A Dark Coast: An Application of Conscience in Contemporary Ethics

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Conscience is a crucial concept in medical ethics, and exemptions on grounds of conscientious objection are a matter of some controversy. This article examines recent guidelines for conscientious objection proposed by a group of leading medical ethicists, and highlights their failure to understand what conscience is and how it works. Further, this paper proposes an alternative understanding of conscience, and then deploys it as a standpoint from which to criticize the proposed guidelines.

In June of 2016, fifteen eminent philosophers and bioethicists (many of them associated with Oxford University) gathered in Geneva, Switzerland, at the Brocher Foundation to discuss conscience in the lives and work of health care practitioners. They published their results through Oxford University's "Practical Ethics."[1] The promising workshop had two goals: to sort out the philosophical issues associated with conscientious objection and to propose a set of guidelines, a practical-political program, in response.[2] There is a great need for more of this sort of dialogue. Attempts at crossing the divide between philosophical conference rooms and theaters of action remain too rare, and as societies grow more complex the need for careful thinking only increases. With bioethics in particular, the pace of technological change and the boundaries of what is possible move so quickly that it's urgent and of manifest importance that serious minds pause to consider the implications—to think about not only what medical professionals *can* do, but what they *should* do.

At the end of three days of meetings, the conferees produced the "Consensus Statement of Conscientious Objection in Healthcare" (Oxford Consensus), a short document of ten principles and proposals. With bracing candor and admirable brevity, they lay out their position on some of the most controversial matters within medicine, including (as the signatories note in the opening paragraph) abortion and "medical assistance in dying."[3]

This paper aims to respond to the document in the following ways: 1) show that the authors are badly confused about what conscience is and how it works; 2) propose an alternative understanding of conscience; 3)

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deploy that alternative understanding in criticizing the practical-political program proposed by the conference.

I. THE OXFORD CONSENSUS'S PHILOSOPHICAL POSITION

Several among the ten statements in the Oxford Consensus touch upon the philosophy underlying the practical-political program they offer. No statement is more direct than the first:

> Healthcare practitioners' primary obligations are towards their patients, not towards their own personal conscience. When the patient's wellbeing (or best interest, or health) is at stake, healthcare practitioners' professional obligations should normally take priority over their personal moral or religious views.[4]

This statement is massively confused and badly mistaken. The sense of the term "obligation" is the philosophical-moral sense of the word, as opposed to the merely legal, I take it, because the second statement treats the same issue, but in a different way and clearly (in part) from the standpoint of the legal or professional understanding of the term. First things first: Healthcare professionals, like everyone else, have as their primary obligation in life, including while at work, to act in accordance with the dictates of their consciences. Furthermore, the Oxford Consensus statement implies a gap between practitioners' obligations to patients and to their consciences. But what kind of gap could that be? If obligation is understood in its primary sense, it is a dictate of conscience, a binding of the practical reason towards an action (or forbearance). If a doctor's professional aim is her patient's health and wellbeing, and her conscience is in some semblance of working order, directing her toward the good, there won't be a conflict because both descriptions point to the same end—one from the standpoint of the doctor (what her conscience requires) and one from the standpoint of the patient (his health and wellbeing). In other words, for there to be a gap between conscience and duties to patients, it would need to be the case that one had a duty to patients that involved immoral action.

Statement one betrays an inadequate understanding not only of what conscience requires, but what it is and how it works. It pits professional obligations against "personal moral or religious views"[5] as though the former come from the outside and can be held in the mind as genuinely obligatory but as separate from the conscience—somehow obligatory without involving the conscience. Further, it treats "personal moral or religious views" as trifles of mere taste or even prejudice. But that's not how conscience works and not what moral understanding is. If one holds that one

ought to act for the sake of the health of the patient, that act of knowing is an act of conscience—from the perspective of the practitioner all duties, all obligations, involve the conscience. In section III, I turn to the right way to understand the operation of conscience and in section IV, I offer specifics that are implications of conscience rightly understood and which respond directly to the claims of the Oxford Consensus. For now, it is enough to mark out the problem with the way the Oxford Consensus understands conscience.

