Theoretical Medicine and Bioethics (2018) 39:143–155
https://doi.org/10.1007/s11017-018-9443-2

Conscientious objection and person-centered care

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Abstract

Person-centered care offers a promising way to manage clinicians' conscientious objection to providing services they consider morally wrong. Health care centered on persons, rather than patients, recognizes clinicians and patients on the same stratum. The moral interests of clinicians, as persons, thus warrant as much consideration as those of other persons, including patients. Interconnected moral interests of clinicians, patients, and society construct the clinician as a socially embedded and integrated self, transcending the simplistic duality of private conscience versus public role expectations. In this milieu of blurred boundaries, person-centered care offers a constructive way to accommodate conscientious objection by clinicians. The constitutionally social nature of clinicians commits and enables them, through care mechanisms such as self-care, to optimize the quality of health care and protect the welfare of patients. To advance these conditions, it is recommended that the medical profession develop a person-centered culture of care, along with clinician virtues and skills for person-centered communication.

Keywords Conscience · Refusal to treat · Ethics · Medical · Person-centered care

Introduction

To become a real boy, the wooden puppet Pinocchio is advised by his friend, Jiminy Cricket, to "always let your conscience be your guide" [1]. Once anointed as Pinocchio's conscience, Jiminy proves unreliable. However, different conceptions of *conscience* impact how people view the reliability and importance of conscientious actions [2, 3]. Under the current view, the conscience is not simply a moral faculty

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of intuition or a motivating set of feelings, which are less readily available for reliable introspection in comparison to other forms of consciousness [4]. Rather, the conscience combines *will*, which commits clinicians to act morally at the most basic level, and reflective moral *judgment*, which determines through moral reasoning the acts that meet or violate this core commitment [5]. Although still fallible and not self-justifying [6], the conscience, so conceived, has increased authority in its function as a guide to persons exercising moral integrity, developing a moral identity and demonstrating “allegiance to something higher and more enduring than the regime of the day” [7]. Nonetheless, critics of conscientious objection continue to question whether or when the conscience ever obliges clinicians to refuse to provide controversial but legally and professionally sanctioned services.

These critics claim that conscientious objection, however sincere it may be, is incompatible with the absolute obligations that come from being a clinician *qua* health professional, public servant, and service provider. This “incompatibility thesis” [8] emphasizes that the prime obligation of clinicians is to protect the welfare of patients by providing them with access—at least, in publicly funded systems—to health care and medical services that they need [9–11]. Asserting that this obligation trumps the conscience duty of the clinician, these critics press legislatures, regulators, health professions, and health care organizations to limit the increasingly available legal protections for conscientious refusal afforded by conscience clauses [8]. The critics further suggest that the use of such limits to compel the provision of legal goods and services does not undermine clinicians’ freedom, since these basic products fall within the scope of state-licensed professional practice in the public sector. Moreover, in general, clinicians voluntarily choose to enter and remain within the health profession [12]. However, the extent to which the law can and should impose obligations that relate to matters of conscience is unclear. Indeed, legally restricting conscientious objection stifles clinicians’ right and obligation to use their conscience to challenge and improve professional practice [13].

How is it possible to move beyond this continuing impasse—and, in particular, beyond unproductive assertions and counter-assertions of duties and rights? How it is possible to respect the conscience of clinicians without indiscriminately justifying whatever objections they want to make, whenever they want to make them, and thus potentially jeopardizing the welfare of patients? The persistent standoff over the scope of conscientious objection in health care has prompted efforts to produce compromise solutions. However, one must consider what it is that compromise entails.

A compromise is an agreement that only partly satisfies each party in a moral conflict. Therefore, even if a compromise can feasibly be negotiated between them, they reach an imperfect consensus. For example, consider a situation in which clinicians are permitted to self-manage conscientious objection by referring patients to a willing colleague. This practice may leave referring clinicians feeling morally complicit in—and, in the chain of causation, vicariously responsible for—the provision of health care that they consider morally wrong. Such clinicians may understand that complicity (or cooperation) in wrongdoing comes in different degrees [14], and they may recognize that felt complicity differs from actual complicity. Nevertheless, feeling complicit in any capacity is undesirable [15], and thus referral presents a situation in which compromise does not fully satisfy them. Alternative approaches to negotiation include *bridging*. As one means of overcoming the limitations of compromise, this integrative approach fully unifies divergent moral interests in conscientious objection.

