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Conscience and clinical practice: medical ethics in the face of moral controversy

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Physicians sometimes refuse to provide legally permitted medical services on the grounds that they cannot do so in good conscience. Such *conscientious refusals* are at least as old as the Hippocratic movement. Yet new events, such as the refusal by health care professionals to prescribe or dispense post-coital ("emergency") contraception, have kindled new debates about what physicians are obligated to do when patients request legal medical interventions to which their physicians have moral objections. In a recent national survey, we found that a large majority of physicians believe they are obligated in such circumstances to present all possible options to the patient, including information about obtaining the requested intervention, and to refer the patient to a clinician who does not object to the requested intervention. Yet a substantial minority of physicians—particularly those who are more religious and/or who themselves object to common controversial practices—disagree with these majority opinions [1].

In hopes of stimulating further discourse about these matters, eight eminent scholars were invited to participate in a conference focusing on the role of the clinician's conscience in the ethical practice of medicine.[1] We asked contributors to address one or more of the following questions: What is the nature of conscience and what part does it play in the moral life, both public and private? In making good clinical decisions, what role should the clinician's conscience play relative to his or her knowledge of scientific data, the standards of professional bodies, and/or the law? What should a clinician do when patients request legal and professionally permitted medical interventions to which he or she has a religious or other moral objection? What boundaries ought the profession place, if any, on the range of

[1] The conference, *Conscience and Clinical Practice: Medical Ethics in the Face of Moral Controversy*, was held March 18, 2008 at the University of Chicago Divinity School.

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clinical practices that may be refused based on conscientious objections? What makes one conscientious objection more defensible than another? Can such distinctions be made reasonably via professional and public policy? How should the profession of medicine proceed in the face of the moral disagreements that arise in our pluralistic democracy?

Six papers from the conference are presented in the following pages, and two others are published elsewhere. Hugh Lafollette, along with Eva Lafollette, presented a previously published argument asserting that although medical professionals have a right of conscientious refusal, that right is substantially qualified by their professional role responsibilities. The Lafolletes propose that claims of conscience be evaluated as to whether the beliefs that undergird such claims are sufficiently plausible, sincere, and central to one's identity [2]. They conclude that those who conscientiously refuse to provide services that are expected of their professional role should demonstrate reciprocal respect for others by providing alternative services. Susan Thistlethwaite also draws the analogy with the treatment of conscientious objectors to war. She proposes that review boards be established to evaluate the consistency and legitimacy of medical professionals' conscientious refusals, formally designating such professionals as having "conscientious objector" status with respect to the relevant practices and excluding them from practicing in areas where such practices are likely to be requested. Furthermore, Thistlethwaite traces distinctions between Protestant and Catholic views of the role of conscience, and concludes that any workable policy must include respect for and mutual recognition of other people's consciences, particularly those of women.[2]

In the first paper of this issue, Daniel Sulmasy indicates that too little attention has been given to the meaning of the term *conscience*. He traces the term's history, noting that it does not refer to moral intuition, motive, feelings, or particular moral principles. Rather, Sulmasy argues, conscience is the conjunction of an overriding commitment to act morally, and practical judgments about whether specific moral acts are consistent with that commitment. In those cases that have stimulated controversies regarding conscience, clinicians are making prospective judgments about whether a particular action would make them complicit in the wrongdoing of others. Sulmasy argues that although conscience can err (and we are therefore obligated to form our consciences correctly), no morality is possible without it. He concludes by proposing that mutual respect for conscience is the true basis for tolerance. In the face of our limited moral knowledge and reasoning, respect for conscience means tolerating the practices of those with whom we disagree, even as tolerance sets boundaries to the range of conscientious practices that a just society will permit.

John Hardt suggests that these debates are animated by secular anxiety about the role of religious arguments in the public and professional realm. That anxiety is itself fed by a widely held conception (on both sides of the debate) of conscience as private, hidden, and beyond rational scrutiny, something "that amounts to little

[2] Susan Thistlethwaite's paper, titled "Other People's Consciences," will be published in a future edition of Science Progress (www.scienceprogress.org).

more than sincerely-held, albeit potentially unreasonable, opinions to which unsuspecting patients in the clinical encounter may be subject." Hardt agrees that conscience so understood is incommensurate with a public and professionally accountable practice like medicine. He seeks to rehabilitate the concept of conscience by turning to resources from what some perceive to be the source of the problem—the Catholic moral tradition. Citing Aquinas, he argues that conscience is better defined as the "act constituted by the making of reasonable decisions in light of moral norms, practical considerations, and contextual facts." Conscience so understood invites scrutiny, consultation, and critique from the surrounding moral community. In this light, conscientious physicians would be open to the feedback of their professional community, and yet they must also be able to question the order of that community. Hardt is skeptical of efforts to separate the personal and professional, or private and public moral spheres. Such compartmentalization, he argues, leads to moral fragmentation and ultimately erodes the possibility of medicine continuing as a moral practice. A more fruitful endeavor, Hardt suggests, is to assess conscientious claims by considering whether the practices in question are consistent with the ends of medicine. Indeed, conscientious refusals are visible expressions of underlying disagreement and uncertainty regarding medicine and its goals.