In statement two, the Oxford Consensus amps up the rhetoric, stating that if a professional rule of conduct contradicts a practitioner's conscience, then the professional rule trumps. It goes so far as to say that if conscience will not allow the practitioner to provide a good or service to the patient, the practitioner "should always ensure that patients receive timely medical care."[6] This statement is a mistake in one of at least two possible ways. If the practitioner adjudges a course of action the patient desires as contrary to the health or wellbeing of the patient and refuses to provide it, that determination *is* medical care and she has satisfied the literal understanding of the statement. But, trying to understand the Oxford Consensus signatories as they understand themselves, they probably mean to assert that if the practitioner cannot provide the desired course of treatment to the patient, then the patient's desire obligates the physician to find someone who will provide it. This version confuses the patient's desire with the patient's health. The patient's desire for an unhealthy or detrimental course of treatment does not transform its unhealthiness into healthiness any more than a patient's reluctance to undertake a course of treatment that would save his life somehow makes that treatment unhealthy. And while a physician should not, with rare exception, force a course of treatment on a patient, her job is to diagnose disease and recommend treatments that can restore health. When she does so consistent with her understanding of medicine, ethics, and all relevant circumstances, she satisfies both her conscience and all proper standards of medical practice.

II. THE OXFORD CONSENSUS'S PRACTICAL-POLITICAL PROGRAM

The Oxford Consensus is much more explicit about how relevant political and medical authorities should effect a shift in the default setting: *away from* prioritizing practitioner conscience (which they regard as the status quo) and *toward* prioritizing professional rules. Recommendations come in two kinds: professional and legislative. As each is detailed, the thrust of the program becomes clear: using the apparatus of the state and professional organizations to coerce those who disagree and set the professional

norms such that those who might object are locked out of the health care professions. This move is what gives real teeth to their philosophical conclusions. If taken up, the Oxford Consensus program would amount to a lockout of Evangelicals, Orthodox and Conservative Jews, Catholics, Muslims, and even secular opponents of controversial procedures such as gender-reassignment surgery, abortion, and physician-assisted suicide. The Oxford Consensus settles the controversy not through dialogue and debate, but through both subtle and brute forms of coercion. In cataloging their recommendations, I will work through them chronologically as a practitioner might experience them over the course of a career in medicine.

The place to begin is pre-professional training. Students in professional programs, whether law or medicine or business, are routinely inculcated into systems of rules, ethics, and norms of professional conduct. Statement nine says, "healthcare practitioners should be educated to use a framework of decision-making incorporating legal, ethical, and professional arguments to identify the basis of their objection."[7] Substantively, such reflection is not necessarily objectionable, but structurally what is clear here is a signal that inculcation in the Oxford Consensus should be incorporated into professional training, beginning in the schools and continuing throughout the careers of professionals. Statement ten adds content. Practitioners are to be trained in "the influence of cognitive bias in their objections."[8] The education component of the Oxford Consensus is to have practitioners take for granted the new professional norms and interrogate whatever beliefs they have which do not align with those norms.

If such a rhetorical *paideia* does not dispel moral objections, the next step in the process is, per statement eight, that medical students "should not be exempted from learning how to perform basic medical procedures they consider to be morally wrong."[9] In many instances (medicine is an art, after all), learning requires doing. For example, while it might not be the case that learning to assist in physician-assisted suicide requires actual participation in one as a medical student (learning the right combination and amounts of drugs would seem to suffice), it is the recommendation of the American College of Obstetricians and Gynecologists that practical, clinical experience with abortions be increased as part of the education of all medical students.[10] Ensuring an identical training for both those who conscientiously object to, say, abortion and those who do not would require that both be trained in the procedure, a training that normally involves doing or being a part of precisely what the objector thinks is morally wrong. Even if the requirements do not go that far, and it is difficult in the age of massive medical malpractice lawsuits to see how they would

not, there will certainly be both a professional expectation and significant social pressure.

After they are trained and enter the job market, conscientious objectors would face additional difficulties under the Oxford regime. Statement six recommends that policy makers should ensure all areas are covered with practitioners willing to perform all services and, as such, that hiring decisions be made on the basis of conscientious objection. In other words, discrimination against conscientious objectors should not only be permitted, but even required. If the practitioner is hired, and wants to exempt herself from the provision of services she finds morally objectionable, the Oxford regime recommends that she bear the burden of proof of justifying her objection (statement four), that she be required to explain her rationale (statement three), and finally that she not only do so to the patient, but before a tribunal (statement five).

There is still more. The practitioner, even if she objects, is required to provide the objectionable service to the patient in emergency situations, forcing her to act against her conscience (statement two). If it is not an emergency, she is still required to refer the patient to someone who will provide it. And, finally, should the practitioner opt out of providing a service she finds objectionable, she would be forced to compensate society for her failure to perform her professional obligations by providing public-benefitting services (statement 7).

