White Coat Radicals
Ethical Dilemmas and Healthcare Politicization

PODCAST 19

SOUND BITE, Dr. Mark Navin:
The primary ethical responsibility of a clinician is to recommend beneficial treatments, beneficial interventions to their patients. So if vaccines are beneficial then physicians and other clinicians, prescribers should recommend those vaccines.

00:19
Dr. Jane Caldwell:
Welcome to *On Medical Grounds*. Our guest for this episode of White Coat Radicals is Dr. Mark Navin, here to talk with us about medical ethics and politicized medicine. Dr. Navin is professor and chair of philosophy at Oakland University. His research is primarily in clinical ethics and ethics in public health.

Hello, Dr. Navin and welcome to *On Medical Grounds*.

Dr. Mark Navin:
Thank you for having me, Jane. I'm really excited to be here.

00:47
Dr. Jane Caldwell:
In 2019, you co-authored an article titled, "Reasons for vaccine refusal and vaccination behaviors." What are the most common reasons for vaccine refusal?

Dr. Mark Navin:
So the reasons people have for refusing vaccines, in particular parents have for refusing childhood vaccines, they vary depending on the vaccine.

Someone might be concerned about autism when it comes to MMR. They might be concerned about other considerations for HPV. And then clearly, we see during COVID whole set of other reasons, but in general, the most common reasons people have for either refusing or being hesitant about vaccines is about safety, or they're worried about adverse events and complications, and efficacy, right?

They believe that either the vaccine doesn't work or that it's unnecessary for them in virtue of their health history, or their strong immune system; less common reasons including ethical or religious objections that aren't so much about safety or efficacy outcomes but are about kind of intrinsic violations of sanctity or of moral requirements.

So for example, we've seen, in the context of COVID, people raise concerns about using vaccines that were developed or tested using materials that were originally derived from aborted fetuses, and then there all kinds of reasons that people might give to delay or to find an alternative vaccine schedule.

And then there are other—these reasons also bear on just differences in attitudes and beliefs that make people more or less hesitant or more accepting of vaccines.

02:22
Dr. Jane Caldwell:
I see. Could you please define vaccination behaviors?

Dr. Mark Navin:
Sure. I mean we sometimes think of vaccination as a binary choice either sort of all in as a vaccine acceptor or as a kind of committed vaccine refuser, and most people are actually somewhere on the spectrum between those extremes. Both for vaccine, and the sort of number of vaccines they accept or refuse, but also for the kinds of attitudes and beliefs they have. So when it comes to routine childhood vaccines, only 1 to 2% of Americans refuse all routine childhood vaccines, but upwards of 40% or more have some concerns about safety, have some concerns about their children may be getting too many vaccines at the same time, and more generally, there's a background of increasing distrust in medical authority, especially sort of politicized medical authority. So we might place that on a spectrum between the extremes. And as I mentioned, many Americans, maybe upwards of a quarter, are engaging in either a slowed down vaccine schedule—so that's when you get all the vaccines, but on a different schedule or an alternative schedule where you maybe skip some doses or some vaccines, but you're still receiving other doses and other factors.

03:38
Dr. Jane Caldwell:
Do medical professionals, such as doctors and nurses have reasons similar to the general public for vaccine refusal?

Dr. Mark Navin:
So both in general and in the context of COVID, clinicians, including physicians and nurses, nurse practitioners have much higher rates of vaccine acceptance of vaccination than the general public. But of course there is vaccine hesitancy and vaccine refusal among this population as well. And many of the reasons are very similar.

