The American Journal of Bioethics, 7(12): 10–14, 2007

ISSN: 1526-5161 print / 1536-0075 online
DOI: 10.1080/15265160701709859

Target Article

Clash of Definitions: Controversies About Conscience in Medicine

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What role should the physician's conscience play in the practice of medicine? Much controversy has surrounded the question, yet little attention has been paid to the possibility that disputants are operating with contrasting definitions of the conscience. To illustrate this divergence, we contrast definitions stemming from Abrahamic religions and those stemming from secular moral tradition. Clear differences emerge regarding what the term conscience conveys, how the conscience should be informed, and what the consequences are for violating one's conscience. Importantly, these basic disagreements underlie current controversies regarding the role of the clinician's conscience in the practice of medicine. Consequently participants in ongoing debates would do well to specify their definitions of the conscience and the reasons for and implications of those definitions. This specification would allow participants to advance a more philosophically and theologically robust conversation about the means and ends of medicine.

Keywords: conscience, ethics, religion, philosophy, Islam, Judaism, Christianity

Recently, scholars have renewed an old debate regarding whether and when physicians may justifiably follow their conscience. The debate often emerges in discussions about prescribing birth control, helping patients obtain abortions, caring for patients at the end of life, and other controversial areas of clinical medicine. Some have argued that the physician's conscience must not interfere with the patient's efforts to obtain medical interventions that are legally permitted and professionally endorsed (Savulescu 2006). Others have claimed that physicians are not obligated to offer all treatments requested by patients or the medical profession (Davis 2004; Miller and Brody 1995; Peppin 1997).

Disagreements about whether physicians may follow their conscience often emerge along religious lines. In a recent national survey of United States physicians, we found that secular physicians are substantially more likely than their religious colleagues to believe that physicians must disclose information about or refer patients for legal medical procedures, even if the physicians have religious or other moral objections to those procedures (Curlin et al. 2007). These empirical findings suggest that disputes about the proper role of the conscience in medicine may manifest theological and philosophical differences that are often unspoken and unexamined. In particular, little attention has been given to the possibility that disputants are operating with contrasting definitions of the conscience. In the absence of consensus on what the conscience is, it may be impossible to agree on what the role of the conscience should be.

Definitions of the conscience tend to diverge with respect to three questions: What information does the conscience convey? How should the conscience be formed and informed? And, what are the consequences for violating one's conscience? To illustrate divergence on these questions, we highlight fundamental disagreements between teachings found in the Abrahamic religions (Christianity, Judaism and Islam) and teachings within contemporary secular moral tradition—two streams of thought that have profoundly influenced cultures in the West. Our goal in this brief essay is to draw attention to and promote discussion about the plurality of ways that the conscience is described, and the differing roles the conscience is said to have. We hope that by giving attention to the deeper disagreements that may underlie debates about the role of conscience in medicine, new light will be cast on current controversies and new strategies will emerge for negotiating accommodations between those who disagree.

WHAT INFORMATION DOES THE CONSCIENCE CONVEY?

Within Christianity, Judaism and Islam, the conscience may be understood as enabling moral agents to know whether

Received 19 December 2006; accepted 17 August 2007.
Acknowledgment: The authors' work on this article was supported by a grant, "Variance on the Margins of Religion and Medicine," from the Greenwall Foundation, New York, NY.
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an act conforms to the divine law, that is, to God's standard of right and wrong. The Christian Reformer John Calvin described the conscience as knowledge *plus* a sense of the divine justice (Calvin [1599] 1845, 3.19.15) and the *Catechism of the Catholic Church* states, "It is by the judgment of his conscience that man perceives and recognizes the prescriptions of the divine law" (Catechism 1994, 1778). Islam teaches individual responsibility and accountability before an all-knowing and just judge (Esposito 1991, 26), and Judaism holds, in the words of Rabbi Abraham Joshua Heschel, that:

> God is *He to whom we are accountable . . . He to whom our conscience is open* . . . We are exposed to the challenge of a power that, not born of our will nor installed by us, robs us of independence by its judgment of the rectitude or depravity of our actions, by its gnawing at our heart when we offend against its injunctions . . . (Heschel 1955, 158).