All told, the Oxford Consensus places enormous burdens on those who would conscientiously object to the provision of certain goods and services within the medical professions. They must endure a curriculum they find repugnant, a practical education that may force their hands to cooperate formally with what they regard as evil. They may be openly discriminated against in hiring practices and hauled before tribunals if, somehow, they persist in their beliefs. And then they may find themselves commanded by such tribunals to perform "public-benefitting" service of some kind each time they invoke their duty to conscience. It is not difficult to foresee the consequences. This regime would be terrifying to a young and aspirational medical student who was also an adherent of, say, the Catholic Church, and it would create an enormous disincentive for most orthodox believers in all the Abrahamic faiths to consider careers in healthcare, one of the most prestigious and lucrative fields in the contemporary work world.

III. CONSCIENCE, RIGHTLY UNDERSTOOD

Following the Oxford practical-political program out step by step is crucial to seeing how a philosophical error ramifies, how the ripples just keep

moving farther out until the effects can be seen quite far from where the stone originally dropped. Ideas have consequences, as Richard Weaver put it. I maintained in Section I that the main ideas upon which the Oxford Consensus is based are mistaken. There, I issued a promissory note to consider the case more fully. Here, I aim to make good on that promise.

Conscience is a word I have used twenty-seven times in this discussion so far, and I have said a fair amount about what it is not: it is not simply a set of beliefs we happen to have, it is not a set of tastes or prejudices, it is not a set of reasons to be equally weighted with social rules and professional norms. But what is it?

The development of thought on conscience has a very Catholic history, and this is no surprise given its central place in Catholic moral life. Thomas Aquinas is a central figure in that history. As he often does, Aquinas communicates something important before one has read the first word about conscience—he communicates through structure. He places his treatment of conscience as an article within a question about the intellectual powers, nested within a group of questions about the most fundamental nature and features of human beings. The careful reader can thus discern Aquinas's view of the deep importance of conscience in structuring human life. Further, this particular treatment of man is sandwiched between the treatment of the six days of creation and God's government of creatures. Conscience touches both: on Aquinas's view, it is a central feature written into the very structure of human life and it is a crucial component of God's provision for, and judgment of, humanity.

As indicated by its etymological components, conscience has to do with knowledge, specifically the act of applying knowledge to practical deliberations.[11] The kind of knowledge at issue here is not like knowledge of chemistry, which is both inert (does not cause us to do anything) and neutral (can be used for good or bad purposes). The knowledge in one's conscience is moral in nature, active in orientation. Conscience, then, has two closely related purposes: to inform one of moral truth and to spur one to live by it.[12] It is a habit of the practical intellect of bringing before the mind moral knowledge when considering what to do. Simply put, conscience is how one knows what's right and wrong, the act of applying knowledge to guide and form action.

Few, if any, thinkers have given a more penetrating answer to the question "what is conscience?" than J. Budziszewski.[13] He offers sound exposition, and vital developments, of the long tradition of conscience in moral philosophy. Conscience, in the broad sense of the full experience (as distinct from *conscientia*, as used below), has four constituent features. Two constitute conscience, and two are so closely connected that

they are part of what we generally experience as conscience, even if formally distinguishable.

The two parts of conscience proper are (1) *conscientia* and (2) *synderesis*. *Conscientia*, or surface conscience, is the act of mind in which one applies moral principles in making practical choices. *Synderesis*, or deep conscience, is the habit of the mind to know the set of deeper premises from which our conscious principles are derived.[14] What seems abstract and complex actually maps an ordinary deliberation rather well. When thinking about whether to take the pack of gum without paying for it, one might think about the punishment for getting caught, the wrong of taking what does not belong to one, the harm of cheating the system of exchange. But one will probably not think, "but should I go after something good?" That good is to be done, and evil avoided, is so deeply written into the fabric of moral thought that hardly anyone ever thinks about it. Hence Budziszewski's term "deep conscience," the conscience beneath the surface of our thoughts. But just because one does not think about it much does not mean it does not bear upon the action; in fact, *synderesis* is at the root of every moral act. Furthermore, *synderesis* can never err, never be obliterated or even occluded by "social constructs." This fact, indicating an ineradicable wellspring of goodness but also laying bare one's true culpability for misdeeds, is both reassuring and terrifying, The only way to stop *synderesis*, the only way it is ever trammeled, and even then only temporarily, is by self-deception.[15] One always knows that the good is to be done and pursued, and evil avoided. One always really knows that friendship is a good thing, that life and health are good things to be pursued, preserved, and protected. The only way to fail to know these things is to lie to oneself.