We recently did a study at my healthcare institution with over 5,000 employees, and found that while many of the reasons were similar, there were some distinct reasons. And in particular, we found that younger and female clinicians, especially nurses, were particularly concerned about fertility. They were not anti-vaccine, they're pro-vaccine but they, many of them, had actually been exposed to COVID and had recovered from COVID, those working in more acute care settings and on our COVID units, so they were not so much concerned about COVID as a disease. They felt they had good immune protection, but they were worried in the light of the fact that the vaccine was recently developed, about potential safety issues. And so they were choosing to delay the vaccine for that reason. And so you might see, while many of the reasons are the same or similar, right, some sort of differences, especially when it comes about physicians

and nurses who maybe have more exposure to medical errors and maybe more informed kinds of distrust of medical institutions.

05:11
Dr. Jane Caldwell:
Is it ethical for a medical professional to encourage their patients to refuse vaccinations?

Dr. Mark Navin:
Well, so the primary ethical responsibility of a clinician is to recommend beneficial treatments, beneficial interventions to their patients. So if vaccines are beneficial then physicians and other clinicians, prescribers should recommend those vaccines.

And if they're not beneficial, they shouldn't. Now of course, for almost all patients, at almost all times, recommended vaccines are going to be beneficial. So physicians ought to recommend them. But it's a difficult question, because while there are there are recognized medical disorders and allergies that might place patients at heightened risk of vaccine complications, there are also broader sort of social reasons why delaying or even abstaining from a vaccine might be useful. So for example, children who are severely mentally disabled, who have to be subject to physical restraints or chemical restraint in order to be vaccinated, there's a reasonable argument to be made that for some vaccines, delaying that vaccine or grouping them differently, might actually be best for the child.

That is to say, in trying to balance the marginal increase to their health outcomes associated with vaccination against the real assault to their person associated with coercive delivery of the vaccine.

06:34
Dr. Jane Caldwell:
In 2020, you co-authored an article, "Reasons to accept vaccine refusers in primary care." I know we just discussed a reason. Are there other ethical reasons, besides physical reasons, such as perhaps religious reasons?

Dr. Mark Navin:
So of course I think physicians should not discriminate against patients who can't be vaccinated, right, for medical reasons. But I think actually that even though physicians have a right to choose their patients, a right that the American Medical Association, I think quite rightfully defended, that the physicians have an obligation to exercise that right in an ethical way. So for example, it would be unethical to discriminate against patients merely based on their race. This isn't the same, but I think, physicians ought not either dismiss or refuse to accept families merely because they express skepticism or refusal about vaccines.

And that's largely because children need to be in care. There's no evidence that threatening to dismiss or not accept these families changes parents minds and makes them more likely to agree to vaccinate. And in fact, we know that what happens is one of three things: either these children, whose families are dismissed or not accepted into a practice, they end up with no care, they end up with substandard care they're with a naturopath or homeopath, or they end up clustered in one of the few remaining pediatricians who will accept them, which increases geometrically the risks of outbreaks in those practices. And also, I think unfairly burdens one's colleagues with families and children who are sometimes very difficult to

care for. I also think the reasons in favor of dismissal and acceptance are not very strong. There's limited evidence clinicians are at increased legal liability for maintaining these patients in their practice. Increased disease transmission risks can, I think, be well addressed in a way that pediatricians deal with having ill patients in clinic all the time. And so I think we ought to be much less complacent than frankly the American Academy of Pediatrics has recently been about this practice, which now a recent paper shows almost half of pediatricians are not accepting or refusing or dismissing these families.

08:44
Dr. Jane Caldwell:
Hmm. Is it ethical to prescribe an unproven treatment to a patient?

Dr. Mark Navin:
Well, there's no proof in science. Proof is something in logic and mathematics. And so in science we have more or less evidence. And of course we should, we would want clinicians to prescribe treatments for which there's very good evidence of their safety and efficacy, of course, there are lots of different kinds of evidence.

When it comes to pharmaceutical products, we look for FDA approval. We also look for medical societies' statements on what they think best practices are. And then, more directly with the research, we want to see high quality review studies based on sort of high quality, large sample size randomized controlled trials.

