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The conscience debate: resources for rapprochement from the problem's perceived source

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Abstract This article critically evaluates the conception of conscience underlying the debate about the proper place and role of conscience in the clinical encounter. It suggests that recovering a conception of conscience rooted in the Catholic moral tradition could offer resources for moving the debate past an unproductive assertion of conflicting rights, namely, physicians' rights to conscience versus patients' rights to socially and legally sanctioned medical interventions. It proposes that conscience is a necessary component of the moral life in general and a necessary resource for maintaining a coherent sense of moral agency. It demonstrates that an earlier and intellectually richer conception of conscience, in contrast with common contemporary formulations, makes the judgments of conscience accountable to reason, open to critique, and protected from becoming a bastion for bigotry, idiosyncrasy, and personal bias.

Keywords Conscience · Catholic · Ends-of-medicine · Physician rights · Patient rights · Moral integrity · Patient autonomy · MacIntyre

Conscience in the clinic: framing the problem

Should physicians' personal consciences be allowed to shape their professional conduct such that physicians could refuse to prescribe legally and socially sanctioned pharmaceuticals or refuse to participate in legally and socially sanctioned medical interventions? If this is an accurate statement of the question at hand, the current debate about conscience pits the protection of physicians' personal and private moral commitments against the protection of patients' rights to

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socially and legally sanctioned medications and interventions. For those who are opposed to conscience shaping the clinical encounter, its presence amounts to the unwarranted and inappropriate intrusion of personal morality into the realm of professional conduct. As some have lamented, the rise of conscience in the delivery of health care signals "the diminution of the difference between our personal lives and our professional duties" [1, p. 2472]. For those who seek to protect physician conscience, its presence is held as morally non-negotiable and beyond critique. Both of these conclusions leave something to be desired.

Much of our current debate about conscience is deficient in its consideration of the moral complexity of the problem of conscience in the clinical encounter. I will consider conscience as a concept that challenges the binary reduction of the debate into a conflict between private moral commitments and professional role-specific duties. This article considers the possibility of recovering a conception of conscience that can assist in moving the conversation past an intellectually unsatisfying declaration of "yes" or "no" to conscience in the clinic. It will propose a conception of conscience that may clear a path toward the shared preservation of physician conscience, patient integrity, and good clinical practice. My comments will concentrate upon a consideration of conscience as a communal practice rooted in reason and as a necessary component of a coherent sense of moral agency. But first I will attempt a description of the conception of conscience with which we are currently working.

Conscience's encumbrances: locating the assumption of the current debate

It is no accident that much of our moral hand-wringing over conscience stems from its religious origins and associations and its subsequent application in a clinical, and often times secular, setting. The religious connotations of conscience are perhaps most readily attributed to the Catholic tradition's development and use of the concept over millennia of moral reasoning and the Church's continued presence in the field of health care [2]. The debate over conscience in the clinical encounter, in addition to raising concern about the fading boundary between the private and the professional, is also prone to dredging up underlying resentments and long-held disagreements that touch upon the meaning of the First Amendment and the separation of church and state. Many of the issues on which conscientious objections arise in health care involve the neuralgic cultural touchstones of our time: abortion, euthanasia, reproduction, contraception and human sexuality. As Edmund Pellegrino has noted, Catholic physicians who practice medicine within the commitments of their faith on these "human life issues" are "becoming progressively counter-cultural" [3, p. 222]. Moreover, the natural law theory that supports Catholic thinking on these issues is perceived by many as increasingly intellectually obscure. The topic of conscience both contributes to and suffers from secular uncertainty about the legitimacy of religious argument both in the public square and the field of bioethics.

The integrity of moral reasoning informed by religious faith is also compromised by immature perceptions of conscience that persist in our collective imagination.