In each of the Abrahamic religions, right and wrong are divinely established categories, which the conscience enables a person to discern.

Although secular traditions of moral reasoning differ regarding where they locate the source of morality, they are alike insofar as they disavow the notion that the moral law is divinely ordained and upheld. Thus Thomas Hobbes ([1651] 2004, 92), Benedict de Spinoza ([1677] 1989, 181), Friedrich Nietzsche ([1886] 1997, 17), and more recently Bertrand Russell and Richard Rorty (1982, 166) all suggested that moral obligations are constructed rather than discovered. In this essay we focus on the ideas of Bertrand Russell because of his continued influence in the decades following his death and because his ideas clearly depart from Abrahamic traditions on many points. Informing our question of what sort of information the conscience conveys, Russell wrote,

> I do not think there is, strictly speaking, such a thing as ethical knowledge. . . All moral rules must be tested by examining whether they tend to realize ends that we desire. I say ends that we desire, not ends that we *ought* to desire. What we "ought" to desire is merely what someone else wishes us to desire. . . If I say that the legislative authority has bad desires, I mean merely that its desires conflict with those of some section of the community to which I belong. Outside human desires there is no moral standard. (Russell 1957, 60–62)

This secular framework therefore concludes that the conscience alerts a moral agent to his or her desires, but does not reveal anything that is universally good or normative for another person.

It is not surprising that contrasting ideas about what the conscience conveys lead to disagreements about the place of the conscience in medicine. Consider, for example, those cases in which physicians refuse to prescribe birth control because to do so would ostensibly violate their conscience. To secular persons, such physicians appear to be simply imposing their own tastes and desires on patients (Manasse 2005), thereby violating the ethical principle of patient autonomy (Savulescu 2006). In contrast, those who believe the conscience is a means for discerning a universally normative moral law may applaud the physicians' conscientious actions even if they believe that the physicians have erred in their particular judgments regarding what the moral law requires.

HOW SHOULD THE CONSCIENCE BE INFORMED?

Although many moral traditions teach that a clear conscience is necessary for ethical behavior, they do not teach that it is sufficient. The conscience must also be properly informed, and how the conscience is to be informed is another area of disagreement.

The Abrahamic religions affirm the universal moral authority of particular sacred texts and traditions, even as they acknowledge the need for contextualized interpretations of those texts and traditions. Catholicism teaches that an individual's conscience should be shaped by reason, the Word of God, prayer, introspection, the gifts of the Holy Spirit, the witness or advice of others, and the authoritative teachings and traditions of the Church (Catechism 1994, 1783–1785). Rabbinic Judaism has put special emphasis on rescuing life (*pikkuah nefesh*). Beyond this, Judaism calls the faithful to inform their consciences by looking to the wisdom of God as preserved in the scriptures, historical interpretations of those texts, and new interpretations that are prompted by present situations (Heschel 1955). Along these lines Emmanuel Levinas blamed Europe's "bad conscience" on its departure from biblical tradition, and unsuccessful attempts to create a society based on reason (Burggraeve 2002, 83). Islam may especially value the influence of Islamic society on the conscience. Farah notes that within Islam, "[the individual] perfects [Islamic society] and is perfected by it, he gives to it and receives from it, and he protects it and is protected by it" (Farah 2003, 131). Protestantism may especially value individual interpretations; thus John Calvin stated that the conscience "has not to do with men but with God only" (Calvin [1599] 1845, 4.10.5). However, each of these worldviews claims that particular texts and traditions provide authoritative norms that should inform the individual conscientious decisions of all people.