But importantly, though, I think off-label prescription is often ethical. It's a mainstay of psychiatry, of pediatrics, and in lots of other specialties, too. And so we should want physicians—especially a point about medical education—we should want physicians to be trained and not just in the core sciences, but in the ability to judge the quality and quantity of evidence so that they can actually be really well-informed and ethically responsible when they are choosing to prescribe off-label or when they are sort of deviating from maybe what has been identified as a best practice or received institutional approval.

10:02
Dr. Jane Caldwell:
Should the doctor tell the patient that this is an unproven treatment or should that patient be made aware that they're trying something that's off-label?

Dr. Mark Navin:
So I think it's a standard part of informed consent that patients are of capacity to make a decision, right? They're doing so voluntarily, without coercion, that they're well-informed about the decision and part of being well-informed about a decision is understanding the kind of evidence that there is. Patients should be informed about whether a treatment is experimental, about whether it is off-label, but for which there's a really good evidence-base. They should have an understanding of the comparative risks and benefits associated with both treatment and non-treatment. And I think that's a standard part of the informed consent process.

10:49

Dr. Jane Caldwell:

That makes sense. Now, if you were to create a Venn diagram with one circle, encompassing medical ethics, and the other containing politics, where would they overlap?

Dr. Mark Navin:

Well, I think of politics as the coordination of social activity via formal rules backed by power.

And if that's what we think politics is, I think almost all of medicine is therefore political because it's about formal coordination of activity backed by power. And I think you don't have to look far to see that. So does the patient have the power to make decisions about their care?

Well, did they have decision-making capacity and who has the power to make that decision? Is an incapacitated patient's surrogate going to be empowered to make decisions? Well, are they acting in a way the surrogate should? Who is making that decision? And we decided that both in the hospital and in the courts, are we going to allow parents to choose to refuse treatments that are beneficial for children? Or are we going to call child protective services or get an ethics consult? How are we going to bring power to bear there? And there are all kinds of contestations of power that are made both explicitly, and frankly, most of them are hidden in medicine, which I think often pretends to be relying on a very patient autonomy voluntarist model. But in fact, sort of inscribes power and all kinds of hidden ways, in ways that I think are political, which is to say medical ethics is not just philosophy, but it's about how we navigate uncertainties and conflicts between differing ethical and religious and value systems in a pluralistic democratic society. So I think in some ways it's much harder than it might first appear to be however, though, if what you mean by political is having to do with Democrats versus Republicans in our kind of partisan conflict, then sure much of medical ethics is political that way. Maybe not all of it, much of it is clearly around life issues, abortion, serialization, contraception, but increasingly also around other kinds of life issues like determination of death by neurological criteria. So for example, my hospital system has had to go to court recently, a number of times to sort of affirm the right of the hospital system to no longer treat corpses of patients who are dead because of neurologic criteria, because the family based on their religious, sort of politicized pro-life ideas, believes that those patients were alive because they maintain circulatory function. And so I think we're likely to see increased politicization of sort of ethically charged conflict in medicine, among other reasons, because we are living in a hyper-politicized time in which the political parties are increasingly polarized.

13:16

Dr. Jane Caldwell:

What do you see as the biggest ethical dilemmas in healthcare today?

Dr. Mark Navin:

I think the biggest problem is lack of access to high-quality healthcare and inequalities in that kind of access based on race and class among other things. That's not a dilemma because we kind of know what the problem is. And we know what we ought to do.

The issue is the lack of political will to solve that problem in terms of dilemmas, right? Dilemmas, when you've got two options and both of them are bad. I think one of the big dilemmas is the age-old dilemma,

which is between doing what we think yields the best outcomes, versus doing what we think best empowers patients and citizens to make decisions for themselves.

And so this occurs all the time in clinic. This is, you know, patients who have mental illness or cognitive disability or the sort. Every year, more and more millions of patients with various stages of Alzheimer's and dementia. How do you empower them at the same time that you're trying to help their families decide what's best for them?