Descriptions of conscience as an angel on the shoulder of the moral agent offering admonition contribute to the perception of moral reasoning informed by faith as a kind of naïve, magical thinking. Indeed, the Catholic tradition itself may unwittingly sometimes contribute to an inadequate, profoundly private conception of conscience as a localized faculty of the mind or heart that establishes a conduit to the divine. The Second Vatican Council's "Pastoral Constitution on the Church in the Modern World," for example, describes conscience as "the most secret core and sanctuary" of a person [4, para. 6, p. 178]. Unintentionally contributing to the common misconception that conscience lies within a distinct, embodied geography, the document claims, "There, [the moral agent] is alone with God, whose voice echoes in his depths" [4]. While one can hope that both Catholic and non-Catholic readers alike interpret this description of conscience in the context of the poetic flourish that characterizes this genre of Church teaching, conscience understood as hidden, private, and inaccessible to outside engagement is an anathema to the practical and public ramifications of its invocation in the clinical encounter. I suspect that this perception of conscience as both "sanctified" and "personal" and yet deployable within the encounter between physician and patient leads to the persistent and deep worry that, in the words of Julian Savulescu, "the door to a 'value-driven medicine' is a door to a Pandora's box of idiosyncratic, bigoted, discriminatory medicine" [5, p. 297]. But this is not the only way to think about conscience.

Resources for rapprochement

Conscience as available to reasoned argument

Conscience, suggests Thomas Aquinas, is quite simply "knowledge applied to an individual case" [6]. Aquinas's definition is noteworthy for the absence of any irrational or overtly religious modifiers. As historian John Mahoney remarks in his history of Catholic moral theology,

> conscience has a much humbler, more pedestrian, and less exalted function than many people appear to suppose…[I]t is simply, as Aquinas argued, the result of thinking hard, honestly, and practically on a particular issue and canvassing aid from wherever possible, rather than being an…internal oracle [7, p. 290].

Moral theologian Herbert McCabe, O.P., observes that for Aquinas and his intellectual peers, conscience is neither a faculty "nor an innate moral code, but simply the judgement we may come to on a piece of our behaviour in the light of various rational considerations" [8, p. 420]. Conscience for Aquinas is an act constituted by the making of reasonable decisions in light of moral norms, practical considerations, and contextual facts. But conscience for us seems quite different, such that "we speak of someone 'consulting her conscience,' rather as one might consult a cookery-book or a railway timetable" [8, p. 420]. Conscience, in our contemporary context, is assumed to function as a set of pre-established guidelines.

Our current understanding of conscience offers no rational appeal beyond one's claim to her internal moral code. As McCabe observes, "If someone says honestly: 'My conscience tells me this is wrong' she is thought to be giving an infallible report on the delivery of her inner source of principles which must call a halt to argument" [8, p. 421]. And here, I think, we come closest to the center of our moral unease about conscience in the clinical encounter. Many of us worry that conscience acts as a kind of moral trump card, closing off all argument and betraying reasonable discussion. We worry, with Joseph Cardinal Ratzinger, that conscience has become "a deification of subjectivity…subjectivity raised to the ultimate standard" [9, p. 51].

Elements of both sides of the debate about conscience have assumed an impoverished conception of it that amounts to little more than sincerely-held, albeit potentially unreasonable, opinions to which unsuspecting patients in the clinical encounter may be subject. If this is the case, moral unease is warranted. But because of our heightened attentiveness to autonomy, we find ourselves treating conscience as a *prima facie* right no matter how ridiculous the opinion. McCabe, again:

> The truth of this can be seen, I think, if we ask ourselves whether there should be tribunals to judge whether a man really holds as a matter of conscience that he should strangle all Jewish babies at birth or that his children's moral education is best served by starving them or burning them with cigarette ends. It is, I think, a mark of the confusion that has prevailed in moral thinking that intelligent people can find it quite hard to give a reasoned answer to such questions [8, p. 52].

Thus, our contemporary judgments about the validity of claims of conscience appear limited to a determination of the authenticity of the objector's sentiment rather than the reasonableness of the objector's position.

