of punishment on learning. Although no live shocks were actually delivered, the "teacher" was under the impression that he was delivering live shocks while the "learner" pretended to receive them. See Stanley Milgram, 1974 *Obedience to Authority*. New York, Harper & Row.

11. This quotation by Thomas Jefferson, the third president of the United States, is found in a letter written in 1803 to his colleague, Dr. Benjamin Rush, a physician and fellow signatory of the Declaration of Independence. See Eyler Robert Coates Sr., *Thomas Jefferson On Politics and Government* retrieved February 7, 2009 from
http://etext.virginia.edu/jefferson/quotations/jeff1500.htm#Cons