This paper suggests a bridging approach to conscientious objection, using the concept of personhood to center attention on health care that accommodates clinician conscience by reframing, conjugating, and optimizing the equal moral interests of all persons, including clinicians and patients alike. Such an approach is needed because while proponents of the incompatibility thesis may understand the threat that acting against the conscience poses to personhood, their commitment to a universalist and impersonal conception of professionalism means that they miss opportunities to accommodate the moral complexities of conscientious objection. Taking advantage of these opportunities could preserve the diversity and integrity of clinicians and the health profession while potentially optimizing the quality of care demanded by patients and the public [16]. The following sections discuss the general ways in which person-centered care may contribute to shaping opportunities to accommodate conscientious objection, before considering three particular mechanisms to this effect: culture, moral character, and safe communication with others.

Person-centered care

At the heart of person-centered care is the concept of person. The meaning of *person*, and hence of person-centered care, is vague and contested. Some social institutions are legally persons and share attributes of moral agents [17]. The core values and commitments of institutions "bear a family resemblance to appeals to conscience by individuals" [8, p. 167]. This perspective solicits an obligation to protect the activity of a so-called "institutional conscience" [18]. As such, there is a risk of conflict between the conscience of individuals and institutions [19]. For the purpose of this paper, it is not necessary to engage the question of whether institutions and businesses indeed warrant treatment as persons, since the focus on managing conscientious objection does not depend on an affirmative response. Here, it suffices to use the everyday meaning of *person* as "human being."

In this way, existentially, all human patients are persons, varying according to their needs and capabilities; yet all persons are not necessarily patients. For example, while attending clinicians are not patients, as human beings they are persons nonetheless. Even if persons are subject to additional inclusion criteria, such as having the ability to reason, all clinicians still count as persons and not merely as health professionals. On the basis of their personhood, clinicians have intrinsic moral value and share fundamental moral interests such as welfare and treatment with respect.

This conceptualization of personhood answers the question of "*what* is a person?" However, the answer to the related question of "*who* is a person?" is as follows: a person is a human being who inhabits a continuously emergent state of becoming whole. Conscience, as a conjunction of will (in an integrated moral wholeness) and revealed judgment [5], enables clinicians—as unified, moral agents with commingling physicality, subjectivity, and spirituality—both to contribute to the healing and welfare of persons and to be responsible for putting this capability to use

[20]. However, moral wholeness also derives from the social nature of persons. The nature of this social embeddedness has two key implications for understanding the clinicians who exercise conscientious objection, elaborated below in turn.

First, clinicians' conscience and other moral interests connect them to that which serves them and their patients as whole persons. As Charles Bardes explained, "the flaw in the metaphor [of patient-centeredness] is that the patient and the doctor must coexist in a therapeutic, social, and economic relation of mutual and highly interwoven prerogatives" [21]. By assuming that clinicians' welfare interests, such as conscientious objection, come second to patient welfare, the model of patient-centered care—and its underlying principle of primacy of patient welfare—risks compromising clinician self-care, clinician welfare, and the delivery of care from clinicians to patients. By contrast, without taking the spotlight off of the patient, person-centered care expands the light to encompass the personhood of the clinician and others.

Note that person-centered care does not lose its focus on the patient. Rather, it adds to this focus an equal and inclusive concern for other participants in health care. As persons, these participants are moral agents in their own right, whose welfare has an impact on the welfare of patients. This development refines, rather than overturns or loses, patient-centered care: patients still occupy the center, just not alone. Such sharing of the center, notwithstanding debate on whether health care even has a center [22], characterizes health care whenever the interests of persons interact. Directly or indirectly, interaction is always evident because health care is a system; it is an organized structure of interdependent parts forming a complex whole whose purpose is to deliver "quality services to all people" [23]. Regardless of how one interprets the intended meaning of the phrase *all people*, such a group includes clinicians.