This contemporary construction of conscience is clearly in opposition to the more substantive conception of conscience offered by Aquinas. As McCabe demonstrates using the example of an objection to nuclear war, a Thomistic conception of a rationally grounded conscience yields a different measure of the validity of a particular claim of conscience. Reasonable argument rather than sincere sentiment becomes the criterion by which we judge a claim of conscience:

> It is not the strength and sincerity of my conviction that the use of nuclear weapons must always be evil but rather the grounds for this conviction that make it morally right for me to refuse any co-operation with such use. Obviously, no tribunal could accept these grounds without becoming conscientious objectors themselves; short of this they can only make a sensible, and therefore just, decision to tolerate me [8, pp. 421–22].

Conscience unencumbered by contemporary assumptions about its role and function in the moral life is nothing more—and nothing less—than the human mind making moral judgments about a practical course of action. As such, its judgments are open to criticism and revision. The validity of conscience's claims ought to be considered on the ground from which they are made. The ongoing debate about the ends of medicine offers one vantage point from which to consider the validity of the arguments that support some of the more common claims to conscience today.

Reasonably grounding claims of conscience: the ends of medicine debate

The issues that populate our debate about conscience in the clinic also appear in the growing body of literature on the "ends of medicine." Some have suggested that the goals of medicine are contained in the prevention of disease and injury, the relief of pain and suffering, care for the chronically ill and dying, and the avoidance of premature death (see e.g., Hanson [10]). But summary statements like this are haunted by the need for specificity. They raise the questions of who determines what constitutes an illness and from where do the ends of medicine come [11, 12]. Certainly, cultural values and the expectations they place on medicine vary across place and time. Yet it seems that the ends of medicine are not wholly social constructed. Identifiable threads of identity and concern span medicine's history. This creates uncertainty about the proper place and function of medicine as a professional practice in society—an uncertainty that has grown in light of technological advance that has expanded the reach of medicine's resources and applications (see e.g., Elliott [13]).

As is evident from a survey of the issues that arise both on questions of conscience and on the ends of medicine, there is much that is still undecided and up for debate on the margins of medicine's common practice. These issues will remain controversial and unsettled in the foreseeable future. Thus, the ends of medicine debate calls our attention to the fact that medicine today has become an increasingly important forum for discourse on the human good (see e.g., McKenny [14]). Ongoing interest in a discussion of the ends of medicine, reinvigorated by the human genome project and growing interest in the possibilities of enhancement technologies, lends moral weight to the validity of many conscience claims insofar as these questions of conscience mirror the issues at stake in the ends of medicine debate. Considered in light of this body of shared concerns, physicians' claims to conscience in the clinical context appear less idiosyncratic or bigoted. Instead, they can be seen more clearly as concrete, practical indications of the underlying philosophical uncertainty about medicine and its goals [15].

Conscience as attentive to context

Because the locus of concern of conscience is what to *do*, conscience must be attuned to the multiplicity of circumstantial facts and judgments in a particular case if it is to reason soundly. Considering the treatment of conscience proposed by Daniel Sulmasy in this same issue, one that is fully compatible with the Thomistic treatment of the subject, we find that conscience functions as a kind of intermediary between general moral principles and lived experience. Whereas *synderesis* suggests that 'x' is generally to be done, *conscientia* applies these general rules to particular acts. Context shapes how one applies general moral rules and suggests the possibilities of alternative courses of action based on circumstances. As Aquinas writes, "[T]he human act ought to vary according to diverse conditions of persons, time and other circumstances: this is the entire matter of morality" [16, p. 135]. Thus, both sides of this debate would do well to resist an unproductive and inflammatory assertion of rights, in which patient rights' of conscience are pitted against physician rights' of conscience absent a

consideration of contextual considerations that may shape what can rightly be claimed by either party. Conscience considers the various goods that are at stake in particular cases. The gate-keeping power of the prescription pad, the challenges posed by geographical or economic scarcity as it affects fair access to medications and interventions, and the potential power differential between physician and patient ought to bear upon a physician's conscientious judgment on how to handle a morally difficult case. A failure to consider these and myriad other contextual factors is evidence of poor judgment. But there are moral lines that can be drawn even at the expense of inconveniencing and disappointing a patient. Elective abortion stands out as an issue on which the law and a variety of moral traditions have recognized the moral gravity of physician participation and have protected physician's rights to opt out of participation in it.

