Religion, conscience and clinical decisions

John D. Lantos (j-lantos@uchicago.edu)1,2, Farr A. Curlin3

1.Center for Practical Bioethics, Kansas City, Missouri, USA
2.Department of Pediatrics, The University of Chicago, Chicago, Illinois, USA
3.Department of Medicine, The University of Chicago, Chicago, Illinois, USA

Consider the following three cases:

A paediatrician is called to the delivery room as a woman is about to give birth to a premature baby at 24 weeks. The mother and father request that the baby not be resuscitated. The baby weighs 760 grams and has an Apgar score of 6 at 1 min. The paediatrician ignores the parents' requests for comfort care and intubates the baby.

A full-term baby with Trisomy 18 develops cyanosis. An echocardiogram reveals a large ventricular septal defect. The parents request surgery. The cardiac surgeon refuses to operate based upon the baby’s poor prognosis for a ‘reasonable quality of life.’

A 15-year old girl is seen for a sports physical. She asks for a prescription for birth control pills and asks the paediatrician not to tell her parents that she is sexually active or using oral contraceptives. The doctor refuses to prescribe the pills without parental permission.

In each situation, the doctor refuses to do what a patient or surrogate requests and instead, insists upon the right to do what he or she believes is the best. In each case, there is ethical controversy. Reasonable practitioners may disagree about the right thing to do. In cases like these, paediatricians make judgments about the rightness or wrongness of clinical actions and sometimes choose a course of action that goes against the stated wishes of a competent patient or surrogate.

The examples chosen highlight the role of the clinician’s conscience in the practice of paediatrics. The Oxford English Dictionary defines conscience as, ‘The faculty or principle which pronounces upon the moral quality of one’s [own] actions or motives, approving the right and condemning the wrong.’ The idea that physicians ought to practice ‘conscientiously’ seems uncontroversial. Ethical practice and professional behaviour depend upon the ability of doctors to morally scrutinize their own behaviour and to resist any temptation to behave unethically. This is true even in situations in which unethical behaviour may not be illegal.

The demands of conscience may be stricter than those of the law, and one ought not violate one’s own sense of moral obligation. In that sense, the doctors in the cases above must be seen as doing the right thing. In another obvious sense, however, the paediatricians’ conscientious judgments in cases like these are quite controversial. Conscientious decisions may be controversial for at least three reasons.

First, there may be ambiguity regarding whether an action is genuinely conscientious. In the second example above, one might question whether the surgeon believes it would be immoral to operate or whether, instead, she merely prefers not to operate. If the latter, she should make a recommendation but should not refuse to operate. In the last example, one might question whether the paediatrician believes that it would be morally wrong to prescribe contraceptives without parental consent or instead, merely wants to avoid facing angry parents and the potential financial impact of losing the family to another practice. Ultimately, only individuals can know whether their actions are genuinely conscientious. That does not mean that judgments of conscience are without reasons or cannot be scrutinized. Practitioners should be able to explain why they act as they do. A conscience claim must be plausible.

The second reason for which some conscientious decisions are controversial is that they involve morally contested areas of clinical practice. In many areas of paediatrics, there is consensus about the best clinical practices. Few would disagree with antibiotic therapy for bacterial pneumonia or with anti-seizure medications for epilepsy. In other areas, differences of practice are uncontroversial because there is a shared recognition of limited data. For example, data do not conclusively establish whether ibuprofen is better than acetaminophen for fever. In light of ambiguity regarding the data, paediatricians choose one or the other without controversy. In some areas, by contrast, disagreements...
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Most Americans, and most paediatricians in the United States, are religious people, and 55% of physicians say their religious beliefs influence their practices of medicine (1). As such, the majority of physicians apply the ideals of a particular set of moral principles and commitments to the circumstances of controversy. For guidance in making decisions under circumstances such as those described above, religious physicians might turn to their scriptures and/or to trusted leaders and scholars within their traditions. A Christian might turn to a pastor or theologian; a Jew might turn to a respected Rabbi. Religious commitments are voluntary commitments in secular pluralist democracies, but they may be experienced as both authoritative and nonnegotiable by those who hold them. In making a conscientious decision, paediatricians may be informed by all of these domains and other considerations specific to the particular context. Although the concept of conscientious objection applies to all three of the clinical scenarios described at the outset, the term is most often raised when physicians’ judgments are explicitly informed by religious commitments. Such objections are controversial, because many believe that religiously derived conscience commitments constitute ‘personal’ values that should not unduly influence physicians’ ‘professional’ practices. Thus, many would argue that the physicians in the examples above might legitimately take into account legal precedents, professional guidelines and bioethical disputations, but they ought not consider religious precepts in coming to a judgment about how they ought to act.

However, as long as medicine is practiced in a pluralistic democracy where some people find moral guidance in religions and others do not, situations will arise in which two paediatricians, both acting deliberately and conscientiously, will choose different responses to a given clinical decision. The policy challenge becomes one of specifying the situations for which conscience claims ought to be tolerated. Some claims may be inconsistent with good medical practice. A Jehovah’s Witness, for example, ought not be a trauma surgeon, because good medical practice in that field inevitably requires that blood transfusions be given and the Jehovah’s Witness’s beliefs would be incompatible with good medical practice. For situations in which disagreement is consistent with good medical practice, practitioners must be free to follow the dictates of conscience. The risks of disallowing conscientious practice to the profession are greater than that of allowing grounded and well-articulated zones of moral pluralism.

Professional guidelines are not usually the result of democratic processes. Instead, they convey expert opinion about matters that are thought of as uniquely within the purview of professionals. Professional guidelines seldom have specific enforcement mechanisms, although they may become the basis for claims about standards of care in tort litigation. Often, they are carefully worded to allow maximum room for individual judgment. In order to have authority in a pluralistic society, professional guidelines must reflect the common core of beliefs held by professionals from a broad spectrum of world views.

Bioethics is a field that incorporates philosophy, law and social science, along with theology, economics and policy studies, to analyse dilemmas such as those illustrated above. Bioethicists generally aspire to inclusive synthesis of various domains of discourse in order to develop responses to controversial situations that are both rigorous and generalizable. As a result, bioethical analysis often focuses more on procedural solutions than substantive ones—specifying how decisions should be reached rather than whether the decisions themselves are morally preferable.