Within secularism however, one finds skepticism of both human traditions and religious truth claims. Instead, reason alone must discern what wisdom and the ethical life require. In Russell's words, "the moral code of any community is not ultimate and self-sufficient but must be examined with a view to seeing whether it is such as wisdom and benevolence would have decreed (Russell 1957, 64)." On a practical level he admits that peoples' consciences are influenced by superstition (religion), the desire for approval, socially determined rewards and punishments and education. According to Russell's view, these influences are unlikely to be eliminated, but community leaders might successfully harness these influences in order to shape peoples' consciences intentionally, thereby promoting social harmony (Russell 1957, 61–65). Thus reason is the only legitimate influence on the conscience, but when people do not listen to reason, leaders may use education and incentives to bring

peoples' consciences into conformity with the dictates of reason.

Divergent ideas about how the conscience should be informed may underlie many controversies in contemporary medicine. For example, if a physician uses arguments from religion and/or tradition to justify the physician's conscientious decision to refuse to participate in terminally sedating a patient, the secular person may criticize the physician for abandoning reason and letting previous generations think in place of the physician. When religious physicians adhere to traditional norms, they seem to frustrate secular efforts to establish social harmony by aligning behaviors (and consciences) with the dictates of reason. In response, some have insisted that medical care should not be influenced by the physician's personal values, but by the codes and policies of the profession (Charo 2005), the law and the patient's informed desires (Savulescu 2006). In contrast, the faithful Christian, Muslim or Jew is likely to applaud sincere efforts to apply sacred doctrines or texts to contemporary situations, even while asking whether the religious resources are properly interpreted in a given case. Thus, with respect to how the conscience is informed, what the secular person may eschew as a corrupting influence, the religious person may cling to as an indispensable resource.

Before moving on, it is worth noting that moral traditions tend to express ambivalence about the extent to which human law should inform the individual conscience. Thomas Aquinas wrote that God's divine law is both the inspiration for human laws and the source from which they derive their moral authority. Yet, both because humanity's knowledge of God's law is limited and because human reason is fallible, human laws are also fallible (Aquinas [1274] 1989, 28.91.1–4). Jean-Jacques Rousseau ([1762] 2005) suggested that laws derive their validity from public support. He therefore concluded that the *general will*, which he defined as the arithmetic mean that remains after the various particular wills have cancelled each other out, must always be followed. Rousseau conceded, however, that laws often embody not the general will but only the will of some particular faction (Rousseau [1762] 2005, 30–31). In contrast to Rousseau, Russell denied that public opinion conveys validity because he believed public opinion is the product of education (Russell 1957, 170). According to Russell's view, the conscience should be informed only by those laws that are legitimately grounded in reason. Of particular note, each of these views recognizes that human law is fallible and therefore may rightly be ignored in some circumstances. Because ambivalence toward the law is so common, in practice people tend to invoke a general obligation to follow the law only in those particular cases in which the law endorses the norms that they support.

WHAT ARE THE CONSEQUENCES FOR NOT FOLLOWING ONE'S CONSCIENCE?

Abrahamic religions warn that an act against one's informed conscience is an act against God and oneself that may be followed by serious adverse consequences. Calvin ([1599] 1845, 2.19.15), the Catholic Catechism (1994, 1038–1039; 1472), the Hebrew and New Testament scriptures (Ge 18:25, Dt 1:17, Lk 12:47–48) and the Qur'an (2:281, 3:21–22, 3:178) indicate that God will judge all wrongdoing, and greater punishment is promised for those who know that what they do is wrong (i.e., those who act against their consciences). Apart from divine retribution, Abrahamic traditions also warn that acting against conscience weakens one's capacity for future ethical discernment and behavior. Catholic theologians warn that ignoring the conscience leads to hardness of heart, a condition in which one "no longer feels guilt or hears the call to repent" (Grisez and Shaw 2004, 45). The Qur'an also mentions a similar hardness of heart (6:43). Rabbi Heschel notes that those who choose to act contrary to God's standards do not find liberty, but bondage (Heschel 1955, 170).