Though in the context of COVID, we've seen a real crisis in the ethical languages we use in public health. We know that vaccines are good for people. We know that herd immunity, community protection is good for all of us. And so we're trying to use power in various ways to make that happen. At the same time, we know that vaccination is also a personal medical choice governed by the norm of informed consent, that is to say that the sort of valorization of a patient's autonomous decision-making. And so I think there's a really difficult conflict there between the late 20th century ideas about bioethics emphasizing patient rights, and a more traditional understanding of public health as focused on overall good outcomes for people.

And that's a dilemma because there aren't any good answers. And I think we, as a country, are struggling to work through that problem as we speak.

15:03
Dr. Jane Caldwell:
Should people who post on social media and politicians be held accountable to the same ethical standards as medical professionals?

Dr. Mark Navin:
Well, medical professionals have a special obligation in particular to patients, to do what's good for them. But I think even when medical professionals are speaking to the public, they also are speaking as members of a profession that has a particular ethical mission to promote health. So not just for the patients, but their communities. And in fact, professional societies, especially American Academy of Pediatrics are very explicit on this, that when pediatricians speak in public, they're governed by a kind of ethical identity to promote what is good for the health of the community. Of course we shouldn't want people in social media lying to us or politicians deceiving or harming us, but they are not governed by similar kinds of professional norms.

Also the language of "held accountable" is interesting. Physicians are as a profession, autonomous, right? They hold each other accountable in light of their shared ethical ideas. Whereas social media, if it's held accountable at all, is held accountable by the market or sometimes by, you know, restrictions on freedom of speech, which is explicitly sort of external kind of power.

And in politicians, in as much as they're the guardians, they are guarded themselves only by the power of the people to sort of kick them out of office because I'm not very confident that they're governed by robust, ethical norms of their own.

16:27
Dr. Jane Caldwell:
I think you already answered this question, but let me reiterate.

So if the healthcare provider or a medical professional is communicating via social media, they're held to the same ethical standards as if they were still at work. Is that correct?

Dr. Mark Navin:
I wouldn't, I wouldn't say that. So at work, when you're talking with a patient, you have a special obligation, right, to care for them, especially if they're already your patient. You can't abandon patients for example. Even if you want to terminate care, there's a positive duty to try and arrange a kind of transfer, a continuation of care. Physicians don't owe that kind of duty to random strangers, right?

So if a physician posts something on the internet and someone says, you know, asks for sort of treatment advice, the physician doesn't have an obligation to enter into a clinical relationship, a therapeutic relationship with that person. I do think though, that physicians who present themselves in public as physicians do have to be governed by the ethical norms more generally of their profession which is about promoting people's good health outcomes, but also trying to empower people to make good choices for themselves. Now it's a really vexed question because in clinic, I think it's pretty straightforward what physicians need to do to try and help patients have good outcomes. Once you're in contested political spaces, it's not so clear. So just to put the point this way, physicians are one of the most trusted professions in the country when it comes to healthcare. In fact, nurses are the most trusted. So you might think that means they should be the most vocal voices in our political conflicts about public health.

But there's reason to think that what happens when physicians and nurses enter the fray that way is they actually become part of partisan politics and they undermine their own status, that they become part of the contested political sphere rather than sort of elevating somehow above it.

I think there's some really difficult questions about how clinicians should use their authority when they are engaging in activism or lobbying, or sort of just speaking in public because they need to do that, I think, but also to do so in ways that are actually going to be effective and not actually backfire or be counterproductive.

18:33
Dr. Jane Caldwell:
What were you hoping that I would ask you today?

Dr. Mark Navin:
I think we've talked about an awful lot. Thank you so much for the chance to have some conversation.

Dr. Jane Caldwell:
Thank you so much for taking time from your busy schedule to speak with us today.

Dr. Mark Navin:
Thanks for this conversation.

Dr. Jane Caldwell:
And thank you for listening to the *On Medical Grounds* podcast.

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