It is acknowledged that the construction of person-centered care advocated in this paper is provocative. Recognizing clinicians and patients as persons implies that these parties are moral equals on the basis of their shared personhood. This state of moral equality undermines the fundamental principle that the welfare of patients trumps the moral interests of other persons—a principle of patient-centeredness that is generally considered self-evident across health professions. Among the key reasons for privileging patient welfare are that patients are less powerful than clinicians, often sick or infirm, vulnerable to exploitation, subject to indignities that most clinicians have not experienced, and obligated to provide direct or indirect payment for health care.

As a consequence, laws, professional codes—such as the Charter on Medical Professionalism [24] and the American Medical Association (AMA) Code of Medical Ethics [25]—and institutional policies are univocal in upholding the principle of primacy of patient welfare, which is central to an internal morality of health care that limits conscientious objection by clinicians [26]. The AMA Council on Ethical and Judicial Affairs' report on "physician exercise of conscience" [27] has refined this perspective by seeking to fairly balance patient rights against clinicians' deeply held personal beliefs. Yet even this excellent report still asserts that the clinician's "first responsibility is to the patient" [27, p. 2], rather than to all persons within health care whose moral interests are inseparably connected. Despite widespread support for putting the welfare of the patient first, it remains unclear that health professions have their own morality, or some particular account of morality, which privileges patient healing and health [26].

Doubt arises because the best moral interests of patients are often uncertain, and attempting to advantage them can harm the fundamental moral interests of clinicians [28], who encounter myriad exceptions to the blanket policy of putting patient welfare first. [29, 30]. Such exceptions elevate the moral interests of parties external to the patient, including clinicians and other members of society [31]. For example, when taking vacations, clinicians may require the use of locum tenentes whose provision of care might not be as good as their own [32]. Beyond the entitlement of all persons to take a vacation, this particular exception exemplifies clinicians' special need for respite from work-related stress and unwellness [33].

The inability to exercise conscientious objection can be a source of such distress for clinicians [34], which may be compounded if it compromises their quality of health care provision [16]. In this way, the need to care for clinicians arises, in part, from having inculcated them with an ethos of altruism, including the principle of putting patient welfare first. By contrast, professional respect for the moral dignity and conscience of clinicians could improve clinicians' well-being as well as their spiritual and socio-psychological readiness to optimize health care provision for patients [8, 35, 36]. So the principle of primacy of patient welfare is "controversial at best, morally offensive at worst" [26]. Indeed, a former editor of the *Journal of Medical Ethics* described it as "a common and absolutist medicomoral cliché" [30, p. 398]. Such straight talk about this central principle of health care underpins a recent attempt by Stephen Buetow to reconstruct person-centered care in terms that resist, more than parenthetically, an almost exclusive focus on the personhood of the patient [22]. This resistance also draws strength from models emphasizing, for example, relationship-centered care [37, 38] and reciprocal care [39]—so as to accommodate the connections between the moral interests of clinicians and those of patients and society.

Thus, the second implication that clinicians' social embeddedness has for understanding their exercise of conscientious objection is as follows: the provision of health care is located beyond the simplistic and untenable compartmentalization of private conscience versus professional and public role expectations. To recognize this transcendence, person-centered care begins with persons, such as conscientious objectors, as constitutionally social beings [40]. Society flows from and socializes them, which may serve, for example, to refine their character [41]. Formed with others in society and openly attentive to context [42], their conscience also has an interest in reproducing itself within its societal context. The presence of this interest *ipso facto* speaks to the situational porosity of society and conscientiously objecting clinicians, as unified moral agents in and beyond their professional roles. Although the meaning of their interpercolating interests may vary across individuals, time, and cultural frameworks [43], conscientious objection and social life are unified under the concept of personhood. Personhood is thus seen to expand the "principle of primacy of patient welfare" into the "principle of equal consideration of equal moral interests," where patients, clinicians, and society hold these interdependent moral interests. The following subsections now turn to examine how person-centered care tends to optimize mutual welfare by promoting (among other things) a humanistic culture, moral character, and safe communication.