In the secular understanding, by contrast, there are neither divine standards to violate nor a final accounting in which people will be judged for their transgressions. The only penalties conscience-violators will suffer are temporal consequences imposed by themselves or by the broader society. These consequences are by no means trivial, for even beyond the penalties imposed by society, individuals may experience considerable distress for having acted contrary to who they perceive themselves to be (Dyck 2005, 180–182; Schore 1994, 485–486). This moral distress affects adherents of both religious and secular moral traditions, but in the secular theories presented here the structures that lead to moral distress may be more readily subject to change, by either reshaping society or reeducating individuals. In Russell's terms, the question for the policy maker, or "legislative moralist," is, "How shall this system of rewards and punishments be arranged so as to secure the maximum of what is desired by the legislative authority?" (Russell 1957, 62). For the secular person, the moral task is to act in such a way as to maximize the realization of human desires without destabilizing the political structures which permit others to do the same (cf. Rousseau [1762] 2005, 17). In a democracy, the legislative authority ultimately is the majority of voters, and if an individual wants what the majority permits, there is no sufficient secular moral reason for the consciences of some minority to stand in the way.

IMPLICATIONS

The two streams of thought presented here do not cover all possible descriptions of the conscience. Yet if our analysis is correct, with more definitions come more opportunities for disagreement about the role of conscience in medicine. For leaders in medicine, there are at least three possible responses. First, individuals might attempt to prove that one moral tradition's ideas are superior. Indeed, the entire controversy could be resolved if proponents of one framework could persuasively demonstrate that their ideas about the conscience are rationally superior to alternatives. However, attempts to prove or disprove the validity of a specific moral tradition invariably run into problems. According to both MacIntyre and Rorty, adherents of one tradition

usually understand their opponent's views only in translation, and so any demonstration of logical inadequacy may prove only that the critic is operating with a flawed translation (MacIntyre 1990, 113; Rorty 1982, 6). Moreover, traditions that have persisted for a significant length of time are likely to be internally consistent and have first principles that are not easily disproved by skeptics. For example, the principle that God exists appears impossible to prove or disprove beyond dispute; Rabbi Heschel suggests that if this principle could have been proven it would have been accomplished a long time ago (Heschel 1955, 154). Søren Kierkegaard famously declared that premises are ultimately chosen, and not simply deduced from reason and data (MacIntyre 19 98, 215–216). If so, rational attempts to prove the superiority of a specific worldview, and establish the superiority of one definition of the conscience, are unlikely to succeed.

The second possible response would be to simplify the conversation by removing the religious category from the class of reasons that might justify a public conscientious action. Contemporary writers often try to achieve this rhetorically by arguing that religion and medicine should be kept separate (Savulescu 2006; Charo 2005; Scheurich 2003) and that public actions must be justifiable based on secular premises. However, these goals are problematic insofar as they ask American physicians—most of whom profess religious affiliation (Curlin et al. 2005)—to extract themselves from the influence of their religious traditions. To the extent that theological claims inhere in all definitions of life, death, health, suffering, humanity, and other concepts intrinsic to medicine, strictly secular moral discourse about the practice of medicine will not be possible (Hall and Curlin 2004).

A third response, which may be the best way forward, is to pursue a more theologically and philosophically informed conversation about the means and ends of medicine. Admittedly, this procedural recommendation lacks the satisfaction that would be provided by an obvious conclusion to the matter, but recognizing disagreement and living with tension may be the only available avenue in a debate that lacks middle ground. Meaningful dialogue about the role of the conscience depends on shared definitions of the relevant terms. Before the threshold of mutual understanding can be reached, participants must specify their definition of the conscience, how they arrive at that definition, and what the definition implies for the subject of concern. Toward that end, policy makers might make efforts to involve theologians and philosophers when debating issues that have substantial theological and philosophical implications. Also, physicians might study to better understand their own moral traditions and to appreciate those of others. Each of these steps would benefit ongoing discussions about the consequences of allowing healthcare professionals to refuse to provide legal medical services requested by patients, and the consequences of using law or policy to constrain the conscientious actions of those with whom one disagrees. ■

REFERENCES

Aquinas, T. [1274] 1989. *Summa Theologiae: A Concise Translation*, ed. T. McDermott. Allen, TX: Christian Classics.