Conscientia is surface conscience, applying derivations from deeper principles that compose the conscious moral beliefs one brings to bear on a decision about what to do. Because the principles of *conscientia* are derived, and our moral powers are limited and hampered, our derivations can, therefore, be wrong. Further, because conscience is an intellectual practice (an act), it can be better or worse developed. Very different from *synderesis*, surface conscience is quite easily warped by social practices, an unruly passion, and bad habits.

Synderesis and *conscientia* are together the components of conscience in the formal sense, but they do not in themselves complete the experience of conscience, and thus Budziszewski adds two more elements: the belt of *synderesis*[16] and paraconscience.[17] The belt of *synderesis* concerns moral conclusions everyone knows (like the stuff of deep conscience), but which are themselves derived (like the stuff of surface conscience). Because they

are known to all, they are more closely aligned with deep conscience, and that is where Budziszewski places them—like the rings around Saturn, they orbit close to *synderesis*, move with it, function as part of it even if technically separate from it. The belt of *synderesis* includes such fundamental moral conclusions as the wrongness of murder.

Paraconscience has to do with the motivating force of conscience. Budziszewski writes, "But conscience, as moral knowledge, does not motivate all by itself. It has helpers—desires and emotions which might be called paraconscience."[18] These are the habitual emotional states that properly dispose one to do what one concludes is the right thing to do. Most fundamentally, paraconscience includes the desire to do good, but also outrage in the face of injustice, which spurs one to do something about it, and compassion, which draws one toward those who need help. The importance of what Budziszewski is doing here lies in connecting intellectual activity—thinking—with moral activity—doing. Emotions are neither excrescences tacked on to the machine-like rational mind, nor, strong as they may be, are they to be in charge. Emotions are crucial to doing good and being good; they are the motivators for action.

These four elements, *synderesis*, the belt of *syderesis*, *conscientia*, and paraconscience, constitute the habit, act, and experience of the mind under the general heading conscience. Together, they operate in three modes: cautionary, accusatory, and avenging.[19] In the cautionary mode, like Robot in the old TV show "Lost in Space," conscience alerts one to moral danger. When heedless of the warnings, or perhaps even when learning that one has made a mistake, conscience moves to accusatory mode, accompanied by feelings of guilt and remorse for the wrong. Finally—and this represents one of Budziszewksi's signal insights into moral psychology—conscience will avenge the good by punishing the wrongs done when one refuses to confront them. Conscience has five furies, which each must be satisfied when a wrong has been committed: remorse,[20] confession,[21] atonement,[22] reconciliation,[23] and justification.[24]

IV. CRITIQUE OF THE CONSENSUS

The point of going into detail on Budziszewski's careful taxonomy of conscience is partly to show how much more to conscience there is than is evident in the "opinions from nowhere" the Oxford Consensus attributes to people. Conscience rightly understood establishes a proper standpoint from which to offer a critique of the Oxford Consensus. More pointedly, the Oxford Consensus issues a challenge, one easily taken up once the confusion is cleared about what conscience is and how it works. The depths

of discrimination, indoctrination, and moral wrong contained in what the Oxford Consensus is proposing come crisply into view.

Statement four of the consensus document says:

> The status quo regarding conscientious objection in healthcare in the UK and several other modern Western countries is indefensible. Healthcare practitioners can conscientiously refuse access to legally available, societally accepted, medically indicated and safe services requested by patients in practice for any reason.[25]

The defense of the "indefensible" is rather straightforward. Let's take the example of abortion. Deep conscience provides the knowledge that the good is to be done and pursued, that life and health are goods constitutive of a flourishing life, and that it is wrong to kill people without justification. No further justification is needed for protecting human life and health than this: it is self-evident that to be alive and healthy is good and that good things should be pursued. Through intellectual knowledge of science, one comes to learn that human fetuses are human lives. Therefore, one concludes that the lives of fetuses cannot be taken without justification. *Conscientia* applies the knowledge and the principles to the circumstances at hand as a doctor, and concludes that abortion is wrong.

Now, of course, people will disagree with that conclusion, perhaps mainly at the levels of intellectual knowledge and *conscientia*. One might object that serious risk of depression justified terminating the life of the fetus. This is not the place to argue that all other conclusions are wrong. The bar the Oxford Consensus set is quite a bit lower than that—mere defensibility. And this argument achieves that, for it is clear how the mechanisms of conscience and intellectual knowledge might move one towards the conclusion that performing abortions is wrong and thus that one must refuse to do so. And it is not obviously callous, irrational, purely emotional, or the product of "cognitive bias." In short, it is not indefensible.