Culture

Education along with workforce policies and practices can foster mutuality by developing a person-centered culture. Almost 150 years ago, Edward Tylor defined *culture* as "that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society" [44, p. 1]. Despite combining internal and external goods, this definition fits the current construction of personhood as a concept that integrates internal goods and external norms, such as religious and philosophical reflection. From this mixed perspective, some educational institutions—including some medical schools—are orienting their staff and students toward a person-centered culture for health care practice. Admissions policies, curricular development, and evaluation procedures in this environment are increasing attentiveness "to the social conscience and ethical development of trainees, as a means of creating skilled humanistic physicians" [45, p. 78]. Compared with those oriented toward patient-centered practice, these clinicians are being enculturated into self-care through personal growth and respect for conscience within certain structural constraints, such as regulation and licensure. In this environment, person-centered clinicians learn to be open to the ways in which patients, to the extent of their capabilities, can care for them [22]. For instance, patients may offer direct care by recognizing the clinician as a person who is vulnerable and fallible or offer indirect care by being a "good" patient.

To be person-centered in managing conscientious objection, licensing boards can function explicitly from an ethos of respect for clinicians as persons. Toward this end, boards have a number of avenues: they can aim less to deliberate between moral objections than to facilitate choice through dialogue aimed at understanding and accommodating them; they can match clinician supply to patient demand for particular services; they can increase opportunities for clinicians to work within private institutional settings on the basis of deep-value pairings; and they can review scope-of-practice issues. Broadening scopes of practice for mid-level clinicians can increase the supply of clinicians willing and able to perform contentious procedures and expand the service choices available to patients. For example, general practitioners (GPs) might be permitted to perform early abortions in places where current laws restrict this procedure to specialist gynecologists and obstetricians [46]. Other types of mid-level clinicians might also increase their repertory of interprofessional care provisions. The contributions of mid-level clinicians are growing across professional role boundaries through practices like early abortions by nurse practitioners, physician assistants, and certified nurse midwives [47]. Meanwhile, developments such as prescription to non-prescription reclassifications of medicines are increasing the scope for patient self-care [48]. Further options for increasing patient access to controversial services, while sanctioning some conscientious objection, include using technologies such as telemedicine.

Character

Patient-centered care has various features that link to different ethical theories [49], but which typically indicate an ethic of professional duty. This ethic is exemplified by "a set of definitive professional responsibilities" in the Physician Charter [24, p. 244]. By contrast, person-centered care is constructed as a virtue ethic that disposes clinicians—and patients—to act on the basis of their understanding of what a person of good character would do in a given circumstance [22]. While ensuring good means of achieving good ends, this disposition derives from cultivating the virtues as context-sensitive, stable traits of good character. These traits facilitate the development and use of conscience to articulate moral interests that are understood to position the clinician and patient in a relationship of mutual interdependency.

Edmund Pellegrino and David Thomasma follow Aristotle in suggesting that the virtues can be taught and activated by moral choices and actions [50]. Similarly, there is a growing literature focused on the so-called "virtuous clinician" [50–53], who acts for the good of the patient [54]. However, person-centered care optimizes the well-being of the patient *and* the clinician by satisfying "the principle of equal respect … rooted in the Kantian categorical perspective" [55, p. 812]. Presumably, producing these ends would require cultivating specific virtues in clinicians—namely, phronesis (practical wisdom) and courage to exercise tolerance in good faith for the sake of justice. Phronesis governs all the virtues [56, pp. 53–57, 119–121], and without them it would be empty. Among them, justice is most central to the egalitarian construction of person-centered care. Justice considers equally the moral interests of patients and clinicians, one of which is conscientious objection. For this reason, compared with patient-centered care, person-centered care more justly balances patients' welfare with clinicians' conscientious objection. Justice depends on society's epistemically humble tolerance of diverse viewpoints that are strongly and sincerely held. Such tolerance maximizes professional freedom within the limits that support and promote its ordered functioning and the common good [57]. In turn, tolerance and courage are needed to act in good faith on beliefs that challenge the principle of primacy of patient welfare, while still fully satisfying patients' moral interests. These primary virtues encompass other virtues like politeness and good faith, which are used toward the negotiation of ideal, mutually beneficial agreements.