Burggraeve, R. 2002. *The Wisdom of Love in the Service of Love: Emmanuel Levinas on Justice, Peace, and Human Rights,* trans. J. Bloechl. Milwaukee, WI: Marquette University Press.

Calvin, J. [1599] 1845. *The Institutes of the Christian Religion*, trans. H. Beveridge. Available at www.reformed.org/book/institutes

Catechism of the Catholic Church. 1994. New York, NY: Doubleday.

Charo, R. A. 2005. The celestial fire of conscience—refusing to deliver medical care. *New England Journal of Medicine* 352(24): 2471–2473.

Curlin, F. A., R. E. Lawrence, M. H. Chin, and J. D. Lantos. 2007. Religion, conscience, and controversial clinical practices. *New England Journal of Medicine* 356(6): 593–600.

Curlin, F.A., J.D. Lantos, C.J. Roach, S.A. Sellergren, and M.H. Chin. 2005. Religious characteristics of US physicians: A national survey. *Journal of General Internal Medicine* 20: 629–634.

Davis, J. K. 2004. Conscientious refusal and a doctor's right to quit. *Journal of Medicine and Philosophy* 29(1): 75–91.

Dyck, A. J. 2005. *Rethinking Rights and Responsibilities: The Moral Bonds of Community, revised edition*. Washington, DC: Georgetown University Press.

Esposito, J. L. 1991. *Islam: The Straight Path, expanded ed*. New York, NY: Oxford University Press.

Farah, C. E. 2003. *Islam: Beliefs and Observances, 7th ed*. New York, NY: Barron's.

Grisez, G., and R. Shaw. 2004. Conscience: knowledge of moral truth. In *Conscience*, ed. C.E. Curran, 39–50. New York, NY: Paulist Press.

Hall, D. E., and F. A. Curlin. 2004. Can physicians' care be neutral regarding religion? *Academic Medicine* 79(7): 677–679.

Heschel, A. J. 1955. *God in Search of Man: A Philosophy of Judaism*. New York, NY: Farrar, Straus and Giroux.

Hobbes, T. [1651] 2004. *Leviathan*. New York, NY: Barnes and Noble.

MacIntyre, A. 1990. *Three Rival Versions of Moral Enquiry: Encyclopaedia, Genealogy, and Tradition*. Notre Dame, IN: University of Notre Dame Press.

MacIntyre, A. 1998. *A Short History of Ethics, 2nd ed*. Notre Dame, IN: University of Notre Dame Press.

Manasse, H.R. 2005. Conscientious objection and the pharmacist. *Science* 308: 1558–1559.

Miller, F. G., and H. Brody. 1995. Professional integrity and physician-assisted death. *Hastings Center Report* 25(3): 8–18.

Nietzsche, F. [1886] 1997. *Beyond Good and Evil: Prelude to a Philosophy of the Future*. trans. H. Zimmern. Mineola, NY: Dover Publications.

Peppin, J. F. 1997. The Christian physician in the non-Christian institution: Objections of conscience and physician value neutrality. *Christian Bioethics* 3(1): 39–54.

Rorty, R. 1982. *Consequences of Pragmatism: Essays 1972–1980*. Minneapolis, MN: University of Minnesota Press.

Rousseau, J. J. [1762] 2005. *The Social Contract*. trans. G.D.H. Cole. New York, NY: Barnes and Noble.

Russell, B. 1957. *Why I Am Not a Christian: And Other Essays on Religion and Related Subjects.* New York, NY: Touchstone.

Savulescu, J. 2006. Conscientious objection in medicine. *British Medical Journal* 332: 294–297.

Scheurich, N. 2003. Reconsidering spirituality and medicine. *Academic Medicine* 78: 356–360.

Schore, A. N. 1994. *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Spinoza, B. [1677] 1989. *Ethics: Including the Improvement of Understanding*. trans. R.H.M. Elwes. Amherst, NY: Prometheus Books.