Quite the contrary, given a proper understanding of conscience, a great deal of what the Oxford Consensus requires becomes deeply problematic. Statement two, when it says, given a conflict between a health care professional's conscience and the desires of the patient, practitioners "should always" get the patient the services he or she wants, assigns a moral duty to act against one's understanding of one's moral duty, which is a contradiction. The statement requires that the practitioner either perform the service or refer the patient to someone who will. This is a failure to understand what conscience is dictating. When the doctor says that she cannot in good conscience recommend that a patient take Drano for a cold, it does not mean merely that she wants to keep her hands clean if the patient ends up drinking Drano, it means that she thinks it would not serve the health of

the patient to take Drano and she will not be part of or enable such a plan. Statement two wants the practitioner to have hands as clean as Pilate's. Statement eight is still worse, requiring that medical students be fully competent to perform the services they object to. The Oxford Consensus would require the students to lie to themselves about matters of deep conscience, to damage themselves, and to invite the harrows of the Five Furies. Truly perilous, and yet the Oxford Consensus is cavalier about the consequences for the physician of laying aside one's conscience or lying to oneself. A genuine understanding of conscience also gives added cause for worry about the "re-education" recommended in statements nine and ten. Again here, the consequences for the practitioner could be profound because, while *conscientia* can be corrupted in such exercises, *synderesis* cannot. The furies will have their revenge and it can be terrible.

What the Oxford Consensus recommends fails philosophically and would be terribly destructive as a practical-political program. It fundamentally misunderstands how conscience works, errs in its insufficient appreciation of the healthcare practitioner as a moral agent, licenses coercion and discrimination by the state and professional organizations against any who depart from its ideology, and lurches the entire healthcare profession down a dangerous path. And yet, there is blithe confidence from the signatories; no indication they sense any delicacy with the questions at hand or reasonableness in those who disagree.

All of this leads to one final observation about what may be going on at the deepest level. Elsewhere in *What We Can't Not Know*, Budziszewski's describes the moral psychology of gang initiation rites, such as those undertaken by Nazi death camp doctors, where gang members must commit a truly heinous act, such as murder, in order to become part of the group—in which mutual guilt serves as a strong interpersonal bond.[26] The Oxford Consensus is a statement of those thoroughly given over to one particular ideology, insisting on uniformity in service of that ideology from every member of the practice (healthcare), and even demanding that medical students commit acts against their conscience in order to join the group as a full-fledged member. Anthropologically, the full-spectrum of coercion, both subtle and brute, recommended by the Oxford Consensus, shares more with the meeting of a street gang than it does a typical conference of professionals.

Technology brings new and surprising moral difficulties to medicine every year. Facing those difficulties rather than letting mere possibility set the bounds of right action is a noble and necessary task, and can be much aided by a proper and foundational understanding of what conscience is and how it works.

Notes

1. Oxford University, "Consensus Statement on Conscientious Objection in Healthcare," http://blog.practicalethics.ox.ac.uk/2016/08/consensus-statement-on-conscientious-objection-in-healthcare/.
2. Ibid.
3. Ibid.
4. Ibid., statement one.
5. Ibid.
6. Ibid., statement two.
7. Ibid., statement nine.
8. Ibid., statement ten.
9. Ibid, statement eight.
10. ACOG Committee for Underserved Women: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Abortion-Training-and-Education.
11. *Summa Theologiae* Ia.79.13 respondio.
12. J. Budziszewski, *What We Can't Not Know: A Guide*, Expanded and Revised Edition (San Francisco: Ignatius Press, 2011), 159.
13. See ibid.
14. This is consistent with Aquinas's treatment, which places *synderesis* and *conscientia* in separate but adjoining articles within the question of intellectual powers.
15. Budziszewski, *What We Can't Not Know*, 80.
16. Ibid. 79.
17. Ibid. 188–90.
18. Ibid. 188.
19. Ibid., 140.
20. Ibid., 141.
21. Ibid., 145.
22. Ibid., 148.
23. Ibid., 152.
24. Ibid., 154.
25. Oxford University, "Consensus Statement on Conscientious Objection in Healthcare," statement four.
26. Budziszewski, *What We Can't Not Know*, 164.