Acting together, the virtues enable the clinician to recognize that the conscience may have epistemic limits, just as respect for the conscience may have moral limits. For example, the conscience of a clinician might selectively tolerate an abortion that results indirectly and unintentionally from a medical procedure aimed at saving the life of a pregnant woman [58]. Considering equal interests equally, person-centered clinicians might reason that preserving a patient's life through such a procedure is as important as losing a new human life through abortion [59]; or they might deny that the right to life of the fetus obligates a woman to use her body to keep it alive [60].

As Jerry Goodstein explains, "It is the nature of virtues, as opposed to rule following, to be selective" [55, p. 814]. Selectivity indicates a limited kind of autonomy to do good—rather than a compromise of autonomy—which persons are free to express through their sense of self in relation to society. Reactance theory suggests that conscientious objection is more likely to be used selectively when clinicians feel that they have the social freedom to discuss and make choices of their own accord rather than feeling coercion to comply, given that forbidding certain courses of action can serve to make them more desirable [61]. The *conscientious action* that ensues from free decision-making could protect the clinician and patient, among others [62].

Conscientious action can be protective because it does not reduce the clinician to a totalizing and standardized social role of uncritical deference to prescribed rules or social norms [16]. Accommodating the fact that some medical procedures are controversial yet mandated within a climate of health care managerialism as well as social and service contracts, this approach applies the conscience as an educable resource for justly independent thinking and moral action. It enables clinicians to “step back from [their] commitments and question them” [62, p. 39]. Qualitative research from Norway [63], for example, indicates how some GPs who refuse to provide abortions strive to demonstrate an even-handed separation between morality and law by not obstructing women’s legal right to abortive services. In this study, the GPs report no clear sense of whether their actions make them morally complicit, and, in general, they either deny ethical inconsistency or accept it in the name of making “a compromise I can live with” [63, p. 5]. This finding accords with other literature indicating that ambivalence is common among abortion providers [64]. The indirect nature of referral may offer one explanation, since, as Frank Chervenak and Laurence McCullough suggest, it is a mistake to think that the clinician is complicit in seeking to respect only a subsequent exercise of autonomy by the patient [65].

Moreover, deference to a clinician’s understanding of moral complicity is important [8] inasmuch as clinicians seem to be able to reflect critically on their conscience and educate its use. They may further develop the courage required to manage the risk or actuality of censure for conscientious refusal after disclosing and, if necessary, defending their core moral values [66]. Patients as well as institutions need such disclosure from clinicians. Open disclosure could help patients to find and pair with clinicians who share their deep values [67] and who have the fortitude to bare their own vulnerability [68]. By disclosing the same core values to their health care institution and co-workers, clinicians could reveal in advance a systems-level need to manage their disposition to conscientious refusal. Steps could then be taken by, or with, the institution to avoid the need for refusal in the first place or to avoid putting undue stress on professional colleagues. Such opportunities assume that most conscientious objectors are morally serious persons who have the will and capacity to develop practical wisdom. They may be expected, therefore, to use this wisdom to orchestrate the virtues they have acquired and thereby optimize their conduct and foster quality in health care [16]. This stage of virtuous practice requires clinicians to develop skills such as person-centered communication.

Communication

Advocacy for the incompatibility thesis sometimes appears uncompromising and even insensitive, causing one clinician to “feel physically sick” [7]. Parading gruesome photographs of fetuses dismembered by certain abortion techniques could elicit the same effect. Thus, if health care focuses on relieving suffering in persons, then in discussing ethical positions on contentious and emotion-laden issues such as conscientious objection, interlocutors must speak with, rather than at, one another. An unmet need exists for person-centered interprofessional communication, as well as communication between clinicians and patients, that demonstrates virtues like prudence and tolerance. Such virtues dispose each party to recognize that moral norms and moral interests—which *ipso facto* preclude interests that are immoral—may differ on contested issues while also being constructed in ways that are sincere, equally well reasoned, and defensible. This argument presupposes that people can learn to receive conscientious judgments with an open mind, as part of a continuing dialogue aimed at producing agreements that integrate common moral interests.