Conscience as formed in communities

Contrary to the perception of conscience as private and hidden, conscience is a moral concept formed in communities of reflection and thought [17]. The communal character of conscience is evident in its Latin roots. *Con-scientia*, expresses the idea of "knowing together" or "joint knowledge" [17]. While a determination of conscience is the act of an individual moral agent,[1] the formation of conscience occurs in consultation with a variety of external sources. The Catholic tradition, for example, asserts that individual conscience is formed by a variety of mutually informing sources: one's own natural inclinations to do the good and avoid evil, the shared experience of the community of which one is a part, reality itself, and divine revelation. But it is not necessary to look to the Catholic tradition to find evidence that good moral judgments include the consideration of others' thoughts and actions. Aristotle's suggestion that virtue is learned in the company of virtuous others tells us much the same thing. The formation of prudent judgment is, as McCabe says, "like most thinking…a communal activity" [8, p. 422].

The consultative formation of one's conscience serves as a safeguard against error—the kind of idiosyncrasy, bias, and bigotry with which many fear unsuspecting patients will be burdened. As Alasdair MacIntyre observes in an article entitled, "Social Structures and their Threats to Moral Agency," all of us are liable to make mistakes in particular moral judgments [18]. Our errors take a variety of forms: drawing conclusions that reach beyond or misinterpret the evidence, allowing personal likes or dislikes to influence our moral reasoning, or being callous toward a particular dimension of human experience like suffering. For this reason, we need to subject our judgments "to the critical scrutiny of reliable others, of co-workers, family, friends" [18, p. 314]. Because these persons might also share our biases or suffer their own failures of judgment, it is necessary that our judgments be "subjected to extended and systematic critical questioning that will teach us how to make judgments in which both we and others may have confidence." In doing this, we confirm our judgments and distinguish them from what might only be "mindless deviance and revolt" [18, p. 316].

[1] See Sulmasy [19] for consideration of whether an institution can be such a moral agent.

Conscience need not necessarily be understood as wholly private and hidden. As has been suggested, a variety of communities of wisdom inform an individual's conscience such that its conclusions follow upon reasons rooted in a moral tradition that is open to critique and review. Thus, while conscience delineates a particular course of action for a particular person, its reasons are neither idiosyncratic nor private but shaped by moral sources outside one's own private thoughts. Nevertheless, the question remains concerning how one is expected to negotiate potential conflicts between the commitments of one's appropriately formed conscience and the expectations of various professional roles that a moral agent embodies.

Conscience, moral agency, and the threat of moral fragmentation

The presumption that conscience is best kept in the realm of one's private conduct is ultimately morally untenable. A coherent understanding of moral agency requires a unified moral agent who carries with her some fundamental moral commitments that inform the conscience across role-specific boundaries. Indeed, moral agency requires the possibility of calling the expectations of social roles into question:

> That human beings have by their specific nature a capacity for recognizing that they have good reason to acknowledge the authority of evaluative and normative standards that are independent of those embodied in the institutions of their own particular social and cultural order…has been a widely held doctrine. Disagreements about what these evaluative and normative standards prescribe and what awareness of their authority consists in have not precluded widespread agreement in ascribing to normal adult human beings as such a capacity that makes them responsible as individuals for not putting their established social and cultural order to the question, if and when they have occasion to do so [18, p. 314].

A coherent understanding of moral agency requires that the physician as a human being is responsible for questioning the social order she inhabits as a physician. As MacIntyre notes, the moral agent must recognize and present herself to others as having an identity other than "the identities of role and office." The moral agent exists as a person both within and beyond the particular role he or she occupies in any given moment.