Jean Bethke Elshtain takes up the question of the relationship between science and politics. She begins by noting that scientists often seem to claim that their work must be set free from the encumbrances of politics, particularly when that work involves morally controversial research. She challenges that idea on theoretical grounds, arguing that the practice of science is intrinsically bound up in politics and that part of political deliberation is to set limits to what scientists do. She also challenges it by tracing the sobering history of "applied biology" in National Socialist Germany, a regime in which scientific ambition supported by the state was unhindered by dissenting moral voices, including those of physicians. When moral qualms were subordinated to the laws of biology, the world's most sophisticated medical and public health system became the engine of some of the greatest atrocities in history. From Nazi Germany, Elshtain turns to contemporary American medicine and cautions that we seem to be drifting toward a more subtle but still regrettable system in which medical science asserts its moral autonomy, the state acts only as a financial enabler, and voices of moral opposition are weakened. Against this trend, she proposes a third way in which all of the organs and institutions of civil society are involved in an ongoing debate about how we are to order our common life. In this third scenario, physicians who conscientiously refuse to participate in controversial practices contribute to a necessary cultural debate.

In the fourth paper, Mark Wicclair examines what he calls the "incompatibility thesis"—namely "that conscience-based refusals to provide legal and professionally permitted medical services are incompatible with the professional obligations of physicians." He considers in turn a number of different theories of physicians' professional obligations that have been advanced to ground this thesis, including consequentialism, contractarianism, rights-based theories, theories of the internal morality of medicine (both essentialist and non-essentialist), reciprocal justice, social contract, and promising. In each case, for reasons specific to the particular

theory in question, he concludes that the incompatibility thesis is not unequivocally supported, at least not with respect to the conscientious refusals that have generated present day controversies. In light of the weaknesses of the incompatibility thesis, Wicclair concludes that conscientious refusals in medicine should be accommodated so long as they do not unduly burden patients.

Dan Brock agrees with Wicclair that the incompatibility thesis does not apply to individual physicians, but he suggests that it does apply to the profession as a whole. The importance of individual moral integrity justifies efforts to accommodate conscientious refusals, but those refusals should not be allowed to prevent the profession from meeting its social obligations to provide a level of service that includes, in Brock's account, "all legal and beneficial medical interventions sought by patients." As such, the profession may reasonably require its members to fulfill the roles that inhere in their professional position, notwithstanding their conscientious objections. Brock takes us full circle to the position seemingly endorsed by the majority of U.S. physicians on our recent survey [1]. Under what he calls the "conventional compromise," a physician may conscientiously refuse to provide a particular medical intervention so long as: (1) the physician provides the patient with all medically relevant information about the intervention, (2) the physician refers the patient to another clinician who is willing to provide the intervention in question, and (3) this process of referral does not impose an undue burden on the patient. Brock argues that this compromise balances the profession's obligations with the individual's moral integrity and is reasonably required of all physicians as a condition of maintaining their professional privileges.

Finally, Armand Antommaria challenges commentators' tendency to frame conflicts about conscience in the language of rights disputes. Using emergency contraception as an example, Antommaria turns to dispute resolution theory to outline our predicament. He notes that efforts to resolve disputes always focus on one or more of three basic elements: rights, power, and interests. When disagreements about conscience are framed as rights disputes, ethicists position themselves as neutral third parties that adjudicate between patients' claims to legal medical interventions and clinicians' claims to not engage in practices they find objectionable. Understood this way, the medical ethicists' task becomes difficult if not impossible because of multiple sources of unresolvable disagreement, including disagreements about the facts, about how to rank harms and benefits, and about human nature. In the face of such disagreements regarding emergency contraception, opposing sides have often resorted to contests of power, using their influence to shape judicial, legislative and regulatory policies. The better way forward, suggests Antommaria, is for ethicists to act as analysts who identify and clarify the relevant interests of the parties to these disputes and to seek solutions that allow those disparate interests to be accommodated. He outlines example policies with respect to emergency contraception to make the point that "conflict resolution need not be a zero-sum game in which gains to one party must come at the expense of the other."

These essays do not resolve disagreements about the role of conscience in clinical practice and the grounds on which conscientious refusals may be justified. However, they do provide a clearer understanding of what the conscience is, what is at stake in disagreements about conscientious refusals, and the implications of

different strategies for resolving the conflicts that arise around these matters in the world of clinical medicine. It remains for the profession and other mediating institutions to work out policies that encourage conscientious practices by clinicians and ensure access for patients to appropriate medical resources.

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