On the issue of abortion, for example, people share moral interests in having choice, in saving "life" (notwithstanding differences in what constitutes human life), and, where feasible, in gifting life. As observed by an article in the *Seattle Times*, even "the most ardent proponent of abortion rights favors life, after all, if only because he or she has one" [69]. Thus emerges the false duality of the "pro-life" versus "pro-choice" polemic. From the notions of shared humanity and collective conscience, one finds that the virtues are conducive to respectful communication focusing less on persuasion than on building common ground and engaging in cooperative action—such as by improving the delivery of sex education to young people.

Only when bridging is not achievable is compromise required in ways that affirm personal integrity through reasonable responsiveness to multiple moral commitments [55]. For example, North Carolinian clinicians objecting to a 2011 State mandate to provide standardized abortion counseling have learnt to comply with this law in ways that partly satisfy their conscience [70]. Within the confines of the law, they adopt procedural strategies such as distancing themselves from endorsing what the law requires. They also implement relational strategies like validating patient experience. These methods succeed in protecting patient welfare and preserving the clinician-patient relationship, while affirming the clinicians' integrity—allowing them to function as best they can within legal, policy, and ethical constraints. Such behavior illustrates how the manner of communication can be as important as what is communicated, requiring clinicians to balance the virtues when they come into conflict. Combining the virtues of politeness and honesty, for instance, can increase trust by blurring personal and professional values.

People in Japan demonstrate how this integration is possible, learning to wear a public face (*tatemae*) that they may struggle to separate from their true feelings (*honne*). Cultural authenticity is maintained through use of indirect communication that permits conscientious compliance. A lesson here is that silence may dissociate clinicians from behavior they find morally objectionable and empower them to intimate in good faith what they perceive that their patients need to hear, while at the same time conveying empathy. Clinicians protect themselves through silence because, though not fully authentic, they avoid inauthenticity in their behavior. If absence of speech proves too difficult in the context of face-to-face communicative exchange, however, then clinicians have recourse to ambiguity and vagueness, since compassion ultimately trumps complete honesty (*pace* Kant).

Conclusion

The incompatibility thesis imposes an absolute role obligation on health professionals to put the welfare interests of patients first, subordinating their own moral interests to those of their patients. However, professionalism is not reducible to a narrow and impermeable social role. While the individuality of clinicians is devalued by the absolutism of the incompatibility thesis and overvalued by conscience absolutism, the concept of personhood helps to overcome the simplistic distinction between individual and society. It finds room for clinicians, as constitutionally social beings in both who they are and how they realize their goals, to exercise their conscience—mindful that it is a product of the social forces that they help to shape. Thus, person-centered health care allows for an integrative approach to managing conscientious objection. This approach considers the equal and porous moral interests of patients and clinicians on a single stratum, as they interact with one another and with social life at large. These interests include liberty and virtues like phronesis, tolerance, and justice. As an absolute good, the cardinal virtue of justice, for example, indicates that, insofar as it does not compromise the welfare of patients, the wellness of clinicians is important too. Just as patients are persons, so too are clinicians persons whose welfare is important and enables them to care for patients within the context of institutional health systems.

Accordingly, respect for clinicians' conscientious objection requires the development of a person-centered culture as well as the cultivation of virtues and skills like communication. The need for this respect is critical, not only because health systems should improve how they look after the well-being of clinicians but also because affording clinicians the freedom to engage in conscientious objection could enhance the quality of twenty-first century health care [16].

Acknowledgements The authors wish to thank the Editor and anonymous reviewers of an earlier version of this article for their first-rate feedback and support. The authors also wish to thank the Managing Editor of the journal, Katelyn MacDougald, for her exceptional work on the final version of this paper.

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