When persons are constrained in their ability to think of themselves and act as moral agents across role-specific boundaries, moral compartmentalization ensues. Compartmentalization is a process by which "each distinct sphere of social activity comes to have its own role structure governed by its own specific norms in relative independence of other such spheres" [18, p. 322]. Compartmentalization leads to the moral fragmentation of the person. In a compartmentalized social construct, individuals that move from sphere to sphere, exchanging one role for another, "become to some important extent dissolved into their various roles." Absent a wider moral vantage point from which she and others can view their respective roles

and role-specific expectations, the value of being a moral agent is lost and replaced by the instrumental value of being a good role-performer.

The survival of an authentic notion of moral agency requires a place in every social order where reflective critical questioning of socially defined standards of expectation and performance can take place. It requires that a moral agent be able to say, "Even though it is almost universally agreed in this social order that in these circumstances someone in my role should act thus, I judge that I should act otherwise" [18, p. 316]. But heightened suspicions about claims of conscience in the clinical encounter gesture toward an expectation that physicians should not—even cannot—call into question the validity of at least some of the socially sanctioned presumptions of what it means to practice medicine today. It would be a disservice to physicians and the practice of medicine were a position on conscience adopted that proved ultimately hostile to medicine existing as a moral practice. The suggestion by some that physicians' licenses should be dependent on their willingness to forego commitments of conscience in an unswerving commitment to perform the expectations of their role seems a potentially dangerous step in that direction [5, p. 296]. The exercise of conscience is required in order to maintain any sense of moral integrity. For this reason, conscience cannot simply be prohibited from the clinical encounter.

Conclusions

I have attempted to recover a conception of conscience that moves beyond the binary construction of the current debate about conscience in the clinical encounter. I have sought to find resources for rapprochement that neither set judgments of conscience apart from rational scrutiny or consequences nor ban the exercise of conscience from the clinical encounter. In proposing a consideration of conscience as a moral concept inextricably bound to our understanding of what it means to be a moral agent, I have suggested that conscience as a moral concept moves fluidly across the boundary that separates private morality from professional role. In an attempt to alleviate concern that conscience is prone to personal idiosyncratic conclusions, I have proposed that a conception of conscience exists that is accountable to reason, attentive to contextual considerations, and formed in communities of thinking and reflection that serve as external correctives to and protections from individual bias and bigotry. Given that many of the same issues of conscience that arise in the clinic are also issues of debate within the philosophy of medicine, prudence warns against prematurely foreclosing these discussions by way of a dismissal of conscience.

But prudence also warns against failing to consider whether the clinical encounter is the appropriate context for this kind of interpersonal moral engagement. Positions of conscience that are wielded as weapons in our ongoing culture wars without consideration of the patient's well being and concern for protecting an element of trust in the physician–patient relationship are an abuse of the power and privilege that come with being a physician. The imbalance of power that characterizes the physician–patient relationship, the threat of perceived illness,

and the patient's surprise at an unexpected denial of a socially accepted prescription or treatment should give conscientious physicians pause as they negotiate the clinical encounter. Patients deserve reasons for physicians' refusals to participate in legally and socially sanctioned interventions. Likewise, physicians have an authentic claim to preserving their moral integrity. Open and forthright conversation about physicians' moral reluctance to participate in a particular course of care can be a valuable and welcome occurrence. Regrettably, this opens the door to potential abuses of power by physicians who handle this exchange poorly. Yet it seems that these undesirable—and arguably rare—outcomes are a necessary risk in preserving the moral agency of physicians and patients alike in a morally plural context.

Given the possibility that some patients would rather avoid such a conversation, it also seems appropriate that patients be given advance warning of how particular moral commitments constrain physician practice. Advance warning will mitigate unnecessary surprise, embarrassment, and argument. It will also help to preserve trust in the physician–patient encounter. Outside of the clinical encounter itself, there is an identifiable need to devise means to both protect physician moral integrity and preserve the social good of making legally sanctioned prescriptions and interventions available to the public. This, too, is a requirement of a morally plural society in which medicine and its ends are rightly open for debate and ongoing discussion. Devising means to accommodate the moral integrity of both physicians and patients while simultaneously preserving a vibrant morally plural society is the next task of the conscience debate (See, e.g., Vischer [20]). But arguments that conscience has no place in the clinical encounter ought to be put behind us.

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